

## Administrative Requirements for Participating Agencies: The Provision of Personal Care Assistance Services

### Table of Contents

I.	PCA Employee Oversight	2-4
II.	Authorizations	5-6
III.	Development of Care Plans	7
IV.	Billing Requirements	8-10
V.	Subcontracting	11
VI.	Steps for Success	12
VII	Documentation in Client File	13

<b>Provider Service Center</b>	Call 1-800-458-5512. Press option 1 for <i>provider</i> , then option 2 to speak with a representative.
<b>Authorizations</b>	For Medica Choice Care and Medica MinnesotaCare, call 1-800-458-5512. Press option 1 for <i>provider</i> , then option 4, then option 4.  For MSHO or MSC+, contact the client's care coordinator or Provider Service Center.
<b>Network Contracting</b>	Call 1-800-458-5512. Press option 1 for <i>provider</i> , then option 5 for contract management.
<b>Fraud Hot-lines</b>	Call 952-992-2237 or 1-866-821-1331. Messages can be left confidentially.

*For more information, see Medica's Utilization Management policy regarding PCA Services on [www.medica.com](http://www.medica.com).*

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## **I. PCA Employee Oversight**

As a Medica contracted agency for PCA services, it is your responsibility to ensure that the services you bill to Medica are in fact performed by your employees. Your responsibility for oversight of PCA services is not limited to qualified professional supervisory visits. You are required to have monitoring in place to ensure that your employees:

- report to work at the designated time,
- stay at work for the entire scheduled time,
- complete time cards truthfully and accurately, and
- perform the services they report.

While it is not possible to observe all the work of every PCA, you are required to have processes in place that will identify any issue with the performance of an individual PCA.

### **A. Care Oversight**

At least every sixty days, while updating the care plan, the qualified professional must include a review of the PCA records. This is an opportunity to ensure that the PCA records accurately represent the actual hours worked. Additional requirements for Care Plans are described in Section III.

### **B. Documented Contingency Plan**

Every client's chart must show evidence of a contingency plan in the event that a PCA does not report to work. Your agency must have a process in place to assure the safety of the client if a PCA does not report to work as scheduled. See Section III for more information on Care Plans.

### **C. Oversight of PCAs**

In addition to the supervision visits, the agency must have a plan to assure that PCAs report to work as scheduled and complete their time cards accurately. For example, Medica suggests making at least one unannounced phone call a week to assure the PCA reported to work as scheduled.

In addition, if the PCA is not on site as expected, progressive discipline must be started immediately. This is critical for two reasons. First, once a need for PCA services has been assessed, it is the responsibility of your agency to assure those services occur for the safety of the enrollee. Second, it is against federal law to bill for Medicaid services that did not occur, and the PCA agency must have mechanisms to assure services occurred as reported.

Specific oversight activities must be documented in the client's file.

### **D. Schedule Work Time and Time cards**

The hours a PCA works must be planned in advance by the agency. PCA employees must work the hours exactly as planned and any change in planned work hours must be approved and documented

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by your agency management in advance of the change. Agency involvement in scheduling is required even if the PCA is a family member and lives with the client.

Hours worked should correspond to the functional needs of the client. For example, if assistance with meals is approved, the PCA should be working during mealtime hours.

Time cards must reflect actual hours worked. Time cards must include a notice that it is a federal crime to provide false information on personal care service billings for medical assistance. Time cards must never be completed or signed prior to work being performed. Time cards must be signed by the PCA, the client or responsible party, and by the supervisor. The supervisor must have confidence that the work was performed before signing a time card. In lieu of a signature, by paying the PCA and billing Medica, the agency assumes responsibility for the accuracy of the time card.

If the client and/or the PCA does not speak English, it is the responsibility of your agency to provide for a translated time card. The time card must be in English as well as the language spoken by the PCA and client.

## **E. Vulnerable Adult Maltreatment**

All medical professionals are mandatory reporters under Minnesota law. Your agency must have a training program for all agency employees that includes details about the Common Entry Point(s) for your service area. For all clients receiving PCA services, the assessment has shown a need for services. After a need for PCA services is assessed, if an employee fails to provide needed services--for example, if the employee does not report to work as scheduled--the client's safety could be at risk. If situations like this put the health of the client in jeopardy, they must be reported to your Common Entry Point.

To determine your Common Entry Point for vulnerable adult maltreatment, see the list on the Minnesota Department of Human Services web site:

<http://www.mnaging.org/advisor/cepd.htm>

## **F. Written monitoring procedures**

Your agency must have written procedures for monitoring PCA services. In addition to the activities listed above, here is a list of the types of activities to consider for your procedure.

- A confidential process for clients and employees to report possible violations.

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### **Examples of Vulnerable Adult Maltreatment that must be reported:**

1. Sexual Assault should be **immediately** sent to OHFC and the police. Instruct the facility to contact the police immediately so that evidence can be collected and appropriate exams completed.
2. Physical abuse by staff, relatives, visitors.
3. Unexplained injuries, such as fractures, large skin tears, and bruises, especially those that are in unusual areas, such as the perineum, breasts, upper inner thigh, should be forwarded to OHFC promptly.
4. Staff taking and using credit cards, checks, and/or money from patients/residents.
5. Neglect: Obtain information about the nature of the neglect that the facility is reporting, e.g., did the facility staff fail to follow the resident's care plan, physician's order, the facility's policies and procedures, etc.

From DHS:

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id\\_057329](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_057329)

- Satisfaction survey of your clients and their responsible parties.

Your agency is free to develop the procedures that it deems most effective to assure the services billed to Medica are in fact performed. The list above is provided as a guideline. *Medica will audit your procedures to ensure that your process is at least as comprehensive as the activities listed above.*

**Please note:** This oversight of PCAs is beyond what is billed to Medica for supervisory visits by a qualified professional and is included in the PCA rate your agency already receives. Your efforts to ensure that your billed services were in fact performed are a standard part of doing business and are not separately reimbursable.

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## II. Authorizations

<b>Non-Seniors</b>	Fax Home Care Request form to 952-992-3556 or 3554  Medica Care Management Department Mail Route CP440 PO Box 9310 Minneapolis, MN 55440
<b>Seniors</b>	Contact the client's care coordinator. Obtain the name of the care coordinator from the client or call Provider Services at 1-800-458-5512.

Before Medica can complete an authorization, re-authorization or a change in authorization, you are required to provide key documentation to the care manager or care coordinator. The information provided can vary, but typically includes:

- Home Care Request form  
[http://provider.medica.com/router/default.pdf?doc=/C15/GeneralToolsForms/Document%20Library/Home\\_Care\\_Request\\_Form.pdf](http://provider.medica.com/router/default.pdf?doc=/C15/GeneralToolsForms/Document%20Library/Home_Care_Request_Form.pdf)
- Orders from the client's primary care physician.
- Two weeks of PCA notes for existing clients
- The most recent care plan for existing clients

**Statement of Need:** Medica requires you to obtain the DHS Statement of Need from the client's physician or nurse. The original should be kept in your file. The DHS Statement of Need form can be found at:

<http://edocs.dhs.state.mn.us/lfsrver/Legacy/DHS-4690-ENG>.

The Statement of Need must be signed by the client's primary care physician and must show that the provider has seen the client within the past year.

Additional documentation may be requested by the Care Manager or Care Coordinator, including additional medical records, care plans for the past year, or additional PCA notes.

### A. New Authorizations

To initiate care for a new client, or an existing client new to Medica, start by sending a Home Care Request Form to Medica. **It is critical that you send Medica a valid address and phone number for the client.** When Medica receives the form, Medica will initiate an assessment for PCA services.

### B. Re-Authorizations

Medica requires that your agency request a re-authorization of services a minimum of 60 days in advance of the end of the authorization. The purpose of this requirement is to assure that there are no disruptions in services to clients. Claims without authorizations will be disallowed as provider

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liability and cannot be billed to the client.

## **C. Changes in Authorizations**

To request a change in authorization, you must provide Medica with written evidence of a change in medical or behavioral need. Typically, the written evidence would be hospital records or medical office notes. Do not send Medica requests for a change in authorization if there is not a change in medical need.

## **D. Change of Agency**

Clients have free choice of participating agencies for their PCA services. The new agency is responsible for the following actions.

- Obtaining approval from the client for the change of agency.
- Contacting the old agency to notify it of the change.
- Contacting Medica to change the authorization.

You must provide Medica with the signed approval from the client.

**Please note:** The new agency must coordinate a future effective date for the change with the old agency. It is the responsibility of the new agency to assure a new authorization is in place. Medica will not pay for retroactive authorizations due to change of agency.

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## III. Development of Care Plans

Thoughtful development of Care Plans is a key part of assuring client needs are met by your PCA employee. For Medicare-certified agencies, you must use the Medicare form-485. Non-Medicare certified agencies may use an equivalent form. The care plan must be refreshed every 60 days, and must be completed by a qualified professional (i.e., an R.N., mental health professional or licensed social worker) or the enrollee's physician. Development and refreshment of the care plans must be based on in person meetings with the clients.

### A. Employee Oversight

While updating the care plan, the qualified professionals should document their review of the PCA notes to assure that the appropriate care was given and accurately represent the actual hours worked.

### B. Flexible Use Documentation

If a client is using flexible use hours, how those hours are to be used must be documented in the care plan. If use of those hours for personal care services exceeds the number of hours authorized (for the six month time period), it is the responsibility of the agency to notify the client. The client's medical record must include documentation of notice to the client that their use of personal care services was approaching or exceeded the number of hours authorized.

**Please note:** In fee for service Medical Assistance, DHS provides notice to the client when their use of PCA hours exceeds the expected use. Unlike fee for service Medical Assistance, Medica requires its agencies to provide notice to clients.

### C. Documented Contingency Plan

Every client's chart must show evidence of a risk management plan. This is critical for the safety of the client as well as for oversight of the PCA employees. There should be an appropriate plan in place for back up coverage appropriate to the needs of the client. Minimally, if a PCA does not report to work or works fewer hours than scheduled, the client or responsible party must contact the agency to report the absence.

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## IV. Billing Requirements

### A. Billing for Supervision

Because the care plan involves an in-person visit by a qualified professional employed by your agency, you may bill Medica for supervision.

The frequency of a supervisory visit is determined by the complexity of care and is not covered unless medically necessary. The necessity for each visit must be documented in the medical record. Supervision includes:

- Care plan development
- Review of medications
- Communication of changes in client needs to the physician or others
- Orientation of PCAs to personal care and needs
- Training PCAs to provide hands-on assistance with special health care tasks

### B. Enrolling New PCA Employees

Medica requires that you notify the health plan of all newly hired employees and terminated employees. Your notification to Medica will be on the PCA Individual/Agency Demographic Change form. Medica only accepts electronic notifications in Excel.

To initiate the process, send an e-mail to [IndividualPCANum@medica.com](mailto:IndividualPCANum@medica.com). Medica will return the Excel template to your email address by secure email. You can then complete the form and return it to us by reply email.

- Enroll PCAs with DHS before you begin the Medica enrollment process.
- Accurate completion of all fields is imperative using the exact format. Medica must receive files electronically in Excel with the exact headings shown on the attachment for auto loading into Medica's system.
- Incomplete spreadsheets will be returned to you for completion.
- Submit each name only once.
- Upon assignment of the number, Medica will send a secure email to you with your billing number.
- If you are waiting for a provider number, you may call Provider Services at 1-800-458-5512. Please allow at least three weeks after your submission for receipt of a Medica provider number.

### C. Claim Form

Agencies must bill for PCA services using the CMS-1500 claim form or as an 837 Professional transaction. Medica will require agencies to bill for each individual PCA's services using a new individual provider number (58-xxxxx) as well as a new agency provider number (58-xxxxx). All PCA services, including extended hours of PCA and shared care, must be billed on the CMS 1500 (or 837 Professional for electronic claims).

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Home health care agencies will continue to bill for non-PCA services on the UB-04 claim form, using current provider number (59-xxxxx).

**Note:** You must bill for services with one line per date of service in accordance with the Minnesota Department of Human Services (DHS) requirement.

## D. Timeliness of Billing

While Medica's contracts allow for a period of 180 days, Medica expects timely billing for services. Medica monitors the billing timeliness of agencies.

## E. Electronic Billing Instructions

Medica encourages electronic billing of claims to Medica for PCA services. In fact, Minnesota law requires electronic billing of all services by July 15, 2009.

The instructions below may be helpful to your vendor in clarifying how the National Provider ID, (NPI), Unique Minnesota Provider Identifier (UMPI) and Medica legacy numbers must be reported on an electronic claim. **Medica requires the use of the legacy number on the record.**

### Home Care Agency (Typical Provider)

#### Billing Provider Organization Information

##### Loop 2010AA

NM1 segment (Name)  
NM108 XX qualifier  
NM109 NPI  
REF segment (secondary identifier)  
REF01 EI qualifier  
REF02 employer's id number (federal tax id)

#### Rendering Provider Information—the PCA Employee (not the agency) is the Rendering Provider

##### Loop 2310B (claim level)

NM1 segment (Name)  
NM108 24 qualifier  
NM109 employer's id number (federal tax id)  
OR  
NM108 34 qualifier  
NM109 social security number  
REF segment (secondary identifier)  
REF01 G2 qualifier  
REF02 Medica legacy number assigned to the individual PCA  
REF segment (secondary identifier)  
REF01 G2 qualifier  
REF02 UMPI number assigned to the individual PCA

#### Rendering Provider Information—the PCA Employee (not the agency) is the Rendering Provider Loop 2420A (service line level): Used when a service line has a different PCA than the claim level.

NM108 24 qualifier  
NM109 employer's id number (federal tax id)  
OR  
NM108 34 qualifier  
NM109 social security number  
REF segment (secondary identifier)  
REF01 G2 qualifier  
REF02 Medica legacy number assigned to the individual PCA  
REF segment (secondary identifier)  
REF01 G2 qualifier  
REF02 UMPI number assigned to the individual

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## PCA Agency (Atypical Provider)

### Billing Provider Organization Information

#### Loop 2010AA

NM1 segment (Name)

NM108 24 qualifier

NM109 employer's id number (federal tax id)

### Rendering Provider Information—the PCA Employee (not the agency) is the Rendering Provider

#### Loop 2310B (claim level)

NM1 segment (Name)

NM108 24 qualifier

NM109 employer's id number (federal tax id)

OR

NM108 34 qualifier

NM109 social security number

REF segment (secondary identifier)

REF01 G2 qualifier

REF02 Medica legacy number assigned to the individual PCA

REF segment (secondary identifier)

REF01 G2 qualifier

REF02 UMPI number assigned to the individual

### Rendering Provider Information—the PCA Employee (not the agency) is the Rendering Provider

Loop 2420A (service line level): Used when a service line has a different PCA than the claim level.

NM1 segment (Name)

NM109 employer's id number (federal tax id)

OR

NM108 34 qualifier

NM109 social security number

REF segment (secondary identifier)

REF01 G2 qualifier

REF02 Medica legacy number assigned to the individual PCA

REF segment (secondary identifier)

REF01 G2 qualifier

REF02 UMPI number assigned to the individual

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## V. Subcontracting

Your contract with Medica only permits subcontracting with Medica's express prior written approval. All employees your agency bills for must be W-2 employees of your agency, unless you have Medica's express written approval.

Medica considers "Supplemental Staffing" a form of subcontracting. "Supplemental staffing" (e.g. using temporary agencies or other PCA agencies), whether they are participating with Medica or not, is not acceptable without Medica's prior written approval.

If your agency bills for services performed by subcontractors and there is no written approval from Medica on file, Medica will recover the payment. Moreover, billing for services performed by a subcontractor as defined above, without Medica's written approval, is considered a material breach and grounds for terminating your contract with Medica. You may not bill your clients for recovered payments for inappropriately subcontracted services.

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**VI. Steps for Success Training**

All Medica contracted agencies providing PCA services must attend the DHS Steps for Success training program. Send the record of attendance for your agency to the e-mail box at [PCACommunication@medica.com](mailto:PCACommunication@medica.com). See the form at the bottom of this page.

For more information on the Steps for Success program, go to:

[http://www.dhs.state.mn.us/main/groups/business\\_partners/documents/pub/dhs16\\_140429.pdf](http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_140429.pdf)

To register for the training, go to:

<http://providertraining.dhs.state.mn.us/>

**Steps for Success Program Attendance**

Medica requires that all of its participating agencies attend the Steps for Success training program offered by the Minnesota Department of Human Services. Steps for Success is a three-day training program to PCA agencies.

Upon program completion, please complete the following form, scan it, and return it to [PCACommunications@medica.com](mailto:PCACommunications@medica.com). Medica will be confirming your attendance with DHS. Thank you!

Name of Agency	
Name of Attendee	
Title of Attendee	
Dates of <u>Steps for Success</u> Program Attended	

I certify that I have attended the entire Steps for Success training program and that I am currently employed for the agency listed above.

\_\_\_\_\_  
Name of attendee

\_\_\_\_\_  
Date

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## VII. Documentation in Client File

You are required to keep specific documentation on file for each Medica enrollee you serve. *You will be audited against these requirements.* You must keep specific documentation on each client for a minimum of 10 years or a longer period of time as required by law. This documentation includes:

### A. Criminal Background Check

You are required to obtain criminal background checks for each employee who provides direct service to a Medica enrollee. This background check must be completed before services are provided and it must be refreshed periodically. It must be specific to your agency. It is your responsibility to disqualify from service any employee who cannot pass the criminal background check.

### B. Authorization Record from Medica

You are required to keep an up-to-date authorization or referral record from Medica, which serves as the “service plan” and is required by law. The prior authorization record includes the elements of a service plan, including the number of hours authorized for your client.

### C. Statement of Need

Medica requires you to retain a copy of the DHS Statement of Need with required documentation before in the medical record. See Section II for more information.

### D. Care Plans

See Section III for more information. As described in Section III, the care plans must include Flexible Use documentation.

### E. Time cards

There must be time cards, signed by your employee, the client or responsible party, and supervisor, for all billed hours. Time cards must reflect actual hours worked. Time cards must include a notice that it is a federal crime to provide false information on personal care service billings for medical assistance. See Section I.D. for more information.

### F. Daily Work Records

The file must include detailed records from the PCA for all services reported on the time card. The records must correspond to the hours billed and adequately describe the work performed in the time period reported. For example, if an employee records three hours on their time card, Medica would expect to see a detailed log of the work that shows three hours’ worth of work performed.

### G. Signed orders

Your file must include signed orders from the primary care physician or nurse.

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