Personal care services

Personal care services (PCS) are defined as tasks that are medically necessary as they pertain to an eligible member's physical requirements. Physical limitations due to illness or injury may necessitate assistance with eating, bathing, dressing, personal hygiene, and bladder or bowel requirements. These services prevent institutionalization and enable the member to be treated on an outpatient basis rather than an inpatient basis to the extent that services on an outpatient basis are projected to be more cost-effective than services provided on an inpatient basis.

What this means to you

Healthy Blue provides PCS as a benefit to members who are eligible.

Covered services

PCS must be provided in the member's home or in another location if it is medically necessary to be outside of the member's home. A member's home is defined as the member's own dwelling, an apartment, a custodial relative's home, a boarding home, a foster home, a substitute family home or a supervised living facility. Institutions such as a hospital, institution for mental diseases, nursing facility, intermediate care facility for the developmentally disabled or residential treatment center are not considered a member's home. PCS provided in an educational setting shall not be reimbursed if these services duplicate services provided by or must be provided by the Department of Education. PCS are not to be provided to meet child care needs nor as a substitute for the parent in the absence of the parent. These services are not allowed for the purpose of providing respite care for the primary caregiver.

The following services are included (not all inclusive):

- Basic personal care
- Toileting and grooming activities (bathing, hair care, dressing)
- Bladder and/or bowel requirements
- Meal preparation (for the member only) and assistance with eating
- Performance of incidental household services that occur as a result of providing assistance (for the member only) and are essential to the member's health and comfort
- Accompanying (not transporting) the member to and from his/her physician and/or medical facility for necessary medical services

The following services are excluded (not all inclusive):

- Insertion and sterile irrigation of catheters
- Transportation of a member
- Routine household chores
- Cleaning of floor/furniture in an area not occupied by only the member
- Irrigation of any body cavities that require sterile procedures
- Application of dressings involving prescription medication and aseptic technique
- Administration of injections of fluid into veins, muscles or skin
- Administration of medicine

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- Laundry (unless incidental in the care of the member)
- Shopping for groceries or household items unless specifically required for the health and maintenance of the member and not for the use of the rest of the household
- Skilled nursing services as defined in the state Nurse Practices Act
- Education of caregiver on how to care for a patient and the disease process
- Specialized nursing procedures
- Rehab services
- Palliative skin care with medicated creams and ointments and/or dressing changes
- Specialized aide procedures (rehab, vital signs, specimen collection, nonmedicated wound care, ostomy care, enemas, etc.)
- Home IV therapy
- Custodial care or provision of only instrumental activities of daily living tasks or provisions of only one activity of daily living task
- Occupational, physical, speech or respiratory therapy
- Audiology services
- Durable medical equipment including O2 or orthotic appliances or prosthetic devices
- Laboratory services
- Personal comfort items
- Social work visits

Qualifications for PCS

Conditions for provisions of PCS are as follows:

Medicaid eligibility

The person must be a categorically eligible Medicaid member, birth through 20 years of age (Early and Periodic Screening, Diagnosis and Treatment [EPSDT] eligible) and have been prescribed PCS as medically necessary by a physician. The physician shall specify the health/medical condition that necessitates PCS.

Medical necessity

To establish medical necessity, the parent or guardian must be physically unable to provide PCS to the child. If the parent(s) is in the home and is not providing care to the member, medical documentation for the parent or guardian must be submitted with the request for the health plan to determine that the parent(s) is physically unable to provide PCS to the child.

The member must be of an age at which the tasks to be performed by the PCS provider would ordinarily be performed by the individual, if he/she was not disabled due to illness or injury.

The member should have 2 or more limitations in the following areas that are likely to continue indefinitely:

- Self-care, such as assistance with eating, bathing, grooming, dressing, toileting, bladder and/or bowel problems
- Receptive and expressive language deficits
- Learning deficits due to an intellectual or physical impairment or combination of intellectual and physical impairments
- Mobility
- Self-direction
- Capacity for independent living

Available supports
When determining whether a member qualifies for PCS, consideration must be given not only to the type of services needed, but also the availability of family members and/or friends who can aid in providing such care. PCS are not to function as a substitute for child care arrangements.

Physician referral
PCS must be prescribed by the member's attending physician initially and every 180 days after that (or rolling six months) or when changes in the plan of care occur as approved by the physician.

Service limitations
Services approved shall be based on the physical requirements of the member and medical necessity for the covered services in the PCS program. There shall be no limit to the number of PCS hours to recipients under the age of 21. Hours may not be saved to be used later or in excess of the number of hours specified according to the approval letter.

Initial and subsequent prior authorization
PCS must be prior authorized by Healthy Blue or its designee. Initial and subsequent PCS shall not be authorized for more than a six-month period without a face-to-face medical assessment being completed by a physician. The member's choice of a PCS provider may assist the physician in developing a plan of care, which shall be submitted for review/approval by Healthy Blue or its designee. Members may contact Healthy Blue directly for assistance in locating a primary care provider.

Required documentation
All prior authorization requests for PCS must be accompanied by the following documents:

- A completed prior authorization form (available on the provider website)
- Plan of care prepared by the PCS agency with physician signature of approval including the following components:
    - Member name, Healthy Blue ID number, date of birth, address and phone number
    - Date personal care services are requested to start
    - Provider name, Medicaid provider number and address of personal care agency

    - Name and phone number of someone from the provider agency that may be contacted, if necessary, for additional information
- Medical reasons supporting the need for PCS (must be accompanied by appropriate medical documentation for member and parent/caregiver if parent/caregiver is disabled)
- Other in-home services the member is receiving including skilled nursing and physical, occupational, speech or respiratory services
- Specific personal care tasks (bathing, dressing, eating, etc.) with which PCS provider is to assist the member
- Goals for each activity
- Number of days services are required each week
- Time requested to complete each activity
- Total time requested to complete each activity each week

Subsequent plans of care
A new plan of care must be submitted at least every 180 days (rolling six months). The subsequent plan of care must:

- Be approved by the member's attending physician.
- Reassess the member's need for PCS.
- Include any updates to information that has changed, such as decrease or increase in activities, number of days services required since the previous assessment was conducted.
- Explain when and why the change or changes occurred.

The physician shall only sign and date a fully completed plan of care that is acceptable for submission to Healthy Blue.

The PCS provider may not initiate services or changes in services under the approved plan of care prior to approval by Healthy Blue.

PCS must be prescribed by the member's attending physician initially and every 180 days after that (or rolling six months) and when changes in the plan of care occur. The prescription should specify the number of hours being requested and must specify PCS and not PCA.

The agency may use their agency-specific forms; however, PCS supporting clinical documentation should have been completed by the physician within the last 90 days and should include at minimum the following:

- Documentation the member requires/would require institutional level of care equal to an intermediate care facility
- Documentation of a face-to-face medical assessment was completed
- Documentation of the personal care activities that the parent or other caregiver is providing and/or requires assistance with, and the reason the parent cannot provide the assistance

- Any other supporting documentation that would support medical necessity (other independent evaluations, etc.)

Requests for prior approval of PCS should be submitted by fax or electronically to Healthy Blue at the following number: [**1-844-864-7868]**. The request shall be reviewed by the health plan and a decision rendered as to the approval or denial of the requested service(s). A letter will be sent to the member, the provider and the support coordination agency, if available, advising of the decision in accordance with the Healthy Louisiana contract timelines.

Changes in plan of care

- Amendments or changes in the plan of care should be submitted as they occur and shall be treated as a new plan of care, which begins a new six-month service period.
- Revisions of the plan of care may be necessary because of changes that occur in the member's medical condition, which warrant an additional type of service, an increase or decrease in frequency of service, or an increase or decrease in duration of service.
- Documentation for a revised plan of care is the same as for a new plan of care. Both a new start date and reassessment date must be established at the time of reassessment. The provider may not initiate services or changes in services under the plan of care prior to approval by Healthy Blue.

Chronic needs designation

- Healthy Blue shall determine in each case if a prior authorized service can reasonably be expected to be required at the same level in future time periods, and if so, services for successive prior authorization requests shall be authorized upon receipt of the physician's prescription only.
- Members and their support coordinator, if any, shall be required to report to Healthy Blue any change in the member's condition that reduces the level of services needed.

Reconsideration request

If the prior authorization request is not approved as requested, the provider may ask for a reconsideration of the previous decision.

The peer-to-peer can only be completed between the medial director for the health plan and the member's attending physician.

The provider or provider representative must contact Healthy Blue within five business days from the initial fax notification of denial to request a peer-to-peer. If the request is made beyond this time requirement, the next course of action for the provider is the appeal process.

A Healthy Blue representative will contact the requesting provider within one business day to schedule the peer-to-peer review. If the provider is not able to meet the schedule requirements for the peer-to-peer, the next course of action for the provider is the appeal process.

Changing PCS providers
Members have the right to change providers at any time; however, approved authorizations are not transferred between agencies. If a member elects to change providers within an authorization period, the current agency must notify the Healthy Blue Outpatient Prior Authorization Unit of the member's discharge, and the new agency must obtain their own authorization through the usual authorization process.

Note: Members may contact Healthy Blue directly for assistance in locating another provider.

Prior authorization liaison
The designated Healthy Blue outpatient prior authorization liaison (PAL) was established to facilitate the authorization process for members who are part of the request for services registry (Chisholm members). The designated PAL assists the member by contacting the provider, member and support coordinator (if the member has one) when a request cannot be approved because of a lack of documentation or a technical error.

Staff assigned to provide PCS shall not be a member of the member's immediate family. (Immediate family includes father, mother, sister, brother, spouse, child, grandparent, in-law, or any individual acting as parent or guardian of the member.) PCS may be provided by a person of a degree of relationship to the member other than immediate family if the relative is not living in the member's home or if he/she is living in the member's home solely because his/her presence in the home is necessitated by the amount of care required by the member.

PCS service delivery
If the member is receiving home health, respite and/or any other related service, the PCS provider cannot perform services at the same time as the other Medicaid-covered service providers such as home health. Within six months of the member aging out of PCS, the plan must send a report to Medicaid staff with the member name, Medicaid ID, member address and member date of birth. This report needs to be sent monthly in order for Medicaid to notify the member that they can access long-term PCS services once they age out of EPSDT-PCS.

PCS providers may provide Children's Choice waiver services to the member on the same date as PCS; however, both Children's Choice waiver services and PCS may not be performed at the same time.