GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

DHCF Transmittal No. 11-10

Officer of the Deputy Director

TO: **Medicaid Providers of Personal Care Aide Services**

FROM: **Linda Elam, PhD, MPH**
Deputy Director - Medicaid

DATE: **May 25, 2011**

SUBJECT: **New, Required Form for Ordering Medicaid Personal Care Aide Services**

As you know, Title 29 of District of Columbia (DC) Municipal Regulations (DCMR) at section 5004.1 requires that:

> "Personal care services shall be prescribed by a physician or advanced practice registered nurse in accordance with the patient's plan of treatment."

Audits conducted by the Department of Health Care Finance (DHCF) reveal the need for stronger mechanisms to ensure that personal care aide (PCA) services are indeed prescribed in accordance with the plan of treatment developed by the patient's physician or APRN. Compliance with this provision is essential to continuity of care and high quality health care overall.

As a result, effective June 30, 2011, DHCF requires that a written order from each new patient's physician or nurse practitioner must precede the delivery of Medicaid PCA services. This written order must be made using the attached *Prescription Form for Medicaid Personal Care Aide Services.* (With respect to this transmittal, APRN means a nurse practitioner).

Two aspects of this form are especially important to note:

1. The form must originate with the physician or nurse practitioner and be forwarded to the agency providing PCA services. The form may not be completed by the personal care provider agency and then forwarded to the physician or NP for signature.

2. In accordance with new federal requirements found in Title 42 of the Code of Federal Regulations at section 455.410(b), only physicians and nurse practitioners enrolled in the DC Medicaid program may order or prescribe PCA services.

Use of this from will be discussed at DHCF's State Plan Home Health provider meeting scheduled for Tuesday, May 31 from 11:00am to 1:00pm. The meeting will take place at 899 North Capitol St. NE, Conference Room 6130. In the interim, if you have any questions, please contact Pamela Hodge, Management Analyst at 202-724-4282 or pamela.hodge@dc.gov.

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE
PRESCRIPTION FORM FOR MEDICAID PERSONAL CARE AIDE SERVICES

Physician / Nurse Practitioner (NP) is to complete shaded sections and transmit to home health agency as the order for personal care services. Shaded sections are NOT to be completed by home health agency.

1 PATIENT INFORMATION			2 ORDERING PHYSICIAN / NP INFORMATION	
A. PATIENT D.C. MEDICAID NUMBER:			A. NPI NUMBER: B. DC MEDICAID PROVIDER NUMBER:	
B. NAME (LAST, FIRST, M.I.) PRINT			C. NAME (LAST, FIRST, M.I.) PRINT	
C. PERMANENT ADDRESS			D. ADDRESS	
D.TELEPHONE NUMBER	E. DATE OF BIRTH	F. SEX M ☐ F ☐	E. TELEPHONE NUMBER	F. FAX NUMBER

3 IS THERE OTHER HEALTH INSURANCE COVERAGE: Y N **If yes, please provide the following:** (To be completed by Home Health Agency providing personal care services)	**4 DATE OF ORDER:** **5 PATIENT LOCATION AND ADDRESS ON DATE OF ORDER:** **HOME:** **HOSPITAL (name):** **NURSING FACILITY(name):** **ICF/MR(name):** **OTHER (name):** **IF IN A FACILIITY, EXPECTED DATE OF DISCHARGE:** **ADDRESS TO WHICH PATIENT WILL BE DISCHARGED :**
PLAN NAME AND POLICY NUMBER:	
NAME OF POLICYHOLDER:	
PLAN ADDRESS AND PHONE #:	

PRESCRIPTION

6 ICD DIAGNOSIS CODE(S)	7 PROCEDURE CODE (to be completed by home health agency provider of personal care services)	8 DESCRIPTION OF PERSONAL CARE SERVICES TO BE PROVIDED: e.g., bathing, feeding, and transferring.	9 Estimated # of days needed per week :	10 Estimated # of hours per day	11 Expected duration of need

12 JUSTIFICATION. ORDERING PHYSICIAN / NP MUST SPECIFY:

A) Diagnosis(es) causing patient's disability(ies):

B) Functional disability/ies of patient. (NOTE: personal care services are available only to individuals with functional limitations in one or more of the following activities: bathing, toileting, dressing, eating, getting in and out of bed, and taking medication prescribed for self-administration. Please write below which of these disabilities are present in this patient.

13. SIGNATURE OF ORDERING PHYSICIAN / NP – I CERTIFY THAT THE SERVICES REQUESTED ABOVE ARE MEDICALLY INDICATED AND PART OF MY TREATMENT PLAN FOR THIS PATIENT, AND THAT THE FOREGOING INFORMATION IS ACCURATE AND COMPLETE.

_____

Signature **Date**