



Pediatric Personal Care Benefit

Frequently Asked Questions for Medicaid Providers | Fall 2015

What is the Pediatric Personal Care Benefit?

The Pediatric Personal Care Benefit helps Colorado Medicaid (Medicaid) members 20 years old and younger with in-home, non-medical support with daily living activities, such as bathing, dressing, meal preparation, and toileting.

What does this benefit cover?

The Pediatric Personal Care Benefit covers support services in the home that do not require a service provider to have medical certification or a professional license to deliver services. Personal care services may take different forms, such as 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. There are 17 personal care tasks included in this benefit. Members who qualify for the benefit can receive support with any of these 17 tasks.

Who qualifies for the Pediatric Personal Care Benefit?

These services are a benefit for Medicaid members who meet the following requirements:

- Are 20 years old or younger
- Qualify for personal care service(s) as assessed by the Personal Care Assessment Tool ([PCAT](#)) (See, "What is the Personal Care Assessment Tool (PCAT)" below), and other supporting clinical documentation.

What are the 17 Personal Care Tasks?

Personal care assistance for the following tasks are covered by this benefit:

1. Ambulation/Locomotion (such as physical support with walking or moving from place to place with or without an assistive device)
2. Bathing/Showering (such as preparing bathing supplies and cleaning up after the bath, as well as applying soap, rinsing, and drying)
3. Dressing (such as putting on and taking off clothing)
4. Feeding (such as making sure food is the right temperature and consistency)



5. Hygiene – Hair Care/Grooming (such as shampooing, conditioning, simple, non-professional styling, and combing)
6. Hygiene – Mouth Care (such as brushing, flossing, swabbing teeth, and rinsing mouth)
7. Hygiene – Nail Care (such as soaking, filing nails, and cuticle care)
8. Hygiene – Shaving (such as shaving face, legs, and underarms with electric or safety razors)
9. Hygiene – Skin Care (such as applying over-the-counter lotion or other skin care products)
10. Meal Preparation (such as preparing, cooking, and serving food)
11. Medication Reminders (such as verbally communicating that it is time for medication and opening a pre-filled container)
12. Mobility – Positioning (such as moving an individual to a new position in a wheelchair while keeping the body properly aligned)
13. Mobility – Transfer (such as physically supporting an individual to safely move the individual from bed to a wheelchair next to the bed)
14. Toileting – Bladder Care (such as assisting an individual with using a toilet or bedpan, changing a diaper, emptying and rinsing the bedpan, and cleaning skin)
15. Toileting – Bowel Care (such as changing and cleaning an individual after a bowel movement, assisting the individual using the bathroom, and changing any clothing or pads)
16. Toileting – Bowel Program (such as emptying an ostomy bag)
17. Toileting – Catheter Care (such as emptying a catheter bag)

The Personal Care Assessment Tool includes detailed information about when the member may need skilled care instead of personal care for any single task.

If the member needs personal care support for any tasks not covered by this list, additional support may be available. Call the



Pediatric Personal Care Line at 303-866-3447 or email PersonalCare@state.co.us with any questions about these or other personal care tasks.

What is the difference between skilled care services and personal care services?

Skilled care services are in-home medical services provided to treat a medical condition. Skilled care services must be provided by a certified nursing assistant (CNA) or registered or licensed nurse. The [Home Health Benefit](#) offers skilled care services to members with a medical need.

Personal care services support members who need assistance with daily living tasks, when these services can be provided by someone without a CNA or nursing license or registration.

The Personal Care Assessment Tool lists the differences between skilled care and personal care for each personal care task to make it easier for families to understand which type of care is right for each task. Please see the “What is the Personal Care Assessment Tool (PCAT)?” section below for more information.

For more information about Home Health services, see the [Home Health Benefit web page](#) or the [Pediatric Assessment Tool FAQs](#).

What is the Personal Care Assessment Tool (PCAT)?

The Personal Care Assessment Tool is a way to consistently evaluate the member’s need for each of the 17 Personal Care Tasks. See the “What are the 17 Personal Care Tasks?” section above for more information. There is also space in the PCAT to include additional information about the member’s need for personal care services.

Note: Although members and their caregivers can participate in completing the PCAT, the personal care provider is responsible for submitting the document for the prior authorization request (PAR) process.

The PCAT is not the only document evaluated to determine the amount of personal care services that the member may receive. The Colorado Medicaid third-party vendor will also look at the Plan of Care and any additional documents that are submitted.

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

What is a 485 Home Health Certification and Plan of Care?

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The 485 Home Health Certification and Plan of Care (Plan of Care) is a form that allows doctors to document in detail the kinds of in-home health services that the patient needs and how often they need each service. This form is required for personal care providers applying for the Personal Care Benefit, as well as the [Home Health Benefit](#). The same Plan of Care form may be used for requesting both Personal Care Benefit services and Home Health Benefits, as long as the form states the need for both of those services. Many providers use an electronic version of this form that includes the same content. As long as all elements of the 485 are included, the Plan of Care will be accepted.

How will this new benefit affect members currently receiving skilled care services through the Home Health Benefit?

Their home health services **will not** change. They may qualify for additional services through this benefit. A Medicaid member must meet the requirements listed above to qualify for personal care services. Please see the “Who Qualifies for Pediatric Personal Care Services?” section above for more information.

If the member qualifies for **both** home health and personal care services, they may receive services from two different providers.

Both Home Health and Personal Care Benefits provide services for defined tasks. If the member is receiving skilled care for a task through the Home Health Benefit, the member will **not** receive personal care for that same task. If any part of a task requires the skills of a CNA or registered or licensed nurse, the whole task will be considered a skilled care task, covered by the Home Health Benefit.

For example, if the member needs skilled assistance with moving into a bathtub or shower, then the bathing task is also considered a skilled task and covered under the Home Health Benefit. However, if the 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 covered under that benefit.

How will this new benefit affect members currently receiving services through one of Colorado’s Home and Community-Based Services (HCBS) waivers?

Most of the personal care services provided for individuals enrolled in waivers will now be available through the Pediatric Personal Care Benefit.

If the member currently receives personal care services through a waiver, they will need to access those services through the Personal Care Benefit when their annual Service Plan is renewed. They have the option to transition sooner if they want.



If the member is receiving personal care services through the following waivers they may need to transition from waiver personal care services to the 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)

Their case manager will help coordinate the transition from waiver personal care services to Personal Care Benefit services.

If the member is on one of the following waivers, which do not include personal care services, they may now be eligible for services through the Personal Care Benefit:

- Children with Autism (CWA)
- Children with Life Limiting Illness (CLLI)
- Children's Home and Community Based Services (CHCBS)

As a personal care provider you will need to complete a Prior Authorization Request (PAR) for these services.

If the member needs personal care services for tasks not covered by the Pediatric Personal Care Benefit, they may still get those services through the standard waiver process. They should speak to their case manager for more information.

Members do **not qualify** for Pediatric Personal Care Benefit services if they are currently getting services through any of the programs listed below 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)
- HCBS-Persons with Developmental Disabilities (DD) waiver
- HCBS-Children's Habilitation Residential Program (CHRP) waiver

Can a member who is receiving a Home Care Allowance to cover personal care services also get Medicaid personal care services?



No, Medicaid members can receive services from only **one** of these two programs: the Home Care Allowance program, which is managed by each county's [Department of Human or Social Services](#), or the [Pediatric Personal Care Benefit](#).

How can members find a personal care provider?

There are currently 57 home care agencies in Colorado that provide personal care services. You can [find a list of these agencies on the Department website](#). If you do not have access to the Internet but want help finding a provider, you may leave a message on the Pediatric Personal Care Line at (303) 866-3447 or email PersonalCare@state.co.us. Medicaid staff will return your call within one business day to help find a provider.

If the member is enrolled in a waiver program, their case manager can help get them connected to local personal care agencies.

I operate a Class A and/or Class B agency and would like to be listed as a personal care provider. What can I do?

Licensed Class A and/or Class B agencies interested in becoming Personal Care Benefit providers must meet the requirements listed in the Benefit Coverage Standard. They must also take the Personal Care Assessment Tool training webinar, which will be available as a recording soon.

Class B agencies that are providing waiver personal care services may need to enroll as Medicaid providers. Please see [the provider enrollment page](#) for more information.

For more information about becoming a provider under this benefit, you may call the Pediatric Personal Care Line at (303) 866-3447 or email PersonalCare@state.co.us. Medicaid staff will return your call within one business day and offer you one-on-one support.

What are the qualifications of personal care workers?

Personal care workers must meet the following qualifications:

1. Have verified experience and training for providing personal care services
2. Are employed by a licensed home care agency
3. Are 18 years of age or older

Home care agencies are responsible for hiring and supervising experienced personal care workers. While there is no certification for personal care workers, home care agencies are licensed by the Colorado Department of Public Health and Environment



(CDPHE). CDPHE monitors all home care agencies to ensure that they are providing the best possible care to their clients.

Can family members provide services to members through this benefit?

The federal Centers for Medicare and Medicaid Services (CMS) sets rules about who can provide Personal Care Benefit services. According to the federal rules, an adult who is legally responsible for a dependent individual is not allowed to get paid by Medicaid for providing personal care services to that individual. This means that parents, spouses, and other legally responsible adults cannot be reimbursed for providing personal care services to their own children, spouses, or otherwise dependent individuals.

How can I start providing personal care services through this benefit?

If a member needs personal care, they may be referred to a personal care agency by any of these health care professionals:

- Their case manager or care coordinator, if they have one
- Their physician
- Their skilled care agency
- A local home care agency that offers personal care
- Medicaid staff: Members may call the Colorado Medicaid Pediatric Personal Care phone number, (303) 866-3447, or email PersonalCare@state.co.us for help getting personal Care Benefit services.

The personal care agency will start the process to request personal care. The personal care provider will need to submit two required documents:

1. Personal Care Assessment Tool ([PCAT](#)). The PCAT needs to be **completed by the 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 the member's doctor**.

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. The personal care provider may also submit additional documentation of the need for the requested Personal Care Benefit services.

The personal care provider will submit the completed forms in an online Prior Authorization Request (PAR). The PAR process verifies that personal care services are



medically necessary and appropriate for each member. All personal care services must be requested through this process.

If Colorado Medicaid's PAR vendor approves the PAR, the personal care provider can then work with the member to start getting services. Each approved PAR is valid for up to one year. If a member needs personal care services for the next year, the personal care provider must submit a new PAR, with a new Plan of Care from their doctor and a new PCAT.

How can the member determine whether personal care services are medically necessary for them?

Their doctor will be able to tell them if their diagnosis, condition, or symptoms make personal care medically necessary for their day-to-day life.

Can services be provided outside of the home, for example, if the member needs personal care at an after-school program not covered by their Individual Education Plan (IEP)?

Personal Care Benefit services can be provided outside of the member's home, as long as those services are not covered by another program. If their IEP does not cover an after-school activity and they require personal care services while participating in that activity, they may be able to receive those services. The PAR should include information about that activity and evidence of medical necessity for personal care at that time and place.

What should the member do if their personal care needs were not fully captured in the completed Personal Care Assessment Tool (PCAT)?

If the member feels that they have personal care needs beyond what was documented in the PCAT, they may use the designated space in the PCAT to identify other personal care needs. Be sure the Plan of Care adequately shows the medical need for more services. If it doesn't, include extra documentation that shows the need for more personal care services. As a personal care provider, you are responsible for entering this information and documents into the online PAR.

What happens once the Prior Authorization Request (PAR) is submitted?

The PAR will be reviewed by licensed clinical reviewers who will assess personal care needs.



If the PAR is approved, then the provider will receive notification of the number of hours that personal care services may be provided. An approved PAR is valid for up to a year, after which a new PAR must be completed and submitted.

Before the PAR is denied or partially denied, the provider who signed the PAR will be called to discuss the PAR in a process called a Peer-to-Peer review.

If a PAR is requested and the third-party vendor does not receive the required documentation within four (4) business days, they will call the provider and request this documentation. If the vendor does not receive the needed documentation, the PAR will be denied for lack of information. The Peer-to-Peer review may help prevent this from happening.

If the Peer-to-Peer review still results in a denied or partially denied PAR, the member can work with their personal care provider and their doctor on these options:

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

They also have the option to:

- Submit a written request for an appeal to the Office of Administrative Courts. For more information, see "The member's Prior Authorization Request was denied and they want to appeal the decision. How do they appeal the PAR decision?" below.

The member's Prior Authorization Request was denied and they want to appeal the decision. How do they appeal the PAR decision?

They have the right to appeal and ask for a hearing if they do not agree with the PAR decision. They will have an appeal hearing with an Administrative Law Judge. They may represent themselves, or have a lawyer, a relative, a friend, or other spokesperson assist them as their authorized representative.

How to appeal:

1. They must request an appeal in writing. This is called a Letter of Appeal.

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2. Their Letter of Appeal must include:
 - a. Their name, address, phone number, and Medicaid number;
 - b. Why they want a hearing; and
 - c. A copy of the front page of the Notice of Action (letter notifying them of the PAR decision) they are appealing.
3. They may ask for a telephone hearing rather than appearing in person.
4. They should mail or fax their Letter of Appeal to:

Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

Fax 303-866-5909

5. Their letter of appeal must be received by the Office of Administrative Courts no later than thirty (30) calendar days from the date of their Notice of Action (their denial letter). The date of the Notice of Action is located on the front of the denial letter.
6. The Office of Administrative Courts will contact them by mail with the date, time, and place of their hearing.

How can I talk to someone directly about the Pediatric Personal Care Benefit?

Send your Pediatric Personal Care Benefit questions to PersonalCare@state.co.us or call the Pediatric Personal Care Line at 303-866-3447. A Medicaid staff member will respond to you within one business day.

