

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
Department of Health Care Finance



DHCF Transmittal No. 11- 13

Office of the Deputy Director

**TO:** Physicians and Hospitals Enrolled in the District of Columbia Medicaid Program

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

**DATE:** May 27, 2011

**SUBJECT:** Effective June 30, 2011: New Form for Ordering Medicaid Personal Care Aide Services

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Effective June 30, 2011, the Department of Health Care Finance (DHCF) is requiring a written order from a patient's physician or nurse practitioner prior to the delivery of Medicaid PCA services to patients new to a home health agency. This written order must be made using the attached *Prescription Form for Medicaid Personal Care Aide Services*.

*Background*

As you may know, the District of Columbia (DC) Medicaid program pays for the delivery of personal care aide (PCA) services such as assistance with bathing, toileting, meal preparation and taking self-administered medications to Medicaid beneficiaries who have functional limitations in one or more activities of daily living.

To ensure that PCA services are provided to individuals truly in need and in a manner that promotes coordination and good quality of care overall, DC Municipal Regulations (DCMR) for the Medicaid program in section 5004.1 of Title 29, require that:

"Personal care services shall be prescribed by a physician or advanced practice registered nurse in accordance with the patient's plan of treatment." (With respect to this transmittal, APRN means a nurse practitioner).

Audits conducted by the Department of Health Care Finance (DHCF) reveal the need for stronger safeguards to ensure that that personal care aide (PCA) services are indeed prescribed in accordance with the plan of treatment developed by the patient's physician or APRN.

As a result, effective June 30, 2011, DHCF is requiring a written order from a patient's physician or nurse practitioner prior to the delivery of Medicaid PCA services to patients new to a home health agency. This written order must be made using the attached *Prescription Form for Medicaid Personal Care Aide Services*.

Guidance and Instructions for Completing the *Prescription Form for Medicaid Personal Care Aide Services*:

1. The *Prescription Form for Medicaid Personal Care Aide Services* was developed from the 719A Prior Authorization Request Form that is currently used by physicians to prescribe durable medical equipment and medical supplies for DC Medicaid beneficiaries. This new form should look familiar to you and is easier to complete, however, we welcome your suggestions for its improvement.
2. The form must originate with the physician or nurse practitioner and be forwarded to the home health agency that is to provide PCA services. The form is not to be completed by the personal care provider agency and then forwarded to the physician or nurse practitioner for signature.
3. 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 DC Medicaid PCA services.
4. Please make photocopies of the attached form and use it to order PCA services for your patients when needed.
5. The completed form should be mailed, faxed or emailed (consistent with HIPAA privacy protections) to the home health agency selected to provide PCA services.

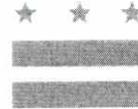
This action is one step in a process that DHCF is taking to safeguard the integrity of and preserve the PCA benefit in a time of financial challenge. We welcome your ideas for further protecting the integrity of this benefit and would also be happy to make presentations to groups of providers to explain its intent, use, or other aspects of the Medicaid PCA benefit.

Thank you in advance for your cooperation. Please contact Ericka Bryson-Walker, Project Manager at 202-442-9054 or [ericka.walker@dc.gov](mailto:ericka.walker@dc.gov) if you have any questions.

Attachment:  
*Prescription Form for Medicaid Personal Care Aide Services*



**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.

<b>1 PATIENT INFORMATION</b>			<b>2 ORDERING PHYSICIAN / NP INFORMATION</b>			
A. PATIENT D.C. MEDICAID NUMBER:			A. NPI NUMBER:			
B. NAME (LAST, FIRST, M.I.) PRINT			B. DC MEDICAID PROVIDER NUMBER:			
C. PERMANENT ADDRESS			C. NAME (LAST, FIRST, M.I.) PRINT			
D. TELEPHONE NUMBER		E. DATE OF BIRTH	F. SEX M <input type="checkbox"/> F <input type="checkbox"/>	D. ADDRESS		
				E. TELEPHONE NUMBER	F. FAX NUMBER	
<b>3 IS THERE OTHER HEALTH INSURANCE COVERAGE: Y N</b> If yes, please provide the following: (To be completed by Home Health Agency providing personal care services)			<b>4 DATE OF ORDER:</b>			
<b>PLAN NAME AND POLICY NUMBER:</b>			<b>5 PATIENT LOCATION AND ADDRESS ON DATE OF ORDER:</b>			
<b>NAME OF POLICYHOLDER:</b>			HOME: _____ HOSPITAL (name): _____ NURSING FACILITY(name): _____ ICF/MR(name): _____ OTHER (name): _____			
<b>PLAN ADDRESS AND PHONE #:</b>			<b>IF IN A FACILITY, EXPECTED DATE OF DISCHARGE:</b>			
			<b>ADDRESS TO WHICH PATIENT WILL BE DISCHARGED :</b>			
<b>PRESCRIPTION</b>						
<b>6 ICD DIAGNOSIS CODE(S)</b>	<b>7 PROCEDURE CODE</b> (to be completed by home health agency provider of personal care services)	<b>8 DESCRIPTION OF PERSONAL CARE SERVICES TO BE PROVIDED: e.g., bathing, feeding, and transferring.</b>		<b>9 Estimated # of days needed per week :</b>	<b>10 Estimated # of hours per day</b>	<b>11 Expected duration of need</b>
<b>12 JUSTIFICATION. ORDERING PHYSICIAN / NP MUST SPECIFY:</b>						
<b>A) Diagnosis(es) causing patient's disability(ies):</b>						
<b>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 <u>self-administration</u>. Please write below which of these disabilities are present in this patient.</b>						
<b>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.</b>						
_____			_____			
Signature			Date			