Early and Periodic Screening, Diagnostic and Treatment - Personal care services

Clinical Policy ID: CCP.1511-04

Recent review date: 9/2024

Next review date: 1/2026

Policy contains: Early and Periodic Screening, Diagnostic and Treatment; EPSDT; personal care services.

AmeriHealth Caritas Louisiana has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas Louisiana's clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered by AmeriHealth Caritas Louisiana when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas Louisiana's clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas Louisiana's clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas Louisiana will update its clinical policies as necessary. AmeriHealth Caritas Louisiana's clinical policies are not guarantees of payment.

Coverage policy

Personal care services 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.

Early and Periodic Screening, Diagnostic and Treatment Personal Care Services (EPSDT – PCS) are clinically proven and, therefore, may be medically necessary when all of the following criteria are met:

- Member is younger than age 21 years.
- Member has been prescribed medically necessary, age appropriate EPSDT – PCS by a practitioner (physician, advance practice nurse, or physician assistant). The practitioner shall specify the health/medical condition that necessitates EPSDT – PCS.
- Member meets medical necessity criteria based on functional and medical eligibility and impairment in at least two activities of daily living (ADL), as determined by AmeriHealth Caritas Louisiana (herein called "the Plan") or its designee. To establish medical necessity, the EPSDT-eligible member must be of an age at which the tasks to be performed by the PCS provider would ordinarily be performed by the member, if not for being disabled due to illness or injury.

- EPSDT – PCS shall be prescribed by the member's attending practitioner initially, every 180 days after that (or rolling six months), and when changes in the plan of care (POC) occur. The POC shall be acceptable for submission to the Plan only after the practitioner signs and dates the completed form. The practitioner's signature must be an original signature and not a rubber stamp.

The member shall be allowed the freedom of choice (FOC) to select an EPSDT – PCS provider. This freedom also extends to the member's right to change providers at any time should he or she finds it necessary to cease the relationship with the current provider.

Service definitions

EPSDT – PCS include the following tasks:

- Basic personal care, including toileting, grooming, bathing, and assistance with dressing;
- Assistance with bladder and/or bowel requirements or problems, including helping the member to and from the bathroom or assisting the member with bedpan routines, but excluding catheterization;
- Assistance with eating and food, nutrition, and diet activities, including preparation of meals for the member only;
- Performance of incidental household services, only for the member, not the entire household, which are essential to the member'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 member. Examples of such activities are:
    - Changing and washing the member's soiled bed linens;
    - Rearranging furniture to enable the member to move about more easily in his/her own home; and
    - Cleaning the member's eating area after completion of the meal and/or cleaning items used in preparing the meal, for the member only.
- Remind/prompt an EPSDT eligible member who is over 18 years of age about self-administered medication;
- Accompanying, not transporting, the member to and from his/her physician and/or medical appointments for necessary medical services; and
- Assisting the member with locomotion in their place of service, while in bed or from one surface to another.
- Assisting the member with transferring and bed mobility.

Intent of services

Intent of services include the following:

- EPSDT – PCS shall not be provided to meet childcare needs nor as a substitute for the parent or guardian in the absence of the parent or guardian;
- EPSDT – PCS shall not be used to provide respite care for the primary caregiver; and
- EPSDT – PCS provided in an educational setting shall not be reimbursed if these services duplicate services that are provided by or shall be provided by the Department of Education.

Location of service

EPSDT – PCS shall be provided in the member's home, or if medically necessary, in another location outside of the member's home. The member's own home includes the following: an apartment, a custodial relative's home, a boarding home, a foster home, or a supervised living facility. Institutions such as hospitals, institutions for mental disease, nursing facilities, intermediate care facilities for members with intellectual disabilities, (ICF/IIDs) or residential treatment centers are not considered a member's home.

Service limitations

EPSDT – PCS are not subject to service limits. The units of service approved shall be based on the physical requirements of the member 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.

Excluded services

The following services are not appropriate for personal care and are not reimbursable as EPSDT – PCS:

- Insertion and sterile irrigation of catheters (although changing of a catheter bag is allowed);
- Irrigation of any body cavities which require sterile procedures;
- Application of dressing, involving prescription medication and aseptic techniques; including care of mild, moderate or severe skin problems;
- Administration of intradermal, subcutaneous, intramuscular, or intravenous injections;
- Administration of medicine;
- Cleaning of the home in an area not occupied by the member;
- Laundry, other than that incidental to the care of the member (e.g., laundering of clothing and bedding for the entire household as opposed to simple laundering of the member's clothing or bedding);
- 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;
- Teaching a family member or friend how to care for a member who requires frequent changes of clothing or linens due to total or partial incontinence for which no bowel or bladder training program for the member is possible;
- Specialized nursing procedures such as:
    - Insertion of nasogastric feeding tube;
    - In-dwelling catheter;
    - Tracheotomy care;
    - Colostomy care;
    - Ileostomy care;
    - Venipuncture; and

    - Injections.
- Rehabilitative services such as those administered by a physical therapist;
- Teaching a family member or friend techniques for providing specific care;
- Palliative skin care with medicated creams and ointments and/or required routine changes of surgical dressings and/or dressing changes due to chronic conditions;
- Teaching of signs and symptoms of disease process, diet, and medications of any new or exacerbated disease process;
- Specialized aide procedures such as:
    - Rehabilitation of the member (exercise or performance of simple procedures as an extension of physical therapy services);
    - Measuring/recording the member's vital signs (temperature, pulse, respiration and/or blood pressure, etc.), or intake/output of fluids;
    - Specimen collection; and
    - Special procedures such as non-sterile dressings, special skin care (nonmedicated), decubitus ulcers, cast care, assisting with ostomy care, assisting with catheter care, testing urine for sugar and acetone, breathing exercises, weight measurement, enemas.
- Home intravenous therapy;
- Custodial care or provision of only instrumental activities of daily living tasks or provision of only one activity of daily living task;
- Occupational therapy;
- Speech pathology services;
- Audiology services;
- Respiratory therapy;
- Personal comfort items;
- Durable medical equipment;
- Oxygen;
- Orthotic appliances or prosthetic devices;
- Drugs provided through the Louisiana Medicaid pharmacy program;
- Laboratory services; and
- Social work visits.

<u>EPSDT – PCS rights and responsibilities</u>

The member shall be allowed the freedom of choice (FOC) to select an EPSDT – PCS provider. This freedom also extends to the member's right to change providers at any time should he or she finds it necessary to cease the relationship with the current provider.

EPSDT – PCS prior authorization

EPSDT – PCS are subject to prior authorization by the Plan or its designee. Services shall not be authorized for more than a six month period. A face-to-face medical assessment shall be completed by the practitioner. The member's choice of a PCS provider may assist the practitioner in developing a plan of care (POC), which shall be submitted for review/approval by the Plan or its designee.

Initial and subsequent prior authorization requests

All initial and subsequent prior authorization requests for EPSDT – PCS shall be accompanied by the following documents:

- Copy of the member's Medicaid eligibility card;
- Practitioner's referral for PCS:
- EPSDT – PCS shall be prescribed by the member's attending practitioner initially and every 180 days after that (or rolling six months), and when changes in the POC occur. The prescription does not have to specify the number of hours being requested, but shall specify PCS and not Personal Care Attendant (PCA);
- The practitioner's signature shall be an original signature or a computer generated electronic signature. Rubber stamped signatures will not be accepted; and
- Signatures by registered nurses on the referrals are not acceptable.
- POC prepared by the PCS agency with practitioner's approval. The provider may not initiate services or changes in services under the POC prior to approval by the Plan;
- EPSDT – PCS Form 90:
- Completed by the attending practitioner;
- Completed within the last 90 days;
- Documents the member requires assistance with at least two (2) activities of daily living (ADL); and
- Documents a face-to-face medical assessment was completed.
- EPSDT – PCS Daily Schedule Form;
- EPSDT – PCS - Social Assessment Form;
- Plan prior authorization request form.
- Other documentation that would support medical necessity (i.e., other independent evaluations).

Information about forms used with a prior authorization request can be downloaded from the Plan website **https://www.amerihealthcaritasla.com/provider/resources/forms/index.aspx**.

Requests for prior approval of EPSDT – PCS should be submitted by fax or electronically (e-PA) to the PA Unit.

The request shall be reviewed by the Plan's physician consultant and a decision rendered as to the approval of the service. A letter will be sent to the member, the provider and the support coordination agency, if available, advising of the decision.

Chronic needs case

Members who have been designated as a “Chronic needs case” are exempt from the standard prior authorization process. A new request for prior authorization shall still be submitted every 180 days; however, the EPSDT-PCS provider shall only be required to submit a Plan prior authorization request form accompanied by a statement from the member’s primary practitioner verifying that the member’s condition has not improved and the services currently approved must be continued. The provider shall indicate “Chronic needs case” on the top of the Plan prior authorization request form. 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 prior authorization request.

NOTE: Only AmeriHealth Caritas or designee will be allowed to grant the designation of a “chronic needs case” to a member.

Plan of care

The POC shall be written on the current version of the EPSDT-PCS POC – 1 Form which can be downloaded from which can be downloaded from www.lamedicaid.com at the “Forms/Files/Surveys/User Manuals” link, or https://www.amerihealthcaritasla.com/provider/resources/forms/index.aspx. The form shall be completed in its entirety and shall specify the personal care task(s) to be provided (i.e., activities of daily living for which assistance is needed) and the frequency and duration required to complete each of these tasks.

Dates of service not included in the POC or services provided before approval of the POC by the Plan or its designee, are not reimbursable. The member’s attending practitioner shall review and/or modify the POC and sign and date it prior to the POC being submitted to the Plan or its designee.

The POC shall include the following information:

- Member name, Medicaid ID number, date of birth and address, phone number;
- Date EPSDT PCS 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 member’s need for PCS;
- Other in-home services the member is receiving;
- 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; and
- Signature of parent/primary caregiver, provider representative and the member’s primary practitioner.

<u>Changes in plan of care</u>

Revisions to the POC shall be submitted as they occur and shall be treated as a new POC which begins a new six month service period. Revisions to the POC may be necessary because of changes that occur in the member's medical condition which warrant an additional type of service, change in frequency of service, or an increase or decrease in duration of service.

Documentation required for a revised POC is the same as for a new POC. Both a new "start date" and "reassessment date" shall be established at the time of reassessment. The EPSDT – PCS provider may not initiate services, or changes in services, under the POC prior to approval by the Plan or its designee.

Subsequent plans of care

A new POC shall be submitted at least every 180 days (rolling six months). The subsequent POC shall:

- Be approved by the member's attending practitioner;
- Reassess the member's need for EPSDT – PCS;
- Include any updates to information which has changed since the previous assessment was conducted; and
- Explain when and why the change(s) occurred. The POC shall be acceptable only after the practitioner signs and dates the completed form. The practitioner's signature shall be an original signature and not a rubber stamp.

Reconsideration requests

If the prior authorization request is not approved as requested, the provider may submit a request for a reconsideration of the previous decision. When submitting a reconsideration request, providers should include the following:

- A copy of the prior authorization notice with the word "Recon" written across the top and include the reason the reconsideration is being requested written across the bottom;
- All original documentation submitted from the original request; and
- Any additional information or documentation which supports medical necessity.

The reconsideration request packet should be sent to the PA Unit via fax or e-PA. After the reconsideration request has been reviewed, a new notification letter with the same prior authorization number will be generated and mailed to the provider, member, and support coordinator, if the member has a case manager.

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 shall notify the PA Unit of the member's discharge, and the new agency shall obtain their own authorization through the usual authorization process.

Members may contact the Plan directly for assistance in locating another provider.

Prior authorization liaison

The Prior Authorization Liaison (PAL) was established to facilitate the authorization process for EPSDT members who are part of the Request for Services Registry. The PAL assists by contacting the provider, member, and support coordinator (if the member has one) when a request cannot be approved by the PA Unit because of a lack of documentation or a technical error.

EPSDT – PCS PROVIDER REQUIREMENTS

Standards of participation

PCS must be provided by a licensed PCS agency that is duly enrolled as a Medicaid provider and a participating Plan provider. Agencies providing EPSDT – PCS shall conform to all applicable Medicaid regulations as well as all applicable laws and regulations by federal, state and local governmental entities regarding wages, working conditions, benefits, Social Security deductions, Occupational Safety and Health Administration (OSHA) requirements, liability insurance, Worker's Compensation, occupational licenses, etc. Agencies shall comply with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

EPSDT – PCS shall only be provided to EPSDT members and only by a staff member of a licensed personal care attendant (PCA) agency enrolled as a Medicaid PCS provider.

A copy of the current PCA license must accompany the Medicaid application for enrollment as a PCS provider.

Copies of current licenses shall be submitted to Louisiana Medicaid Provider Enrollment thereafter, as they are issued for inclusion in the enrollment record. The provider's enrollment record shall include a current PCA license at all times.

PCS shall be authorized only when provided by a licensed PCS agency, which is duly enrolled as a Louisiana Medicaid provider and certain out-of-state providers located only in the trade areas of Arkansas, Mississippi, and Texas. Provider agencies shall comply with the policies and procedures contained in the PCS provider manual for the EPSDT – PCS program.

Electronic visit verification

The agency shall use an electronic visit verification (EVV) system for time and attendance tracking and billing for EPSDT – PCS. EPSDT – PCS providers identified by the Plan shall use the following:

- The (EVV) system designated by the Department; or
- An alternate system that has successfully passed the data integration process to connect to the designated EVV system, and is approved by the Department.

Reimbursement for services may be withheld or denied if an EPSDT – PCS provider fails to use the EVV system, or uses the system not in compliance with Medicaid's policies and procedures for EVV.

Staffing

The licensed PCS agency is responsible for ensuring that all direct service workers (DSW) providing EPSDT – PCS meet all training requirements applicable under state law and regulations. Individuals who provide coverage in the PCS worker's absence must meet all staffing requirements for the PCS worker or supervisor.

Providers must conduct criminal background checks on the direct care and supervisory staff. A worker may be assigned to provide services to a member prior to the results of the criminal background check under the direct supervision of a permanent employee or in the presence of a member of the immediate family of the member or a caregiver designated by the immediate family of the member as outlined in R.S. 40:1300.52(C)(2). If the results of any criminal background check reveal that the employee was convicted of any offenses as described in R.S. 40:1300.53, pursuant to the statutory revision authority of the Louisiana State law institute, the employer shall not hire or may terminate the employment of such person.

EPSDT – PCS services shall be provided by an individual who meets the following qualifications:

- Must be at least 18 years of age at the time the offer of employment is made;
- Must have the ability to read and write in English, and to carry out directions promptly and accurately; and
- Must pass a criminal background check.

The following persons are prohibited from serving as the DSW for the member:

- Father;
- Mother;
- Sister/brother;
- In-law;
- Grandparent;
- Curator;
- Tutor;
- Legal guardian;
- Member's responsible representative; or
- Person to whom the member has given representative and mandate authority (Power of Attorney).

The PCS may be provided by a person of a degree of relationship to the member other than immediate family, only 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.

If the provider proposes involuntary transfer, discharge of a member, or if a provider closes in accordance with licensing standards, the following steps must be taken:

- The provider shall give written notice to the member and the responsible representative, if known, at least 30 calendar days prior to the transfer or the discharge;
- Written notice shall be made via certified mail, return receipt requested and shall be in a language and manner that the member understands;
- A copy of the written discharge/transfer notice shall be put in the member's record;
- When the safety or health of members or provider staff is endangered, written notice shall be given as soon as possible before the transfer or discharge;

The written notice shall include the following:

- A reason for the transfer or discharge;

- The effective date of the transfer or discharge;
- An explanation of a member's right to personal and/or third party representation at all stages of the transfer or discharge process;
- Contact information for Disability Rights Louisiana;
- Names of provider personnel available to assist the member and family in decision-making and transfer arrangements;
- The date, time and place for the discharge planning conference;
- A statement regarding the member's appeal rights;
- The name of the director, current address and telephone number of the Division of Administrative Law (DAL); and
- A statement regarding the member's right to remain with the provider and not be transferred or discharged if an appeal is timely filed.

Provider transfer or discharge responsibilities shall include:

- Holding a transfer or discharge planning conference with the member, legal representative, support coordinator (if applicable), and advocate, if such is known;
- Developing discharge options that will provide reasonable assurance that the member will be transferred or discharge to a setting that can be expected to meet his/her needs;
- Preparing an updated service plan, as applicable, and preparing a written discharge summary that shall include, at a minimum, a summary of the health, behavioral issues, social issues and nutritional status of the member; and
- Providing all services required prior to discharge that are contained in the final update of the service plan, as applicable, and in the transfer or discharge plan.

NOTE: The requirements above do not apply when the member is being discharged from the EPSDT – PCS program by the Plan.

Failure of the provider to meet the minimum standards shall result in a range of required corrective actions including, but not limited to, the following:

- Removal from the Freedom of Choice listing;
- A citation of deficient practice;
- A request for corrective action plan; and/or 4. Administrative sanctions.

<u>EPSDT – PCS service delivery</u>

EPSDT – PCS providers may not provide services at the same time as other covered services, unless medically necessary.

AmeriHealth Caritas Louisiana prohibits multiple professional disciplines from being present in the member's residential setting at the same time. However, multiple professionals may provide services to multiple members in the same residential setting when it is medically necessary. This includes but is not limited to nurses, home health aides, and therapists. The Plan will determine medical necessity for fee-for-service members.

Children's Choice waiver services and PCS may be performed on the same date, but not at the same time. If the member 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.

Members who receive EPSDT – PCS may also receive hospice services on the same date, but not at the same time. The hospice provider and the PCS provider must coordinate services and develop the member's plan of care.

EPSDT – PCS record keeping

Providers must maintain case records for all EPSDT – PCS members 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 six (6) years. Billing records must be maintained for a period of six years from the date of payment.

Any error made in a member'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 member's or employee's record.

There shall be a clear audit trail between the:

- Prescribing practitioner;
- Personal care services provider agency;
- Person providing the PCS to the member; and
- Services provided and reimbursed by the Plan.

Member records

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

- Copies of all plans of care (POC), social assessments, EPSDT – PCS Form 90, EPSDT – PCS daily schedule forms, and practitioners order/prescription for EPSDT – PCS;
- 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;
- Documentation of approval of services by the Plan or its designee; and
- Documentation of the provision of services by the PCS worker including signed daily notes by the worker, and supervisor if appropriate, that include the following:
- Date of service;
- Services provided (checklist is adequate);
- Total number of hours worked;
- Time period worked;
- Condition of member;

- Service provision difficulties;
- Justification for not providing scheduled services; and
- Any other pertinent information.

Availability of records

Providers must make member and personnel records available to the Plan, its designee and/or other state and federal agencies upon request. The provider shall be responsible for incurring the cost of copying records for the Plan or its designee.

Background

Not applicable.

Findings

Not applicable.

References

On February 6, 2024, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were “EPSDT” and “personal care services.” We included the best available evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

Louisiana Department of Health. 2009. *Personal care services provider manual*. Section 30. https://www.lamedicaid.com/provweb1/Providermanuals/manuals/PCS/pcs.pdf. Last issued December 21, 2023.

Policy updates

4/2022: initial review date and clinical policy effective date: 5/2022

4/2023: Policy references updated.

4/2024: Policy references updated. Coverage modified.

5/2024: Coverage modified.