



May 8, 2020

To: Service Coordinators and Providers in the Act 150 Program

Subject: Temporary Changes to the Act 150 Program

The Centers for Medicare & Medicaid Services (CMS) approved the following temporary changes to the CHC and OBRA 1915(c) waivers from March 6, 2020 through June 30, 2020. Approval of these changes is covered under Appendix K, Emergency Preparedness and Response, which states may use during emergency situations to request amendments to their approved waivers. These changes address potential staffing shortages and the need for service provision not included in approved service descriptions to ensure participant health and safety needs can be accommodated for the duration of the COVID-19 statewide emergency. The duration of the approval may be extended depending on the length of the declared emergency. The Office of Long-Term Living (OLTL) is extending the same flexibilities to the Act 150 Program.

The changes outlined below provide flexibilities for Service Coordinators and providers as they work with participants who may be facing disruption in services due to COVID-19. The flexibilities outlined below will not apply to all participants and should not be considered across-the-board changes that must be implemented for each participant. **These flexibilities must be evaluated on a case-by-case basis in coordination with the Service Coordinator and the OLTL Participant Services Review Unit.** Service Coordinators should contact RA-PWURGENTREVIEW@pa.gov for service plan issues related to the Appendix K flexibilities.

Guidance for Determining Whether the Amendments in Appendix K Also Apply to Act 150 Participants

All changes authorized by Appendix K, as explained below, may only be implemented for participants impacted by COVID-19. The following questions can be used to determine whether requests and authorizations will be covered under Appendix K:

What change occurred for the participant as a result of COVID-19?

- a. Was the participant receiving services in a setting that closed?
- b. Has the participant tested positive for COVID-19 that requires relatives to render services when direct care workers are unwilling or unable to render services while the participant remains positive for COVID-19?
- c. Has the participant's caregiver or a person with whom they live tested positive for or exhibited symptoms of COVID-19?

- d. Has the participant's direct care worker tested positive for or exhibited symptoms of COVID-19?
- e. Is the participant's direct care worker isolating at home or quarantined due to exposure to someone who tested positive or exhibited symptoms of COVID-19?
- f. Is the participant's direct care worker unable to render services due to caring for a child or children due to closure of schools or day care programs as a result of COVID-19?
- g. Is the participant's direct care worker unable to render services due to caring for a family member who tested positive for or exhibited symptoms of COVID-19?
- h. Is the provider unable to provide staffing at pre-COVID-19 required levels due to overall shortages of staffing and inability to secure additional staff?

General Billing Guidance

On February 20, 2020, the Centers of Disease Control and Prevention (CDC) issued official diagnosis coding guidance for health care encounters related to COVID-19. The CDC guidelines may be reviewed here: <https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Guidance-Interim-Advice-coronavirus-feb-20-2020.pdf>

Based on this guidance, when services are related to COVID-19, providers and service coordinators must use the following ICD-10-CM billing codes –

Z03.818 - *Encounter for Observation for Suspected Exposure to Other Biological Agents Ruled Out*, for claims where there is a concern about a possible exposure to COVID-19.

Z20.828 - *Contact with And (Suspected) Exposure To Other Viral Communicable Diseases*, where there is an actual exposure to someone who is confirmed to have COVID-19.

Example #1: If a participant's spouse temporarily serves as a paid direct care worker because the scheduled worker is suspected of having been exposed to COVID-19 (and a replacement worker is not available), the provider must use Z03.818 in addition to the primary diagnosis code used when billing for HCBS services.

Example #2: If a participant's spouse temporarily serves as a paid direct care worker because the scheduled worker has tested positive for COVID-19 (and a replacement worker is not available), the provider must use **Z20.828** in addition to the primary diagnosis code used when billing for HCBS services.

- Providers and Service Coordinators must bill the applicable procedure and place of service codes and include the appropriate COVID-related ICD-10 diagnosis code, in

addition to the primary diagnosis code, to indicate service, setting or staffing exceptions that are approved in Appendix K.

- When temporary Appendix K changes are implemented as a precautionary measure to protect a participant, even when there is no concern for possible exposure, providers and Service Coordinators must use **Z03.818** in addition to the primary diagnosis code used when billing for HCBS services.
- Where a participant is exposed to or tested positive for COVID-19, providers and Service Coordinators must use **Z20.828** in addition to the primary diagnosis code when billing for all HCBS services, not just those approved in Appendix K.
- For services provided on or after March 6, 2020, providers and Service Coordinators should resubmit any claims that are not in compliance with this billing guidance.
- Providers must contact the participant's Service Coordinator to communicate changes to services or settings.
- If a provider decides to change their business practice, e.g., limiting services or suspending services, the provider must contact OLTL's enrollment team at RA-HCBSEnProv@pa.gov before making the change.

Act 150 Program Services

For all program services – services may not be reduced on the Individual Service Plan (ISP), except when requested by the participant or their representative. However, it is possible that not all services on the ISP can be delivered during the COVID-19 emergency declaration. Providers should be given flexibility to ensure delivery of crucial, life-sustaining services and, if necessary, delay less crucial services such as housekeeping tasks. The Service Coordination Entity may need to identify and prioritize services to participants with critical issues and at the same time allow for missed shifts for participants who have adequate informal supports or less-critical issues. The Service Coordinator may also seek guidance from OLTL on case-specific instances where additional technical assistance may be needed or where a service plan may need to be updated to ensure delivery of crucial, life sustaining services.

For the following services, service limitations are temporarily lifted during the COVID-19 emergency declaration:

- **Personal Assistance Services (Agency and Participant-Directed) –**

Normally, some family members can provide Personal Assistance Services and Participant-Directed Community Supports, with exceptions.

Temporarily, spouses, legal guardians, and persons with power of attorney may serve as paid direct care workers only when scheduled workers are not available due to COVID-19 and the participant's emergency backup plan cannot be implemented. Spouses, legal guardians and persons with power of attorney will be allowed to serve as paid direct care workers only until a replacement direct care worker is in place and in no case beyond the duration of the COVID-19 emergency declaration.

This temporary flexibility does not apply in circumstances where a participant or their representative refuses services due to COVID-19 safety concerns despite the direct care worker(s) being available to provide services.

Under the participant-directed model, spouses, legal guardians and persons with power of attorney must be enrolled as direct care workers through PPL and undergo criminal background checks and child abuse clearances as required by law.

For agency employees, background checks and child abuse clearance requirements must be performed as required by law.

Level of Care Assessments and Needs Assessments/Reassessments

- **Initial Level of Care Assessments using the FED** - may be conducted remotely using phone or video conferencing; the face-to-face requirement is temporarily waived.
- **Annual Reassessments, including the needs assessment and level of care** - may be conducted remotely using phone or video conferencing; the face-to-face requirement is temporarily waived. The 365-day time limit for annual reassessments to be performed is also temporarily waived. If a reassessment is going to be delayed beyond 365 days, the Service Coordinator must contact the participant at least 30 days prior to the normal reassessment due date to verify with the participant or representative that the current ISP, including services and providers, remains acceptable for the upcoming year. If necessary, the Service Coordinator will ensure the ISP is modified to allow for additional supports and/or services due to changes in participant needs. If no updates to the participant's ISP are needed due to COVID-19 or a change in the participant's needs that require an increase in services, the existing ISP will remain in place until the annual reassessment can be completed. At the end of the COVID-19 emergency declaration, the Service Coordinator will have up to 6 months to complete the annual reassessment and update the ISP.

- **Comprehensive Needs Reassessments** - may be conducted remotely using phone or video conferencing when a participant's needs change, when the participant requests a reassessment, or following trigger events.

The qualifications for the individuals conducting these assessments will not change.

Individual Service Planning/Service Coordination

- **Monitoring of the ISP** – Service Coordinators may monitor participants and ISPs remotely by telephone where face-to-face contacts are usually required. Service Coordinators are encouraged to contact participants frequently to ensure participants' needs are being met during the COVID-19 emergency declaration.
- **Service Planning meetings and plan development** – may be conducted entirely using telecommunications. Members of the planning team, determined at the discretion of the participant, may also participate remotely using phone or video conferencing.

Incident Management Reporting Requirements

- **Critical Incident Reports** - Providers must submit critical incident reports for Service Interruptions even if the reason for the Service Interruption is due to insufficient staff to provide care due to COVID-19.
- **Critical Incident Investigations** - Providers will not need to conduct an investigation for Service Interruptions when the Service Interruption is due to insufficient staff to provide care due to COVID-19. Providers must ensure that participants at highest risk continue to receive services.

Retainer Payments to Address Emergency Related Issues

- **Personal Assistance Services** – During the COVID-19 emergency, retainer payments to direct care workers in agency and participant-directed models may be made when the participant is hospitalized, absent from their home, or in isolation and unable to receive services due to COVID-19. Personal Assistance Services retainer payments may not exceed 15 days – the number of days for which OLTL authorizes a payment for "bed-hold" in nursing facilities. Retainer payments will not be available when another reasonably equivalent assignment is made available to a direct care worker or when the worker is laid off and collecting unemployment.

Billing Guidance:

- Providers must bill the applicable procedure code (W1792, W1793, W1792 TU) and must only be billed with the COVID-19 ICD-10 diagnosis code Z20.828.
- Providers should bill for the scheduled hours during the time the participant is hospitalized or absent from their home. For example, if the participant is hospitalized for COVID-19 and was scheduled for 5 hours of Personal Assistance Services for 8 of the 15 consecutive calendar days, the provider would bill for 40 hours (5 hours x 8 days).

Authorization for Changes to the ISP

- **Verbal and Email Approval** – If delays are occurring while waiting for approval and authorization of ISP changes in HCSIS, documented verbal approval or email approval of changes and additions to ISPs will suffice as authorization. Upon validation that a verbal or email approval was provided for requested changes, Service Coordinators may backdate authorizations for waiver services.

Documenting what actions were taken and maintaining evidence for why actions were taken.

In addition to notifying OLTL, providers and Service Coordination Entities should document any changes to their operations as a result of COVID-19 and maintain evidence to support why the changes were made. Doing so will help demonstrate the basis for an action. In general, evidence that should be maintained includes, but is not limited to:

- **Orders or notices from Federal, State, and local authorities that support changes to operational procedures.**
- **Correspondence and other records demonstrating inability to meet required staffing ratios or response times.** Example: Provider's employees are unable to report to work due to COVID-19-related reasons. Provider attempts to secure temporary staff from three staffing agencies, but each agency reports that they too are experiencing staff shortages. As a result, Provider is out of compliance with required staffing ratios. Provider should maintain documentation of employee unavailability and retain copies of correspondence with each of the three staffing agencies to demonstrate that all possible efforts were made to secure enough staff.



- **Document all services performed to include but not limited to:**
 - Participant name
 - Participant date of birth
 - Date of service
 - Services performed
 - Start and stop times of the services performed
 - Diagnosis
 - Individual performing the services
 - Service location

- **Providers should maintain fiscal records in accordance with 55 Pa. Code §§ 52.15 and 1101.51 to document service delivery and claims submissions.**