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Pediatric Personal Care Special Bulletin

In this issue:

Pediatric Personal Care Benefit....	1
Eligible Members	2
Eligible Providers and Requirements 2	
Personal Care and Skilled Care	3
Personal Care and HCBS Waivers....	3
Programs Excluded	4
Enrolling Members	4
The Personal Care Assessment Tool	5
The 485 Home Health Certification..	5
PAR Instructions.....	5
Billing and Reimbursement	7
Agency Coordination	7
Training Schedule and Information .	7
Claim Submission	8

New Pediatric Personal Care Benefit Overview

Colorado Medicaid will offer a new benefit beginning October 19, 2015. The Pediatric Personal Care Benefit helps Medicaid members 20 years old and younger with in-home services that do not require a service provider to have a medical certification or a professional license to safely provide.

Personal Care (PC) services assist members with personal care tasks in order to meet their physical, maintenance, and supportive needs. This assistance may take the following forms: completing a task for someone, supervising someone to ensure a task is performed safely, showing someone how to complete a task, or reminding or cueing someone to complete a task.

Members who qualify for the benefit can receive support with any of these 17 personal care tasks:

1. Bathing/Showering
2. Dressing
3. Feeding
4. Medication Reminders
5. Ambulation/Locomotion
6. Meal Preparation
7. Hygiene – Hair Care/Grooming
8. Hygiene – Mouth Care
9. Hygiene – Nail Care
10. Hygiene – Shaving
11. Hygiene – Skin Care
12. Toileting – Bowel Care
13. Toileting – Bowel Program
14. Toileting – Catheter Care
15. Toileting – Bladder Care
16. Mobility – Positioning
17. Mobility – Transfer



**Xerox State Healthcare
Denver Club Building
518 17th Street, 4th floor
Denver, CO 80202**

Contacts

Billing and Bulletin Questions
1-800-237-0757

Claims and PARs Submission
P.O. Box 30
Denver, CO 80201

**Correspondence, Inquiries, and
Adjustments**
P.O. Box 90
Denver, CO 80201

**Enrollment, Changes, Signature
Authorization and Claim
Requisitions**
P.O. Box 1100 Denver, CO 80201

ColoradoPAR Program PARs
www.coloradopar.com

Eligible Members

Personal care is a benefit for Medicaid members who meet all three (3) of the following requirements:

- 20 years old or younger
- Meet the guidelines provided in the Personal Care Assessment Tool ([PCAT](#))
- Have a medical need for moderate to total assistance in at least three (3) of the 17 Personal Care tasks (Note: requests for personal care for one (1) or two (2) of the listed tasks will be evaluated.)

Eligible Providers and Provider Requirements

Ordering/Prescribing Providers

All requests for Pediatric Personal Care Benefit services must include an order signed by a provider with the following credentials:

- Physician: either a Doctor of Medicine (MD) or a Doctor of Osteopathic Medicine (DO); or
- Advanced Practice Nurse



Note: All ordering and prescribing providers must be enrolled in the Colorado Medicaid Program prior to requesting services.

Rendering Providers

All Pediatric Personal Care Benefit services must be provided by agencies that meet the following requirements:

- Class A or Class B home care agencies with up-to-date licenses, as regulated by the Colorado Department of Public Health and Environment (CDPHE), can offer personal care services under this benefit. A list of the agencies that have agreed to provide personal care is available on the [Pediatric Personal Care Benefit](#) web page.
- Providers must complete the Department's Personal Care Assessment Tool webinar training. Providers who complete the training will receive a certificate of completion. This certificate is a required component of an agency's records and may be subject to audit.
- Providers must be enrolled with Colorado Medicaid as Personal Care Agency. Enrollment information can be found on the [Provider Enrollment](#) web page.
- Providers must maintain up-to-date personnel files for each personal care worker (PCW), containing proof of current training, education, and PCW competency, as appropriate to the member's needs and as required by CDPHE.

Personal Care Workers

Pediatric Personal Care Services provided by the member's parent, spouse, or other legally responsible adult cannot be reimbursed by Medicaid.

Personal Care Workers (PCW) must meet all of the following requirements:

- Not excluded from participation in federally funded health care programs by the U.S. Department of Health and Human Services (HHS)/Office of Inspector General (OIG);
- Employed by, or providing services under a contract with, the licensed Class A or Class B Home Care Agency (HCA), through which the HCA may bill for the PCW's services;

- Completed the required training to complete the Personal Care Assessment Tool (PCAT); and has verified experience in the provision of PC Services for members, as regulated by the Colorado Department of Public Health and Environment (CDPHE) at 6 CCR 1011-1, Chapter 26, Section 8.5.

Personal Care and Skilled Care Under the Home Health Benefit

The Pediatric Personal Care Benefit aligns with the Home Health Benefit by providing non-medical services to Medicaid members whose level of care does not warrant CNA-level, medically skilled care for certain tasks.

A Medicaid member can receive **either** skilled care **or** personal care for any one (1) task. Members receiving skilled care under the Home Health Benefit for a particular task **cannot** receive personal care for that task. If a member requires skilled care for any part of a particular task and personal care for the rest of it, the whole task will be considered a skilled care task.



For example, if a member requires a skilled transfer to the bathtub or shower, then the bathing task is also considered a skilled task and covered under the Home Health Benefit. However, if a member needs a sponge bath or a shower that does not require a skilled transfer, then the bathing task is considered a personal care task and is covered under the Pediatric Personal Care Benefit.

When a Medicaid member receives services under both the Home Health and Pediatric Personal Care Benefits, both agencies providing these services must be in regular communication to best coordinate care for each member to ensure that: the member does not receive duplicate services, the appropriate Prior Authorization Request (PAR) is revised if and when necessary, and all agencies are informed about all aspects of necessary care.

Personal Care and Home and Community Based Services (HCBS) Waivers

Members currently receiving personal care services through an HCBS waiver will need to access those services through the Pediatric Personal Care Benefit first. They do not need to make this transition until their current service plan is up for renewal, although they have the option of transitioning sooner if they want.

Members receiving personal care services through the following waivers may need to transition from waiver personal care services to the Pediatric Personal Care Benefit:

- Brain Injury ([BI](#))
- Elderly, Blind and Disabled ([EBD](#))
- Community Mental Health Supports ([CMHS](#))
- Spinal Cord Injury ([SCI](#))
- Supported Living Services ([SLS](#))
- Children's Extensive Support ([CES](#))

Case Managers will help waiver members coordinate the transition of waiver personal care services to the new Pediatric Personal Care Benefit.

Members on the following waivers – which do not include personal care services – may now be eligible for services through the Pediatric Personal Care Benefit:

- Children with Autism ([CWA](#))

- Children with Life Limiting Illness ([CLLI](#))
- Children's Home and Community Based Services ([CHCBS](#))

Personal Care providers will need to complete a PAR for these services. Case managers will help members start this process and coordinate waiver and Pediatric Personal Care Benefit services. Members who need personal care services for tasks not covered by the Pediatric Personal Care Benefit may still get those services through the standard waiver process. They should speak to their Case Manager for more information.

Programs Excluded from the Personal Care Benefit

Members do not qualify for Pediatric Personal Care Benefit services if they are currently getting services through any of the following programs, because personal care services are provided as a primary component of them:

- Consumer-Directed Attendant Support Services ([CDASS](#))
- In-Home Support Services ([IHSS](#)) (except through the CHCBS waiver, which does not provide personal care)
- Home Care Allowance ([HCA](#))
- Residential Habilitation Services and Supports ([RHSS](#))
- Persons with Developmental Disabilities ([DD](#))
- Children's Habilitation Residential Program ([CHRP](#))

Enrolling Members into Pediatric Personal Care Benefit Services

Medicaid members have multiple points of entry into the Pediatric Personal Care Benefit:

- A physician or an advanced practice nurse.
- A local home care agency that offers personal care
- A case manager or care coordinator, if a member has one (1)
- The Colorado Medicaid Home Health phone number, 303-866-3447, or email, PersonalCare@state.co.us.



Any of the professionals listed above should be able to start the process for requesting personal care services.

In order to receive Personal Care services, a PAR must be through the [ColoradoPAR](#) program. Note: An approval of the PAR must be acquired, prior to rendering services. The following two (2) documents are required for the PAR process:

1. Personal Care Assessment Tool (PCAT): The PCAT needs to be **completed by a personal care provider**.
2. 485 Home Health Certification and Plan of Care form (or another form with the same content) (Plan of Care): The Plan of Care form needs to be **completed by a physician or an advanced practice nurse**.

The Plan of Care form must order in-home personal care services and describe in detail what services are medically necessary and how often they are needed.

Personal Care providers must get the Plan of Care form from the member's doctor, because personal care providers are responsible for submitting PARs.

The Personal Care Assessment Tool (PCAT)



The PCAT is used to consistently evaluate an individual's need for personal care services. The PCAT assesses the need for personal care support for each of the 17 Personal Care tasks. There is also space in the PCAT to include additional information about a member's need if requesting personal care services beyond what the PCAT assigns.

The PCAT is not the only document evaluated to determine the amount of personal care services that an individual is eligible to receive. The Colorado Medicaid's third-party utilization management (UM) vendor, eQHealth Solutions, will also look at the Plan of Care and any additional documents that the personal care provider submits to determine this amount.

The [Personal Care Assessment Tool](#) is available on the Department's website.

The 485 Home Health Certification and Plan of Care

The 485 Home Health Certification and Plan of Care (Plan of Care) is a form that allows physicians or advance practice nurses to document in detail the kinds of in-home health services that members need and how often they need each service. This form is required for members who request Personal Care Benefits (as well as the Home Health Benefit). Although they must be submitted independently, the same Plan of Care form may be used for both personal care services and home health services, as long as it states the need for both services. Many providers use an electronic version of this form that includes the same content, and it will be accepted as long as all elements of the 485 are included.

Prior Authorization Requests (PAR) Instructions

The ColoradoPAR Program is Colorado Medicaid's Utilization Management (UM) Program. The third-party UM vendor, eQHealth Solutions, reviews PARs to ensure items and services requested meet medical necessity guidelines and are within Colorado Medicaid's policies.

The ColoradoPAR Program's third-party UM vendor processes electronic PARs through an online PAR portal. The online PAR portal is a web-based, HIPAA-compliant PAR system that offers providers 24/7 accessibility to the information and functions providers need. All clinical documentation will be accepted in the following formats:



doc, docx, xls, xlsx, ppt, pdf, jpg, gif, bmp, tiff, tif, and jpeg

Contact the ColoradoPAR provider helpline at 888-801-9355 for support with submitting the PAR electronically via the online PAR portal. **PAR determination status may be verified in the online PAR portal or by contacting the ColoradoPAR provider helpline.**

The approved PAR identification number must be submitted with the claim to receive payment. The approved PAR identification number can be found on the PAR letter listed under PA NUMBER. PAR letters can be accessed through the Colorado Medical Assistance Program Web Portal ([Web Portal](#)) File and Report Service (FRS).

Note: PAR letters are not accessible through PAR Status Inquiry.

With the exception of Case Management Agencies, only the billing provider's Trading Partner ID will receive the PAR Letter in the FRS. Rendering providers will receive PAR letters in the mail. Users must be assigned the FRS User Role in order to access PAR letters from FRS in the Web Portal.

Claims for prior authorized services must be submitted within 120 days of the date of service. Services rendered prior to the authorized date will be denied reimbursement.

Approval of the PAR does not guarantee payment by Medicaid. The member and the PC provider shall meet all applicable eligibility requirements at the time services are rendered and services shall be delivered in accordance with all applicable service limitations. Medicaid is the payer of last resort and the presence of an approved or partially approved PAR does not release the agency from the requirement to bill Medicare or other third-party insurance prior to billing Medicaid.

Prior Authorization Request Requirements

- All Pediatric Personal Care Services require prior authorization by Colorado Medicaid's third-party UM vendor using the approved prior authorization request online portal. Providers who submit on average less than five (5) PARs per month may contact the ColoradoPAR Provider Helpline at 888-801-9355 to be exempted from online PAR submission and allowed submission via fax.
- The PAR is comprised of the completed Personal Care Assessment Tool (PCAT) and physician or advance practice nurse ordered Plan of Care. The PCAT can be completed by a Class A or Class B agency. Personal care services shall be ordered in writing by the member's prescribing provider as part of a written Plan of Care. Prescribing provider's signed Plan of Care must be submitted with the PCAT tool as part of the PAR.
- Pediatric Personal Care Benefit PARs may be submitted for up to a full year of anticipated services unless: the member is not expected to need a full year of services; the member's eligibility is not expected to span the entire year; or as otherwise specified by Colorado Medicaid.
- A PAR will be pended if all of the required information is not provided in the PAR, or additional information is required to complete the review. If the required documentation is not received within four (4) business days the PAR will be denied for lack of information.
- PARs must be submitted to Colorado Medicaid's third-party UM vendor in accordance with 10 CCR 2505-10 § 8.058.
- It is the personal care provider's responsibility to provide sufficient documentation to support the medical necessity for the requested services.
- When a PAR includes a request for reimbursement for two (2) staff members at the same time to perform two (2)-person transfers or another Pediatric Personal Care task, documentation supporting the need for two (2) people and the reason adaptive equipment cannot be used must be included in the PAR.
- All other information determined necessary by Colorado Medicaid's third-party UM vendor to make a decision on the medical necessity and appropriateness of the proposed treatment plan must be included.
- If/when the member experiences a change in condition necessitating a change in the amount, duration, or frequency of Pediatric Personal Care services being delivered to the member, the personal care provider is required to submit a PAR revision, which should include revisions to all documentation, including the Plan of Care.
- PAR requests that do not include all of the required elements will not be processed until all documents are received. It is the personal care provider's responsibility to provide



sufficient documentation to support the necessity for the requested services. If the third-party UM vendor does not receive the required documentation within four (4) business days the PAR will be denied for lack of information.

- The personal care provider is required to request a revision to the Plan of Care as necessary when the member experiences a change in condition necessitating a change in the amount, duration, or frequency of Pediatric Personal Care services being delivered.

The PAR will be reviewed by qualified clinical reviewers that work for the Colorado Medicaid program's third-party UM vendor. Nurses and doctors will decide if the request for personal care meets the rules for medical necessity and for the Pediatric Personal Care Benefit.

An approved PAR is valid for up to a year. After a year, a personal care provider must submit a new PAR for another year of Pediatric Personal Care Benefit services.

Prior to denying a PAR, the physician who requested the PAR will be contacted to discuss the PAR in a process called a peer-to-peer review. If the peer-to-peer review still results in a denied PAR, the personal care provider can work with the doctor on these two (2) options:

- PAR Reconsideration: A PAR Reconsideration is similar to a second opinion and must be requested by the personal care provider. A different physician than the one who made the PAR denial will re-review the PAR along with any new information and make a final PAR decision. Additional documents not submitted with the original request may be submitted during the Reconsideration process.
- PAR Resubmission: Submit a new PAR that includes additional medical information needed for the PAR review.

If a member receives a PAR denial letter, that member also has the option to submit a written request for an appeal to the Office of Administrative Courts.

Billing and Reimbursement



Providers should use procedure code **T1019** for personal care claims. **T1019** is reimbursed at \$4.75 per unit. Each unit is 15 minutes.

Providers should use their unique billing ID number as the billing provider and rendering provider ID.

Agency Coordination

Home Care Agencies are required to maintain a record of evidence of care coordination among agencies when the member is receiving additional services. These agencies may include providers for Medicaid home health services, HCBS waiver services, or services from other payers.

Department training will include guidelines for personal care agencies conducting care coordination in conjunction with their provision of services.

Training Schedule and Information

For training on the billing process for Personal Care refer to the [Provider Training](#) web page under "Billing Trainings and Workshops" then "Specialty Presentations".

- Personal Care Assessment Tool (PCAT) Training Webinars:

An online training on how to use the PCAT tool:

- September 24, 2015 9-10am - To register [click here](#).
- September 25, 2015 3-4pm (repeat) - To register [click here](#).

- Case manager/waiver program training:
 - October 7, 2015 2-3:30pm
 - October 13, 2015 10-11:30am
 Registration information will be sent to HCBS waiver program case managers
- PAR portal training:
 - Training for personal care agencies on the new ColoradoPAR program third-party UM vendor will be provided prior to the benefit implementation.

Claim Submission

Electronic Claims

Instructions for completing and submitting electronic claims are available through the 837 Professional (837P) Web Portal User guide via the [Web Portal](#) and also on the Department's Colorado Medical Assistance Program Web Portal page.

The Colorado Medical Assistance Program collects claim information interactively through the Colorado Medical Assistance Program Secure Web Portal (Web Portal) or via batch submission through a host system. Please refer to the CMS 1500 General Billing Information Manual for additional electronic billing information.

The Special Program Indicator (SPI) must be completed on claims submitted electronically. Claims submitted electronically and on paper are identified by using the specific national modifiers along with the procedure code. The appropriate procedure codes and modifiers for each HCBS waiver are noted throughout appropriate billing manuals. When the services are approved, the claim may be submitted to the Department's fiscal agent.

Please refer to the [Personal Care Billing Manual](#) for a claims example.



Paper Claims

Pediatric Personal Care services claims are submitted on the CMS 1500 claim form. Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the Department. Requests may be sent to the Department's fiscal agent, Xerox State Healthcare, at P.O. Box 90, Denver, CO 80201-0090.

The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit five (5) claims or fewer per month (requires approval)
- Claims that, by policy, require attachments
- Reconsideration claims

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

For more detailed CMS 1500 billing instructions, please refer to the [Personal Care Billing Manual](#) for more information.

If a confirmation has not been received at least two business days prior to the workshop, please contact the Department's fiscal agent and talk to a Provider Relations Representative.

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