GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Deputy Director **DHCF Transmittal No. 12-07**

TO: Medicaid Providers of Personal Care Aide Services

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

DATE: MAR 16 2012

SUBJECT: **UPDATED:** Billing and Prior Authorization of Personal Care Aide (PCA) Services under the District of Columbia (DC) Medicaid State Plan and EPD Waiver

This Transmittal addresses billing and prior authorization of PCA services provided as a benefit under the DC Medicaid State Plan, and as a benefit provided under the DC Elderly and Persons with Physical Disabilities (EPD) Waiver. This Transmittal supersedes Transmittal No. 10-04.

The purpose of this transmittal is to remind providers about how these benefits should be provided and billed, and to provide home health providers with updated billing information that must be used when submitting claims for PCA services. This Transmittal also serves to remind home health providers of DHCF's prior authorization requirements for extended personal care aide services, which are found in the District's Medicaid State Plan and in 29 DCMR §5009.

Providing and Billing for State Plan PCA Services
Under DC's Medicaid State Plan, each beneficiary may receive, as needed, up to eight (8) hours of PCA services per day. The actual amount (not to exceed eight hours per day) must be determined based on each beneficiary's inability to perform activities of daily living without assistance, and the amount, duration and scope of PCA services they need to compensate for their disabilities. These PCA services (that may not exceed eight hours per day) may be delivered, as necessary, for up to 1,040 hours per calendar year without needing to be prior authorized. Because PCA services are billed in 15 minute increments, with each increment being one (1) unit of service, a maximum of 32 units of PCA services may be billed per beneficiary per day under

the State Plan. PCA services are billed using procedure code T1019. Finally, as you know, all PCA services beyond 1,040 hours per calendar year ("extended PCA services") must be prior authorized by DHCF. All extended State Plan PCA services must be billed with its prior authorization number and using procedure code T1019 with modifier U6 (T1019-U6). All State Plan PCA services must be billed using the Home Health Agency (HHA) State Plan provider number.

DHCF reiterates that *prior* authorization means prior to the delivery of service. Therefore, extended PCA services must be approved before services are provided. DHCF will not grant authorization to exceed the 1,040 limit after services exceeding this limit have been provided.

In order for home health agencies to make sure that they timely request and receive authorization for extended PCA services, HHAs **MUST** track the number of hours of PCA services given to a beneficiary beginning on January 1 of each year. The annual limit of PCA services does not start over if a beneficiary changes providers. If a beneficiary changes providers, the new provider agency should contact the old agency and request the total number of hours of PCA services provided to that beneficiary during the current calendar year. The former provider is expected to supply accurate information to the new provider.

All HHAs must submit a request for prior authorization of extended PCA services before a beneficiary reaches his or her annual 1,040 hour limit for PCA services. As per DC Medicaid Transmittal #10-04, providers should submit initial requests for extended PCA services when a beneficiary reaches 850 hours of PCA services in the calendar year. Additional prior authorization requests should be submitted two weeks (ten business days) before the expiration date of the existing prior authorization.

Further, all providers of PCA services must submit a request for prior authorization of extended PCA services via submission of a complete prior authorization request package to the DC Medicaid web portal. A complete package includes:

1. A DC Medicaid Request for Prior Authorization for Extended Medicaid State Plan Personal Care Aide (PCA) Services Form (Form Attached);
2. A copy of the physician's or Nurse Practitioner's Prescription Form for Medicaid Personal Care Aide Services (Form Attached);
3. The DC Medicaid Personal Care Aide Assessment Instrument required in DC Medicaid Transmittal #11-16.
4. The Beneficiary's Plan of Care (form attached). The beneficiary's plan of care must cover the period of time specified in the request for prior authorization for extended personal care aide services.

5. Additionally, if a request for prior authorization has been previously granted, and if the beneficiary transitions to another HHA when he/she is receiving extended PCA services under the prior authorization previously granted to the initial HHA, a subsequent request for prior authorization of extended PCA services must also include the DHCF Medicaid State Plan Personal Care Aide (PCA) Services Inter-Agency Transfer Form (See Attached Form) in the prior authorization request package.

If approved, an authorization for extended PCA services will be issued for up to 90 days.

Providing and Billing for PCA Services under the EPD Waiver.
Because PCA services that are not in excess of eight hours per day can be delivered through the Medicaid State Plan benefit, only PCA services in excess of eight hours per day should be billed under the EPD Waiver. If a beneficiary needs PCA services in excess of eight hours per day, the first eight hours should be billed to the State Plan, and the remainder should be billed to the waiver. DHCF has become aware that some providers delivering care under the waiver are not enrolled as State Plan providers and are thus billing all PCA services to the waiver. DHCF strongly encourages all providers of PCA services under the waiver to enroll as State Plan providers as soon as possible. DHCF intends to enact as soon as possible regulatory requirements that all providers of PCA service under the waiver must also be a provider of State Plan PCA services.

As you know, all PCA services under the EPD Waiver must be prior authorized before services are delivered. EPD Waiver PCA services are limited to a maximum of sixteen (16) hours per day per beneficiary. Because PCA services are billed in 15 minute increments, with each increment being one (1) unit of service, a maximum of 64 units of PCA services may be billed per beneficiary per day under the EPD Waiver.

EPD Waiver PCA services must be billed using procedure code T1019 with modifier U3 (T1019-U3).

In summary, the first eight hours per day of PCA services up to 1,040 hours of PCA services annually must be billed using procedure code T1019. Any hours up to eight hours per day but in excess of the 1,040 hours annually must be billed using procedure code T1019-U6. All State Plan claims should be submitted using a UB-04 form using the state plan provider number. Under the EPD Waiver program, up to sixteen (16) hours of additional PCA services beyond the eight hours available through the State Plan may be billed using procedure code T1019-U3. Providers must bill for these services using a CMS-1500 form.

Claims for PCA services billed to the waiver must include a prior authorization number. Providers are to use their EPD Waiver Provider ID when submitting claims for services provided under the EPD Waiver. Claims submitted without this information will be denied.

This information is summarized in the chart below:

	Billing for PCA Services: State Plan and EPD Waiver				
Benefit	**Provider ID**	**Daily Limit**	**Prior Authorization (PA) Requirements**	**Billing Procedure Codes**	**Claim Form**
State Plan PCA Benefit	Medicaid State Plan provider Number and National Provider Identifier + Taxonomy Code	8 hours/day total (32 units)	No PA required for first 1,040 hours during a calendar year.	T1019	UB-4 (or 837i electronic submission
			More than 1,040 hours during a calendar year requires PA.	T1019-U6+prior authorization number	
EPD Waiver PCA Benefit	EPD Waiver Provider ID number and National Provider Identifier + Taxonomy Code	16 hours/day total (64 units) as prior authorized	All EPD Waiver Services require a PA.	T1019-U3+ prior authorization number	CMS-1500 (or 837p electronic submission)

For questions about this policy, please contact Pamela Hodge, Management Analyst, Division of Long-Term Care at (202) 724-4282.

Attachments:

1) Request for Prior Authorization for Extended Medicaid State Plan Personal Care Aide (PCA) Services Form.
2) Prescription form for Medicaid Personal Care Aide Services.
3) Plan of Care for Medicaid Personal Care Aide (PCA) Home Health Aide and/or Skilled Nursing Services.
4) Medicaid State Plan Personal Care Aide (PCA) Services Interagency Transfer Form.

Government of the District of Columbia
Department of Health Care Finance
Division of Long-Term Care

Request for Prior Authorization for Extended Medicaid State Plan Personal Care Aide (PCA) Services Form

Please print clearly and complete all sections.

(1) Name of Beneficiary: _____
First Name Middle Initial Last Name

(2) Permanent Address: _____

(3) Phone (_____) _____ – _____ (4) Date of Birth _____ / _____ / _____ (5) Sex _____

(6) SS# _____-_____-_____ (7) Medicare # _____ (8) Medicaid # _____

(9) Date the home health agency began serving the patient: _____

(10) Contact information for Next of Kin/Responsible Party (Indicate N/A, if applicable):

_____
First Name Middle Initial Last Name

(11) Permanent Address _____

(12) Phone (_____) _____ – _____

(13) Diagnosis(es) causing patient's disability(ies) and other pertinent or surgical procedures:

_____

_____

Contact information for the RN completing form:

(14) Name of RN: _____
First Name Middle Initial Last Name

(15) Home Health Agency_____ Address _____

(16) Phone (_____) _____ – _____ Fax (_____) _____ – _____

(17) Signature of RN completing form: _____ (22) Date: _____ / _____ / _____

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(18) Attached Files (please check those that apply):

____ Beneficiary Assessment (required)
____ Beneficiary Plan of Care (required)
____ Prescription Form for Medicaid Personal Care Aide Services (if completed on or after June 30, 2011)
____ Inter-Agency Transfer Form (if applicable)

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

Physician / Nurse Practitioner (NP) is to complete all sections except sections 3 and 7 and transmit to home health agency as the order for personal care services. Sections 1, 2, 4, 5, 6, and 8-13 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):
PLAN NAME AND POLICY NUMBER:	
NAME OF POLICYHOLDER:	
PLAN ADDRESS AND PHONE #:	IF IN A FACILITY, EXPECTED DATE OF DISCHARGE: ADDRESS TO WHICH PATIENT WILL BE DISCHARGED :

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

Government of the District of Columbia
Department of Health Care Finance
Division of Long-Term Care

Plan of Care for Medicaid Personal Care Aide (PCA), Home Health Aide and/or Skilled Nursing Services

To be completed by the Licensed Home Health Agency (DC Medicaid Provider). Please print clearly and complete all sections. If you have questions about this form, please call DHCF at (202) 724-4282.

Name of Home Health Agency_____

Address _____

Phone (_____) _____ – _____ Fax (_____) _____ - _____

Signature of RN completing form: _____ Date: ___/___ /_____

Start of care date: _____/_____/_____

Plan of Care Certification Period: From: _____ To: _____ [ ] initial [ ] recertification

This Plan of Care is for (check): [ ] Home Health Visits [ ] Home Health Hours [ ] Personal Care Aide Hours

(1) Name of Beneficiary: _____
First Name Middle Initial Last Name

(2) Permanent Address: _____

(3) Phone (_____) _____ – _____ (4) Date of Birth _____ / _____ / _____ (5) Sex _____

(6) SS# _____-_____-_____ (7) Medicare # _____ (8) Medicaid # _____

(9) Contact information for Next of Kin/Responsible Party (Indicate N/A, if applicable):

_____
First Name Middle Initial Last Name

(10) Permanent Address _____

(11) Phone (_____) _____ – _____

(12) Describe the home environment and the patient's support system (family and community resources):

_____

_____

_____

Name of Medicaid Beneficiary: _____

Medicaid ID: _____

(13) Diagnosis(es) causing patient's disability(ies) and other pertinent diagnoses or surgical procedures:

_____

_____

_____

(14) FUNCTIONAL LIMITATIONS:

[ ] Bathing
[ ] Toileting
[ ] Dressing
[ ] Eating
[ ] Getting in and out of bed
[ ] Taking medication prescribed for self-administration
[ ] Toilet independently
[ ] Unstable gait
[ ] Other (specify) _____

ACTIVITIES PERMITTED:

[ ] Bedrest
[ ] Complete bedrest
[ ] BRP
[ ] Up as tolerated
[ ] Transfer bed/chair
[ ] Crutches
[ ] Cane
[ ] Wheelchair
[ ] Walker
[ ] No restriction

[ ] Transfer bed/chair
[ ] Toilet with assistance
[ ] Other (specify) _____

(15) Allergies: ❑ Yes, please explain ❑ No

_____

(16) Medication(s) (dose, route, and frequency):

_____

_____

_____

(17) Skilled Nursing Service(s) Ordered (Specify amount/frequency/duration. If none, state none):
Wound Care assessment: include the stages of tissue destruction, location, size, drainage and depth of the impaired skin integrity

_____

_____

_____

(18) Personal Care Aide/Home Health Aide Services Ordered (Specify amount/frequency/duration. If none, state none):

_____

_____

_____

Name of Medicaid Beneficiary: _____

Medicaid ID: _____

(19) Does the patient have a 24-hour management plan (i.e., a plan for care that includes home health services/personal care aide services that are not in the home)?

❑Yes, please explain ❑No, RN documents recommendations

_____

_____

_____

(20) Nutritional Requirements:

❑Yes, a specific diet is required. Explain below. ❑No. Indicate 'None' below.

_____

_____

_____

(21) Safety Measures (Check all that apply):

[ ] Use of assistant device when ambulating
[ ] Clear pathways of all obstructions (rugs, cords, etc.)
[ ] Support during transfer and lifting
[ ] No smoking or open flames in vicinity of oxygen
[ ] Keep hard candy on patient at all times
[ ] Wash hands before and after wound care procedure
[ ] Seizure precautions
[ ] Coumadin precautions
[ ] Client cannot be left unattended
[ ] Keep side rails up at all times
[ ] other (specify):_____

(22) Mental Status (Choose all that apply):

[ ] Oriented
[ ] Disoriented
[ ] Comatose
[ ] Lethargic
[ ] Forgetful
[ ] Agitated
[ ] Depressed
[ ] Other: _____

(23) Goals

Patient will be maintained in a safe and comfortable environment with PCA services.
Patient /Caregiver(s) will be knowledgeable and competent in all aspects of:

[ ] dietary regimen [ ] medication regimen [ ] wound care performance and management
[ ] disease process [ ] diabetic regimen [ ] use of glucometer
[ ] Insulin preparation and administration [ ] coudmadin/O2/seizure precautions
[ ] Foley/superpubic/condom catheter care and management [ ] NG G-Tube care and management

Patient will achieve maximum level of functioning in _____ weeks.
Caregiver(s) will demonstrate competency in patient care in _____ weeks

(24) HHA/PCA Goals: _____

_____

Name of Medicaid Beneficiary: _____

Medicaid ID: _____

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(25) Prognosis: [ ] Poor [ ] Guarded [ ] Fair [ ] Good [ ] Excellent

(26) Rehabilitation Potentials: [ ] Poor [ ] Guarded [ ] Fair [ ] Good [ ] Excellent

(27) Discharge Plans:

Patient will be discharged to care of self/caregiver(s)/MD when:

[ ] Patient needs skilled care and goals are met.
[ ] Patient is referred to outpatient services
[ ] Patient/family members are able to provide care.
[ ] Other (specify)_____

Contact information for the RN completing form:

(28) Name of RN:

_____

First Name Middle Initial Last Name

Practitioner approving Plan of Care

(29) Name of Physician/Nurse Practitioner

_____

First Name Middle Initial Last Name

(30) Address_____

(31) Phone (____) _____-_____ (32) Fax (____) _____-_____

(33) Physician/Nurse Practitioner Signature_____(34) Date: ___/____/_____

The practitioner must sign the form within 30 days of its development

For Division of Long-Term Care use only

( ) Approved For_____ **( ) Disapproved**

Approval Period_____

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH CARE FINANCE
DIVISION OF LONG-TERM CARE

Medicaid State Plan Personal Care Aide (PCA) Services
Inter-Agency Transfer Form

Please print clearly and be sure to complete all sections. If you have questions about this form, please call DHCF at (202) 724-4282.

Name of Medicaid Beneficiary: _____

Address: _____

Phone: (____) ____-_____ Date of Birth: ____/____/_____

Medicaid ID: _____

Name of Discharging Home Health Agency: _____

Last day PCA services will be provided: ____/____/_____

Number of PCA hours beneficiary receives per day: _____

Number of days per week PCA services provided: _____

As of ____/____/_____, the total number of hours of Medicaid state plan PCA services provided during
Date of Discharge
the current calendar year will be _____ hours.
List # PCA Hours Received

Reason for Transfer: _____

_____

Name of Receiving Home Health Agency: _____

Receiving agency start-of-care date: ____/____/_____

All aspects of the transfer, including last and first date of services, should be coordinated between and mutually agreed upon by the discharging and receiving agencies.

Discharging Home Health Agency:
Name of Director of Nursing or Designee (please print): _____

Director of Nursing or Designee Signature: _____

Date: ____/____/_____

Receiving Home Health Agency:
Name of Director of Nursing or Designee (please print): _____

Director of Nursing or Designee Signature: _____

Date: ____/____/_____