

Personal Assistance Checklist Protocol

Service Recipient's Name _____ Date of Birth _____
(Last, First)

Reviewer's Name _____ Date Request Submitted _____
(Last, First)

Technical Review

<input type="checkbox"/> YES <input type="checkbox"/> NO	<p>Is the correct funding source, site code, and service code used in Section C of the Individual Support Plan?</p> <p>If YES, continue to Question #1 in Section A, B, or C as applicable.</p> <p>If NO and the wrong funding source, site code and service code is due to a simple error, correct the error and continue to Question #1 in Section A, B, or C as applicable.</p> <p>If NO based on lack of a site code because the provider is not licensed or does not have an approved provider agreement, deny as non-covered due to failure to meet provider qualifications as specified in the waivers and in the TennCare rules applicable to the waivers.</p>
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A. Initial Personal Assistance

1. <input type="checkbox"/> YES <input type="checkbox"/> NO	<p>Is the service recipient a minor (under age 18 years)? (A.1)</p> <p>If YES, proceed to question #2.</p> <p>If NO, skip to question #3.</p>
2. <input type="checkbox"/> YES <input type="checkbox"/> NO	<p>Will Personal Assistance be provided by service recipient's parent, whether relationship is by blood, marriage, or adoption? (NOTE: The PA provider must provide the ISC with a statement to be submitted with the ISP that services will not be provided by a parent of a minor.) (A.2)</p> <p>If YES, deny as a <u>non-covered service</u>. ("Waiver cannot pay the parent to provide care of a minor.")</p> <p>If NO, proceed to question #3.</p>
3. <input type="checkbox"/> YES <input type="checkbox"/> NO	<p>Will Personal Assistance be provided by service recipient's spouse? (NOTE: The PA provider must provide the ISC with a statement to be submitted with ISP that services will not be provided by the service recipient's spouse.) (A.3)</p> <p>If YES, deny as a <u>non-covered service</u>. ("Waiver cannot pay the husband or wife to provide care of spouse.")</p> <p>If NO, proceed to question #4.</p>

<p>4. <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Is Personal Assistance being requested for one of the following reasons which are specifically <i>excluded</i> in the waiver service definition:</p> <ul style="list-style-type: none"> a. To transport or otherwise take children to and from school; OR b. To provide Personal Assistance in school settings; OR c. To provide Personal Assistance to a service recipient who receives a residential Service (i.e., Residential Habilitation, Supported Living, Medical Residential Services, or Family Model Residential Support); OR d. To provide Personal Assistance during the time period when the service recipient is receiving a Day Service? <p>If YES, stop and deny that portion of the requested Personal Assistance that is attributable to the excluded services as non-covered based on the waiver service definition. If only part of the request was denied as non-covered, proceed to Question #5.</p> <p>If NO, proceed to Question #5.</p>
<p>5. <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Medical necessity review questions:</p> <ul style="list-style-type: none"> a. Is there sufficient information in the Individual Support Plan (ISP) to document that the service recipient has: <ul style="list-style-type: none"> (1) Functional limitations that justify the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, feeding/assistance with eating, toileting and incontinence care, assistance with transfer and mobility) or instrumental activities of daily living (e.g., meal preparation, household chores, budget management, and accompaniment to medical appointments or on personal errands); OR (2) Aggressive or inappropriate behavior that jeopardizes the health and safety of the service recipient or others and requires supervision and intervention; AND b. Does the ISP and/or supporting documentation identify the specific types of direct assistance needed with activities of daily living and instrumental activities of daily living and, if applicable, the behavioral supervision and/or intervention (either with or without a Behavior Support Plan) that the Personal Assistant will provide to ensure the service recipient's safety; AND c. Is there sufficient information in the ISP and/or supporting documentation to show that the amount of requested Personal Assistance services requested will not replace uncompensated care that is the responsibility of the primary caregiver and that could reasonably and appropriately be provided by the primary caregiver or other unpaid caregivers to meet the needs of the service recipient; AND d. Is there no other caregiver available during the time that Personal Assistance is requested, including a caregiver who may be authorized to provide a different level of assistance, such as a registered nurse or licensed practical nurse? <p>NOTE: Except under <i>exceptional circumstances</i>, two Personal Assistants may not be authorized or reimbursed to provide Personal Assistance services to the same service recipient during the same period of time. If exceptional circumstances are warranted and approved by the DMRS Central Office,</p>

	<p>reimbursement will be made using a special 2-person reimbursement rate only (i.e., service units may not be approved and billed separately for each Personal Assistant providing services during the same time period.)</p> <p>Except under <i>exceptional circumstances</i>, Personal Assistance may <u>not</u> be authorized or reimbursed <i>at the same time</i> as:</p> <ol style="list-style-type: none"> (1) Waiver Nursing Services; (2) TennCare Private Duty Nursing; (3) TennCare Home Health Skilled Nursing Services; (4) TennCare Home Health Aide Services; or (5) TennCare EPSDT Personal Care services. <p>Any request for exception must be submitted <i>in writing</i> to the DMRS Central Office and must specify:</p> <ul style="list-style-type: none"> • The total number of hours of <i>each</i> type of service requested (i.e., Personal Assistance, waiver Nursing Services, TennCare Private Duty Nursing, TennCare Home Health Skilled Nursing Services, TennCare Home Health Aide Services, or TennCare EPSDT Personal Care services); • The service recipient's medical condition(s), diagnoses, and/or disabilities that creates the need for such services; • The specific skilled nursing functions to be performed and the frequency such skilled nursing functions are requested (as applicable); • The specific functions or tasks each Personal Assistant, Personal Care staff, and/or Home Health Aide is expected to perform, including the frequency with which each task must be performed; and • A schedule of how such services will be coordinated that clearly demonstrates the total amount of time during which the service recipient will be receiving more than one (1) such service <i>at the same time</i>. <p>DMRS must provide to the TennCare Division of Long Term Care a copy of all information pertaining to all such authorization approvals.</p> <p>If YES to all four of the criteria specified in "5.a" through "5.d" above, proceed to Question #6.</p> <p>If NO to any of the criteria specified in "5.a" through "5.d" above, stop and deny as <u>not medically necessary</u>.</p>
<p>6. <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Is the frequency (per day, per week, per month, etc.), amount (# of units) and duration (# of weeks or months) of Personal Assistance requested <i>consistent with</i> and not <i>in excess of</i> the amount of services needed to perform the specific functions or tasks the Personal Assistant is expected to perform as specified in "5.b" above and to provide, if applicable, the type(s) and amount of behavioral supervision and/or intervention needed to ensure the service recipient's safety?</p> <p>If YES, proceed to Question #7.</p> <p>If NO, deny as <u>not medically necessary</u> that portion of the total amount of Personal Assistance requested that is <i>in excess of</i> the amount of services needed to perform the specific functions or tasks the Personal Assistant is expected to perform as specified in "5.b" above and to provide, if applicable, the type(s) and amount of behavioral supervision and/or intervention needed to ensure the service recipient's safety.</p> <p>AND, proceed to Question #7 to determine coverage of that portion of the total</p>

	amount of Personal Assistance requested that is <i>consistent with</i> the amount of Personal Assistance to perform the specific functions or tasks the Personal Assistant is expected to perform as specified in "5.b" above and to provide, if applicable, the type(s) and amount of behavioral supervision and/or intervention needed to ensure the service recipient's safety.
7. <input type="checkbox"/> YES <input type="checkbox"/> NO	Is the service recipient age 21 years or older? (A.7) If YES , approve (as determined in question #6 above.) If NO , proceed to question #8
8. <input type="checkbox"/> YES <input type="checkbox"/> NO	Is the request for Personal Assistance based <i>only</i> on the service recipient's need for direct hands-on assistance with activities of daily living (instead of a need for behavioral supervision and intervention or assistance with household chores)? (A.8) If YES , proceed to Question #9 If NO , approve (as determined in Question #6 above.)
9. <input type="checkbox"/> YES <input type="checkbox"/> NO	Was a request submitted to the TennCare Managed Care Organization (MCO) for "Home Health Aide Services" (hands on care of the service recipient which is provided in the home by a licensed Home Health Agency) and/or for "Personal Care Services" (hands on care of the service recipient which may be provided by a licensed Home Health Agency for children under age 21 outside the home as a TennCare EPSDT benefit), as applicable, and denied through the TennCare MCO fair hearing process? (A.9) If YES , approve (as determined in Question #6 above) that portion of the total amount of Personal Assistance requested that is <i>consistent with</i> the amount of services needed to perform the specific functions or tasks the Personal Assistant is expected to perform as specified in "5.b" above and to provide, if applicable, the type(s) and amount of behavioral supervision and/or intervention needed to ensure the service recipient's safety If NO , deny Personal Assistance based on the waiver being the <u>payor of last resort</u> .
<input type="checkbox"/> Approved	
<input type="checkbox"/> Denied	Criteria _____ not met.

B. Continuation of Personal Assistance

(NOTE: This section applies to service recipients who are *currently* approved for Personal Assistance through the waiver and who request *continuation* of Personal Assistance or an *increase* in Personal Assistance.)

1. <input type="checkbox"/> YES <input type="checkbox"/> NO	Is the service recipient a minor (under age 18 years)? (B.1) If YES , proceed to question #2. If NO , skip to question #3.
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<p>2. <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Will Personal Assistance be provided by the service recipient's parent, whether relationship is by blood, marriage, or adoption?(PA provider must provide the ISC with statement(to be submitted with the ISP) that the services will not be provided by a parent of a minor) (B.2)</p> <p>If YES, deny as a <u>non-covered service</u>. ("Waiver cannot pay the parent to provide care of a minor.")</p> <p>If NO, proceed to question #3.</p>
<p>3. <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Will Personal Assistance be provided by the service recipient's spouse? (PA provider must provide the ISC with statement (to be submitted with the ISP) that the services will not be provided by the service recipient's spouse. (B.3)</p> <p>If YES, deny as a <u>non-covered service</u>. ("Waiver cannot pay the husband or wife to provide care of a spouse.")</p> <p>If NO, proceed to question #4.</p>
<p>4. <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Is continuation of Personal Assistance being requested for one of the following reasons specifically excluded in waiver definition: (B.4)</p> <ul style="list-style-type: none"> a. Transport or otherwise take children to and from school settings; OR b. To provide Personal Assistance in school settings; OR c. To provide Personal Assistance to service recipient that receives DMRS funded residential service; OR d. To provide Personal Assistance during period that service recipient is receiving DMRS day service. <p>If YES, deny continuation of that portion of the requested Personal Assistance that is attributable to the excluded services as <u>non-covered</u> based on the waiver service definition. If only part of the request was denied as non-covered, proceed to Question #5.</p> <p>If NO, proceed to question #5. (The ISC or case manager must state in the ISP the specific functions or tasks the PA is expected to perform in order to document that services are not being provided for exclusions.)</p>
<p>5. <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Medical necessity review questions:</p> <ul style="list-style-type: none"> a. Is there sufficient information in the Individual Support Plan (ISP) and/or supporting documentation to show that the service recipient <i>continues</i> to have: <ul style="list-style-type: none"> (1) Functional limitations that justify the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, feeding/assistance with eating, toileting and incontinence care, assistance with transfer and mobility) or instrumental activities of daily living (e.g., meal preparation, household chores, budget management, and accompaniment to medical appointments or on personal errands); OR (2) Aggressive or inappropriate behavior that jeopardizes the health and safety of the service recipient or others and requires supervision and intervention; AND

	<p>b. Does the ISP and/or supporting documentation identify the specific types of direct assistance needed with activities of daily living and instrumental activities of daily living and, if applicable, the behavioral supervision and/or intervention (either with or without a Behavior Support Plan) that the Personal Assistant will provide to ensure the service recipient's safety AND</p> <p>c. Is there sufficient information in the ISP and/or supporting documentation to show that the amount of requested Personal Assistance services requested will not replace uncompensated care that is the responsibility of the primary caregiver and that could reasonably and appropriately be provided by the primary caregiver or other unpaid caregivers to meet the needs of the service recipient; AND</p> <p>d. Is there no other caregiver available during the time that Personal Assistance is requested, including a caregiver who may be authorized to provide a different level of assistance, such as a registered nurse or licensed practical nurse?</p> <p>NOTE: Except under <i>exceptional circumstances</i>, two Personal Assistants may not be authorized or reimbursed to provide Personal Assistance services to the same service recipient during the same period of time. If exceptional circumstances are warranted and approved by the DMRS Central Office, reimbursement will be made using a special 2-person reimbursement rate only (i.e., service units may not be approved and billed separately for each Personal Assistant providing services during the same time period.)</p> <p>Except under <i>exceptional circumstances</i>, Personal Assistance may not be authorized or reimbursed <i>at the same time</i> as:</p> <ol style="list-style-type: none"> (1) Waiver Nursing Services; (2) TennCare Private Duty Nursing; (3) TennCare Home Health Skilled Nursing Services; (4) TennCare Home Health Aide Services; or (5) TennCare EPSDT Personal Care services. <p>Any request for exception must be submitted <i>in writing</i> to the DMRS Central Office and must specify:</p> <ul style="list-style-type: none"> • The total number of hours of <i>each</i> type of service requested (i.e., Personal Assistance, waiver Nursing Services, TennCare Private Duty Nursing, TennCare Home Health Skilled Nursing Services, TennCare Home Health Aide Services, or TennCare EPSDT Personal Care services); • The service recipient's medical condition(s), diagnoses, and/or disabilities that creates the need for such services; • The specific skilled nursing functions to be performed and the frequency such skilled nursing functions are requested (as applicable); • The specific functions or tasks each Personal Assistant, Personal Care staff, and/or Home Health Aide is expected to perform, including the frequency with which each task must be performed; and • A schedule of how such services will be coordinated that clearly demonstrates the total amount of time during which the service recipient will be receiving more than one (1) such service <i>at the same time</i>. <p>DMRS must provide to the TennCare Division of Long Term Care a copy of all</p>
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	<p>information pertaining to all such authorization approvals.</p> <p>If YES to all four of the criteria specified in “5.a” through “5.d” above, proceed to Question #6.</p> <p>If NO to any of the criteria specified in “5.a” through “5.d” above, stop and deny as <u>not medically necessary</u>.</p>
<p>6. <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Is the frequency (per day, per week, per month, etc.), amount (# of units) and duration (# of weeks or months) of Personal Assistance requested still <i>consistent with</i> and not <i>in excess of</i> the amount of services needed to perform the specific functions or tasks the Personal Assistant is expected to perform as specified in “5.b” above and to provide, if applicable, the type(s) and amount of behavioral supervision and/or intervention needed to ensure the service recipient’s safety?</p> <p>To the extent that the request includes any increase in the frequency, amount, or duration of Personal Assistance services, is there sufficient information in the ISP and/or supporting documentation to demonstrate that the service recipient’s needs have changed and/or the previously approved frequency, amount, or duration of Personal Assistance services is no longer sufficient to perform the specific functions or tasks the Personal Assistant is expected to perform as specified in “5.b” above and to provide, if applicable, the type(s) and amount of behavioral supervision and/or intervention needed to ensure the service recipient’s safety?</p> <p>If YES, approve <i>continuation</i> of that portion of the total amount of Personal Assistance requested that is <i>consistent with</i> the amount of services needed to perform the specific functions or tasks the Personal Assistant is expected to perform as specified in “5.b” above and to provide, if applicable, the type(s) and amount of behavioral supervision and/or intervention needed to ensure the service recipient’s safety.</p> <p>If NO, deny as <u>not medically necessary</u> <i>continuation</i> of that portion of the total amount of Personal Assistance requested that is <i>in excess of</i> the amount of services needed to the amount of services needed to perform the specific functions or tasks the Personal Assistant is expected to perform as specified in “5.b” above and to provide, if applicable, the type(s) and amount of behavioral supervision and/or intervention needed to ensure the service recipient’s safety.</p>
<input type="checkbox"/> Approved	
<input type="checkbox"/> Denied	Criteria _____ not met.