Government Business Division
Policies and Procedures

Section (Primary Department) **Health Care Management – Utilization Management**		**SUBJECT (Document Title)** **Pediatric Day Health Care and Personal Care Services – LA**	
Effective Date November 12, 2018	**Date of Last Review** ~~December 9, 2019~~July 19, 2021	**Date of Last Revision** ~~December 9, 2019~~July 19, 2021	**Dept. Approval Date** ~~December 9, 2019~~July 19, 2021
Department Approval/Signature : **Policy applies to health plans operating in the following State(s). Applicable products noted below.**			

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☐ California	☐ Kentucky	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☒ Louisiana	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ Wisconsin
	☐ Georgia	☐ Missouri	☐ South Carolina	☐ West Virginia
	☐ Indiana	☐ Nebraska		

POLICY:

To provide guidance for the administration of Pediatric Day Health Care (PDHC) and Personal Care Services (PCS) consistent with standards set forth by the Louisiana Department of Health (LDH), and ensure services offered under the Early and Periodic Screening, Diagnostic, ~~is~~ [WJL1][NS2][WJL3]and Treatment (EPSDT) program are provided in the most appropriate, cost-effective, and least restrictive setting, compatible with medical necessity as determined by the severity of illness and/or the intensity of the services needed to contribute to an improved health status. PDHC and PCS are covered benefits when medical necessary for beneficiaries~~recipients~~ under twenty-one (21) years of age~~up to twenty-one (21) years of age~~.

DEFINITIONS:

** Denotes terms for which Healthy Blue must use the State-developed definition.*

Activities of Daily Living (ADL) – Those daily activities that are required by an individual for continued well-being, health, and safety. The function or basic self-care tasks which are performed by an individual in a typical day, either independently or with supervision/assistance. ADLs include bathing, dressing, eating, grooming, walking, transferring, and/or toileting. The extent to which a person requires assistance to perform one (1) or more of these activities is often a level of care criterion.

Early and Periodic Screening, Diagnostic~~is~~, and Treatment (EPSDT) – Medicaid's comprehensive and preventive child health program for individuals who are under the age of twenty-one (21). All medically necessary Section 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT-eligible beneficiaries ages birth to twenty-one (21), in accordance with 42 USC §1396d(r). This includes but is not limited to, conditions which are discovered through EPSDT Well Child screening services, whether or

not such services are covered under the Medicaid State Plan [42 USC §1396d(r)(5) and the CMS State Medicaid Manual].

Electronic Visit Verification (EVV) – A web-based system that electronically records and documents the precise date, start and end times that services are provided to beneficiaries ~~recipients~~[WJL4]. The EVV system ~~helps to~~helps to[NS5] ensure [WJL6]that beneficiaries~~recipients~~ are receiving services authorized in their plan of care (POC), reduce inappropriate billing/payment, safeguard against fraud and improve program oversight.

Medically Complex Condition – A medically complex condition involves one (1) or more physiological or organ systems and requires skilled nursing care and therapeutic interventions performed by a knowledgeable or experienced licensed professional registered nurse (RN) or licensed practical nurse (LPN) on an ongoing basis to preserve and maintain health status, prevent death, treat/cure disease, ameliorate disabilities or other adverse health conditions and/or prolong life.

Medically Necessary Services* – Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the beneficiary. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the beneficiary requires at that specific point in time. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

NOTE: The fact that a provider has prescribed, recommended or approved medical or allied care, goods or services, does not in itself make such care, goods or services medically necessary, or a covered service. Medicaid reimburses for services that are deemed medically necessary, do not duplicate another provider's service and meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
- Be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the patient's needs;

- Be consistent with generally accepted professional medical standards as determined by the Medicaid program and not experimental or investigational;
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative, more integrated or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the beneficiary~~recipient~~, the beneficiary~~recipient~~'s caretaker or the provider.

Pediatric Day Health Care (PDHC) – An array of services to meet the medical, social and developmental needs of children from birth up to twenty-one (21) years of age who have a complex medical condition which requires skilled nursing care and therapeutic interventions on an ongoing basis to preserve and maintain health status, prevent death, treat/cure disease, ameliorate disabilities or other adverse health conditions and/or prolong life. PDHC is to serve as a community-based alternative to long-term care and extended in-home nursing care. PDHC does not provide respite care, and it is not intended to be an auxiliary (back-up) for respite care. PDHC is intended to be for individuals needing a higher level of care that cannot be provided in a more integrated community-based setting.

Personal Care Services (PCS) – Tasks provided by direct service workers~~attendants~~ that are medically necessary as they pertain to an Early and Periodic Screening, Diagnostic~~is~~, and Treatment (EPSDT) eligible's ~~-~~physical requirements when physical or cognitive limitations due to illness or injury necessitate assistance with eating, bathing, dressing, personal hygiene, bladder or bowel requirements, and these services prevent institutionalization and enable the beneficiary~~recipient~~ 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. PCS does not include medical tasks such as medication administration, tracheostomy care, feeding tubes, or catheters.[NS7][WJL8][NS9][WJL10]

~~**Plan of Care (POC)** – An person-centered, individualized, and comprehensive written document developed by the member[NS11][NS12][WJL13], his/her authorized representative, and provider based on assessment results. The document identifies each service area and outlines how services will be delivered to a beneficiary[NS14][WJL15][NS16][WJL17][NS18]. The strategies are designed to guide health care professionals involved with patient care. Such plans are patient-specific and meant to address the total status of the patient. Care plans are intended to ensure optimal outcomes for patients during the course of their care. PDHC facility for each child to receive medical, nursing, psychosocial, developmental and educational therapy services, in conjunction with the recipient (or parent/guardian) that outlines how services will be delivered to the recipient and support achievement of care goals.~~ **Plan of Care (POC)** – A person-centered, individualized, comprehensive written document developed by the beneficiary, his/her authorized representative, and provider based on assessment results. The document identifies

each service area and outlines how services will be delivered to a beneficiary based on his/her preferences. Strategies are designed to guide health care professionals involved with patient care. Such plans are patient-specific and meant to address the total status of the patient. Care plans are intended to ensure optimal outcomes for patients during the course of their care. For example, it is a comprehensive plan developed by the pediatric day health care (PDHC) facility for each child to receive medical, nursing, psychosocial, developmental and educational therapy services, in conjunction with the beneficiary (or parent/guardian) that outlines how services will be delivered to the beneficiary and support achievement of care goals.

Precertification – Medical necessity review of a healthcare service, treatment plan, equipment, or prescription drug that is prospective or conducted prior to the member's utilization of service or course of treatment in a hospital or other facility. Also referred to as prospective review, prior authorization (PA), prior approval, or preauthorization.

PROCEDURE:

Pediatric Day Health Care (PDHC) provides an array of services to meet the medical, social, and developmental needs of children from birth up to twenty-one (21) years of age who have a complex medical condition which requires skilled nursing care and therapeutic interventions on an ongoing basis to preserve and maintain health status, prevent death, treat/cure disease, ameliorate disabilities or other adverse health conditions and/or prolong life. PDHC is to serve as a community-based alternative to long-term care and extend in-home nursing care. PDHC is intended for individuals needing a higher level of care that cannot be provided in a more integrated community-based setting.[NS19][WJL20][NS21]

All PDHC services must be prior authorized. Services may be provided seven (7) days per week and up to twelve (12) hours per day for qualified Medicaid beneficiaries~~recipients~~ as documented in the plan of care (POC). Services may be provided for a full or partial day and include transportation.

- A full day of service is more than six (6) hours, not to exceed a maximum of twelve (12) hours per day, and reimbursed on a per diem basis (T1025).
- A partial day of service is equal to six (6) or less hours per day and reimbursed on an hourly basis (T1026). PDHCs may only bill an additional hour of skilled services if thirty (30) or more minutes of care has been provided.
- For full and partial days, PDHCs must document in the clinical record the start and end time that skilled services were provided.
- If the beneficiary~~recipient~~ is approved for full days of services, partial hours will be automatically generated with the prior authorization for a percentage of the number of full days approved.

- Transportation is reimbursed in a separate per diem (T2002). Transportation time is not included in determining reimbursement of PDHC hours. The transportation benefit is part of PDHC program rather than a service within the non-emergency medical transportation (NEMT) program.[NS22][WJL23][NS24][WJL25]

The PDHC per diem rate includes the following services/equipment:

- Nursing care;
- Respiratory care;
- Physical therapy;
- Speech-language therapy;
- Occupational therapy;
- Social services;
- Personal care services (PCS) for activities of daily living (ADL); and
- Transportation to and from the PDHC facility (paid in a separate per diem).[NS26][WJL27]

~~The~~ PDHC does **not** include the following services:

- Education and training services;
- Before and after school care;
- Respite services;
- Child care due to work or other parental time constraints;
- Medical equipment, supplies and appliances;
- Parenteral or enteral nutrition; and
- Infant food or formula.

PDHC does not provide respite care and is not intended to be an auxiliary (back-up) for respite care. P~~However, p~~arental or guardian availability ~~"Parent availability"~~ cannot be used as a factor in the determination of authorization for services.

To be eligible for PDHC services, the beneficiary~~recipient~~ must require nursing supervision and possible therapeutic interventions due to a medically complex condition. The determination for services is based on medical necessity and may consider other services currently provided or available to the member. ~~"Parent availability" cannot be used as a factor in the determination of authorization for services.~~ In order to qualify for PDHC services, a beneficiary~~recipient~~ must meet all of the following criteria:

1) Be Louisiana Medicaid eligible;
2) Be from birth up to twenty-one (21) years of age;
3) Have a medically complex condition which involves one (1) or more physiological or organ systems and requires skilled nursing care and therapeutic interventions performed by a knowledgeable or experienced licensed professional registered nurse (RN) or licensed practical nurse (LPN) on an ongoing basis to preserve and maintain health status, prevent

death, treat/cure disease, ameliorate disabilities or other adverse health conditions, and/or prolong life;
4) Be a candidate for outpatient medical services in a home or community-based setting; and
5) Have a signed physician's order and POC by the beneficiary~~recipient~~'s physician specifying the frequency and duration of services.
   a) The POC must clearly outline the skilled nursing care and therapeutic interventions that will be performed in the PDHC.
   b) The POC must be individualized, specific and consistent with the symptoms or confirmed diagnosis of the disease, condition, or injury under treatment, and not in excess of the beneficiary~~recipient~~'s needs.

PDHC services require prior authorization (PA) and must be approved prior to the delivery of services. The PDHC PA form is standardized regardless of the health plan covering the services. To receive PA, the following documentation must be sent for each request:
1) Standardized PA form which must include why the services provided at the PDHC cannot be provided elsewhere, including the school system;
2) The physician's order and POC for PDHC;
3) Physician's most recent note(s) documenting medical necessity for PDHC;
4) The PA checklist indicating the beneficiary~~recipient~~'s skilled nursing care requirements; and
5) Medical records needed to establish medical necessity and support orders and POC.

Necessity for PDHC services will include consideration of all services the beneficiary~~recipient~~ may be receiving, including waiver services and other community supports and services. These services must be reflected and documented in the beneficiary~~recipient~~'s treatment plan.

The approval period may not exceed ninety (90) days. Re-evaluation of PDHC services are performed, at a minimum, every ninety (90) days. At the discretion of the authorizing Medical Director, exceptions to the ninety (90) day standard may be made. Services shall be revised during evaluation periods to reflect accurate and appropriate provision of services for current medical status. This evaluation must include:
1) A review of the beneficiary~~recipient~~'s current medical POC;
2) A provider agency documented current assessment and progress toward goals;
3) Documentation of a face-to-face evaluation between the prescribing physician and beneficiary~~recipient~~ held every ninety (90) days;
4) A completed PA form; and
5) A completed PA checklist indicating the beneficiary~~recipient~~'s skilled nursing care needs.

Services shall be ordered by the beneficiary~~recipient~~'s prescribing physician. A face-to-face evaluation between the beneficiary~~recipient~~ and prescribing physician must be held every ninety (90) days. In exceptional circumstances, at the discretion of the authorizing Medical

Director, the face-to-face evaluation requirement may be extended to one hundred eighty (180) days. [NS28][WJL29][NS30]

The physician's order for services is required to individually meet the needs of the beneficiary~~recipient~~ and shall not be in excess of the beneficiary~~recipient~~'s needs. The order shall contain:

1) The beneficiary~~recipient~~'s name;
2) Date of birth;
3) Sex;
4) Medicaid ID number;
5) Description of current medical conditions, including the specific diagnosis codes;
6) The parent/guardian's name and phone number; and
7) The provider's name and phone number.

The physician shall acknowledge if the beneficiary~~recipient~~ is a candidate for outpatient medical services in a home or community-based setting. The physician shall sign, date, and provide his/her National
Provider Identifier (NPI) number. Specific medical records may be requested from the physician.

In the event, the Medical Director of the PDHC facility is also the beneficiary~~recipient~~'s prescribing physician, the order and POC will be reviewed by Healthy Blue for the recommendation of the beneficiary~~recipient~~'s participation in the PDHC program.

Signed parental/guardian consent is required for participation in PDHC. The consent form shall outline the purpose of the facility, parental/guardian's responsibilities, authorized treatment and emergency disposition plans. A conference shall be scheduled prior to admission with the parent/guardian(s) and the PDHC representative to develop the POC based upon documentation of medical necessity provided by the physician.

If the beneficiary~~recipient~~ is hospitalized at the time of the referral, planning for PDHC participation shall include the parent/guardian(s), relevant hospital medical, nursing, social services and developmental staff to begin the development of the POC that will be implemented following acceptance to the PDHC facility.

The individualized POC addressing the beneficiary~~recipient~~'s medically complex condition, goals, skilled nursing care and therapeutic interventions needed to achieve the desired outcomes shall be developed under the direction of the facility's Nursing Director in collaboration with the prescribing physician prior to placement in the facility. The POC shall ensure the beneficiary~~recipient~~'s skilled nursing care and therapeutic needs are addressed, identify specific goals for care and plans for transition to discontinuation of care. The POC must

be signed by the parent/guardian, PDHC representative, and prescribing physician. A copy shall be given to the prescribing physician and to the parent/guardian if requested. The facility shall retain a copy in their records. Services shall be administered in accordance with the POC. The POC is written to cover a specific time-frame. The plan for achieving the goals shall be determined and a schedule for evaluation of progress shall be established.

The development of the plan shall begin within seventy-two (72) hours of the referral. A POC is required prior to the first day PDHC services begin. The beneficiary~~recipient~~'s treatment plan must consider and reflect all services the beneficiary~~recipient~~ is receiving, including waiver and other community supports and services. The POC for continuation of services shall be reviewed and updated, at a minimum, every ninety (90) days or as indicated by the needs of the beneficiary~~recipient~~.

The initial POC should consist of the following components:

1) Provider Information – name and Medicaid provider number;
2) Start of care date and certification period;
3) Beneficiary~~Recipient~~'s functional limitations, rehabilitation potential, mental status, level of activity status, precautions, method of transportation to and from facility and allergies;
4) Other special orders/instructions;
5) Medications, treatments and any required equipment;
6) Monitoring criteria, monitoring equipment and supplies;
7) Nursing services to be provided;
8) Diet as indicated and how beneficiary~~recipient~~ is to be fed;
9) Beneficiary~~Recipient~~'s current medical condition and hospitalizations within last six (6) months;
10) Risk factors associated with medical diagnoses;
11) Special goals for care identified – plans for achieving the goals shall be determined and an evaluation schedule of progress shall be established;
12) Frequency/duration of PDHC services – number of days/week, hours/day and anticipated duration;
13) All services the beneficiary~~recipient~~ is receiving, including waiver and other community supports and services must be considered and reflected; and
14) Discharge plans – contain specific criteria for transitioning from or discontinuing participation in the PDHC with the facility.

The POC must be signed by the prescribing physician, an authorized representative of the facility, and the beneficiary~~recipient~~'s parent/guardian. All signatures on the POC must be legible and dated. The facility staff shall administer services and treatments in accordance with the POC as ordered by the physician.

For continuation of services, the POC shall include the above components. In addition, the renewal must:

1) Be reviewed and updated, at a minimum, every ninety (90) days or as indicated by the needs of the beneficiary~~recipient~~;
2) Include accomplishments toward goals, assessment of effectiveness of services, and acknowledgment of face-to-face evaluation between beneficiary~~recipient~~ and prescribing physician every ninety (90) days;
3) Consider and reflect all services the beneficiary~~recipient~~ is receiving, including waiver and other community supports and services;
4) Be completed by a registered nurse of the facility;
5) Be reviewed and ordered by the prescribing physician:
   a) The PDHC shall send medical documentation to the referring physician that demonstrates services rendered as well as progress reports on the child;
   b) Physician shall provide updated medical information and progress notes from the required face-to-face visits;
   c) The physician will certify on the prior authorization form that he/she has read the progress report from the previous period; and
6) Be incorporated into the beneficiary~~recipient~~'s clinical record within seven (7) calendar days of receipt of the prescribing physician's order.

The PDHC facility's Medical Director shall review the POC in consultation with the PDHC staff and the prescribing physician every ninety (90) days or more frequently as the beneficiary~~recipient~~'s condition dictates. Prescribed services and therapies included in the POC shall be adjusted in consultation with the prescribing physician to accommodate the beneficiary~~recipient~~'s condition.

Each beneficiary~~recipient~~ shall have a medical record developed at the PDHC facility at the time of acceptance and maintained throughout care of the beneficiary~~recipient~~. The beneficiary~~recipient~~'s medical record must be signed by authorized personnel and contain at least the following documents:

1) Medical plan of treatment and nursing POC;
2) Referral and admission documents;
3) Physician orders;
4) Medical history;
5) Immunization documentation;
6) Medication/treatment administration record;
7) Case notes;
8) Documentation of nutritional management and diet;
9) Documentation of physical, occupational, speech and other therapies;
10) Correspondence concerning the beneficiary~~recipient~~;

11) An order written by the prescribing physician if the beneficiary~~recipient~~ terminates services with the facility, if applicable; and
12) A summary including the reason for termination, if applicable.

The parent or guardian is to supply medications each day as prescribed by the beneficiary~~recipient~~'s attending physician or by a specialty physician after consultation and coordination with the PDHC facility. PDHC staff shall administer these medications, as ordered or prescribed, while the beneficiary~~recipient~~ is on-site. The medications shall be kept in their original packaging and contain the original labeling from the pharmacy, and be individually stored in a secure location at the appropriate temperature recommended. Each PDHC facility shall maintain a record of medication administration. The record shall contain:

1) Each medication ordered and administered;
2) The date, time and dosage of each medication administered; and
3) The initials of the person administering the medication.

The PDHC facility shall provide or arrange transportation of the beneficiary~~recipient~~ to and from the facility; however, no beneficiary~~recipient~~, regardless of his/her region of origin, may be in transport for more than one hour on any single trip. The PDHC facility is responsible for the safety of the beneficiary~~recipient~~ during transport. The family may choose to provide their own transportation. Providers who offer transportation or contract transportation with an agency must adhere to all of the rules and regulations outlined in the PDHC Facilities, Licensing Standards governing transportation. Transportation to and from the PDHC facility is reimbursed at a daily per diem on a per case basis in accordance with 42 CFR 440.170(a).

All transportation provided by a PDHC must meet the standards for commercial transport as specified under the Americans with Disabilities Act (ADA) and the U.S. Department of Transportation (DOT) regulations. The beneficiaries~~recipients~~ may not be transported in a private vehicle owned or operated by any employee and/or owner. The transporting vehicle must be licensed in the state and meet all vehicle inspection criteria. Appropriate insurance is required according to state laws.

The parent/guardian shall provide a signed authorization designating the person(s) the beneficiary~~recipient~~ can be released to for transportation purposes. The authorization shall provide the location where the beneficiary~~recipient~~ can be picked up or dropped off. The release shall name the facility and to whom the beneficiary~~recipient~~ shall be released.

The driver and one (1) appropriately trained staff member shall be required at all times in each vehicle when transporting any beneficiary~~recipient~~. Staff shall be appropriately trained on the needs of each beneficiary~~recipient~~, and shall be capable and responsible for administering interventions when appropriate.

The driver or attendant shall be provided with a current master transportation list including:
1) Each beneficiary~~recipient~~'s name;
2) Pick up and drop off locations; and
3) Authorized persons to whom the beneficiary~~recipient~~ may be released to.

An attendance record shall be maintained by the driver or attendant for each trip. The record shall be signed by the driver or attendant and the PDHC representative who accepts and releases the beneficiary~~recipient~~ each day. The record shall include the following:
1) Driver's name;
2) Date of the trip;
3) Names of all passengers (beneficiary~~recipient~~ and adults) in the vehicle; and
4) Name to whom the beneficiary~~recipient~~ was released to and the time of the release.

Each beneficiary~~recipient~~ shall be safely and properly:
1) Assisted into the vehicle;
2) Restrained in the vehicle;
3) Transported in the vehicle; and
4) Assisted out of the vehicle.

The driver or appropriate staff person shall check the vehicle at the completion of each trip to ensure that no beneficiary~~recipient~~ is left in the vehicle. Appropriate staff person(s) shall be present when each beneficiary~~recipient~~ is delivered to the facility.

The PDHC facility shall maintain an attendance record for each trip. The record shall include:
1) Method used to transport the beneficiary~~recipient~~ to and from the facility;
2) Name of the person transporting the beneficiary~~recipient~~;
3) Date and time of the trip release; and
4) Signatures of the driver or parent/guardian and the PDHC representative.

Personal Care Services (PCS) are defined as tasks that are medically necessary when physical or cognitive limitations due to illness or injury necessitate assistance with eating, toileting, bathing, bed mobility, transferring, dressing, locomotion, personal hygiene, and bladder or bowel requirements. PCS must be prior authorized. Services may be provided up to seven (7) days per week as documented in the POC.

By definition, PCS does not include any medical tasks such as medication administration, tracheotomy care, feeding tubes, or catheters. PCS does not provide respite care, and it is not intended to be an auxiliary (back-up) for respite care.

PCS include the following tasks:

1) Basic personal care, toileting and grooming activities, including bathing, care of the hair and assistance with clothing;
2) Assistance with bladder and/or bowel requirements or problems, including helping the beneficiary~~recipient~~ to and from the bathroom or assisting the beneficiary~~recipient~~ with bedpan routines, but excluding catheterization;
3) Assistance with eating and food, nutrition and diet activities, including preparation of meals for the beneficiary~~recipient~~ only;
   Performance of incidental household services, only for the beneficiary~~recipient~~, not the entire household, which are essential to the beneficiary~~recipient~~'s health and comfort in his/her home. This does not include routine household chores such as regular laundry, ironing, mopping, dusting, etc., but instead arises as the result of providing assistance with personal care to the beneficiary~~recipient.~~
4) Examples of such activities are:
   a) Changing and washing the beneficiary~~recipient~~'s soiled bed linens;
   b) Rearranging furniture to enable the beneficiary~~recipient~~ to move about more easily in his/her own home; and
   c) Cleaning the beneficiary~~recipient~~'s eating area after completion of the meal and/or cleaning items used in preparing the meal, for the beneficiary~~recipient~~ only.

   ~~)~~a) ~~This does not include routine household chores such as regular laundry, ironing, mopping, dusting, etc., but instead arises as the result of providing assistance with personal care to the recipient.~~

~~6)~~5) Accompanying, not transporting, the beneficiary~~recipient~~ to and from his/her physician and/or medical appointments~~facility~~ for necessary medical services.

~~7)~~6) Assisting the beneficiary~~recipient~~ with locomotion in their place of service, while in bed or from one surface to another; and assisting the beneficiary~~recipient~~ with transferring and bed mobility.

The following services are **excluded, not appropriate** for personal care, and are **not reimbursable** as PCS:

1) Custodial care or provision of only instrumental ADL tasks or provision of only one (1) ADL task;
2) Cleaning of the home, floor, and furniture in an area not occupied by only the beneficiary~~recipient~~ (~~E~~example: Cleaning an entire living area or an area shared with other household members, if the beneficiary~~recipient~~ occupies only one (1) room);
3) Laundry, other than that incidental to the care of the beneficiary~~recipient~~ (~~E~~example: Laundering of clothing and bedding for the entire household as opposed to simple laundering of the beneficiary~~recipient~~'s clothing or bedding);

~~4) Shopping for groceries or household items other than items required specifically for the health and maintenance of the recipient, and not for items used by the rest of the household;~~

~~5)~~4) Skilled nursing services as defined in the state Nurse Practices Act, including medical observation, recording of vital signs, teaching of diet and/or administration of medications/injections, or other delegated nursing tasks;

~~6)~~5) Specialized nursing procedures such as:

a) Insertion of nasogastric feeding tube;
b) In-dwelling catheter;
c) Tracheotomy care;
d) Colostomy care;
e) Ileostomy care;
f) Venipuncture; or
g) Injections;

~~7)~~6) Insertion and sterile irrigation of catheters (although changing of a catheter bag is allowed);

~~8)~~7) Irrigation of any body cavities which require sterile procedures;

~~9)~~8) Home IV therapy;

~~10)~~9) Administration of injections of fluid into veins, muscles or skin;

~~11)~~10) Administration of medicine (the PCS worker may only remind or prompt self-administered medication for beneficiaries~~recipients~~ over eighteen (18) years of age);

~~12)~~11) Palliative skin care with medicated creams and ointments and/or required routine changes of surgical dressings and/or dressing changes due to chronic conditions;

~~13)~~12) Application of dressing, involving prescription medication and aseptic techniques, including care of mild, moderate, or severe skin problems;

~~14)~~13) Teaching a family member or friend how to care for a patient who requires frequent changes of clothing or linens due to total or partial incontinence for which no bowel or bladder training program for the patient is possible;

~~15)~~14) Teaching a family member or friend techniques for providing specific care;

~~16)~~15) Teaching of signs and symptoms of disease process, diet and medications of any new or exacerbated disease process;

~~17)~~16) Specialized aide procedures such as:

a) Rehabilitation of the patient (exercise or performance of simple procedures as an extension of physical therapy services);
b) Measuring/recording patient vital signs (temperature, pulse, respiration and/or blood pressure, etc.), or intake/output of fluids;
c) Specimen collection; or
d) Special procedures such as non-sterile dressings, special skin care (non-medicated), decubitus ulcers, cast care, assisting with ostomy care, assisting with catheter care, testing urine for sugar and acetone, breathing exercises, weight measurement, enemas;

~~18)~~17) Rehabilitative services such as those administered by a physical therapist;
~~19)~~18) Occupational therapy;
~~20)~~19) Speech pathology services;
~~21)~~20) Audiology services;
~~22)~~21) Respiratory therapy;
~~23)~~22) Durable medical equipment;
~~24)~~23) Oxygen;
~~25)~~24) Orthotic appliances or prosthetic devices;
~~26)~~25) Personal comfort items;
~~27)~~26) Drugs provided through the Louisiana Medicaid pharmacy program;
~~28)~~27) Laboratory services; and
~~29)~~28) Social work visits.

Intent of PCS:

1) Persons under the age of twenty-one (21), for whom the services are intended, must have a condition(s) that causes him/her not to be capable of completing at least two (2) age-appropriate ADLs. ADLs include eating, bathing, dressing, personal hygiene and bladder or bowel requirements.

~~1)~~2) PCS is not to be provided to meet child~~-~~care needs nor as a substitute for the parent or guardian in the absence of the parent or guardian.

~~2)~~3) PCS is not to be used to provide~~allowable for the purpose of providing~~ respite care for the primary care~~-~~giver.

~~3)~~4) PCS provided in an educational setting shall not be reimbursed if these services duplicate services provided by or should be provided by the Department of Education.

Staff assigned to provide personal care services shall not be a member of the beneficiary~~recipient~~'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 beneficiary~~recipient~~. PCS may be provided by a person of a degree of relationship to the beneficiary~~recipient~~ other than immediate family~~,~~ only if the relative is not living in the beneficiary~~recipient~~'s home, or~~,~~ if he/she is living in the beneficiary~~recipient~~'s home solely because his/her presence in the home is necessitated by the amount of care required by the beneficiary~~recipient~~. The presence or physical ability of a caregiver, regardless of beneficiary~~recipient~~ age, is not to be a determinant in authorization or reimbursement for services. Focus must be placed on the needs of the beneficiary~~recipient~~ and not the availability or needs of the parent/caregiver.

PCS must be provided in the beneficiary~~recipient~~'s home or, if medically necessary, in another location outside the beneficiary~~recipient~~'s home. The beneficiary~~recipient~~'s home is defined as the beneficiary~~recipient~~'s own dwelling: an apartment, a custodial relative's home, a boarding

home, a foster home, or a supervised living facility. Institutions such as a hospital, institution for mental disease~~s~~, nursing facility, intermediate care facility for individuals with intellectual disabilities, or residential treatment center are not considered a beneficiary~~recipient~~'s home.

EPSDT-PCS providers may not provide services at the same time as other covered services, unless medically necessary. Medicaid prohibits multiple professional disciplines from being present in the beneficiary's residential setting at the same time. However, multiple professionals may provide services to multiple beneficiaries in the same residential setting when it is medically necessary. This includes but is not limited to nurses, home health aides, and therapists.

Children's Choice waiver services and PCS may be performed on the same date, but may not be performed at the same time. If the member~~recipient~~[WJL31] is receiving home health, respite, and/or any other related service, the PCS provider cannot provide service at the same time as the other Medicaid covered service provider. Beneficiaries~~Recipients~~ may receive hospice services on the same date as PCS, but not at the same time. The PCS and hospice providers must coordinate services and develop the patient~~recipient~~'s POC.

~~Recipient c~~Criteria and conditions for provisions of PCS are as follows:

1) Medicaid Eligibility:
   a) The person must be a categorically eligible Louisiana Medicaid beneficiary~~recipient~~ birth through twenty (20) years of age (EPSDT eligible) and have been prescribed medically necessary, age appropriate EPSDT ~~- — —~~PCS ~~as medically necessary~~ by a practitioner (physician, physician assistant, or advance practice nurse).
   b) The practitioner shall specify the health/medical condition which necessitates PCS.
2) Medical Necessity:
   a) An EPSDT eligible must meet medical necessity criteria as established by the Bureau of Health Services Financing (BHSF) which shall be based on functional and medical eligibility and impairment in at least two (2) age-appropriate ADL tasks, as determined by BHSF or its designee.
   b) To establish medical necessity, the EPSDT eligible 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.
   c) Emphasis must be placed on whether the child/youth is capable of completing the ADLs independently. Reminding or prompting the beneficiary~~recipient~~ to complete these daily tasks does not meet medically necessity for the service.
   ~~c)~~d) The provision of PCS is based on whether the child is able to perform two (2) or more age-appropriate ADLs. It is not based on whether the child has a physical disability.
3) Physician Referral:

a) PCS must be prescribed by the beneficiary~~recipient~~'s attending practitioner initially and every one hundred eighty (180) days after that (or rolling six (6) months), and when changes in the POC occur.
b) The POC shall be acceptable for submission only after the practitioner signs and dates the completed form.
c) The practitioner's signature must be an original signature and not a rubber stamp.

Services shall not be authorized for more than a six (6) month period. A face-to-face medical assessment must be completed by the practitioner. The beneficiary~~recipient~~'s choice of a PCS provider may assist the practitioner in developing a POC which shall be submitted for review/approval.

PCS are not subject to service limits. The units of service approved shall be based on the physical requirements of the beneficiary~~recipient~~ and medical necessity for the covered services. Hours may not be "saved" to be used later or in excess of the number of hours specified according to the approval letter.

~~Services shall not be authorized for more than a six (6) month period. A face-to-face medical assessment must be completed by the practitioner. The recipient's choice of a PCS provider may assist the practitioner in developing a POC which shall be submitted for review/approval.~~

All initial and subsequent PA requests for PCS must be accompanied by the following documents:

1) Physician's referral for PCS;
   a) PCS must be prescribed by the beneficiary~~recipient~~'s attending practitioner initially and every one hundred eighty (180) days after that (or rolling six (6) months), and when changes in the POC occur.
   b) The prescription ~~must~~does not have to specify the number of hours being requested, ~~and~~ but must specify PCS and not personal care attendant (PCA).[NS32][WJL33]
   c) The practitioner's signature must be an original signature or a computer generated electronic signature. Rubber stamped signatures are not accepted.
2) POC prepared by the PCS agency with practitioner's approval;
   a) The provider may not initiate services or changes in services under the POC prior to approval by Healthy Blue.
3) EPSDT~~-~~ PCS Form 90;
   a) Completed by the attending practitioner;
   b) Completed within the last ninety (90) days;
   c) Documents the beneficiary~~recipient~~ requires assistance with at least two (2) ADLs; and
   d) Documents a face-to-face medical assessment was completed.
4) EPSDT~~-~~ PCS Daily Schedule Form;

5) EPSDT—-PCS Social Assessment Form; and
6) Other documentation that would support medical necessity (i.e., other independent evaluations).

The POC must be written on the current version of the EPSDT—-PCS POC 1 Form which can be downloaded from the Louisiana Medicaid website. The form must be completed in its entirety and must specify the personal care task(s) to be provided (i.e., ADLs for which assistance is needed) and the frequency and duration required to complete each of these tasks. Dates of services not included in the POC or services provided before approval of the POC by Healthy Blue are not reimbursable.

The beneficiary~~recipient~~'s attending practitioner shall review and/or modify the POC and sign and date it prior to the POC being submitted to Healthy Blue. The POC shall include the following information:

1) Beneficiary~~Recipient~~ name, Medicaid ID number, date of birth, address, and phone number;
2) Date services are requested to start;
3) Provider name, Medicaid provider number and address of personal care agency;
4) Name and phone number of someone from the provider agency that may be contacted, if necessary for additional information;
5) Medical reasons supporting the need for PCS;
6) Other in-home services the beneficiary~~recipient~~ is receiving;
7) Specific personal care tasks (bathing, dressing, eating, etc.) with which the PCS provider is to assist the beneficiary~~recipient~~;
8) Goals for each activity;
9) Number of days services are required each week;
10) Time requested to complete each activity;
11) Total time requested to complete each activity each week; and
12) Signature of parent/primary caregiver, provider representative and the beneficiary~~recipient~~'s primary physician.

Amendments or changes in the POC should be submitted as they occur and shall be treated as a new POC which begins a new six (6) month service period. Revisions of the POC may be necessary because of changes that occur in the beneficiary~~recipient~~'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 POC is the same as for a new POC. 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 POC prior to approval by Healthy Blue.

A new POC must be submitted at least every one hundred eighty (180) days (rolling six (6) months). The subsequent POC must:

1) Be approved and signed by the beneficiary~~recipient~~'s attending practitioner;
2) Reassess the beneficiary~~recipient~~'s need for PCS;
3) Include any updates to information which has changed since the previous assessment was conducted; and
4) Explain when and why the change(s) occurred.

Beneficiaries~~Recipients~~ who have been designated by Healthy Blue as a "Chronic Needs Case" are exempt from the standard PA process. A new request for PA must still be submitted every one hundred eighty (180) days; however, the provider shall only be required to submit a PA form accompanied by a statement from the beneficiary~~recipient~~'s primary physician verifying that the beneficiary~~recipient~~'s condition has not improved and the services currently approved must be continued. The provider must indicate it as "Chronic Needs Case" request. This determination only applies to the services approved where requested services remain at the approved level. Requests for an increase in these services will be subject to a full review requiring all documentation used for a traditional PA request. **NOTE:** Only Healthy Blue is allowed to grant the designation of a "Chronic Needs Case" to a beneficiary~~recipient~~.

The beneficiary~~recipient~~ shall be allowed the freedom of choice to select a provider. This freedom also extends to the beneficiary~~recipient~~'s right to change providers at any time; however, previously approved authorizations are not transferred between agencies. If a beneficiary~~recipient~~ elects to change providers within an authorization period, the current agency must notify Healthy Blue of the beneficiary~~recipient~~'s discharge, and the new agency must obtain their own authorization through the usual authorization process.

Providers must maintain case records for all PCS beneficiaries~~recipients~~ and personnel records on all supervisory and direct care staff. Records must be complete, accurately documented, readily accessible, and organized. All records must be retained for a period of five (5) years. Billing records must be maintained for a period of five (5) years from the date of payment. Any error made in a beneficiary~~recipient~~'s or employee's record must be corrected using the legal method which is to draw a line through the incorrect information, write "error" by it and initial the correction. Correction fluid must never be used in a beneficiary~~recipient~~'s or employee's record.

There must be a clear audit trail between the:

- Prescribing practitioner;
- PCS provider agency;
- Person providing the PCS to the beneficiary~~recipient~~; and
- Services provided and reimbursed by Medicaid/Healthy Blue.

Providers must provide reasonable protection for beneficiary~~recipient~~ records against loss, damage, destruction, and unauthorized use. A provider must have a separate written record for each beneficiary~~recipient~~ that includes:

1) Copies of all POC, Social Assessments, EPSDT-PCS Form 90, EPSDT-PCS Daily Schedule Forms, and Practitioner's Order/Prescription for EPSDT-PCS;
2) Dates and results of all evaluation/diagnosis provided in the interest of establishing or modifying the POC including the tests performed and results, copies of evaluation and diagnostic assessment reports signed by the individual performing the test and/or interpreting the results;
3) Documentation of approval of services; and
4) Documentation of the provision of services by the PCS worker including signed daily notes by the worker, and supervisor if appropriate, that include:
   a) Date of service;
   b) Services provided (checklist is adequate);
   c) Total number of hours worked;
   d) Time period worked;
   e) Condition of beneficiary~~recipient~~;
   f) Service provision difficulties;
   g) Justification for not providing scheduled services; and
   h) Any other pertinent information.

Providers must make beneficiary~~recipient~~ and personnel records available to Healthy Blue, its designee and/or other state and federal agencies upon request. The provider shall be responsible for incurring the cost of copying records for Healthy Blue, LDH, or its designee.

Healthy Blue requires PCS and home health care providers to use the state-contracted electronic visit verification (EVV) system, the Louisiana Service Reporting System (LaSRS), in accordance with the timeframes set forth in the 21st Century Cures Act or as directed by LDH to electronically report begin and end time (i.e., clock-in and clock-out) for PCS~~.~~[WJL34]. ~~EVV~~This is a federal requirement that applies to all managed care EPSDT-PCS providers.~~,~~ EVV is a web-based system that electronically verifies service visit occurrences and documents the precise time services begin and end via smart devices. The purpose of the system is to verify and ~~helps to~~ [NS35]ensure [NS36][WJL37]that individuals are receiving the services authorized in the POC, reduce inappropriate billing/payment, safeguard against fraud, and improve program oversight. [WJL38]Healthy Blue must require its providers to use LaSRS. [WJL39]Healthy Blue may withhold or deny reimbursement for services i~~s~~ a provider fails to use the EVV system.[WJL40]

EXCEPTIONS:

All service authorization processes and procedures are consistent with 42 CFR §438.210, 42 CFR Part 441, Subpart D, state laws and regulations, Medicaid State Plan and waivers, and the court-ordered requirements of Chisholm v. Gee for initial and continuing authorization of services. Refer to *Prior Authorization Liaison (PAL) Policy – LA* for Chisholm requirements.

The services listed below are typically not reimbursed by commercial health plans. Managed Care Organizations (MCOs) are to~~should~~ [WJL41][WJL42]accept claims billed directly from the provider without requiring an explanation of benefits from the primary carrier and pay as primary payer.

- EPSDT-PCS Procedure Code: T1019
- PDHC Procedure Code(s): T1025, T1026, and T2002

Long term-PCS (LT-PCS) for those ages twenty-one (21) and older is an excluded service. Excluded services are those services that members may obtain under the Louisiana State Plan or applicable waivers, and for which Healthy Blue is not financially responsible. However, Healthy Blue is responsible for informing members on how to access excluded services providing all required referrals and assisting in the coordination of scheduling such services.

LDH temporarily changed qualification for EPSDT-PCS and PDHC providers during the COVID-19 health emergency. Refer to *Health Plan Advisories 20-10* and *20-13* for applicable guidelines.[NS43][WJL44][NS45]

REFERENCES:

- CFR Title 42
- Associates Performing Utilization Review – LA
- Clinical Criteria for Utilization Management Decisions – Core Process
- Clinical Information for Utilization Review – LA
- Continuity of Care – LA
- Health Care Management Denial – LA
- Health Plan Advisory 12-7
- Health Plan Advisory 15-18
- Health Plan Advisory 16-16
- Health Plan Advisory 19-15
- Health Plan Advisory 20-10
- Health Plan Advisory 20-13
- Informational Bulletin 19-2
- Pediatric Day Health Care Prior Authorization Checklist
- Pediatric Day Health Care Provider Manual
- Personal Care Services Provider Manual

- Louisiana State Contract
- NCQA Accreditation Standards and Guidelines
- Precertification of Requested Services – LA
- Prior Authorization Liaison (PAL) Policy – LA

RESPONSIBLE DEPARTMENTS:

Primary Department:
Health Care Management – Utilization Management

Secondary Department(s):
Claims
Health Care Management – Case Management

REVISION HISTORY:

Review Date	Changes
11/12/2018	• New
12/09/2019	• Annual review; • Updated to new template • Revisions made throughout for New LA Emergency Contract • Edits to policy, definitions, procedure, exceptions, and reference sections • Claims and HCM – CM added as Secondary Departments
07~~11~~/19~~11~~/2021~~0~~	• Annual Review • Updated to reflect Contract Amendment 3 effective 12/1/2020 • Updated "recipient" references to "beneficiary" when in alignment with LDH resources • Updated the policy, d~~D~~efinitions, procedure, exceptions, and references ~~updated~~