TITLE: PERSONAL CARE ASSISTANCE

EFFECTIVE DATE: November 19, 2018

THIS POLICY APPLIES TO MEMBERS WHO ARE COVERED BY MEDICA CHOICE CARESM MSC+ (MINNESOTA SENIOR CARE PLUS [MSC +] AND MEDICA DUAL SOLUTION® (MINNESOTA SENIOR HEALTH OPTIONS [MSHO]).

This policy was developed with input from specialists in internal medicine, family practice and pediatrics and endorsed by the Medical Policy Committee.

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

These services may or may not be covered by all Medica plans. Please refer to the member’s plan document for specific coverage information. If there is a difference between this general information and the member’s plan document, the member’s plan document will be used to determine coverage. With respect to Medicare and Minnesota Health Care Programs, this policy will apply unless those programs require different coverage. Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Medica utilization management policy may call the Medica Provider Service Center toll-free at 1-800-458-5512.

Medica utilization management policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care and treatment.

PURPOSE

To promote consistency between reviewers in utilization management decision-making by providing the criteria that generally determine the medical necessity of personal care assistance. The Benefit Considerations box below outlines the process for addressing the needs of individuals who do not meet these criteria.

BACKGROUND

I. Definitions

A. Activities of Daily Living (ADLs) means grooming, dressing, bathing, transferring, mobility, positioning, eating, and toileting.

B. Assessment means a review and evaluation of a recipient's need for personal care assistance services conducted in person. Assessments for personal care assistance services shall be conducted by a qualified assessor as determined by the Department of Human Services (DHS). Please refer to the DHS Assessment Tool for additional assessment guidelines and instructions.

C. Behavior are those categories of behavior that allow a recipient to qualify for additional time for PCA services, provided recipients have a behavior that requires assistance at least four times per week. Having one or more behaviors qualifies a person with more than one dependency in ADLs and/or a Level I behavior for more time of personal care assistance services in addition to the time determined by the PCA home care rating. The three categories of behaviors are:
   1. Physical aggression towards self or others, or destruction of property that requires the immediate response of another person (referred to as “Level 1 behavior”);
   2. Increased vulnerability due to cognitive deficits or socially inappropriate behavior;
   3. Increased need for assistance for recipients who are verbally aggressive or resistive to care so that the time needed to perform activities of daily living is increased.

D. Complex Health-Related Needs means a category to determine the home care rating for personal care assistance services and is based on the criteria outlined in Minn. Stat. § 256B.0659. Complex Health-Related Needs qualifies a member with two or more ADL dependencies for more time of personal care assistance services.
assistance services than is determined by the PCA home care rating. Assessment for Complex Health-Related Needs must meet the criteria in this paragraph. During the assessment process, a recipient qualifies as having Complex Health-Related Needs if the recipient has one or more of the following interventions that are ordered by a physician and specified in a personal care assistance care plan:
1. Tube feedings
2. Wounds
3. Parenteral therapy
4. Respiratory interventions
5. Insertion and maintenance of catheter
6. Bowel program more than two times per week requiring more than 30 minutes to perform each time
7. Neurological interventions; and
8. Other congenital or acquired diseases creating a need for significantly increased direct hands-on assistance and interventions in at least six ADLs.

E. **Critical ADLs** means transferring, mobility, eating, and toileting, which qualifies a person with two or more ADL dependencies for more time of personal care assistance services than is determined by the PCA home care rating.

F. **Dependency in ADLs** means a person has a daily need, or need on the days of the week the activity is completed, for cueing and constant supervision or hands-on assistance to begin and complete one or more of the ADLs.

G. **Face-to-face encounter**
1. A face-to-face encounter by a qualifying provider must be completed for all home health services regardless of the need for prior authorization, except when providing a onetime perinatal visit by skilled nursing. The face-to-face encounter may occur through telemedicine as defined in section 256B.0625, subdivision 3b. The encounter must be related to the primary reason the recipient requires home health services and must occur within the 90 days before or the 30 days after the start of services. The face-to-face encounter may be conducted by one of the following practitioners, licensed in Minnesota:
   a. a physician;
   b. a nurse practitioner or clinical nurse specialist;
   c. a certified nurse midwife;
   d. a physician assistant;
2. The allowed nonphysician practitioner, as described in this subdivision, performing the face-to-face encounter must communicate the clinical findings of that face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the recipient's medical record. To assure clinical correlation between the face-to-face encounter and the associated home health services, the physician responsible for ordering the services must:
   a. document that the face-to-face encounter, which is related to the primary reason the recipient requires home health services, occurred within the required time period; and
   b. indicate the practitioner who conducted the encounter and the date of the encounter.
3. For home health services requiring authorization, including prior authorization, home health agencies must retain the qualifying documentation of a face-to-face encounter as part of the recipient health service record, and submit the qualifying documentation to the commissioner or the commissioner's designee upon request.

H. **Flexible Use Option** allows members to use authorized personal care assistance hours in a flexible way to meet their needs and schedules for medically necessary covered services as specified in the assessment. Personal care assistance hours are available as flexible use with authorization. Hours are allocated considering the ongoing needs of the member over an entire year divided into periods of flexible use of no more than six months. Members do not have to use their hours on the same schedule each day. The use of authorized units of personal care assistance services may vary within the length of the service authorization. Authorized hours not used within the service authorization period may not be carried over to another time period. Flexible use does not increase the total amount of authorized units available. No more than 75% of the total authorized personal care assistance services time for a 12-month authorization may be used in a six-month date span. Refer to the DHS PCA Program Manual at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=PCA_Home and the Medica Provider Administrative Manual for further information.

I. **Instrumental Activities of Daily Living (IADLs)** means activities to include meal planning and preparation; basic assistance with paying bills; shopping for food, clothing, and other essential items;
J. **Level I Behavior** is the specific behavior category that must be met to be eligible for a Level I behavior home care rating category. For the purpose of determining eligibility for a Level I behavior home care rating category, a member needs to have had the Level I behavior occur at least one time in the year leading up to the PCA assessment. In accordance with Minn. Stat. § 256B.0659, Level I behavior means physical aggression towards self, others, or destruction of property that requires the immediate response of another person.

K. **Personal Care Assistant (PCA)** is a trained individual providing assistance and support to persons with disabilities living independently in the community, including the elderly and others with special health care needs. A PCA must meet required qualifications and be employed by a personal care assistance provider organization/agency (PCPO/PCPA), a home health agency, or be jointly employed by the member and a PCA Choice Provider. The PCA maintains daily written records detailing the actual services provided to the member and the amount of time spent providing the services.

L. **Personal Care Assistance Care Plan (Care Plan)** is a written description of personal care assistance services developed by the personal care assistance provider according to the PCA Assessment and Service Plan.

M. **Choice Option** is an option of the personal care assistance program that allows the recipient who receives personal care assistance services to be responsible for the hiring, training, scheduling, and firing of PCAs. This program offers greater control and choice for the recipient in choosing who provides the personal care assistance service and when the service is scheduled. The recipient or the recipient’s responsible party must choose a personal care assistance choice provider agency as a fiscal intermediary. This personal care assistance choice provider agency manages payroll, invoices the state, is responsible for all payroll related taxes and insurance, and is responsible for providing the consumer training and support in managing the recipient's personal care assistance services.

N. **PCA Assessment and Service Plan** is a written summary of the assessment and description of the services needed by the recipient.

O. **Personal Care Assistance Provider Organization/Agency (PCPO/PCPA)** is a medical assistance enrolled provider that provides or assists with providing personal care assistance services and includes personal care assistance provider organizations, a personal care assistance choice agency, a class A licensed nursing agency, and a Medicare-certified home health agency.

P. **Qualified Professional (QP)** is a registered nurse (RN), a mental health professional, a licensed social worker, or a qualified designated coordinator. The QP is responsible for PCA supervision.

Q. **Residence** is the place a person uses as his/her primary dwelling place that is not a hospital, intermediate care facility or nursing facility.

R. **Responsible Party (RP)** is an individual (or two persons for reasons such as divided households and court-ordered custodies) capable of providing the support necessary to assist the member to live in the community and who enters into a written agreement with the PCPO/PCPA to be the identified RP. The recipient or the recipient's legal representative shall appoint an RP if necessary to direct and supervise the care provided to the recipient. An RP is required when the person is less than 18 years of age, an incapacitated adult, or the assessment determines that the recipient is in need of a RP to direct the recipient’s care. Each person named as RP must meet the following program criteria and responsibilities:

1. **Criteria:**
   a. Must be at least 18 years of age;
   b. Must be identified at the time of the Assessment and listed on the recipient's service agreement and Care Plan; and
   c. Must NOT be the:
      i. PCA
      ii. QP
      iii. Home care provider agency owner or manager
      iv. Home care provider agency staff unless staff, who are not listed above (i – iii), are related to the recipient by blood, marriage or adoption
      v. County staff acting as part of employment
      vi. A licensed family foster parent who lives with the recipient unless the family foster parent meets the other RP requirements.
2. **Responsibilities.** An RP shall enter into a written agreement with a PCPO/PCPA to perform the following duties:
   a. Be available while care is provided in a method agreed upon by the individual or the individual's legal representative and documented in the recipient's Care Plan
   b. Monitor personal care assistance services weekly to ensure the recipient's Care Plan is being followed
   c. Review and sign personal care assistance time sheets to provide verification of the personal care assistance services
   d. Actively participate in planning and directing of personal care assistance services; and
   e. Attend all assessments for the recipient.

S. **Restricted Recipient Program** is a program for members who have received medical care and have not followed the rules or have misused services. While in the Restricted Recipient Program, the member must obtain all health services from one designated doctor, pharmacy, hospital or other designated provider. The member may be assigned to a home health agency and may not be allowed to use the Choice Option or Flexible Use Option. Placement in the program will stay with the member if he/she changes health plans or changes to/from fee-for-service coverage through the State.

T. **Shared Care Option** is an option where two or three members choose to share personal care assistance services in the same setting at the same time from the same PCA. Medica expects shared care to be utilized and billed as such when the eligibility criteria are met and the PCPO/PCPA offers the shared care option.

U. **Standard Use Option** allows personal care assistance service hours/units to be authorized on a daily average allocation with flexibility only within each month. Personal care assistance hours do not transfer from month to month.

V. **Supervision of personal care assistance services by the QP** includes, but is not limited to:
   1. Care Plan development and maintenance
   2. On-going monitoring and supervision of personal care assistance services
   3. Completion of all required documentation
   4. Communication of changes in client needs to the physician, public health nurse, and/or MCO care coordinator
   5. Orientation of PCAs to personal care and needs
   6. Training PCAs to provide hands-on assistance with special health care tasks
   7. Evaluation of PCAs to ensure that care is provided correctly; and
   8. Evaluation of member satisfaction with personal care assistance services.

W. **Ventilator Dependence** means a member who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent on a ventilator for at least 30 consecutive days.

II. Comments

The personal care assistance services eligible for payment include services and supports furnished to a member, as needed, to assist in:

A. **ADLs**

B. **Health-Related Procedures and Tasks**, including those associated with the Complex Health-Related Needs of a recipient if the PCA is trained by a QP and demonstrates competency to safely complete the procedures and tasks. Delegation of health-related procedures and tasks and all training must be documented in the Care Plan and the recipient’s and PCA’s file

C. **IADLs**

D. Observation and Redirection of Behaviors, when there is a need for redirection due to behaviors, as determined during the assessment, as described below. Training of the PCA must occur based on the needs of the recipient, the Care Plan, and any other support services provided.

E. In accordance with Title II of the Americans with Disabilities Act, Medica is obligated to administer services for public programs in the most integrated setting appropriate to the needs of qualified individuals with disabilities. “Integrated setting” means one that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible. Integrated settings are those that provide individuals with disabilities opportunities to live, work, and receive services in the greater community, like individuals without disabilities.

1. In particular, Medica must provide community-based services to government program recipients with disabilities when: (i) such services are appropriate; (ii) the affected recipients do not oppose community-based treatment; and (iii) community-based services can be reasonably accommodated,
Personal Care Assistance
Medica Policy No. III-HOM.03

BENEFIT CONSIDERATIONS

NOTE: Additional information regarding coverage requirements for personal care assistance services is available on the Minnesota Department of Human Services PCA Program Manual available at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=PCA_Home and in the references listed below.

1. Prior authorization is required for payment of personal care assistance services except in the case of members transitioning to Medica with active personal care assistance services as described under section II(A)(4) of the Medical Necessity Criteria section. Please see the prior authorization list for product specific prior authorization requirements.
   A. Requests for re-authorization of services must be submitted at least 60 days in advance of the end of the authorization.
   B. Claims will not be paid without an authorization.

2. Coverage may vary according to the terms of the member’s plan document and/or as specified in related state statutes and rules.
   A. Personal care assistance services are eligible for coverage when all of the following criteria are met:
      i. Provided by a person who meets the qualifications of a PCA.
      ii. Provided through a participating home health care agency or PCPO/PCPA.
      iii. Patient’s residence is not a hospital, nursing facility, intermediate care facility, or a health facility that is licensed by the Department of Health or a foster care setting where there are more than four residents.
      iv. Personal care assistance services are supervised by a QP.
      v. Criteria in the Medical Necessity section of the policy are met.
   B. Requests for personal care assistance hours require authorization at least annually.
   C. Non-covered services include:
      i. Personal care assistance services provided without or beyond the authorization from Medica
      ii. Sterile procedures
      iii. Injections of fluids into the veins, muscles, or skin
      iv. Application of restraints or implementation of procedures as described under Minn. Stat. § 245.825
      v. Home maintenance or chore services
      vi. Homemaker services that are not an integral part of the personal care assistance services
      vii. IADLs for children under the age of 18, except when immediate attention is needed for health or hygiene reasons integral to the PCA and the need is listed in the PCA Assessment and Service Plan by the assessor
      viii. Services provided in lieu of other staffing options in a residential or child care setting
      ix. Services provided solely as a child care or babysitting service
      x. Services that are not specified in the Care Plan
      xi. Services that are not supervised by a QP
      xii. Services provided by the member’s licensed foster provider (unless a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met), spouse, paid legal guardian, or parent of a member under the age of 18
      xiii. Services provided by the RP for a member who cannot direct his/her own care
      xiv. Services provided in residential settings by a provider of home care services (who is not related by blood, marriage or adoption) who owns or otherwise controls the living arrangement including licensed or unlicensed services
      xv. Services provided by the residential or program license holder in a residence for more than four persons

taking into account the resources available and the needs of others who are receiving disability services.

2. People with disabilities have the right to experience meaningful, inclusive and integrated lives in their communities, supported by an array of services and supports appropriate to their needs that they choose (including PCA services).
xvi. Services provided in a residential setting that are the responsibility of a residential or program license holder under the terms of a service agreement and applicable administrative rules (this includes foster care providers)

xvii. Until the state transitions to using Certified Assessors, assessments for personal care assistance completed by agencies and/or assessors not contracted by Medica

xviii. Services provided solely to meet Medicare home health agency certification requirements.

3. If a member is placed in the Restricted Recipient Program, the member may not use the Choice Option or Flexible Use Option during the period of time the member is in the Restricted Recipient Program.

4. The personal care assistance assessor provides an assessment of the member’s needs on a typical day, without regard for other services or informal supports given to the member. Medica’s authorization of personal care assistance services is based on assessed need and qualifying dependencies. Other services may be authorized in conjunction with personal care assistance to meet a member’s needs and will be considered to determine appropriate personal care assistance service authorization.

5. Approved hours may be used inside or outside the home when normal life activities take the member outside the home, and when, without the provision of personal care assistance services, the member’s health and safety would be jeopardized. Total hours for personal care assistance services, whether actually performed inside or outside of the member’s home, cannot exceed that which is otherwise allowed for personal care assistance services in an in-home setting.

6. PCPO/PCPAs must keep specific documentation on file for each member for 10 years. Required documentation is described in the Medica Provider Administrative Manual and Minnesota Statutes.

7. For personal care assistance services to be eligible for reimbursement, PCAs must comply with the requirements in Minnesota Statutes 256B.0659, 256B.0625, 256B.0651, 256B.0652 and other related statutes and rules.

8. Medicaid PCA services requested by a government program member to support a move into a less restrictive community setting (from a hospital, skilled nursing facility, or other institution) cannot be denied because the cost exceeds that of the facility.

A. For MSHO and MSC+: The cost restriction on Medicaid PCA services are determined by the Continuing Care Service Rate limits associated with the MA Home Care Rating found on the DHS Home Care Nursing Service Decision Tree DHS-4071-C. If a government program member is open to the Elderly Waiver, the cost of PCA services must fit within the Elderly Waiver Case Mix cap. Coordination of services that fit within the Case Mix cap is the responsibility of the assigned Medica Care Coordinator.

9. If the Medical Necessity and Coverage Criteria are met, Medica will authorize benefits within the limits in the member’s plan document and related Minnesota Statutes and rules.

10. If it appears that the Medical Necessity and Coverage Criteria are not met, the case will be reviewed by the medical director or an external reviewer. Practitioners are advised of the appeal process in their Medica Provider Administrative Manual.

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**MEDICAL NECESSITY CRITERIA**

I. Indications for personal care assistance services

**All of the following** criteria must be met for a member to qualify for personal care assistance services:

A. The services must be medically necessary.

B. The services must be under the supervision of a QP.

C. The member must require personal care assistance services in order to live independently in the community.

D. The member must meet one of the following criteria:
   1. Must be able to identify his/her own needs, direct and evaluate PCA task accomplishment, and provide for his/her own health and safety
   2. Must have an RP who can make decisions about care for the member.

E. The member must meet one of the following criteria:
   1. A member must be assessed as dependent in at least two ADLs based on the person’s need, on a daily basis or on the days of the week the activity is completed, for:
      a. Cueing and constant supervision to complete the task;
      b. Hands-on assistance to complete the task.
   2. Members with two or more ADL dependencies can receive additional time for Critical ADLs, Behaviors, and Complex Health-Related Needs.
3. Members with no more than one dependency in an ADL and/or Level I Behavior are eligible for a maximum of 30 minutes or two units of PCA services per day and they cannot receive additional time for Critical ADLs, Behaviors, or Complex Health-Related Needs.

F. A child may not be found to be dependent in an ADL if, because of the child’s age, an adult would either perform the activity for the child or assist the child with the activity. Assistance needed is the assistance appropriate for a typical child of the same age.

II. Authorization of personal care assistance hours

A. Initial and ongoing authorization of personal care assistance hours

   All of the following must be completed:

   1. An assessment, conducted by a qualified assessor as determined by the Department of Human Services, validates criteria under section I above, based on an evaluation of the member’s need, ability, preferences, and history of service use. Hours are allocated considering the ongoing needs of the member over an entire year.

   2. Service and support planning and referral. The assessor must review the assessment with the recipient or responsible party and determine referrals for other payers, services, and community supports as appropriate. The recipient must be referred for evaluation, services, or supports that are appropriate to help meet the recipient’s needs including, but not limited to, the following circumstances: a) when there is another payer who is responsible to provide the service to meet the recipient’s needs; b) when the recipient qualifies for assistance due to mental illness or behaviors under this section, a referral for a mental health diagnostic and functional assessment must be completed, or referral must be made for other specific mental health services or other community services; c) when the recipient is eligible for medical assistance and meets medical assistance eligibility for a home health aide or skilled nurse visit; d) when the recipient would benefit from an evaluation for other service; and e) when there is a more appropriate service to meet the assessed needs.

   3. A written Care Plan based on the PCA Assessment and Service Plan must be developed by the QP with the recipient and RP if an RP has been appointed. The Care Plan must be completed within the first week after start of services with a PCPO/PCPA and must be updated as needed when there is a change in need for PCA services. A new Care Plan is required annually at the time of the reassessment. The Care Plan must specify the personal care assistance needs of the member and contain the components outlined in the administrative requirements for personal care assistance services.

   4. Authorization for members transitioning to Medica with active personal care assistance services

      a. The amount and type of personal care assistance services authorized by the previous payer will remain in effect for the duration of the authorization, unless the assessment by Medica indicates otherwise or unless the service needs change, at which time a new personal care assistance services assessment is warranted.

      b. Required documentation will include the most recent authorization from the previous payer and the most recent PCA Assessment and Service Plan or completed Form CMS-485 – Home Health Certification and/or PCPO/PCPA Care Plan.

   5. Ongoing authorization requires that an assessment of the member’s need for personal care assistance services, conducted at least annually, demonstrates that all of the criteria in Sections I and II continue to be met.

B. Authorization of additional personal care assistance hours

   1. Temporary authorization of personal care assistance services

      a. Medica may provide temporary authorization of personal care assistance services based on the PCA Assessment and Service Plan or Care Plan information.

      b. Temporary authorizations may not exceed 45 calendar days.

      c. The level of services authorized as a temporary authorization will not have any bearing on future authorizations.

      d. Documentation that demonstrates a change in the member’s condition and a need for increased services may be requested for additional hours to be authorized. If the change of condition is expected to be long-term, Medica may require a new assessment. Refer to the DHS PCA Program Manual at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=PCA_Home for additional information.
2. Additional personal care assistance hours will not be authorized to supplement a service authorization exhausted before the end date when there has been inappropriate management of flexible personal care assistance hours. The PCA, together with the member or responsible party, must monitor and document the use of authorized units and ensure that the services are managed effectively throughout the authorized period. If personal care assistance hours are exhausted before the end of the authorization period, the PCPO/PCPA must notify the member and Medica.

III. Written documentation specifying the medical necessity, according to the criteria above, is required. Requested documentation may include, but is not limited to:
   A. An assessment of the member’s need for personal care assistance services, at least annually, conducted by a qualified assessor as determined by the Department of Human Services, with more frequent assessments according to clinical need
   B. A written Care Plan provided upon request.
   C. Home health agency must retain documentation of the face-to-face encounter (refer to definitions for more info).

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Original Effective Date</th>
<th>December 1, 2003</th>
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<tbody>
<tr>
<td>Administrative Updates</td>
<td>05/01/2017, 01/01/2019</td>
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References

Pre-09/2015 MPC:

09/2015 MPC:
No new references

09/2016 MPC:
References 1, 3 & 8 from above still current. References 2, 4, 5, 6, 7 updated – see below:

09/2017 MPC:
References 1, 3, 8, 9, 14-16 from above still current. References 10-13 updated – see below:

02/2018 MPC:

09/2018 MPC:
Going forward all current references will be listed for each MPC review.