Personal Care Services for Children Enrolled in the Consumer-Directed Care Plus Program

June 2012

Purpose

- Provide an overview of consumer directed personal care services provided through the Medicaid State Plan.
- Gain an understanding of the various requirements to receive services.
- Target Audience
  - Providers
  - Consumer Representatives
  - Consultants and Waiver Support Coordinators
  - Local Agency for Health Care Administration and Agency for Persons with Disabilities' Area Offices

Key Terms and Acronyms

- CDC+ – Consumer Directed Care Plus
- Consumer – Medicaid recipient/CDC+ Representative requesting personal care services
- Provider – Individual(s) or Group(s) rendering the personal care service and receiving payment through the CDC+ program
- Quality Improvement Organization or QIO – entity contracted with Florida Medicaid to perform medical necessity reviews (eQHealth Solutions, Inc.)
- Agency – Agency for Health Care Administration
- APD – Agency for Persons with Disabilities

Background

- Children under the age of 21 who are enrolled in the CDC+ program have two options for accessing personal care services:
  1. Self-direct their personal care services through the CDC+ monthly budget
  2. Select a Medicaid enrolled state plan provider and receive services from a home health agency or unlicensed personal care provider, which will not be included in the CDC+ monthly budget.
- Transition of consumer directed personal care services for children will be by area.
- The transition will begin June 2012.

Authority

- 1915 J State Plan Amendment
  - Authorizes the Agency and the APD to work together to develop a process that would allow children to continue to self-direct their Medicaid state plan personal care services.
- Medicaid Home Health Coverage and Limitations Handbook
  - Provides general guidelines for reviewing and approving requests for Medicaid state plan personal care services.

Transition Overview

- Implementation Schedule

CDC+ PERSONAL CARE ASSISTANCE UNDER 21 TRANSITION FROM WAIVER TO MSP								
TRAINING TO IMPLEMENTATION*	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13
Areas 9 & 10								
Areas 11								
Areas 1 & 2								
Areas 4, 12 & 13								
Areas 8 & 23								
Areas 3, 7, 14 & 15								

*TRAINING TO IMPLEMENTATION INCLUDES TRAINING OF CONSUMERS/REPRESENTATIVES, CONSULTANTS, AREA STAFF; CONSUMERS' DOCTOR'S APPT; DEVELOPMENT OF DOCUMENTS; REVIEW BY CONSULTANT; FAXED SUBMITTAL TO EQ HEALTH SOLUTIONS; DETERMINATION ISSUED; COST PLAN APPROVAL; DEVELOPMENT OF PURCHASING PLAN CHANGE; SUBMITTAL, REVIEW & APPROVAL OF PP; BEGINNING OF SERVICE DELIVERY (TIMELINE MAY VARY DEPENDING ON TYPE OF DETERMINATION ISSUED)

Transition Overview

- Training Schedule

Consumer Directed Care Plus Personal Care Services Transition Provider Training Dates		
Location/Area	**Date**	**Time**
APD Area 9 & 10	June 5, 2012 June 14, 2012	10 am – 12 pm
APD Area 11	July 10, 2012 July 19, 2012	10 am – 12 pm
APD Area 1 & 2	August 7, 2012 August 16, 2012	10 am – 12 pm
APD Area 4, 12, & 13	September 4, 2012 September 13, 2012	10 am – 12 pm
APD Area 8 & 23	October 2, 2012 October 11, 2012	10 am – 12 pm
APD Area 3,7, 14, & 15	November 8, 2012 November 13, 2012	10 am – 12 pm

Personal Care Services

- Personal care services provides assistance with activities of daily living (ADLs).
- Assistance with activities of daily living is defined as individual assistance with:
  - Ambulating
  - Transferring
  - Bathing and grooming (including hair care and shaving)
  - Dressing
  - Eating (includes assistance with fluid intake)
  - Oral hygiene
  - Toileting and eliminating

Who Can Provide Personal Care Services

- The consumer can select the provider of their choice. Examples include:
  - Parent or legal guardian
  - Relative (aunt, uncle, cousin, etc.)
  - Family friend
  - Home health agency
- It does not have to be a Medicaid enrolled provider.
- It is recommended that they consider having a back-up provider in the event their primary provider cannot perform the service.
- Consumer's representative can not be a paid provider.

Provider Qualifications

- The consumer is responsible for ensuring that their provider can safely render the service and meet their needs.
- The consumer can establish minimum provider qualifications to render the service. These qualifications can exceed those stated in the *Home Health Coverage and Limitations Handbook.*
- It is recommended (not required) that the provider minimally be:
  - Able to furnish the care required of the consumer based on physician's order and the consumer's functional limitations
  - Possess training in key areas such as CPR and infection control.

Requirements for Personal Care Services

- **Services must be:**
  - Medically necessary,
  - Ordered by a physician,
  - Documented in a signed and individualized plan of care, and
  - Prior authorized by the QIO (eQHealth Solutions).

Medical Necessity Criteria

- To be medically necessary, the service must be:
  - Individualized,
  - Consistent with the symptoms or confirmed diagnosis of the developmental disability under treatment, and
  - Not be in excess of the consumer's needs.
- The fact that a physician has prescribed, recommended, or approved services does not, in itself make such services medically necessary or a covered service.

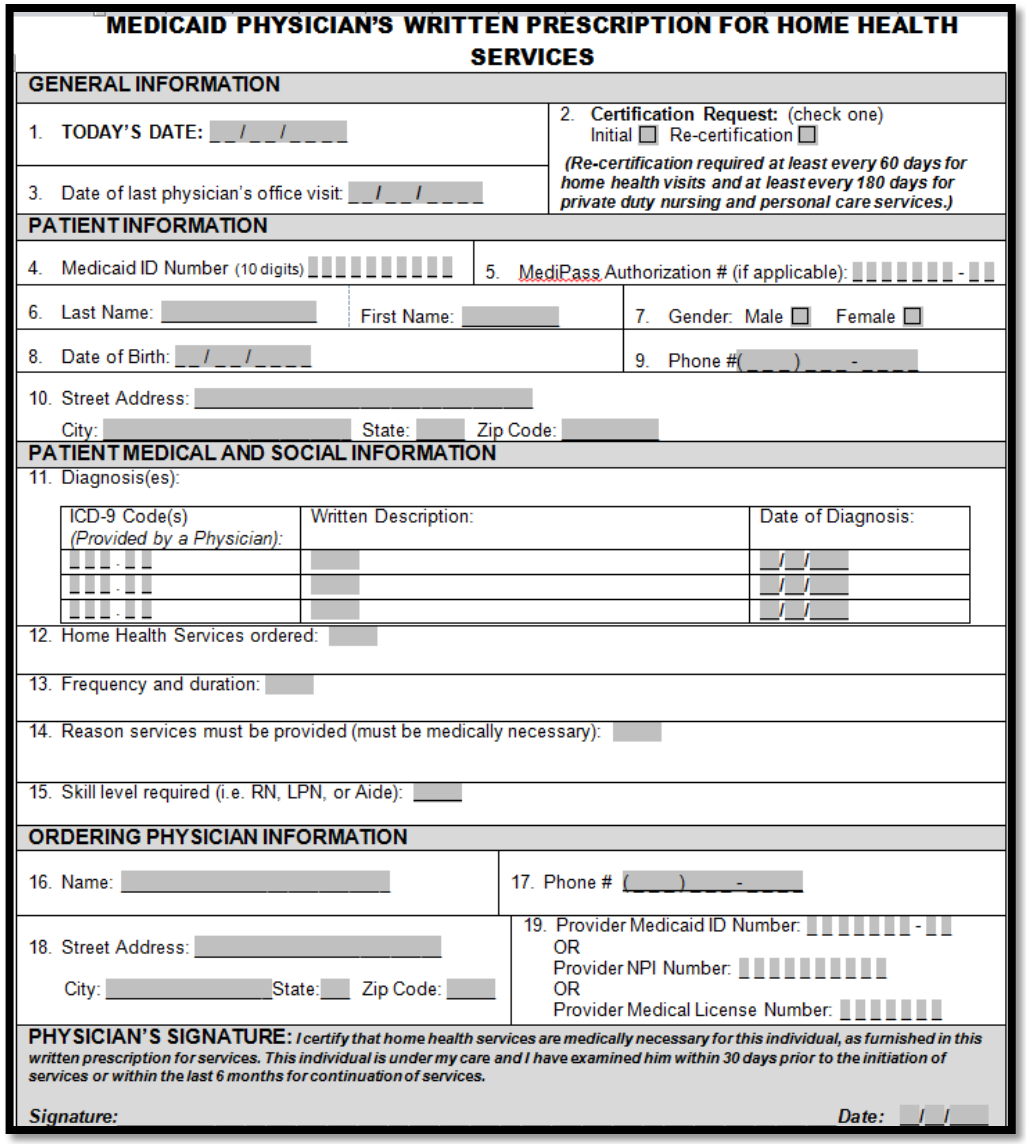
Medical Necessity Criteria Continued

- The service must not duplicate another service being provided
  - For example:
    - Respite
    - Residential Rehabilitation
- Personal care services cannot be approved just for the convenience of the consumer, the consumer's caretaker or the provider.
- AHCA contracts with a Quality Improvement Organization, eQHealth Solutions, to perform medical necessity reviews of requests for personal care services.

Physician Order

- Obtaining the physician's order is the first step in the process.
- A new written physician's order must be obtained every 180 days.
- At a minimum, the order must describe the:
  - Consumer's medical condition or diagnosis that causes him/her to need personal care services,
  - Documentation regarding the medical necessity for the service(s),
  - Home health services needed (e.g., personal care services), and
  - Frequency and duration of service.

Example Physician's Written Prescription



MEDICAID PHYSICIAN'S WRITTEN PRESCRIPTION FOR HOME HEALTH SERVICES

GENERAL INFORMATION

1. TODAY'S DATE: __/__/____

2. **Certification Request:** (check one)
Initial ☐ Re-certification ☐
(Re-certification required at least every 60 days for home health visits and at least every 180 days for private duty nursing and personal care services.)

3. Date of last physician's office visit: __/__/____

PATIENT INFORMATION

4. Medicaid ID Number (10 digits) _____

5. MediPass Authorization # (if applicable): _____-__

6. Last Name: _____ First Name: _____

7. Gender: Male ☐ Female ☐

8. Date of Birth: __/__/____

9. Phone #(____)____-____

10. Street Address: _____
City: _____ State: ____ Zip Code: _____

PATIENT MEDICAL AND SOCIAL INFORMATION

11. Diagnosis(es):

ICD-9 Code(s) *(Provided by a Physician)*:	Written Description:	Date of Diagnosis:
___.__		__/__/____
___.__		__/__/____
___.__		__/__/____

12. Home Health Services ordered: _____

13. Frequency and duration: _____

14. Reason services must be provided (must be medically necessary): _____

15. Skill level required (i.e. RN, LPN, or Aide): _____

ORDERING PHYSICIAN INFORMATION

16. Name: _____

17. Phone # (____)____-____

18. Street Address: _____
City: _____ State: ___ Zip Code: _____

19. Provider Medicaid ID Number: _____-__
OR
Provider NPI Number: _____
OR
Provider Medical License Number: _____

PHYSICIAN'S SIGNATURE: *I certify that home health services are medically necessary for this individual, as furnished in this written prescription for services. This individual is under my care and I have examined him within 30 days prior to the initiation of services or within the last 6 months for continuation of services.*

Signature: ***Date:*** __/__/____

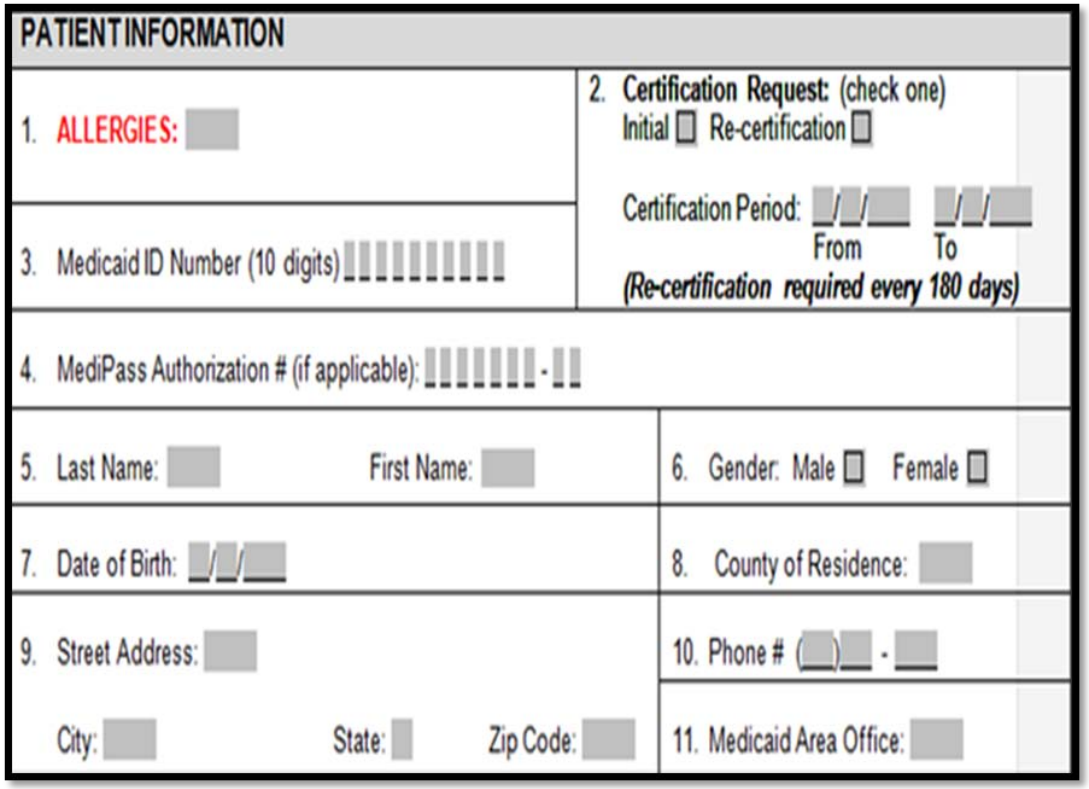
Plan of Care

- The next step in the process is to begin developing the plan of care.
- A plan of care is an individualized written program designed to meet the medical and health care needs of the consumer.
- Primary PCA Provider/CDC+ Representative is responsible for completing the "Personal Care Services Plan of Care" located in Appendix B of the *Home Health Services Coverage and Limitations Handbook.* Exception: Licensed home health agencies can continue to use the CMS 485 plan of care.
  - *This should be a collaborative effort between the primary care provider, parent, CDC+ representative, and physician.*

(Home Health Services Handbook, page B-6)

Plan of Care (POC) – Patient Information

1. Enter any known medication allergies or other allergies (ask the consumer's doctor if you do not know about the consumer's history with allergies).
2. Enter the certification period. It should not exceed 180 days (This will be completed by PCP or Physician).
3. Enter the consumer's Medicaid ID Number.
4. Leave this field blank.
5. Enter the consumer's legal first and last name.


PATIENT INFORMATION

1. ALLERGIES:

2. Certification Request: (check one)
Initial ☐ Re-certification ☐

Certification Period: __/__/____ __/__/____
From To
(Re-certification required every 180 days)

3. Medicaid ID Number (10 digits)

4. MediPass Authorization # (if applicable): -

5. Last Name: First Name:

6. Gender: Male ☐ Female ☐

7. Date of Birth: __/__/____

8. County of Residence:

9. Street Address:

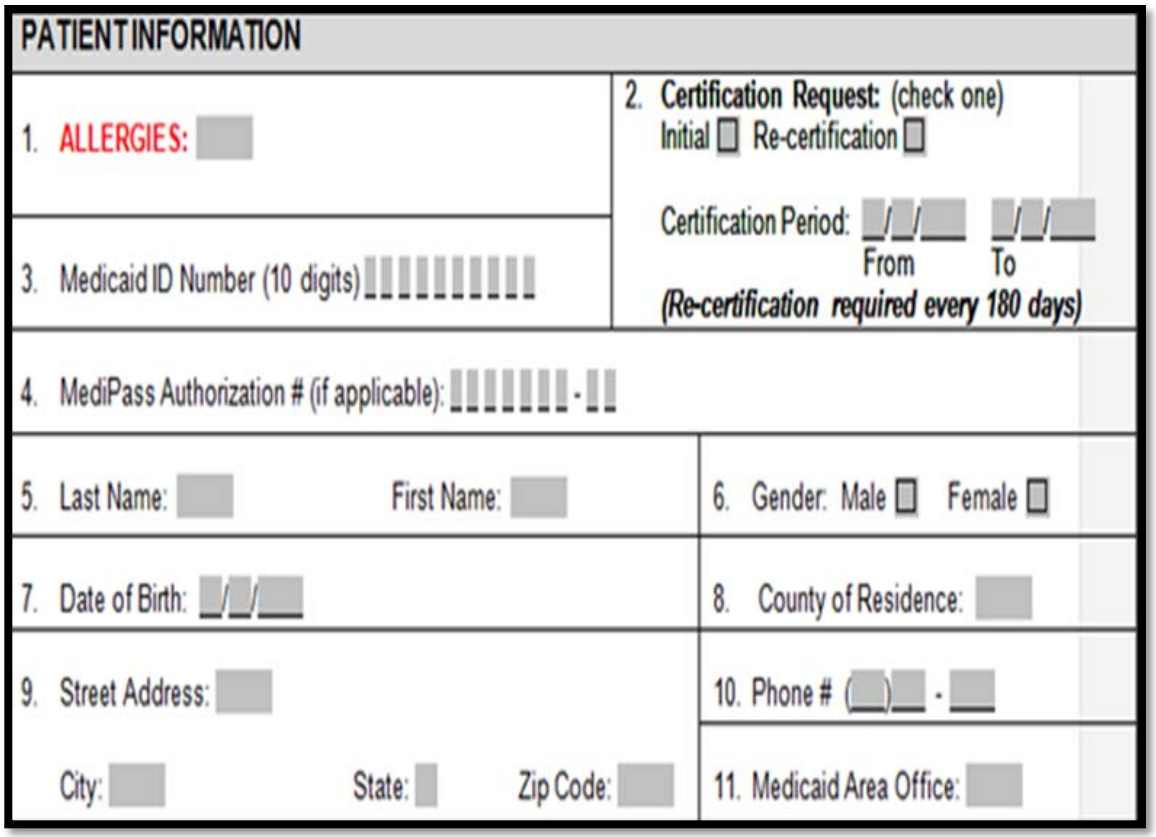
10. Phone # (__)__ - ____

City: State: Zip Code:

11. Medicaid Area Office:

Plan of Care (POC) – Patient Information

6. Check the appropriate gender.
7. Enter the consumer's date of birth.
8. Enter the consumer's county of residence.
9. Enter the consumer's physical street address.
10. Enter the consumer's contact number.
11. Enter consumer's local AHCA Medicaid area office.


PATIENT INFORMATION

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Initial ☐ Re-certification ☐

Certification Period: __/__/____ __/__/____
From To
(Re-certification required every 180 days)

3. Medicaid ID Number (10 digits) ☐☐☐☐☐☐☐☐☐☐

4. MediPass Authorization # (if applicable): ☐☐☐☐☐☐☐-☐☐

5. Last Name: First Name:

6. Gender: Male ☐ Female ☐

7. Date of Birth: __/__/____

8. County of Residence:

9. Street Address:

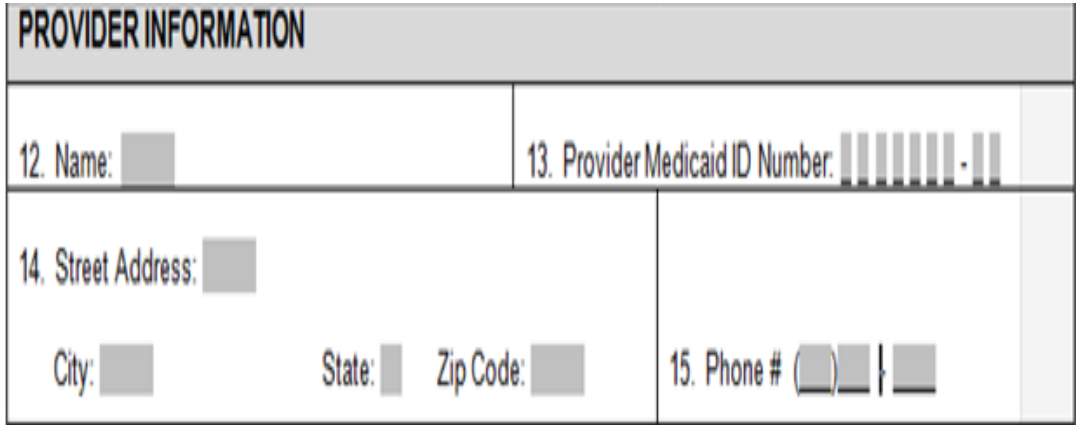
10. Phone # (___)___-____

City: State: Zip Code:

11. Medicaid Area Office:

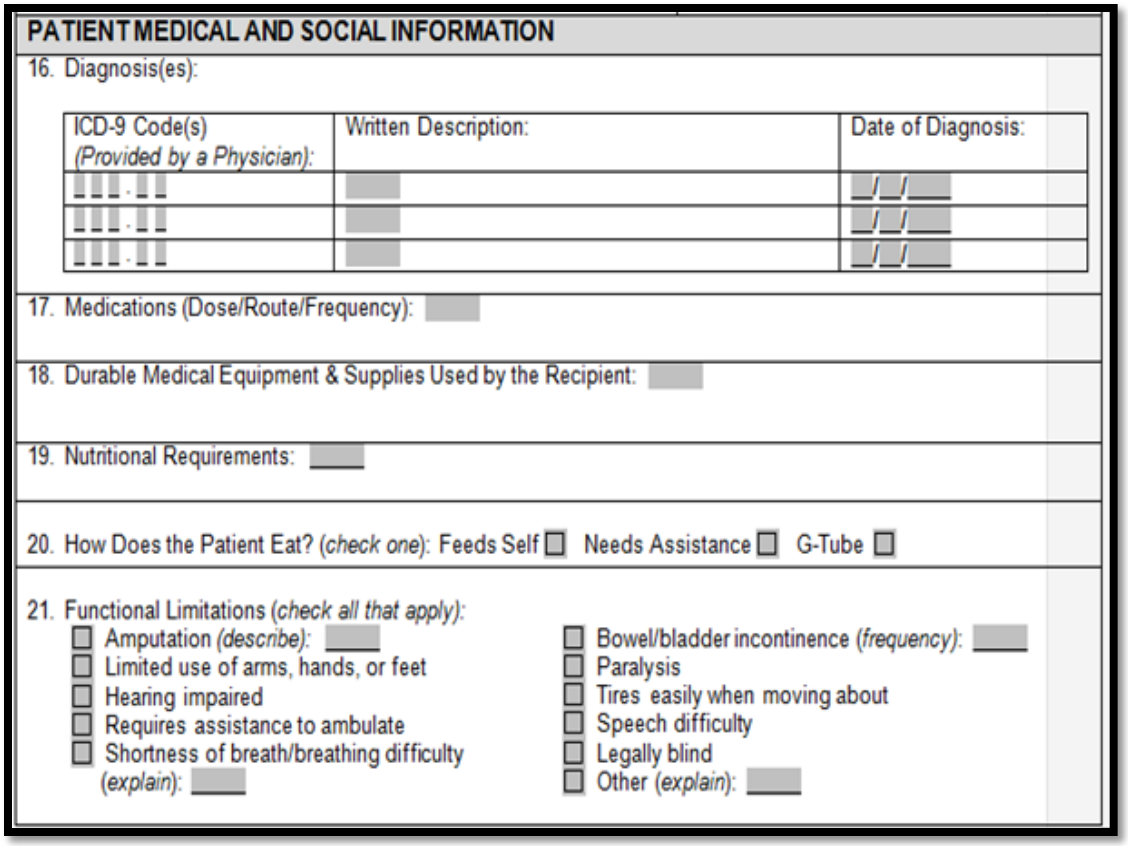
Plan of Care – Provider Information

12. Enter the provider's name (this is the person actually performing the personal care services).
13. Enter the provider's Medicaid provider number. Leave this field blank if the provider is not a Medicaid enrolled provider.
14. Enter the provider's mailing address.
15. Enter the provider's phone number.



Plan of Care – Patient Medical and Social Information

16. List the consumer's diagnosis(es), along with the ICD - 9 codes. This must come from the child's physician and be documented on the physician's order.
17. List **ALL** prescribed medications, including the dosage (*mg, one, two, etc.*), route (*oral, rectal*), and frequency (*how often*). Include prescription vitamins and supplements. This information must be obtained from the consumer's physician.



PATIENT MEDICAL AND SOCIAL INFORMATION

16. Diagnosis(es):

ICD-9 Code(s) *(Provided by a Physician)*:	Written Description:	Date of Diagnosis:
___.__		__/__/____
___.__		__/__/____
___.__		__/__/____

17. Medications (Dose/Route/Frequency):

18. Durable Medical Equipment & Supplies Used by the Recipient:

19. Nutritional Requirements:

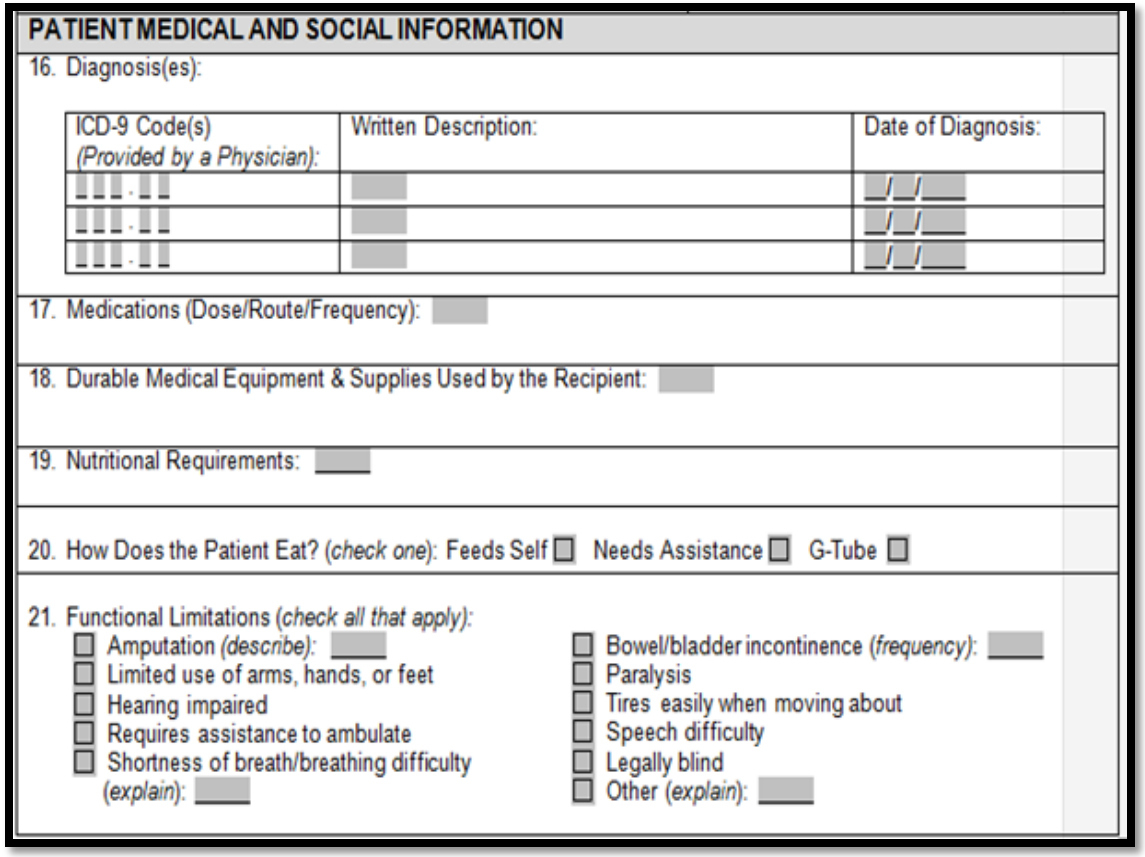
20. How Does the Patient Eat? (*check one*): Feeds Self ☐ Needs Assistance ☐ G-Tube ☐

21. Functional Limitations (*check all that apply*):

- ☐ Amputation (*describe*):
- ☐ Limited use of arms, hands, or feet
- ☐ Hearing impaired
- ☐ Requires assistance to ambulate
- ☐ Shortness of breath/breathing difficulty (*explain*):
- ☐ Bowel/bladder incontinence (*frequency*):
- ☐ Paralysis
- ☐ Tires easily when moving about
- ☐ Speech difficulty
- ☐ Legally blind
- ☐ Other (*explain*):

Plan of Care - Patient Medical and Social Information

18. List any durable medical equipment (DME) and supplies used by the consumer (*For example: gloves, wheel chair, commode, incontinence supplies, walker, cane, etc*.).
19. Describe the consumer's diet (For e*xample: normal, soft, liquid, etc*.). Enter specific dietary requirements and restrictions as prescribed by the consumer's physician.
20. Check the most appropriate box.
21. Check current limitations as assessed by the physician.



PATIENT MEDICAL AND SOCIAL INFORMATION

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_ _ _ . _ _		__/__/____
_ _ _ . _ _		__/__/____

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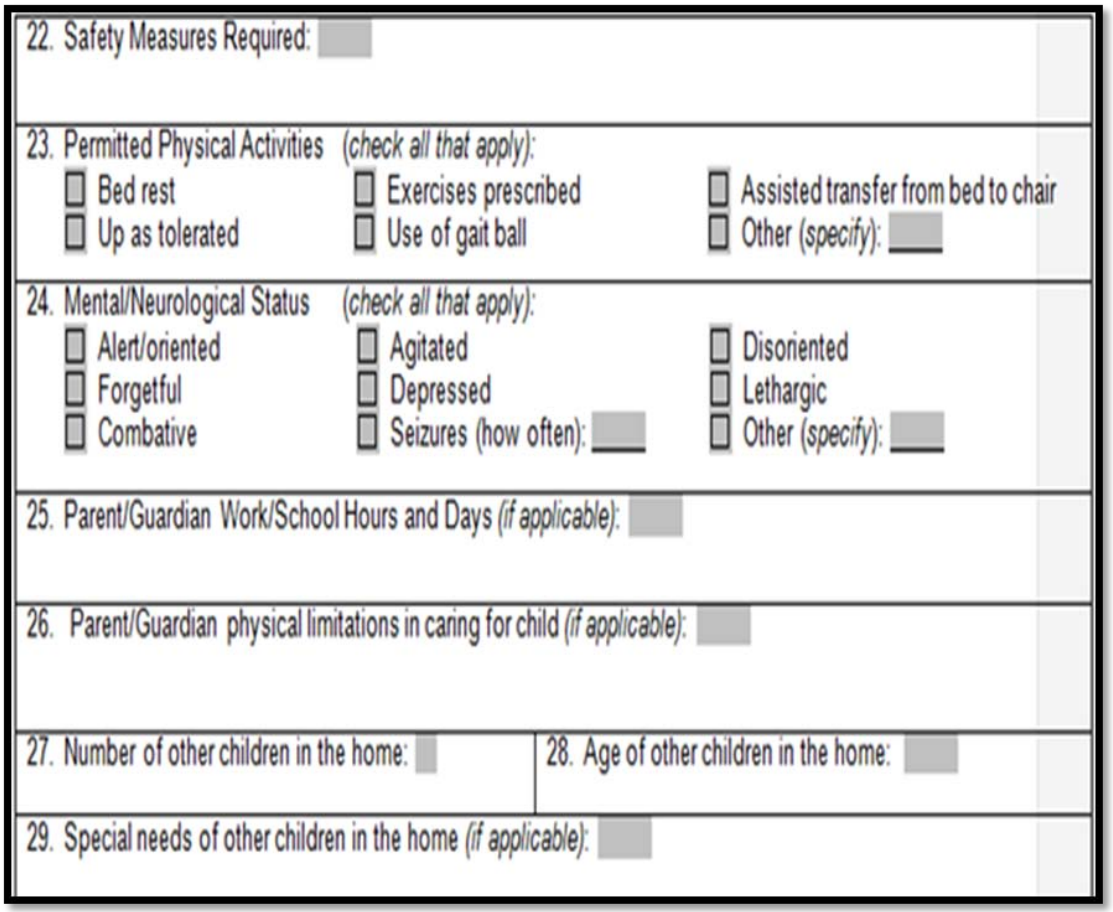
- ☐ Requires assistance to ambulate
- ☐ Shortness of breath/breathing difficulty *(explain)*:
- ☐ Bowel/bladder incontinence *(frequency)*:
- ☐ Paralysis
- ☐ Tires easily when moving about
- ☐ Speech difficulty
- ☐ Legally blind
- ☐ Other *(explain)*:

Plan of Care - Patient Medical and Social Information

22. Describe any safety precautions (*For example: keep path ways clean, requires assistance with walking, etc.).*
23. Check all activities permitted. It is recommended that you consult the consumer's physician.
24. Check the most appropriate boxes that describe the consumer's mental/neurological status
25. Enter parent/legal guardian work schedule (*If applicable*).


22. Safety Measures Required:

23. Permitted Physical Activities *(check all that apply)*:
- ☐ Bed rest
- ☐ Up as tolerated
- ☐ Exercises prescribed
- ☐ Use of gait ball
- ☐ Assisted transfer from bed to chair
- ☐ Other *(specify)*:

24. Mental/Neurological Status *(check all that apply)*:
- ☐ Alert/oriented
- ☐ Forgetful
- ☐ Combative
- ☐ Agitated
- ☐ Depressed
- ☐ Seizures (how often):
- ☐ Disoriented
- ☐ Lethargic
- ☐ Other *(specify)*:

25. Parent/Guardian Work/School Hours and Days *(if applicable)*:

26. Parent/Guardian physical limitations in caring for child *(if applicable)*:

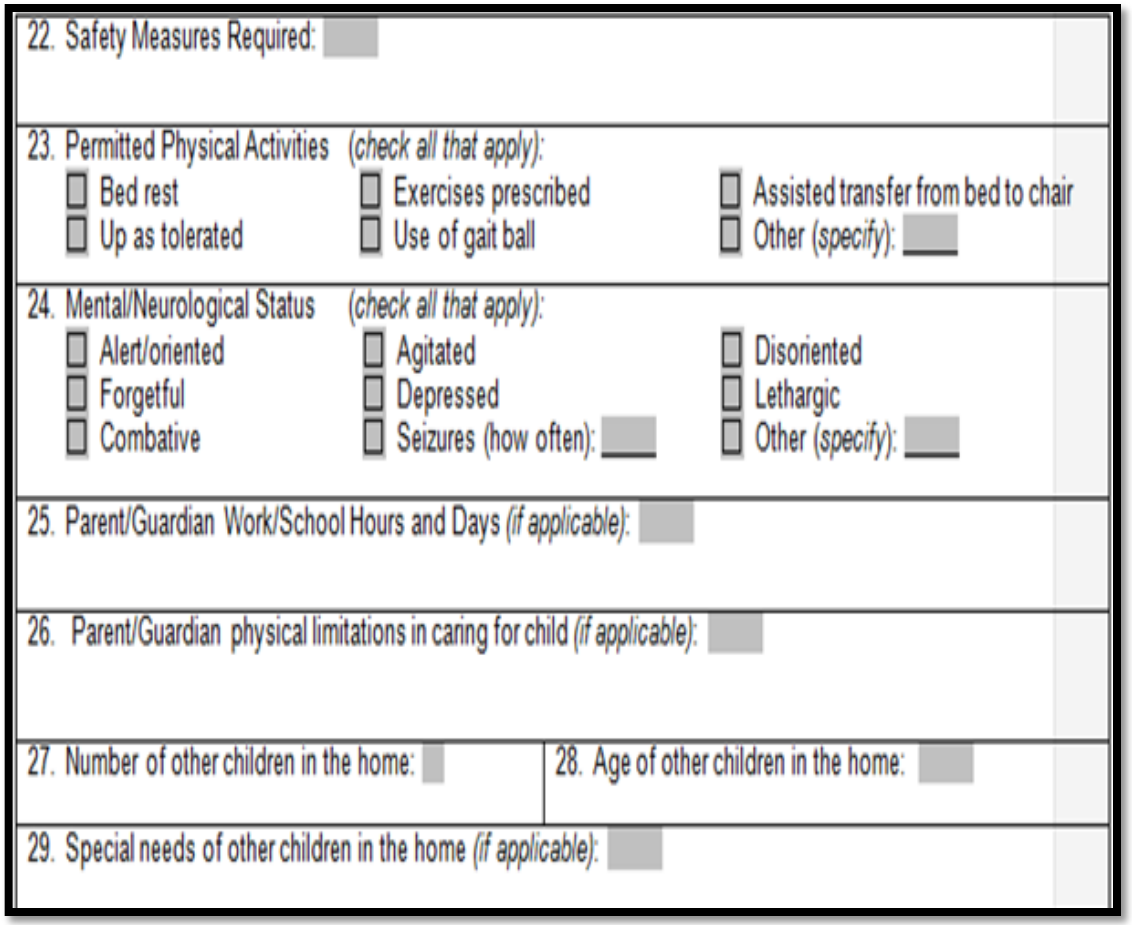
27. Number of other children in the home:

28. Age of other children in the home:

29. Special needs of other children in the home *(if applicable)*:

Plan of Care - Patient Medical and Social Information

26. Enter any medical or physical limitations that the parent or legal guardian has that would prevent him/her from participating in the consumer's care to the fullest extent. *(For example: Parent is unable to lift more than 30 lbs.).*
27. Enter number of children who live in the same household with the consumer.
28. Enter the age of each of the children living in the household.
29. Enter any special needs of the other children who live in the household.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- ☐ Other (*specify*):

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- ☐ Agitated
- ☐ Depressed
- ☐ Seizures (how often):
- ☐ Disoriented
- ☐ Lethargic
- ☐ Other (*specify*):

25. Parent/Guardian Work/School Hours and Days *(if applicable)*:

26. Parent/Guardian physical limitations in caring for child *(if applicable)*:

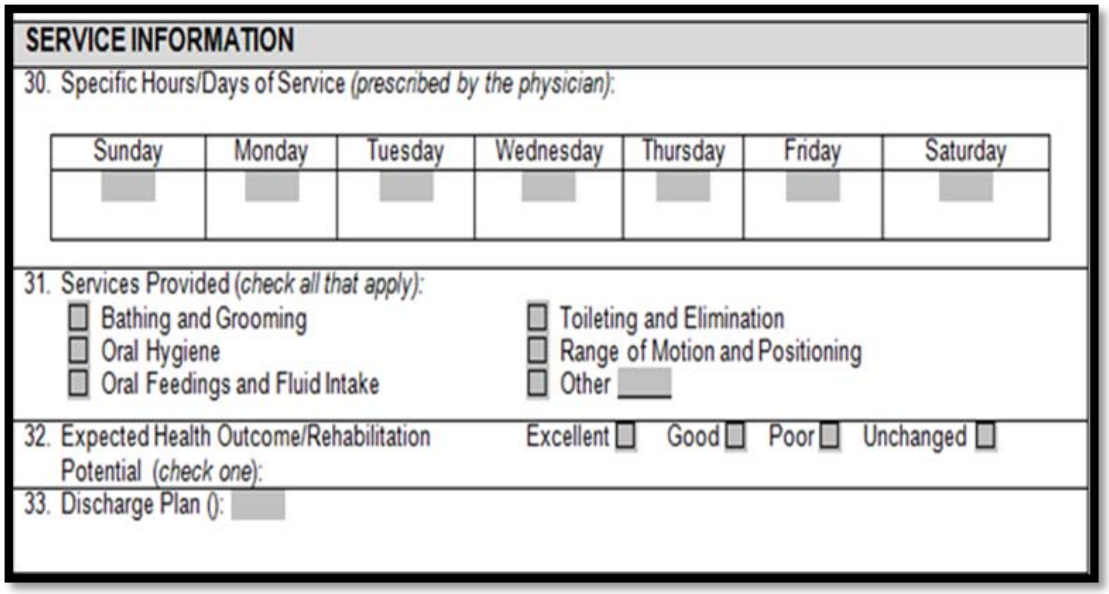
27. Number of other children in the home:

28. Age of other children in the home:

29. Special needs of other children in the home *(if applicable)*:

Plan of Care – Service Information

30. Enter specific hours per day and days of week service will be provided by a paid provider (For example: 8 Hours per day).
31. Check all activities of daily living/self care tasks that you will be assisting the consumer to accomplish
32. Check the most appropriate box that describes the consumer's expected health outcome and the ability for the consumer to achieve goals.
33. Address discharge plans (*If Applicable*).



SERVICE INFORMATION

30. Specific Hours/Days of Service *(prescribed by the physician)*:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

31. Services Provided *(check all that apply)*:

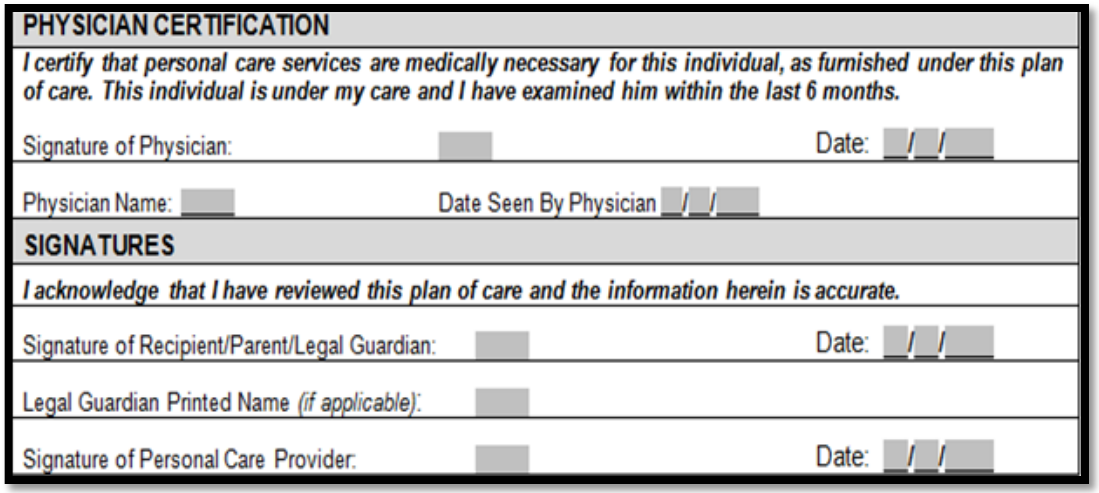
- ☐ Bathing and Grooming
- ☐ Oral Hygiene
- ☐ Oral Feedings and Fluid Intake
- ☐ Toileting and Elimination
- ☐ Range of Motion and Positioning
- ☐ Other ____

32. Expected Health Outcome/Rehabilitation Potential *(check one)*: Excellent ☐ Good ☐ Poor ☐ Unchanged ☐

33. Discharge Plan ():

Plan of Care – Physician Certification and Other Signatures

- The consumer's physician must sign the plan of care.
- The parent or legal guardian must sign the plan of care.
- If the consumer is capable of signing the plan of care, it is recommended that the provider obtain their signature as well.
- The provider must also sign the plan of care.



PHYSICIAN CERTIFICATION

I certify that personal care services are medically necessary for this individual, as furnished under this plan of care. This individual is under my care and I have examined him within the last 6 months.

Signature of Physician: Date: / /

Physician Name: Date Seen By Physician / /

SIGNATURES

I acknowledge that I have reviewed this plan of care and the information herein is accurate.

Signature of Recipient/Parent/Legal Guardian: Date: / /

Legal Guardian Printed Name *(if applicable)*:

Signature of Personal Care Provider: Date: / /

Plan of Care Continued

- Medicaid does not reimburse attending physicians for certifying the plan of care (POC).
- The POC, with the original signature, must be retained in the consumer's central record.
- The physician must review POC every **180 days.**
- The POC must be signed by the attending physician before submitting the request for prior authorization to eQHealth Solutions.

Parental Responsibility

- Medicaid state plan personal care services are meant to supplement care provided by parents and caregivers, not replace care.
- Parents and caregivers must participate in providing care to the fullest extent possible.
- A parent's scheduled employment for providing services to their child in CDC+ is considered a work schedule.
- Medicaid can authorize personal care services through the CDC+ program if the parent/legal guardian is the provider receiving payment for services; however, this does not relieve a parent/legal guardian from providing some uncompensated care for their child.
- Medicaid can reimburse personal care services rendered to a consumer whose parent or caregiver is not available or able to perform the child's self care tasks.

Prior Authorization

- Prior authorization of personal care services is required every **180 days**.
- The CDC+ representative will be responsible for submitting all of the necessary documentation to the consultant so the request can be submitted to eQHealth Solutions.
- The CDC+ consultant will be responsible for submitting the prior authorization requests to eQHealth Solutions.
- eQHealth Solutions will make medical necessity determinations based on the clinical information and supporting documentation submitted.

Supporting Documentation

- The submission of supporting documentation is required in order to get approval for personal care services.
- This documentation must be submitted to eQHealth Solutions.
- Required documents include:
  - Plan of Care
  - Physician's Order
  - Physician's Visit Documentation
- Additional supporting documentation is needed to substantiate a parent or caregiver's work/school schedule or inability to participate in the care of the consumer because of a medical limitation.
  - Link to documents: http://fl.eqhs.org/HomeHealthPPEC/FormsandDownloads.aspx
- For the **INITIAL** request, the consumer's cost plan and support plan is required. For all subsequent authorizations **ONLY** the support plan is necessary.

Supporting Documentation cont'd

- Many of the required and supplemental forms can be downloaded from eQHealth Solutions' web site under the Home Health tab.
  - Link to documents: http://fl.eqhs.org/HomeHealthPPEC/FormsandDownloads.aspx
- Forms can also be copied from the Home Health Coverage and Limitations Handbook.
  - Link to handbook: http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/42/Default.aspx
- Templates include:
  - Parent/Legal Guardian Work Schedule Form
  - Parent/Legal Guardian School Schedule Form
  - Parent/Legal Guardian Medical Limitations Form
  - Physician Visit Documentation Forms
  - Personal Care Services Plan of Care Form

Payment for Services

- Once eQ Health Solutions issues prior authorization, the CDC+ Consumer/Representative will be required to submit a purchasing plan change and attach the authorization.
  - This documentation should be submitted to the CDC+ Consultant.

Getting Assistance

- If you have questions, please contact your local AHCA Medicaid area office.

Please Submit Your Questions to derica.smith@ahca.myflorida.com