Clinical Policy: Personal Care Services (PCS) BH

Reference Number: LA.CP.MP.508c
Date of Last Revision: 07/24

Coding Implications
Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Background Information- Personal care services (PCS) include assistance and/or supervision necessary for members/enrollees with mental illness to enable them to accomplish routine tasks and live independently in their own homes. Louisiana Health Care Connections provides coverage for PCS services based on the application of medical necessity criteria and submission of all required documentation. All members eligible for this service are assigned an LHCC liaison who can help guide the member and/or provider with clarification regarding PCS services.

I. Provider and Direct care Staff Qualifications

A. The Provider *Agency* must adhere to the following criteria:

1. Be licensed by LDH as a Home and Community Based Service provider/Personal Care Attendant agency per Revised Statute 40:2120.1 et seq. and LAC 48:I. Chapter 50.
2. Arrange for and maintain documentation that all persons, prior to employment, pass criminal background checks through the Louisiana Department of Public Safety, State Police. If the results of any criminal background check reveal that the potential employee (or contractor) was convicted of any offenses against a child/youth or an elderly or disabled person, the provider shall not hire and/or shall terminate the employment (or contract) of such individual. The provider shall not hire an individual with a record as a sex offender nor permit these individuals to work for the provider as a subcontractor. Criminal background checks must be performed as required by R.S. 40:1203 et seq., and in accordance with R.S. 15:587 et seq. Criminal background checks performed over 30 days prior to date of employment will not be accepted as meeting this requirement.
3. Arrange for and maintain documentation that all persons, prior to employment, are free from TB in a communicable state as defined by the LAC 51:II.Chapter 5 to reduce the risk of such infections in recipients and staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement.
4. Establish and maintain written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use (See Appendix D located in the LDH Behavioral Health Provider manual).
5. Maintain documentation that all direct care staff, who are required to complete First Aid and CPR training, complete a training with a curriculum based on guidelines published by the American Heart Association (AHA) within 90 days

of hire, which shall be renewed within a time period recommended by the AHA (Located in the LDH Behavioral Health Provider manual).

6. Review the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions website prior to hiring or contracting any employee or contractor that performs services that are compensated with Medicaid/Medicare funds including, but not limited to, licensed and unlicensed staff, interns and contractors.
    a) Once employed, the lists must be checked once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected or extorted any individual or if they have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General. The provider is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, anyone who has a negative finding placed on the Louisiana State Adverse Action List, or who have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General.
    b) Providers are required to maintain results in personnel records that checks have been completed. The OIG maintains the LEIE on the OIG website (https://exclusions.oig.hhs.gov) and the LDH Adverse Action website is located at https://adverseactions.ldh.la.gov/SelSearch.
7. Ensure and maintain documentation that all unlicensed persons employed by the organization complete a documented training in a recognized Crisis Intervention curriculum prior to handling or managing crisis responses, which shall be updated annually
8. Maintain documentation of verification of completion of required trainings for all staff.

B. Allowed Provider Types and Specialties:

1. PT 24 Personal Care Attendant Agency:
    a) PS 5A (PCS-LTC) or 5D (PCS-LTC/EPSDT)
    b) Provider Subspecialty 8E CSoC/Behavioral Health
2. PT 24 Personal Care Attendant Agency, PS 8E CSoC/Behavioral Health

C. The Direct Care *Staff* must meet the following qualifications:

1. Be at least 18 years of age.
2. Have a high school diploma, general equivalency diploma or trade school diploma in the area of human services (See Appendix B located in the LDH Behavioral Health Services Provider Manual.), or demonstrate competency or verifiable work experience in providing support to persons with disabilities.
3. Pass criminal and professional background checks through the Louisiana Department of Public Safety, State Police prior to employment.
4. Pass a TB test prior to employment in accordance with the LAC 51:II.Chapter 5; OR be free from Tuberculosis (TB) in a communicable state as defined by the LAC 51:II.Chapter 5.
5. Pass drug screen testing as required by agency's policies and procedures.

6. Complete a basic clinical competency training program approved by OBH prior to providing services. Psychiatrists and LMHPs are exempt from this training. (Located in the LDH Behavioral Health Provider manual).
7. Complete First Aid and CPR training with a curriculum based on guidelines published by the American Heart Association (AHA). Psychiatrists, APRNs/CNSs/PAs, RNs and LPNs are exempt from this training (Located in the LDH Behavioral Health Provider manual).
8. Pass a motor vehicle screen.
9. Not be excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General.
10. Not have a finding on the Louisiana State Adverse Action List.
11. Possess and provide documentation of a valid social security number.
12. Comply with law established by R.S. 40:2179 et seq. and R.S. 40:2120 et seq., and meet any additional qualifications established under Rules promulgated by LDH in association with these statutes.

II. Provider Responsibilities for the provision of care

A. Providers must submit a prior authorization. Providers must submit sufficient documentation to determine medical necessity. Failure to do so may result in a partial or non-authorization for services. Please see section (III).

B. Services should be delivered with member/enrollee involvement in the planning and provision of care and delivered in the manner that includes the following:
   1. Delivered in a culturally and linguistically competent manner in accordance with member's/enrollee's preferences and needs
   2. Respectful of the member/enrollee receiving services
   3. Appropriate to members/enrollees of diverse racial, ethnic, religious, sexual and gender identities and other cultural and linguistic groups
   4. Appropriate for age, development, and education

C. Report any changes in the member's/enrollee's condition or behavior that impact the member's/enrollee's health and safety to LHCC and if applicable, the community case manager.

D. Participate in team meetings as requested by the member's/enrollee's case manager.

E. Providers must abide by all staffing and training requirements and ensure that staff and supervisors possess the minimum requisite education, skills, qualifications, training, supervision, and coverage as set forth by their respective licensing authorities and in accordance with all applicable Louisiana Department of Health (LDH) policies.

F. Providers shall have the capacity and resources to provide all aspects of any service they are enrolled to provide in the specified service area.

G. PCS providers must develop a back-up staffing plan in the event the assigned direct service worker is unable to provide support due to unplanned circumstances or emergencies that may arise during the direct service worker's shift. PCS providers must discuss available options for back-up coverage with the member/enrollee or his/her authorized representative and complete the required staffing plan. In all instances when a direct service worker is unable to provide support, he/she must contact the provider and

family/member/enrollee immediately. Actions shall then be taken according to the member's/enrollee's back-up staffing plan. PCS providers must assess on an ongoing basis whether the back-up plan is current and being followed according to the plan. The provider shall collaborate with the member/enrollee, his/her authorized representative, case manager if applicable, and protective services if applicable to assure that any back-up staffing issues are resolved appropriately The plan must include:

1. Person or persons responsible for back up coverage (including names, relationships, and contact phone numbers)
2. A toll-free telephone number with 24-hour availability that allows the recipient to contact the provider if the worker fails to show up for work
3. Provider and member/enrollee signatures and dates

H. Providers shall not refuse to serve any member/enrollee who chooses their agency, unless there is documentation to support an inability to meet the member's/enrollee's needs, or all previous efforts to provide service and supports have failed and there is no option but to refuse services. LHCC must be notified immediately of the circumstances surrounding the refusal. The refusal request must be made in writing by the provider to LHCC, and to the member/enrollee detailing why the provider is unable to serve the member/enrollee. This requirement may only be waived by LHCC.

I. If the provider proposes involuntary transfer, discharge of a member/enrollee, or if a provider closes in accordance with licensing standards, the following steps must be taken: The provider shall give written notice to the member/enrollee, a family member/enrollee and/or the authorized representative, if known, and the case manager, if applicable, at least 30 calendar days prior to the transfer or the discharge.

1. Written notice shall be made via certified mail, return receipt requested and shall be in a language and manner that the member/enrollee understands.
2. A copy of the written discharge/transfer notice shall be put in the member's/enrollee's record.
3. When the safety or health of members/enrollees or provider staff is endangered, written notice shall be given as soon as possible before the transfer or discharge to the member/enrollee, a family member and/or the authorized representative, if known, and the case manager.
4. The written notice shall include the following:
    a) A reason for the transfer or discharge;
    b) The effective date of the transfer or discharge;
    c) An explanation of a member's/enrollee's right to personal and/or third parties' representation at all stages of the transfer or discharge process;
    d) Contact information for the Advocacy Center;
    e) Names of provider personnel available to assist the member/enrollee and family in decision making and transfer arrangements;
    f) The date, time and place for the discharge planning conference;
    g) A statement regarding the member's/enrollee appeal rights;
    h) The name of the director, current address and telephone number of the Division of Administrative Law;
    i) Written statement regarding the member's/enrollee right to remain with the provider and not be transferred or discharged if an appeal is filed timely.

5. Provider transfer or discharge responsibilities shall include:
    a) Holding a transfer or discharge planning conference with the member/enrollee, family, case manager (if applicable), legal representative and advocate, if such is known;
    b) Developing discharge options that will provide reasonable assurance that the member/enrollee will be transferred or discharge to a setting that can be expected to meet his/her needs;
    c) Preparing an updated service plan, as applicable, and preparing a written discharge summary that shall include, at a minimum, a summary of the health, behavioral issues, social issues and nutritional status of the member/enrollee;
    d) Providing all services required prior to discharge that are contained in the final update of the service plan, as applicable, and in the transfer or discharge plan.

L. Providers shall conduct self-audits, including conducting home visits, to ensure staff follow internal policies and procedures, and comply with service requirements established by LDH and LHCC.

M. Utilize the LDH-designated electronic visit verification system (EVV) to "check in" and "check out" when direct service workers begin and end service delivery for a member/enrollee in accordance with LDH-established EVV policies and procedures. The policies and procedures may be accessed at https://ldh.la.gov/page/3819; Providers shall have available computer equipment, software, and internet connectivity necessary to participate in required prior/post authorization, data collection, and electronic visit verification activities.

III. Required Documentation

A. Documentation is required when requesting services that are below or exceed twenty (20) hours per week.

1. Services are limited to 20 hours per week. An exception may be made by the MCO Medical Director to exceed this limit with documentation that services are medically necessary, and the member does not qualify for personal care services under another Medicaid-funded program.
2. The weekly limit does not include the per diem rate, which is to be used for temporary, time limited events in which a member may need additional assistance, such as following a member's hospitalization. The per diem rate shall not exceed 30 calendar days in a one-year period.
3. Members/enrollees and providers who are requesting more than 20 hours per week of services need to provide documentation from OAAS that the member does not meet the level of care for Long-Term Personal Care Services. The contact information for OAAS to apply for these services is as follows:
    a) Contact: 1-877-456-1146. At that number, a prospective recipient may speak to a representative of the Long-Term Care Access contractor. This contractor serves as an agent of the State of Louisiana to assist in the administration of this program. If a Responsible Representative is calling to apply for an applicant, he/she must have the potential recipient's name,

physical/home address, and Medicaid number readily available when he/she calls, contacts, or corresponds with the Long-Term Care Access contractor.

B. The necessary documentation needed with the prior authorization should include but not limited to:

1. **Service Plan**: Providers must develop a service plan in collaboration with the member/enrollee/member's family to include the specific activities to be performed, including frequency and anticipated/estimated duration of each activity, based on the member's/enrollee's goals, preferences, and assessed needs.
    a) The service plan must be developed prior to service delivery and updated at least every six (6) months, or more frequently based on changes to the member's/enrollee's needs or preferences.
    b) The PCS provider shall provide the plan to the member/enrollee prior to service delivery and when the plan is updated.
2. **Letter or Prescription**: This should specify the number of hours per week needed for the service.
3. **ADL/IADL Evaluation**: This evaluation should outline the Activities of Daily Living (ADL) and/or Instrumental Activities of Daily Living (IADL) that the member requires assistance with, along with the level of dependency (e.g., how much assistance is needed for each ADL/IADL (e.g., fully dependent, partially dependent).
    a) The ADL/IADL evaluation can be incorporated into the service plan.
4. **Progress Notes**: These notes document the ongoing progress and any changes in the member's condition or needs.
5. **Other Supporting Reviews and Evaluations**: Any additional assessments or evaluations that support the need for the requested services.

C. All concurrent requests without a change in hours requested must include:

1. **Service Plan**: Providers must develop a service plan in collaboration with the member/enrollee/member's family to include the specific activities to be performed, including frequency and anticipated/estimated duration of each activity, based on the member's/enrollee's goals, preferences, and assessed needs.
    a) The service plan must be developed prior to service delivery and updated at least every six (6) months, or more frequently based on changes to the member's/enrollee's needs or preferences.
    b) The PCS provider shall provide the plan to the member/enrollee prior to service delivery and when the plan is updated.
2. **Service Logs**: Service logs document the Personal Care Services (PCS) provided and billed for services delivered by the direct service worker. Direct service workers must complete a standardized service log at each visit to reflect services provided, and variations from the approved service plan and reason. The service log must be Completed daily as tasks are performed (service logs may not be completed prior to the performance of a task) and signed and dated by the direct service worker and by the member/enrollee or responsible representative after the work has been completed at the end of the week also must contain:
    a) Name of the member/enrollee;
    b) Name of provider and direct service worker provider the service;
    c) Assistance provided;

d) Date of service contact.

D. If concurrent request/authorization renewal has a change in hours requested a new request must be initiated.

Assignment of a Liaison: Each eligible member is assigned a liaison who can provide guidance and clarification regarding the required information/documentation.

This structure ensures that requests for services are supported by comprehensive documentation, outlining the specific needs of the member and justifying the requested hours of service per week. The involvement of a liaison further assists in ensuring clarity and completeness of the documentation submitted.

IV Disaster Preparation and Emergency Preparedness.

A. Providers must ensure each member/enrollee has a documented individualized emergency plan in preparation for, and response to, emergencies and disasters that may arise. This plan must identify specific resources available through the provider, natural resources, and the community. The provider must assess on an ongoing basis whether the emergency plan is current and being followed according to the plan. The emergency plan must be signed and dated by the member/enrollee, authorized representative, and provider. If the emergency plan is activated, the *provider* bears responsibility for performance of those tasks agreed to in the plan.

V Types of Assistance provided by Personal Care Services

A. Provides minimal assistance with, supervision of, or prompting the member/enrollee to perform activities of daily living (ADLs) including eating, bathing, grooming/personal hygiene, dressing, transferring, ambulation, and toileting.

B. Assistance with, or supervision of, instrumental activities of daily living (IADLs) to meet the direct needs of the member/enrollee (and not the needs of the member's/enrollee's household), which includes:

1. Light housekeeping, including ensuring pathways are free from obstructions
2. Laundry of the member's/enrollee's bedding and clothing, including ironing
3. Food preparation and storage
4. Assistance with scheduling (making contacts and coordinating) medical Appointments.
5. Assistance with arranging transportation depending on the needs and preferences of the member/enrollee
6. Accompanying the member/enrollee to medical and behavioral health appointments and providing assistance throughout the appointment
7. Accompanying the member/enrollee to community activities and providing assistance throughout the activity
8. Brief occasional trips outside the home by the direct service worker on behalf of the member/enrollee (without the member/enrollee present) to include shopping to meet the health care or nutritional needs of the member/enrollee or payment of

bills if no other arrangements are possible and/or the member's/enrollee's condition significantly limits participation in these activities

9. Medication reminders with self-administered prescription and nonprescription medication that is limited to:
    a) Verbal reminders
    b) Assistance with opening the bottle or bubble pack when requested by the member/enrollee
    c) Reading the directions from the label
    d) Checking the dosage according to the label directions
    e) Assistance with ordering medication from the drug store

***NOTE: PCS workers are NOT permitted to give medication to members/enrollees. This includes taking medication out of the bottle to set up pill organizers.**

10. Assistance with performing basic therapeutic physical health interventions to increase functional abilities for maximum independence in performing activities of daily living, such as range of motion exercise, as instructed by licensed physical or occupational therapists, or by a registered nurse.

VI. PCS services are <u>medically necessary</u> when the following indications are met:

A. Members/enrollees must be at least 21 years of age.
B. Member/enrollee has Transitioned from a nursing facility or been diverted from nursing facility level of care through the <u>My Choice Louisiana program.</u>
C. Services are recommended by the member's/enrollee's treating licensed mental health professional (LMHP) or physician within their scope of practice.
D. Members/enrollees must be medically stable. The member/enrollee appears to be in no acute medical or physical distress, and reports no acute or chronic health symptoms or problems for which medical treatment beyond routine medical care is required or anticipated. Those with a chronic, but stable illness, managed with medication and routine monitoring, such as diabetes, hypertension, or a well-controlled seizure disorder, may be considered medically stable.
E. Requires at least limited assistance with one or more ADLs.
    1. The interRAI assessment defines Limited Assistance for most ADLs as the receipt of physical help or a combination of physical help and weight-bearing assistance during the assessment's look-back period.
F. Able to participate in his/her care and be able to direct their care independently, or through a responsible representative.

VII. Criteria that <u>do not support</u> Medical Necessity:

A. Members/enrollees who are enrolled in or eligible for a Medicaid-funded program which offers a personal care service or related benefit, including Long Term Personal Care Services (LT-PCS).
B. Any care needs that exceed that which can be provided under the scope and/or service limitations of this personal care service.

C. Members/enrollees who are enrolled a Medicaid-funded program which offers a personal care service or related benefit or receiving Long Term Personal Care Services (LT-PCS).

D. Any care needs that exceed that which can be provided under the scope and/or service limitations of this personal care service.

E. PCS does not include administration of medication; insertion and sterile irrigation of catheters; irrigation of any body cavities which require sterile procedures; complex wound care; or skilled nursing services as defined in the State Nurse Practice Act.

F. Services must be provided in home and community-based settings, and may not be provided in the following settings.

1. In a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed provider of personal care services.
2. In the direct service worker's home.
3. In a nursing facility, Intermediate Care Facility for the Developmentally Disabled, Institute for Mental Disease, or other licensed congregate setting.

G. There shall be no duplication of services including the following:

1. PCS may not be provided while the member/enrollee is attending or admitted to a program or setting that provides in-home assistance with ADLs or IADLs or while attending or admitted to a program or setting where such assistance is provided.
2. IADLs may not be performed in the member's/enrollee's home when the member/enrollee is absent from the home. Exceptions may be approved by the Medicaid managed care medical director on a case-by-case, time-limited basis.
3. PCS may not be billed during the time the member/enrollee has been admitted to a hospital, nursing home, or residential facility. Services may be provided and billed on the day the member/enrollee is admitted to the hospital and following the member's/enrollee's discharge.

H. PCS shall not supplant care provided by natural supports.

I. PCS does not include room and board, maintenance, upkeep, and/or improvement of the member's/enrollee's or family's residence.

J. PCS may not be provided outside the state of Louisiana unless a temporary exception has been approved by LHCC.

K. Direct service workers may not work more than 16 hours in a 24-hour period.

L. The following individuals are prohibited from being reimbursed for providing services to a member/enrollee:

1. Biological, legal or step first-, second-, third- or fourth-degree relatives
2. First-degree relatives include parents, spouses, siblings, and children.
3. Second-degree relatives include grandparents, grandchildren, aunts, uncles, nephews, and nieces.
4. Third-degree relatives include great-grandparents, great-grandchildren, great aunts, great uncles, and first cousins.
5. Fourth-degree relatives include great-great grandparents, great-great grandchildren, and children of first cousins.
6. Curator, tutor, legal guardian, authorized representative, and any individual who has power of attorney.

VIII. Billing

A. The service unit is 15 minutes and is reimbursed at a flat rate, with the exception of the per diem rate for which the unit is a per day rate. The per diem rate is to be used for temporary, time-limited events when the member needs additional assistance, such as following a member's hospitalization. The per diem rate shall not exceed 30 calendar days in a one-year period.

B. Reimbursement for services may be withheld or denied if the provider fails to use the EVV system or does not use the system in compliance with LDH's policies and procedures for EVV.

C. Transportation is not a required component of PCS although providers may choose to furnish transportation for members/enrollees during the course of providing PCS. If transportation is furnished, the provider must accept all liability for their employee/direct service worker transporting a member/enrollee. It is the responsibility of the provider to ensure the employee/direct service worker has a current, valid driver's license, automobile liability insurance, and pass a motor vehicle screen prior to transporting members/enrollees.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2023, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only and may not support medical necessity. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
S5125	Personal care services (billable for < 28 units/day) – per 15 minutes
S5126	Personal care services (billable for ≥ 28 units/day) – per diem

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
Original approval date	1/22		
Defined staff and provider qualifications. Description of provider responsibilities for the provision of care, required documentation, member disaster preparation and emergency preparedness, type of allowed and prohibited types in service delivery and care. Description of medical necessity of the services and when criteria that do not support medical necessity Updated billing reminders for providers.	4/23	7/11/23	

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
Annual Review. Removed DOJ from title and added BH. In Description, added "All members eligible for this service are assigned an LHCC liaison who can help guide the member and/or provider with clarification regarding PCS services." In Section II. added "see section III." In Section III. Provider Responsibilities for the provision of care, added clarification and requirements. In Section VIII, added "The per diem rate is to be used for temporary, time-limited events when the member needs additional assistance, such as following a member's hospitalization. The per diem rate shall not exceed 30 calendar days in a one-year period;" References Reviewed and updated.	7/24	9/24/24	10/25/24

References

1. LDH Behavioral Health Provider Manual. 2.3 Outpatient Services-Peer Support Services. Issued 9/01/23. Replaced 10/04/22.
2. LDH Personal Care Provider Manual
3. Revised Statute 40:2120.1 et seq
4. LAC 48:I. Chapter 50

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or

withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This clinical policy is the property of LHCC. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.