wisconsin Medicaid update
and BadgerCare
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Wisconsin Medicaid and BadgerCare Information for Providers

To:
Personal Care Providers
HMOs and Other Managed Care Programs

Documentation of personal care worker time

This *Update* introduces two new optional record of care forms for fee-for-service Medicaid providers. Personal care providers may choose to adapt these forms for use by their personal care workers (PCWs) to record the time they spend providing personal care. These new PCW record of care forms provide a place for the recipient's signature, a requirement which will go into effect on January 1, 2001.

Policy reviewed in response to providers' requests

Subsequent to publishing the Personal Care Handbook, and at the request of personal care providers, the Department of Health and Family Services (DHFS) has reviewed Wisconsin Medicaid policies regarding the documentation of personal care worker (PCW) time and the need for recipient signatures on the PCW record of care. The information presented in this *Update* should be used in addition to that presented in the Medicaid Personal Care Handbook.

Medicaid policy for documenting personal care service time

All Medicaid providers are required to prepare and maintain records of the quantity of services they provide [HFS 106.02(9)(a)(5), Wis. Admin. Code]. These are records of care.

In the General Information section of the Personal Care Handbook, personal care providers are instructed to document when each period of Medicaid-covered personal care started and ended. The record of care allows a PCW to document the actual time spent providing personal care services for a one-week period. On page 23, providers are given an example of a form that they may adapt to their needs. This particular example has been successfully used by PCWs providing only Medicaid-covered personal care services for a single recipient in the home.

Providers have asked for examples of forms that accommodate more complex personal care arrangements, such as:

- A PCW providing both Medicaid personal care and other services paid by non-Medicaid sources for the same recipient during the same visit. Other payers may include Medicaid home and community-based waiver programs, such as the Community Options Program-Waiver (COP-W), Community Integration Programs (CIP), Community Supported Living Arrangements (CSLA), and the Brain Injury Waiver (BIW); and the Community Options Program (COP).
- A PCW providing care for more than one recipient in a group living situation.

Two new optional record of care forms that meet DHFS documentation requirements, the Medicaid Personal Care Worker Weekly Record of Care and the Medicaid Personal Care Workers Daily Record of Care, have been created and are attached to this *Update*.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *www.dhfs.state.wi.us/medicaid/*.

You may use one of the two record of care forms introduced in this *Update* or the example in the Personal Care Handbook, but you are not required to use these forms. All three optional record of care forms fulfill Wisconsin Medicaid documentation requirements if filled out properly and completely.

Optional record of care forms

To simplify recording requirements for PCWs assisting with or performing care, an alternative method may be used to document the quantity of personal care services provided. Wisconsin Medicaid will accept this alternative method, which uses initials and checkmarks rather than time-in and time-out for individual tasks.

Personal care worker weekly record of care

Attachment 1 of this *Update* contains instructions for using an optional PCW *weekly* record of care form. Attachment 2 is a sample of the optional PCW weekly record of care. This weekly record of care allows a PCW to record Medicaid-covered personal care services provided to a single recipient for a period of one week. The form will allow the PCW to record time spent providing Medicaid-covered services, even if services not funded by Medicaid are performed during the same visit. The form may also be used if only Medicaid-funded services are provided.

Personal care worker daily record of care

Attachment 3 contains instructions for using an optional PCW *daily* record of care form. Attachment 4 is a sample of the optional PCW daily record of care. The daily record of care is suitable for more than one worker to record Medicaid personal care services provided to a single recipient residing in a group living situation. It may be used by up to nine workers in a 24-hour period or any portion thereof, such as an eight-hour shift.

Blank copies of weekly and daily personal care worker record of care forms

Attachment 5 contains a blank copy of both the optional weekly record of care form and the optional daily record of care form. Providers may duplicate the forms, adapt them to fit their agency's specific needs, or use them in the design of their own forms as long as those forms include the information in the attached optional forms.

Personal care worker guidelines for completing a record of care

Whether using an optional record of care offered by Wisconsin Medicaid or a record of care provided by the agency, PCWs:

- Must record the *actual* start time and end time of personal care each day.
- Must record the time *actually* spent providing Medicaid-covered tasks, not the time estimated by the agency or on the prior authorization.
- Must complete a record of care for each recipient they care for each day.
- Must record each task performed by entering any one of the following:
  - √ A checkmark for each task.
  - √ The number of minutes spent on each task.
  - √ The time each task was started and ended.
- May complete the record of care at the end of each shift based on memory, rather than immediately after each task is performed.

Recipient signature is required

Effective January 1, 2001, the recipient's signature and date of signature is required on all records of care completed by PCWs. If the recipient does not sign the record of care, the agency must document in the medical record why not.

Effective January 1, 2001, the recipient's signature and date of signature is required on all records of care completed by PCWs.

ATTACHMENT 1
Instructions for completion of the optional Personal Care Worker Weekly Record of Care

Item 1: Patient Name – Enter the recipient's name.

Item 2: Employee Name – Enter the name of the personal care worker (PCW) providing care. (Each PCW caring for a recipient needs to complete a separate record of care.)

Item 3: Year – Enter the year personal care services are provided.

Item 4: Recipient Identifying Number (optional) – Provider may enter the recipient's Medicaid identification number or an internal identifying number.

Item 5: Date of Service – Enter the month and date (month/day) of each date of service.

Item 6: Start Time – Enter the time personal care begins.

Item 7: End Time – Enter the time personal care ends.

Item 8: ADL Tasks, Housekeeping – Enter the time spent providing Medicaid-funded tasks only. To document the time spent, PCWs may choose any of the following:

- Enter check mark(s) for each task provided.
- Enter the time (in minutes) *actually* spent providing each task.
- Enter the time each task was started and ended.

If two or more tasks are performed simultaneously (e.g., laundry and meal preparation), total time recorded for those tasks cannot exceed the total unduplicated time spent performing them.

Item 9: Total Medicaid Time – Each day, enter the total amount of time spent providing Medicaid-covered services on that date of service. The PCW must record the total time *actually* spent for Medicaid-covered tasks, not time estimated by the agency or on the prior authorization.

Item 10: Recipient Signature – Recipient signs and dates the form. If the recipient does not sign the record of care, the agency must document in the medical record why not.

Item 11: Comments – Enter any comments about the recipient's condition. Always document reason(s) for changes in the time it takes to provide care. Date and initial each notation. Examples include:

- General comments.
- Changes in recipient's condition.
- Emergency hours.
- Refusal of care.
- Institutional admission and discharge, including time of admission or discharge and time of cares given.

Item 12: Travel Time – To enter travel time, choose one of the following:

- Check the box provided if using a computer-generated itinerary.
- Complete the chart in entirety if:
  - ✓ Deviating from the computer-generated itinerary.
  - ✓ Not using a computer-generated itinerary.

When a PCW changes the routine itinerary, either a new itinerary must be documented or the PCW must complete the travel time chart on the record of care form. If a computer-generated method is used, the provider must maintain the following information on file in the agency records:

- The computer-generated map documenting the shortest time between travel locations.
- The routine itineraries for each PCW.
- The address of locations for which "to" and "from" travel occurs.
- The recipient's name and address.
- The dates of service, start and end times, and personal care services provided.

Item 13: PCW Signature – The PCW signs and dates the form.

Item 14: RN Supervisor Signature – The RN supervisor signs and dates the form.

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1151 (10/2000)

ATTACHMENT 2

STATE OF WISCONSIN

MEDICAID PERSONAL CARE WORKER WEEKLY RECORD OF CARE

(single recipient with one or more funding sources)

Optional Form

(1) **PATIENT NAME** Sally Smith (3)

(2) **EMPLOYEE NAME** Sue Jones **YEAR** 2000

(4) **RECIPIENT IDENTIFYING NUMBER** 555555555

(5)	SUN	MON	TUES	WED	THUR	FRI	SAT
DATE OF SERVICE	/	1/12	/	1/14	/	1/16	/
(6) **START TIME**		9 AM		9 AM		9 AM	
END TIME		5 PM		5 PM		5 PM	
(7)							
(8) **ADL TASKS**							
Bathing		✓				✓	
Shower							
Hair Care/Shampoo		✓				✓	
Oral Care		✓		✓		✓	
Skin Care		✓		✓		✓	
Nail Care		✓		✓		✓	
Dressing/Undressing		✓		✓		✓	
Teds							
Splints/Braces (apply/remove)							
ROM							
Eye Glasses/Hearing Aid Care		✓		✓		✓	
Cath Care							
Transfers		✓		✓		✓	
Toileting		✓		✓		✓	
Bowel Program							
Vital Signs							
Medications							
Dressings							
Medical Appointments							
Feed Breakfast							
Feed Lunch							
Feed Supper							
Housekeeping							
Meal Prep		✓				✓	
Bed (change/make)				✓			
Light Cleaning							
Laundry							
Food Shopping							
(9) **TOTAL MEDICAID TIME**		2 hrs.		1 hr.		2 hrs.	

(10) **RECIPIENT SIGNATURE**

I verify this record is **accurate**.

Sally Smith — **SIGNATURE** - Recipient

1/14/2000 — Date signed

(11) COMMENTS

Always document reason(s) for changes in the time it takes to provide care. Date and initial all notations.

1-4-2000 Recipient refused bath today because family was visiting. - SJ.

1-6-2000 For lunch, prepared only soup for recipient due to small appetite. - SJ.

Note the following:

- General comments.
- Changes in recipient's condition.
- Emergency hours.
- Refusal of care.
- Institutional admission or discharge, including time of admission or discharge and time of cares given.
  (Example: Hospital admission on 12/4/99 at 2 p.m., cares given 9 a.m. to 1:30 p.m. Hospital discharge 2/14/99 at 5 p.m.)

(12) TRAVEL TIME

☒ Check this box if using computer-generated itinerary for travel time.
Complete the chart if deviating from routine itinerary or if not using computer-generated itinerary.

Date (MM/DD)	Travel TO Client				Travel FROM Client				Daily Total (rounded minutes)
	From Where	Time Begin	Time End	Total Time	Time Begin	Time End	Time Total	To Where	
Sun. /									
Mon. /									
Tues. /									
Wed. 01/04	office	8:45am	9am	15 MIN	5pm	5:10pm	10 MIN	Home	30 MIN
Thurs. /									
Fri. /									
Sat. /									

(13) PERSONAL CARE WORKER SIGNATURE

I verify that both pages of this record are **accurate** and **complete**.

Sue Jones — 1/6/2000

SIGNATURE - Personal Care Worker — Date signed

(14) RN SUPERVISOR SIGNATURE

Kathy Larson, RN — 1/7/2000

SIGNATURE - RN Supervisor and Title — Date signed

Page 2 of 2 pages

ATTACHMENT 3
Instructions for completion of the optional Personal Care Workers Daily Record of Care

(Two or more PCWs for one recipient in a group living situation)

Item 1: Patient Name – Enter the recipient's name. (A record of care must be filled out for each recipient the PCW cares for in the residence.)

Item 2: Recipient Identifying Number (optional) – Provider may enter the recipient's Medicaid identification number or an internal identifying number.

Item 3: Date – Enter the date (month/day/year) service was provided.

Item 4: PCW Name – Enter the name of each PCW in a separate column.

Item 5: Start Time – Enter the time personal care begins.

Item 6: End Time – Enter the time personal care ends.

Item 7: ADL Tasks, Housekeeping – Enter the time spent providing Medicaid-funded tasks only. To document the time spent, PCWs may choose any of the following:

- Enter check mark(s) for each task provided.
- Enter the time (in minutes) *actually* spent providing each task.
- Enter the time each task started and ended.

Medicaid reimburses only one PCW to perform a task for a recipient, except for prior authorized two-person transfers. If a supervisor chooses to direct workers to share tasks, only the worker who is primarily responsible may record the task and the total amount of time spent by all workers on that task. If a housekeeping task benefits more than one recipient, the total unduplicated time reported must be divided among the recipients who benefit.

Item 8: Total Medicaid Time – At the end of each day, each PCW should enter the total amount of time spent providing Medicaid-covered services on that date of service. The PCW must record the total time *actually* spent for Medicaid-covered tasks, not time estimated by the agency or on the prior authorization.

Item 9: PCW Initials – Each PCW should initial his or her column on the form.

Item 10: Recipient Signature – Recipient signs and dates the form. If the recipient does not sign the record of care, the agency must document in the medical record why not.

Item 11: Comments – Enter any comments about the recipient's condition. Always document reason(s) for changes in the time it takes to provide care. Date and initial each notation. Examples include:

- General comments.
- Changes in recipient's condition.
- Emergency hours.
- Refusal of care.
- Institutional admission and discharge, including time of admission or discharge and time of cares given.

Item 12: PCW Signature(s) – Each PCW signs and dates the form.

Item 13: RN Supervisor Signature – The RN supervisor signs and dates the form.

ATTACHMENT 4

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1152 (10/2000)

STATE OF WISCONSIN

MEDICAID PERSONAL CARE WORKERS DAILY RECORD OF CARE

(Two or more PCWs for one recipient in a group living situation)
Optional Form

(1) **PATIENT NAME** Sally Smith

(2) **RECIPIENT IDENTIFYING NUMBER** 555555555

(3) **DATE** 1/1/2000

(4) PCW NAME(S)	Mary	Rick	Ken	Peter	Nancy				
(5) START TIME	7 AM	7 AM	10am	3 PM	3 pm				
END TIME	3 PM	3 PM	5 pm	11 PM	11 pm				
(6)									
(7) ADL TASKS									
Bathing	✓								
Shower									
Hair Care/Shampoo	✓								
Oral Care	✓			✓					
Skin Care	✓								
Nail Care	✓								
Dressing/Undressing	✓			✓					
Teds									
Splints/Braces (apply/remove)									
ROM									
Eye Glasses/Hearing Aid Care									
Cath Care									
Transfers	✓	✓	✓		✓				
Transfers					✓				
Transfers									
Toileting	✓	✓			✓				
Toileting					✓				
Toileting									
Bowel Program									
Vital Signs									
Medications									
Dressings									
Medical Appointments									
Feed Breakfast		✓							
Feed Lunch			✓						
Feed Supper				✓					
Housekeeping									
Bed (change/make)									
Light Cleaning									
Laundry									
(8) INDIVIDUAL PCW TOTAL TIME	1.5 hrs.	45 min	20 min.	45 min	10 min				
(9) PCW INITIALS	MJ	RC	KH	PT	NC				

TOTAL ALL MEDICAID HOURS 3.5

(10) **RECIPIENT SIGNATURE**
I verify this record is **accurate** and **complete**.

Sally Smith — 1/1/00

SIGNATURE - Recipient — Date signed

COMMENTS

(11) Always document reason(s) for changes in the time it takes to provide care. Date and initial all notations.

1/1/2000 - Recipient reported that her joints ache a little today due to the weather - MJ

1-1-2000 Recipient reported at bedtime that her joints feel better. - NC

Note the following:

- General comments.
- Changes in recipient's condition.
- Emergency hours.
- Refusal of care.
- Institutional admission or discharge, including time of admission or discharge and time of cares given. (Example: Hospital admission on 12/4/99 at 2 p.m., cares given 9 a.m. to 1:30 p.m. Hospital discharge 2/14/99 at 5 p.m.)

(12) **PERSONAL CARE WORKER SIGNATURE(S)**

I verify that both pages of this record are **accurate** and **complete**.

SIGNATURE - PCW	Date	SIGNATURE - PCW	Date	SIGNATURE - PCW	Date
Mary Jones	1/1/00	Peter Turner	1/1/00		/ /
Rick Crow	1/1/00	Nancy Carr	1/1/00		/ /
Ken Holton	1/1/00		/ /		/ /

(13) **RN SUPERVISOR SIGNATURE**

Beth Crow, RN — 1/4/2000

SIGNATURE - RN Supervisor and Title — Date signed

ATTACHMENT 5

Blank copies of the optional "Medicaid Personal Care Worker Weekly Record of Care" and the optional "Medicaid Personal Care Worker Daily Record of Care" forms are on the following pages

MEDICAID PERSONAL CARE WORKER WEEKLY RECORD OF CARE

(single recipient with one or more funding sources)
Optional Form

PATIENT NAME _____

EMPLOYEE NAME _____ **YEAR** _____

RECIPIENT IDENTIFYING NUMBER _____

	SUN	MON	TUES	WED	THUR	FRI	SAT
DATE OF SERVICE	/	/	/	/	/	/	/
START TIME							
END TIME							

ADL TASKS							
Bathing							
Shower							
Hair Care/Shampoo							
Oral Care							
Skin Care							
Nail Care							
Dressing/Undressing							
Teds							
Splints/Braces (apply/remove)							
ROM							
Eye Glasses/Hearing Aid Care							
Cath Care							
Transfers							
Toileting							
Bowel Program							
Vital Signs							
Medications							
Dressings							
Medical Appointments							
Feed Breakfast							
Feed Lunch							
Feed Supper							
Housekeeping							
Meal Prep							
Bed (change/make)							
Light Cleaning							
Laundry							
Food Shopping							
TOTAL MEDICAID TIME							

RECIPIENT SIGNATURE
I verify this record is **accurate**.

_____ ____/____/_____
SIGNATURE - Recipient Date signed

COMMENTS

Always document reason(s) for changes in the time it takes to provide care. Date and initial all notations.

Note the following:

- General comments.
- Changes in recipient's condition.
- Emergency hours.
- Refusal of care.
- Institutional admission or discharge, including time of admission or discharge and time of cares given.
  (Example: Hospital admission on 12/4/99 at 2 p.m., cares given 9 a.m. to 1:30 p.m. Hospital discharge 2/14/99 at 5 p.m.)

TRAVEL TIME

❑ Check this box if using computer-generated itinerary for travel time.
Complete the chart if deviating from routine itinerary or if not using computer-generated itinerary.

Date (MM/DD)	Travel TO Client				Travel FROM Client				Daily Total (rounded minutes)
	From Where	Time Begin	Time End	Total Time	Time Begin	Time End	Time Total	To Where	
Sun. /									
Mon. /									
Tues. /									
Wed. /									
Thurs. /									
Fri. /									
Sat. /									

PERSONAL CARE WORKER SIGNATURE

I verify that both pages of this record are **accurate** and **complete**.

_____ ____/____/_____

SIGNATURE - Personal Care Worker Date signed

RN SUPERVISOR SIGNATURE

_____ ____/____/_____

SIGNATURE - RN Supervisor and Title Date signed

MEDICAID PERSONAL CARE WORKERS DAILY RECORD OF CARE

(Two or more PCWs for one recipient in a group living situation)
Optional Form

PATIENT NAME _____

RECIPIENT IDENTIFYING NUMBER _____

DATE ___/___/_____

PCW NAME(S)									
START TIME									
END TIME									

ADL TASKS									
Bathing									
Shower									
Hair Care/Shampoo									
Oral Care									
Skin Care									
Nail Care									
Dressing/Undressing									
Teds									
Splints/Braces (apply/remove)									
ROM									
Eye Glasses/Hearing Aid Care									
Cath Care									
Transfers									
Transfers									
Transfers									
Toileting									
Toileting									
Toileting									
Bowel Program									
Vital Signs									
Medications									
Dressings									
Medical Appointments									
Feed Breakfast									
Feed Lunch									
Feed Supper									
Housekeeping									
Bed (change/make)									
Light Cleaning									
Laundry									
INDIVIDUAL PCW TOTAL TIME									
PCW INITIALS									

TOTAL ALL MEDICAID HOURS ____

RECIPIENT SIGNATURE
I verify this record is **accurate** and **complete**.

_____ _____/_____/_____
SIGNATURE - Recipient Date signed

COMMENTS

Always document reason(s) for changes in the time it takes to provide care. Date and initial all notations.

Note the following:

- General comments.
- Changes in recipient's condition.
- Emergency hours.
- Refusal of care.
- Institutional admission or discharge, including time of admission or discharge and time of cares given.
  (Example: Hospital admission on 12/4/99 at 2 p.m., cares given 9 a.m. to 1:30 p.m. Hospital discharge 2/14/99 at 5 p.m.)

PERSONAL CARE WORKER SIGNATURE(S)

I verify that both pages of this record are **accurate** and **complete**.

_____ ___/___/___	_____ ___/___/___	_____ ___/___/___
SIGNATURE - PCW Date	**SIGNATURE** - PCW Date	**SIGNATURE** - PCW Date
_____ ___/___/___	_____ ___/___/___	_____ ___/___/___
SIGNATURE - PCW Date	**SIGNATURE** - PCW Date	**SIGNATURE** - PCW Date
_____ ___/___/___	_____ ___/___/___	_____ ___/___/___
SIGNATURE - PCW Date	**SIGNATURE** - PCW Date	**SIGNATURE** - PCW Date

RN SUPERVISOR SIGNATURE

_____ ____/____/_____

SIGNATURE - RN Supervisor and Title Date signed