

# *Chapter 8*

# Home Care Services

## Overview

Chapter 8 includes the criteria that must be met for Medicare certified home care services, some billing information regarding billing for Medicare certified home health contracted services, provides information on billing for home infusion services, and Personal Care Attendant (PCA) services. It also outlines the standards for all contracted PCA providers.

## **This Chapter Includes:**

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# Home Care Services Criteria

## **A. Medicare Programs** (*UCare for Seniors*)

UCare follows Medicare criteria for coverage of home care services. Services must be delivered by a Medicare certified home health agency. Members must meet Medicare criteria.

- Medicare home health services DO NOT include coverage for custodial care, general household services such as laundry, meal preparation, shopping, or other home care services furnished mainly to assist people in meeting personal, family, or domestic needs.
- The member is responsible for 20% of the cost under the Point-of-Service coverage, if this benefit is being used. Medicare requires an “out-of-pocket maximum” for this benefit. UCare has added a \$20,000 maximum per calendar year and a \$100,000 plan benefit maximum.

## **B. Minnesota Health Care Programs (MHCP):**

### **1. Dual-eligible members: UCare’s Minnesota Senior Health Options (MSHO) and UCare Connect (Special Needs Basic Care – SNBC)**

- UCare follows both Medicare and Medicaid criteria for coverage of home health care for MSHO and SNBC.
- Medicare criteria will be reviewed first to determine coverage.
- If a request for home care does not meet Medicare criteria, it will be reviewed per Medicaid criteria.
- Refer to the MHCP Provider Manual for criteria guidelines for home care services or Chapter 23: Medical Necessity Criteria, of this manual.

### **2. Minnesota Senior Care Plus (MSC+), UCare Connect-Medicaid only (SNBC), Prepaid Medical Assistance Program (PMAP), and MinnesotaCare (MnCare)**

- UCare follows Medicaid criteria for MSC+, *UCare Connect*- Medicaid only, PMAP, and MnCare (Expanded Benefit set only).
- For members with MSC+, UCare may be the secondary payer. To verify additional coverage, please call UCare’s Provider Assistance line at **612-676-3300** or **1-888-531-1493**.
- Medicaid services may be covered if the following member and provider eligibility conditions are met:
  - Services are provided to an eligible member.
  - Physician-ordered services are provided to recipients in their own residence.
  - Services may be provided in a foster care setting, assisted living or group home licensed by the Commissioner of Health. Foster care settings must have no more than four foster care residents.

- Services are documented in a written service plan, reviewed by the member's physician at least once every 60 days for home health agency or private duty nursing\* services.

***\*Private duty nursing (PDN) for UCare Connect members may be covered. Contact the member's county of residence or Department of Human Services (DHS) to determine approval authority for PDN. Providers who provide PDN MUST be Medicare Certified.\****

Note: Please refer to UCare's Provider Manual, Chapter 5: Prior Authorization and Notification, to verify PDN agency requirements.

### **C. Home Care Services**

Effective August 1, 2010, if a home care provider determines it is unable to continue providing care to a recipient; the provider must notify the recipient, responsible party, and MHCP at least 30 days before terminating services and assist the recipient in transitioning to another home care provider. If the termination is a result of sanctions on the provider, the provider must give each recipient a copy of the home care bill of rights at least 30 days before terminating services. Information can be found LEG-10-01:2010 Legislative Changes Ch 352, art 1, sec 8.

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# Billing Medicare Certified Home Health Services

**Billing for Skilled Home Health Care services depends on which product the member is on.**

## ***UCare for Seniors, Medicare Advantage members.***

- Members must meet Medicare criteria.
- Providers must bill the Medicare Rates specified under Exhibit B in your Participation Agreement.
- Providers must bill specific G-Codes along with the Revenue Codes when billing.
- Bill units in visits vs. 15 minute units.
- Must be bill on a UB-04 or 837I (electronic institutional claim form).

## **MSHO and *UCare Connect* – dual members.**

- Members must meet Medicare criteria when billing Medicare rates.
- Providers must bill the Medicare rates specified under Exhibit B in your Participation Agreement.
- Providers must bill specific G-Codes along with the Revenue Codes when billing Medicare reimbursement.
- Bill units in visits vs. 15 minute units.
- If members do not meet Medicare criteria then they must meet Medicaid criteria.
- Providers must bill the specific Medicaid rates specified under Exhibit B in your Participation Agreement.
- Providers must bill specific T-Codes along with the Revenue Codes when billing for Medicaid reimbursement.
- Must be billed on an 837I.

## **MHCP members, including PMAP, MSC+, *UCare Connect-Medicaid only*, and MinnesotaCare.**

- Members must meet Medicaid home health criteria.
- Providers must bill the Medicaid rates specified under Exhibit B in your Participation Agreement.
- Providers must bill the appropriate T-Code along with the Revenue Code.
- Must be billed on an 837I.

## **Billing for more than one visit on the same day:**

When billing for more than one visit on the same day for the same services such as skilled nurse visit (SNV), physical therapy (PT), occupational therapy (OT), speech therapy (ST), or home health aide (HHA), the second visit must be billed using a 76 modifier to prevent the second visit on the same from denying for a duplicate.

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# **Enrollee Rights and Provider Responsibilities for Medicare Advantage (*UCare for Seniors*)**

**A. Medicare Advantage (MA) (*UCare for Seniors*)** members have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with their MA plan's decision that Medicare coverage of their services from a home health agency should end.

## **B. Regulations**

Home health agencies must provide an advance notice of Medicare coverage termination to Medicare Advantage members no later than two days before coverage of their services will end. If the member does not agree that covered services should end, the member may request an expedited review of the case by the QIO in that state. The provider must furnish a detailed notice explaining why services are no longer necessary or covered. The review process will be completed within 48 hours of the member's request for a review.

1. Unless otherwise notified in writing by UCare, all UCare contracted providers are required to determine the discharge date and provide the explanation of termination of services notices to members.
2. The provider delivers the Notice of Medicare Non-Coverage (NOMNC) Form - Minnesota; Notice of Medicare Non-Coverage (NOMNC) Form - Wisconsin to the member no later than two days before their covered services end.
3. The member (or authorized representative) must acknowledge receipt of the NOMNC and contact the QIO (within specified timelines) if they wish to obtain an expedited review.
4. The QIO contacts the Medicare Advantage organization and the provider if a member requests an expedited review. The QIO makes a determination no later than the day Medicare coverage is predicted to end.

## **C. When to Deliver the NOMNC**

Based on UCare or the delegated approval authority's determination of when services should end, the provider is responsible for delivering the NOMNC no later than two days before the end of coverage. If services are expected to be fewer than two days, the NOMNC should be delivered upon admission. If there is more than a two-day span between services (e.g., in the home health setting), the NOMNC should be issued on the next to last time services are furnished. Providers should deliver the NOMNC as soon as the service termination date is known. A provider need not agree with the decision that covered services should end, but has a responsibility under its Medicare provider agreement to carry out this function.

## **D. How to Deliver the NOMNC**

The provider must deliver the NOMNC. The member, (or authorized representative) must sign and date the notice to acknowledge receipt. Authorized representatives may be notified by telephone if personal delivery is not immediately available. The authorized representative must be informed of the contents of the notice, the call must be documented, and the notice must be mailed to the representative.

### **E. Expedited Appeal Process**

If the enrollee decides to appeal the end of coverage, he or she must contact the QIO no later than noon of the day before services are to end (as indicated in the NOMNC) to request a review. The QIO will inform UCare and the provider of the request for a review. The provider is responsible for providing the QIO and member with a second notice, the Detailed Explanation of Non-Coverage (DENC). The provider may need to present additional information needed for the QIO to make a decision. Providers must cooperate with the QIO's requests for assistance in gathering required information. The QIO decision should take place by close of business of the day coverage is to end.

### **F. Timely notification**

Providers should structure their notice delivery and discharge patterns to ensure arrangements for follow-up care are in place; scheduling equipment to be delivered (if needed), and writing orders or instructions in advance.

### **More Information**

Further information on this process, including frequently asked questions, and the required notices and related instructions can be found on the Center for Medicare & Medicaid Services (CMS) website. The regulations are at 42 CFR 422.624, 422.626, and 489.27, and Chapter 13 of the Medicare Advantage Manual includes information on the process.

[Notice of Medicare Non-Coverage \(NOMNC\) Form - Minnesota](#)

[Notice of Medicare Non-Coverage \(NOMNC\) Form - Wisconsin](#)

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# Notice of Denial of Medical Coverage (NDMC) Process

The [Notice of Denial of Medical Coverage Form](#) is issued to *UCare for Seniors* members when home health care services are being denied.

## Denial Process

1. Medicare has approved reasons for denial of service for CMS Region IX. These approved reasons have been adopted by UCare for use in this process.
2. The Notice of Denial of Medical Coverage Form must be given to the member at the time of the decision. The provider fills out the notice and indicates the service and reason for denial. The member must sign the notice. A physician must review all denial for medical necessity. If the member was not given the form at the time of decision, the provider must document that the notice was mailed to the member. A copy of the notice is retained in the member's chart.

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# Home Infusion Services

On January 1, 2010, UCare re-contracted its home infusion network. Providers will now bill the Pharmacy Benefit Manager (PBM) for all home infusion drugs and continue to bill UCare for the administration services, including nurse visits and per diem therapy services.

## **Billing home infusion services:**

- Must be contracted with UCare for per diems and home infusion nurse visits.
- Must bill the per diems to UCare using most appropriate S-code.
- Must bill SNV to UCare using most applicable CPT code.
- Must be contracted with UCare's PBM.
- Must bill PBM for all drugs, including Synagis.
- If providers utilize/sub-contract with Medicare certified agencies for SNV, the contracted home infusion provider bills for the SNV, not the home health care agency.
- Drugs dispensed to a primary care clinic (PCC) are not considered home infusion services and the PCC is responsible for billing.

## **Home Care Services:**

Effective August 1, 2010, if a home care provider determines it is unable to continue providing care to a recipient; the provider must notify the recipient, responsible party and MHCP at least 30 days before terminating services and assist the recipient in transitioning to another home care provider. If the termination is a result of sanctions on the provider, the provider must give each recipient a copy of the home care bill of rights at least 30 days before terminating services. Information can be found LEG-10-01:2010 Legislative Changes Ch 352, art 1, sec 8.

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## PCA Provider Standards

To ensure that UCare members have access to PCA services from qualified providers, the provider of PCA services must meet the following standards to be eligible for participation in UCare's network:

- The PCA provider agency must perform a criminal background check on all individual PCAs. The PCA must have a passed status before they provide services to UCare members. The agency must provide documentation upon UCare's request.
- The PCA provider agency must have professional liability coverage at all times. UCare requires a minimum of \$1 million per incident and \$3 million aggregate.
- The PCA provider agency must have surety bond coverage in the amount of \$50,000 or 10% of the provider's payments from Medicaid in the previous year, whichever is less.
- The PCA provider agency must have fidelity bond coverage in the amount of \$20,000.
- The PCA provider agency must have proof of workers compensation insurance.
- The PCA agency must support UCare's efforts in promoting self-care and independence for all UCare members. Home care as a maintenance service does not meet UCare's criteria for medical necessity.
- PCA provider agencies that service members who also need ongoing skilled nursing services must be Medicare Certified. PT, OT, ST, SNV, and HHA must be provided by the Medicare certified home health services.
- PCA provider agencies, who also provide PDN services, must be Medicare certified as specified in Chapter 5.
- The PCA provider agency must only employ individuals who have the personal background and experience that demonstrates the capacity to serve UCare members safely and competently as a PCA. Agencies must follow all requirements listed under Minnesota Statute 256B.0659 when hiring individual PCA's.
- The PCA provider agency must present its internal PCA written policies and procedures as stated under Minnesota Statute 256B.0659 UCare upon our request.
- The PCA provider agency must not solicit UCare members or engage in case finding or misrepresentation of its relationship with UCare and/or its relationship with potential clients.
- The use of the UCare name or logo in any marketing efforts by the agency is strictly prohibited without prior approval from UCare.
- All time cards must be signed by the UCare member or their responsible party. Signatures must be obtained at the time of service to confirm services provided. ***A member's name, handwritten by the PCA, will not be accepted and may be cause for further investigation.***
- The PCA provider agency will follow Minnesota Statute 256B.0659, requirements for initial enrollment of personal care assistance provider agencies.
- Effective January 1, 2010, PCA provider agencies cannot provide both PCA services in homes owned or controlled by the provider of PCA services. Please refer to MHCP Provider Update PCA09-03.

- PCA provider agencies must provide PCA supervision for all members receiving PCA services.
- PCA's must not work more than 275 hours per month. Provider agencies must coordinate weekly work schedules with other agencies that employ the individual to ensure the PCA's combined scheduled hours do not exceed these hours.
- PCA provider agencies must provide each recipient or their designee, a written home care bill of rights at the time the recipient agrees to services or before services are started, whichever is earlier. Agencies must keep documentation of notice in the recipients file.
- Effective August 1, 2010, if a home care provider determines it is unable to continue providing care to a recipient; the provider must notify the recipient, responsible party and MHCP at least 30 days before terminating services and assist the recipient in transitioning to another home care provider. If the termination is a result of sanctions on the provider, the provider must give each recipient a copy of the home care bill of rights at least 30 days before terminating services. Information can be found LEG-10-01:2010 Legislative Changes Ch 352, art 1, sec 8.
- Providers must have locked filing cabinets and computers to keep non business related personnel from obtaining private member information. Agencies must follow ALL applicable Health Insurance Portability and Accountability Act (HIPAA) laws and regulations pertaining to privacy.
- PCA provider agencies must have a business phone number and fax number specific to their PCA provider agency. The voicemail needs to be set up with business professional information and the phone should be answered at all times in a business professional manner.
- PCA provider agencies must inform UCare immediately upon ownership changes to your agency, including co-owner information.
- Providers are required to keep a copy of the member's service plan in their file.
- To ensure a member does not exhaust PCA hours before the prior authorization expires; PCA provider agencies are responsible to develop month-to-month care plans for use of PCA hours and to monitor use of PCA services in accordance with Minn.Stat. 256B.0659 Subd. 15.
- Agencies are required to carefully monitor the planned use of PCA hours when flexible use occurs. UCare will send notices when a recipient is at risk of overuse of hours.
- The agency must have a signed agreement between two recipients who voluntarily choose shared care, as determined at the time of assessment.
- A PCA provider agency must request a PCA reassessment to UCare 60 days before the end of the service authorization.
- PCA provider agencies must follow all requirements listed under Minnesota Statute 256B.0659 at all times.
- The PCA provider agency cannot burden recipients' free exercise of their right to choose service providers by requiring PCAs to sign an agreement not to work with any particular PCA recipient or for another PCA provider agency after leaving the agency and that the agency is not taking action on any such agreements regardless of the date signed.

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# PCA Individual and PCA Provider Agency Training Requirements

## Individual PCA Training requirements

DHS now requires all individual PCA providers to register for and pass a one-time Individualized Personal Care Assistance Training online test.

All PCA provider agencies must provide individual training to their employed PCAs. PCA training must include successful completion of the following training components:

- Meeting the requirements of the 2009 legislation.
- Basic first aid.
- Vulnerable adult/children maltreatment.
- OSHA universal precautions.
- Basic roles and responsibilities of an individual PCA.

Upon completion of the training components, the PCA must demonstrate the competency to provide assistance to recipients. A copy of completion of training must be provided upon UCare's request.

Individual PCA's may be subject to monitoring by UCare. If a violation occurs the agency is required to implement a corrective action plan or take disciplinary action.

**\*\*NOTE: Currently, MHCP has not announced a date the training will be mandatory, yet all individual PCA providers will be required to successfully complete the standardized training. UCare requires all agencies to make sure all individual PCAs successfully complete the training. For more information regarding the individual PCA standardized training, please refer to DHS enrolled provider home page and training for Individual PCA Standardized Training.\*\***

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## **PCA Provider Agency Training requirements**

Legislation requires PCA provider agency owners, managing employees, and qualified professionals (QPs) to successfully complete the three days Steps for Success by January 1, 2011. DHS is holding workshop sessions through 2010. You must be registered or have already taken the course and received a certificate of completion. Once a certificate of completion is provided to each required personnel within the agency, the agency is required to submit copies to UCare upon request for your files. All currently contracted agencies will have 18 months to complete the mandatory training. Any new owners and new managing employees are required to complete mandatory training as a requisite of hiring. All QPs must attend Steps for Success within six months of the date hired by a PCA provider agency. Employees in management and supervisory positions, and owners who are active in day-to-day operations of an agency and QPs who have completed the required training do not need to repeat the required training if hired by another agency within three years of completing the training. PCA provider agencies certified for participation in Medicare as a home health agency are exempt from the training.

Billing training is required for PCA provider agencies before the end of 2010 through DHS. PCA agencies must designate and report one person as the person responsible for billing their PCA services. This person must register and attend the one-day PCA Provider Agency Billing Lab and provide the certificate of completion to UCare upon our request.

For more information regarding the Steps for Success training, please refer to DHS enrolled provider home page and Training for PCA Provider Agencies Steps for Success.

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# PCA Authorization Process

Authorization is required for payment of all PCA services as outlined in Minnesota Statute 256B.0652 Subdivision 6. and 256B.0659. PCA provider agencies must follow the specified authorization procedures and cooperate with all phases of the authorization process. Requests can be faxed to (612) 884-2094.

## A. Member Eligibility

**(Ref: Minnesota Rules 9505.0335 Personal Care Services Subpart 1 [H])**

"Qualified recipient" means a recipient who needs personal care services to live independently in the community, is in a stable medical condition, and does not have acute care needs that require inpatient hospitalization or cannot be met in the recipient's residence by a nursing service as defined by Minnesota Statutes, section [148.171](#), subdivision 15. Member eligibility should be verified monthly via MN-ITS or UCare Provider Portal.

## B. Member Programs with PCA Benefits

PCA services are available only to members enrolled in PMAP, MSC+, MSHO, or Minnesota Care Expanded Benefit set (pregnant women and children under age 21).

*NOTE: There is no PCA benefit for UCare for Seniors, and adult, non-pregnant MinnesotaCare members. For SNBC, please contact county of the member's residency or DHS. Member may be eligible for PCA; however, UCare or its delegates are not the approval authority for PCA Services for members covered in SNBC.*

## C. Starting PCA Services

An independent assessment is required to begin PCA services for a member.

- The member, member's family, member's representative, primary care clinic, Care Coordinator, PCA provider agency, or physician must contact the authorizing entity to request the assessment.
- The authorizing entity will accept the request by phone, fax or mail.

## Initial Assessment

### 1. Public Health Nurse (PHN)

State Statute requires use of the PCA Assessment and Service Plan (DHS-3244-ENG or DHS- 3428D) for the independent PCA Assessment.

Ref: **Minnesota Statutes** 256B. 0659 Subdivision 3a.

- The PCA Assessment and Service Plan is the tool that establishes the need for and level of PCA services.
- The assessment must be performed by a PHN from the County or an UCare contracted agency or delegate.
- A county PHN agency that is also a provider of PCA services cannot conduct assessments for their PCA clients. These counties must contract with another PHN agency or an independent certified PHN they do not employ, or who is not employed or under contract with an enrolled PCPO to conduct the assessment and reassessments.

- The county or agency must complete the assessment within 30 days of the request and provide a copy of the service plan to the member and the PCA agency with 10 days of the assessment.
- The PCA Assessment and Service Plan must be complete and legible when submitted to the authorizing entity.

## **2. The PCA provider agency must:**

- Contact the authorizing entity for approval before providing service.
- Request reassessments for PCA Services at least 60 days prior to the current authorization expiration.
- Allow 30 days from request date for the completion of the PCA Assessment.
- Allow 14 days for an authorization decision from the authorizing entity after completion of the PCA assessment.

## **3. Authorizing Entity**

Upon receipt of the completed assessment the authorizing entity will review the assessment recommendations and make a determination and provide a written response within 14 calendar days/10 business days.

### **I. Temporary Start of PCA Services** (Minnesota Statutes 256B. 0652 Subdivision 9)

A temporary start of PCA services requires authorization prior to or at the start of service.

The agency nurse, independently enrolled private duty nurse, or county PHN must:

- Request authorization from the authorizing entity upon receipt of the request for a temporary start of care.
- Provide documentation to support the immediate need for the service.

The authorizing entity may:

- Issue an approval for up to 45 days. The level of services authorized under this provision shall have no bearing on future authorizations.

### **J. Request for Increase in PCA Services:**

A request for increase in services may be made when a member has a temporary, long term or permanent change in medical status, as described below:

- Temporary changes are those that last 45 days or less.
- Long term changes are those that are longer than 45 days and up to 365 days.
- Permanent changes are those that are chronic or lifetime in nature.

Or

Medical or caregiver status changes that includes, but are not limited to:

- A change in the member's health or level of care.
- Change in physician request for services.
- Recent facility placement.
- A change in the primary caregiver's availability.

**K. Change of Agency :**

Request for Change of Agency must be received via fax to include:

- Member demographics, including member UCare ID.
- Name of current PCA Agency.
- Member or Responsible Party signature.

**L. Transition of Care/Services:**

Request for continued authorization of previously approved services by another health plan:

- Agency must submit via fax, copy of previous Health Plan or DHS service agreement or,
- Copy of members current PCA assessment (DHS-3244/3428D).

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# PCA Billing Guidelines

When billing for PCA services, please use the correct agency's provider identification number. Your agency could be set up in our system with either a National Provider Identifier (NPI) (if you provided one to UCare), or it will be set up with a six digit UCare provider legacy number along with a four digit UCare Group Practice number.

## **Billing PCA Services:**

- Bill on an 837P EDI Format.
- Bill NPI in loop 2010AA (if you have an NPI).
- If you do not have a NPI, bill the four digit UCare group practice number in loop 2010AA.
- Bill the Unique Minnesota Provider Identifier (UMPI) (individual PCA number provided by DHS) in loop 2310B, rendering provider loop.

**DATE SPAN BILLING FOR PCA SERVICES:** Date span billing is no longer allowed when billing PCA services. You must line item bill for EACH DAY a PCA service is rendered.

**BILLING FOR MORE THAN ONE PCA FOR THE SAME DAY:** If you are billing for more than one PCA on the same day, separate the claim and bill **EACH** individual PCA on a different claim for each day along with each of their UMPI numbers.

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## **Making changes to individual PCA UMPI numbers (additions/changes/deletions)**

PCA numbers are not automatically updated in our systems for individual PCA's. If you have a new PCA with a new UMPI number, it is the agency responsibility to provide us the information.

When there are additions, changes, or deletions to your PCA UMPI listing, the agency must notify UCare by completing the PCA UMPI Information online form. The form can be found in the "Forms" page on the navigational link of our UCare Provider web site at [www.ucare.org/providers/pages/forms.aspx](http://www.ucare.org/providers/pages/forms.aspx).

When you complete and submit the UCare PCA UMPI form online, you will get two confirmation numbers, one for the PCA UMPI form and one for the Practitioner Demographic Information form. If you need to know the status of the request, you may contact the Provider Assistance Center at **612-676-3300** or **1-888-531-1493** (toll free) to find out the status, they will need the confirmation numbers that you received when you submitted the forms. If you provide us your e-mail address in your request, you will receive an e-mail message from us when your request has been completed. **Please allow 15 days for your request to be reviewed and completed.**

**\*\*When sending updated or new UMPI numbers to be loaded, please DO NOT send your entire PCA individual UMPI roster/listing. This only hinders and slows down the process and may take longer to get your changes made.\*\***

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# Qualified Professional (QP) Supervision Standards

**Definition of QP:** A registered nurse, mental health professional or licensed social worker, or a qualified developmental disabilities specialist who is responsible for supervision of PCA services.

## Qualified Professionals (QP) must:

- Pass and initial background check upon hire to provide supervision of PCA services.
- Upon initial agency enrollment or within six months of date of hire with an enrolled agency, complete the DHS Steps for Success training.
- Develop the recipients care plan:
  - With the recipient/responsible party.
  - Within the first week after start of services with an agency.
- Authorization is required for all supervision services.
- Direct observation is required, at a minimum, for new PCA services AND for a change in PCA to a member with established PCA services.

Supervision must occur at the frequency cited Minnesota Statute 256B.0659, Subd. 14:

- The qualified professional shall evaluate the personal care assistant within the first 14 days of starting to provide regularly scheduled services;
  - at least every 90 days thereafter for the first year;
  - every 120 days after the first year of a recipient's service or whenever needed for response to a recipient's request for increased supervision of the personal care assistance staff; and
  - after the first 180 days of a recipient's service, supervisory visits may alternate between unscheduled phone or Internet technology and in-person visits, unless the in-person visits are needed according to the care plan.
- Update the care plan as needed when the recipient needs a change in PCA services.
  - Monitor the care plan monthly.
  - Develop a new care plan at the time of the recipient's annual re-assessment.

All personal care assistants but be supervised by a qualified professional.

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# Qualified Professional Responsibilities

## **1. Ensure and document that the PCA meets the required qualifications and is:**

- Capable to provide the required personal care services.
- Knowledgeable about the plan of personal care services\* before the PCA performs those services.
- Knowledgeable about the essential observations of the member's health.
- Knowledgeable about any conditions that should be immediately reported to the QP or physician.

## **2. Develop the recipients Care Plan as follows:**

- With the recipient and/or responsible party.
- Within the first week after start of services with an agency.
- Update the care plan as needed when the recipient needs a change in PCA services.
- Monitor the care plan monthly.
- Develop a new care plan at the time of the recipient's annual reassessment.

## **3. Perform all required supervisory functions at each evaluation visit including;**

- Direct observation of the PCA's work.
- Record in writing the results of the observations.
- Identify any deficiencies in the work of the PCA.
- Record all actions taken to correct any deficiencies in the work of the PCA.
- Review the plan of personal care services with the member.
- Work with the member to revise, as necessary, the plan of personal care services.
- Ensure that the PCA and the member are knowledgeable about a change in the plan of personal care services.
- Ensure that records are kept that show the services provided and the time spent providing those services by the PCA.
- Determine that a qualified member is capable of directing his or her own care or resides with a responsible party.
- Determine with a physician that a recipient is a qualified recipient.
- Satisfaction level of the recipient with personal care assistant services.
- Review month-to-month plan for use of personal care assistance services.
- Review of documentation of personal care assistance services provided.
- Whether the personal care assistance services are meeting the goals of the service as stated in the personal care assistance care plan and services plan.
- A written record of the results of the evaluation and actions taken to correct any deficiencies in the work of the PCA.
- Revision of the personal care assistance care plan as necessary in consultation with the recipient or responsible party, to meet the needs of the recipient.

\*NOTE: "Plan of personal care services" means a written plan of care specific to personal care services.

**4. Provide for the member's cultural and linguistic needs.**

- Identify and provide for interpretation services when necessary.
- Refrain from use of family members and the PCA as interpreters for evaluation visits and assessments.
- Use a UCare contracted agency for all interpretation needs.

UCare reserves the right to monitor for compliance to the above requirements. The PCA agency is required to enforce compliance, to implement a corrective action plan if deficiencies occur, or to take immediate disciplinary action if so directed by UCare.

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