wisconsin Medicaid update
and BadgerCare
August 2006 ● No. 2006-71
Wisconsin Medicaid and BadgerCare Information for Providers

To:
Home Health Agencies
Personal Care Agencies
HMOs and Other Managed Care Programs

Wisconsin Medicaid Announces Release of Personal Care Screening Tool

Effective September 1, 2006, the new Wisconsin Medicaid Personal Care Screening Tool (PCST) will be available for providers to begin using in either a Web-based or paper version. Wisconsin Medicaid has developed a new prior authorization (PA) process that utilizes the PCST when submitting PAs for personal care services. The PCST will determine the number of personal care units allocated for a recipient based on information entered by the provider about the recipient's personal care needs.

During the phase-in period of September 1, 2006, through November 30, 2006, Wisconsin Medicaid will address issues and make adjustments to improve the PCST as deemed necessary based on the experiences of providers using the new screening tool and overall feedback.

Prior authorization requests received by Wisconsin Medicaid on and after December 1, 2006, must be submitted using the new PA process that utilizes the PCST.

New Wisconsin Medicaid Personal Care Screening Tool

Together, the Division of Disability and Elder Services (DDES) and the Division of Health Care Financing have developed the new Wisconsin Medicaid Personal Care Screening Tool (PCST) to assist providers in determining the number of units of medically necessary personal care services to include when requesting prior authorization (PA).

The Department of Health and Family Services is implementing the PCST to streamline the process for requesting and authorizing Wisconsin Medicaid fee-for-service personal care. The PCST has also been developed to improve consistency in determining recipient needs for personal care services. The PCST is a companion screen to the adult Long Term Care Functional Screen (LTC FS) that is in use statewide for determining an applicant's eligibility for home and community-based waiver services.

Providers may choose to complete either a Web-based or paper version of the PCST as part of the new PA process for personal care services. Either version may be used for any recipient who requires personal care services. Completion instructions for both versions are contained in the same document and are available on the Forms page of the Wisconsin Medicaid Web site and in Attachment 1 of this *Wisconsin Medicaid and BadgerCare Update*.

Web-Based Version

Providers who choose to complete the Web-based version of the PCST will see the number of units of personal care services that may be

authorized without additional supporting clinical documentation when submitted with the PA request. The number of units allocated and other important information will be included on the PCST Summary Sheet. Refer to Attachment 13 for a sample PCST Summary Sheet.

Providers are encouraged to utilize the Web-based version to immediately receive the number of units that may be included when submitting PA requests. Using the Web-based version can also reduce processing time. Providers who have been granted user access may access the Web-based version of the PCST at *https://www.dwd.state.wi.us/desltc/*.

Paper Version

Providers may also choose to complete a paper version of the PCST. To avoid delays in processing, providers are required to respond to all required elements as stated in the completion instructions. After Wisconsin Medicaid receives the paper version of the PCST with the provider's PA request, Wisconsin Medicaid will enter the PCST data into the Web-based PCST for the provider. The authorized number of units will be communicated back to the provider. The paper version of the PCST may be downloaded and printed from the Forms page of the Wisconsin Medicaid Web site or photocopied from Attachment 2.

Implementation Schedule

On and after December 1, 2006, PA requests and PA amendment requests received by Wisconsin Medicaid must be submitted using the new PA and PA amendment processes.

Beginning September 1, 2006, providers are strongly encouraged to use the new PA process that utilizes the PCST when submitting PA requests and PA amendments. Providers may choose to submit PA requests between September 1 and November 30, 2006, using the former PA process; however, PA requests received by Wisconsin Medicaid between September 1 and November 30, 2006, will not exceed six months. Upon renewal of the PA, providers will be required to submit a new PA request using the new PA process that utilizes the PCST.

On and after December 1, 2006, PA requests and PA amendment requests received by Wisconsin Medicaid must be submitted using the new PA and PA amendment processes.

Discontinued Forms

Both the Home Care Assessment Form and Home Care Assessment Update Form will become obsolete with the implementation of the new PA process that utilizes the PCST. Prior authorization requests received by Wisconsin Medicaid on and after December 1, 2006, that include either the Home Care Assessment Form or Home Care Assessment Update Form will be returned to the provider.

Other New Forms for Requesting Prior Authorization

In addition to the PCST, Wisconsin Medicaid has developed two other forms for providers to use when submitting PA for personal care services.

Personal Care Prior Authorization Provider Acknowledgement

The Personal Care Prior Authorization Provider Acknowledgement, HCF 11134 (dated 09/06), indicates that the *supervising registered nurse* (RN) will perform *each* of the following tasks *before* personal care services are provided for the claims submitted to Wisconsin Medicaid:

- Obtain physician's signed and dated orders.
- Conduct an assessment at the recipient's place of residence.
- Develop the plan of care (POC).

This form must be submitted to Wisconsin Medicaid with the PA request. The Personal Care Prior Authorization Provider Acknowledgement may be downloaded and

printed from the Forms page of the Wisconsin Medicaid Web site or Attachment 3.

Personal Care Addendum

The Personal Care Addendum, HCF 11136 (dated 09/06), is a form to be completed as directed to supply additional information when requesting PA or an amendment to a PA request.

Providers may obtain the Personal Care Addendum Completion Instructions and Personal Care Addendum from the Forms page of the Wisconsin Medicaid Web site. The form is available in fillable Adobe® Portable Document Format (PDF) and fillable Microsoft® Word format. The completion instructions and form are also available in Attachments 4 and 5.

New Process for Requesting Prior Authorization

To obtain PA for personal care services, providers will be required to submit documents to Wisconsin Medicaid that accurately and completely demonstrate the need for the requested personal care services.

To obtain PA for personal care services, providers will be required to submit documents to Wisconsin Medicaid that accurately and completely demonstrate the need for the requested personal care services. If the documentation contains errors or is incomplete, adjudication of the PA will be delayed while the request is returned to the provider to supply the required information.

Minimum Documentation That Providers Are Required to Submit

The new process for requesting PA for personal care services requires providers to submit all of the following documents to Wisconsin Medicaid:

- Prior Authorization Request Form (PA/RF), HCF 11018 (revised 10/03).
- Either a copy of the PCST Summary Sheet (when using the Web-based PCST) or a copy of the completed paper version of the PCST.
- Personal Care Prior Authorization Provider Acknowledgement.

Documentation Providers Are Required to Maintain on File

Under the new process for requesting PA for personal care services, providers *are required* to maintain all of the following on file:

- Copies or the originals, as appropriate, of all documents submitted to Wisconsin Medicaid with the PA request. (Providers completing the Web-based PCST are required to maintain the *entire* PCST on file, not just the PCST Summary Sheet.)
- The recipient's POC.
- Signed and dated physician orders reflecting the number of units to be provided.
- The nursing assessment.
- The personal care worker's (PCW's) assignment, a record of all assignments, and a record of the RN supervisory visits.
- The time and activity records of all visits by the PCW, including observations and assigned activities, completed and not completed.
- Travel time.
- A list of the recipient's medications, regardless of the involvement with medication administration assistance.
- A list of the recipient's regularly scheduled activities outside the place of residence.
- A copy of written agreements between the personal care provider and RN supervisor, if applicable.

Under the former process for requesting PA, providers were instructed to include some of these documents when submitting PA requests to Wisconsin Medicaid. In some instances, providers will now be required to submit some of these documents with PA and amendment requests. Regardless of their need for submission, these documents *must* be

maintained on file. Refer to the Personal Care Handbook for other documentation that also must be maintained on file.

Registration Required for User Access to Web-Based Personal Care Screening Tool

Before a Wisconsin Medicaid-certified personal care provider may use the Web-based PCST, the provider is required to register and be approved for user access to the Web-based PCST. User access to the PCST is not automatically granted to providers authorized to use the LTC FS; providers with LTC FS access are required also to register for user access to the PCST.

An authorized representative of the Wisconsin Medicaid-certified personal care provider is required to register for agency user access by completing the Agency Application for Access to Web-Based Personal Care Screening Tool, DDE-418 (dated 06/06), and submitting it to the DDES. The Agency Application for Access to Web-Based Personal Care Screening Tool form may be downloaded and printed in fillable Microsoft® Word format from *dhfs.wisconsin.gov/forms/DDES/dde0418.doc* or in Adobe® PDF from *dhfs.wisconsin.gov/forms/ddes/dde0418.pdf*. Providers may also call the DDES at (608) 267-2455 to request a copy.

Note: Providers should contact the DDES (not Wisconsin Medicaid Provider Services) for assistance with accessing the PCST.

After the DDES approves the request, information will be sent to the provider about how to grant user access to individuals within the agency and how to create user identification numbers and passwords. As changes occur, the provider is responsible for contacting the DDES to update information on those persons who require user access.

Using the Personal Care Screening Tool

Providers may choose to use either the Web-based or paper version of the PCST when submitting PA requests to Wisconsin Medicaid for personal care services. The PCST should be completed based on the recipient's needs for personal care services in his or her place of residence.

Only a screener authorized to use the LTC FS or agency-designated RN may complete the PCST.

Only a screener authorized to use the LTC FS or agency-designated RN may complete the PCST. To become an authorized screener, an individual is required to be a screener for an agency authorized to complete the LTC FS and meet specific qualifications.

Web-Based Personal Care Screening Tool

When requesting PA for personal care services using the Web-based PCST, the basic steps include the following:

- The authorized screener or agency-designated RN completes all information requested on the PCST to determine the number of personal care units allocated for the recipient.
- The provider completes all documentation listed in the "Minimum Documentation That Providers Are Required to Submit" section of this *Update*. Include the following on the PA/RF:
  - ✓ A number of weekly units equal to or lesser than the number of weekly units allocated by the PCST.
  - ✓ A number of annual pro re nata (PRN) units equal to or lesser than the number of annual units allocated by the PCST.
  - ✓ A separate number of weekly units for travel time, if necessary.
- Submit all documentation to Wisconsin Medicaid.

- Wisconsin Medicaid adjudicates the PA request.
- The provider is notified of the number of authorized units.

Refer to Attachment 6 for a diagram illustrating how to request PA using the Web-based PCST.

Web-Based Personal Care Screening Tool Resulting in Insufficient Units

If after the PCST is completed the RN determines that an insufficient number of units have been allocated for the recipient's personal care services, the RN should identify the factors present to justify a greater allocation of units than that computed by the PCST.

If after the PCST is completed the RN determines that an insufficient number of units have been allocated for the recipient's personal care services, the RN should identify the factors present to justify a greater allocation of units than that computed by the PCST.

If zero units are allocated, the recipient might not qualify for personal care services, or the RN may determine that there are factors present to justify units of personal care services.

If an RN determines that a greater allocation of units is justified for the recipient, providers should do the following:

- Complete all documentation listed in the "Minimum Documentation That Providers Are Required to Submit" section of this *Update*. Include the following on the PA/RF:
  - ✓ A number of weekly units equal to the number of units allocated by the PCST *plus* the additional weekly units being requested.
  - ✓ A number of annual PRN units equal to the number of units allocated by the PCST *plus* the additional annual PRN units being requested.
  - ✓ A separate number of weekly units for travel time, if necessary.
- Complete the Personal Care Addendum including the recipient's POC.
- Complete supporting documentation, as directed.
- Submit all documentation to Wisconsin Medicaid.

Wisconsin Medicaid will adjudicate the PA request and notify the provider of the number of authorized units.

Refer to Attachment 7 for a diagram illustrating how to request PA using the Web-based PCST when the units computed for the recipient are insufficient.

Paper Personal Care Screening Tool

When requesting PA for personal care services using the paper version of the PCST, the basic steps include the following:

- The authorized screener or agency-designated RN completes all information requested on the paper PCST. (To avoid delays in processing, providers are required to respond to all required elements as stated in the completion instructions.)
- The provider completes all documentation listed in the "Minimum Documentation That Providers Are Required to Submit" section of this *Update*. Include the following on the PA/RF:
  - ✓ Zero units of personal care services.
  - ✓ A separate number of weekly units for travel time, if necessary.
- Submit all documentation to Wisconsin Medicaid.
- Wisconsin Medicaid enters the information from the paper PCST into the Web-based PCST and the PA is adjudicated according

to the number of personal care units allocated by the Web-based PCST.
- The provider is notified of the number of authorized units.

Refer to Attachment 8 for a diagram illustrating how to request PA using the paper PCST.

If after the PA is adjudicated the RN determines that a greater number of units than those authorized are justified for the recipient, providers should complete a PA amendment. Refer to the "Prior Authorization Amendments" section of this *Update* for more information on amendments.

Paper Personal Care Screening Tool with Additional Documentation

Providers who choose to complete the paper version of the PCST might consider submitting the Personal Care Addendum, POC, and supporting documentation as directed with the initial submission of the PA request instead of waiting to receive the authorized number of units back from Wisconsin Medicaid. Doing so might avoid delays in processing and the need for a PA amendment should the number of authorized units not meet the personal care needs of the recipient.

To request PA using the paper PCST and additional documentation, providers should do the following:

- The authorized screener or agency-designated RN completes all information requested on the paper PCST. (To avoid delays in processing, providers are required to respond to all required elements as stated in the completion instructions.)
- The RN completes the POC.
- The provider completes all documentation listed in the "Minimum Documentation That Providers Are Required to Submit" section of this *Update*. Include the following on the PA/RF:
  - ✓ The number of weekly units of personal care services requested based on the POC.
  - ✓ A separate number of weekly units for travel time, if necessary.
  - ✓ The number of PRN units necessary per year.
- Complete the Personal Care Addendum form (including the recipient's POC.)
- Complete supporting documentation, as directed.
- Submit all documentation to Wisconsin Medicaid.

Wisconsin Medicaid will adjudicate the PA request and notify the provider of the number of authorized units.

Refer to Attachment 9 for a diagram illustrating how to request PA using the paper PCST and additional documentation.

Providers who choose to complete the paper version of the PCST might consider submitting the Personal Care Addendum, POC, and supporting documentation as directed with the initial submission of the PA request instead of waiting to receive the authorized number of units back from Wisconsin Medicaid.

Services Incidental to Activities of Daily Living

When the provider indicates on the PCST that services incidental to the activities of daily living (ADLs) are needed by the recipient and will be performed by the PCW, the PCST will automatically calculate the maximum number of units for those services. The number of units calculated is included in the total number of weekly units allocated by the PCST.

Of the total weekly units allocated, the PCST includes an amount of units for housekeeping services that are incidental to ADLs. The units

for incidental services are allocated at an amount equal to one third of the units allocated for direct services. For example, when the PCST calculates three units of direct services, it adds one unit for incidental services to bring the total allocation to four units per week.

For every three units of direct personal care provided and billed, providers may bill up to one unit for incidental services that have been provided.

Components Requiring Manual Review by Wisconsin Medicaid

The PCST does not include the following types of personal care services when calculating the number of units allocated for the recipient:

- Additional information pertaining to ADLs when the "age appropriate" response is selected in the Activities of Daily Living section.
- Any information pertaining to medically oriented tasks listed in Part III of the Medically Oriented Tasks section (Element 34).

When age-appropriate ADL or medically oriented tasks listed in Part III of the Medically Oriented Tasks section (Element 34) are included on the PCST, Wisconsin Medicaid will perform a manual review if the RN determines that the units initially allocated were insufficient to meet the recipient's needs. Providers are required to include the Personal Care Addendum, the recipient's POC, and any other supporting documentation, as directed, when submitting the PA request.

Wisconsin Medicaid has revised the Prior Authorization Amendment Request, HCF 11042 (revised 07/06), for providers to begin using immediately for personal care PA amendments.

Prior Authorization Amendments

When using the new process for requesting PA, situations in which providers may submit amendment requests include, but are not limited to, the following:

- To increase PRN time not previously requested.
- After the PA is adjudicated, the RN determines that the units allocated by the PCST and approved by Wisconsin Medicaid are insufficient to meet the recipient's needs. (There has been no change in informal supports or the recipient's condition.)
- To adjust approved units for a short-term change in informal supports or in the recipient's condition. Short-term changes are anticipated to persist for three months or less.
- To adjust approved units for a long-term change in informal supports or in the recipient's condition.
- The PA request needs to be discontinued. Refer to the Prior Authorization section of the Personal Care Handbook for a list of reasons PA may be discontinued.

Refer to Attachment 12 for tables detailing the documentation providers are required to submit to Wisconsin Medicaid for each of these PA amendment request situations.

Prior Authorization Amendment Request Form Revised

Wisconsin Medicaid has revised the Prior Authorization Amendment Request, HCF 11042 (revised 07/06), for providers to begin using immediately for personal care PA amendments. This form is mandatory when used with the

PCST. Providers may obtain the Prior Authorization Amendment Request Completion Instructions and Prior Authorization Amendment Request from the Forms page of the Wisconsin Medicaid Web site. The form is available in fillable Adobe® PDF and fillable Microsoft® Word format. The completion instructions and form are also available from Attachments 10 and 11.

Case Sharing

If the recipient requires more personal care services than one provider can deliver, the provider may case share to meet the recipient's needs. When two or more providers are case sharing, those providers should develop a system for requesting authorization of units to meet the recipient's needs. Only one provider is permitted to complete the PCST (either the Web-based or paper version) for the recipient. The provider that completes the PCST is responsible for *coordinating and leading* the PA case sharing activities; however, each provider is responsible for *completing* its own PA request and amendments.

The combined number of weekly units requested by all providers sharing the case must be equal to or less than the total of all weekly units authorized for the recipient.

Weekly units for travel time must be added separately to each providers' PA/RF, if necessary. Additionally, providers are required to include the schedule reflecting each agency's responsibilities for the recipient's care when case sharing with another provider.

Amendments

If an amendment is needed on a case that is being shared by multiple providers, only as many providers as necessary should prepare amendments requesting additional units.

The combined number of weekly units requested by all providers sharing the case must do both of the following:

- Be equal to or less than the total number of weekly units being requested in the amendment.
- Not exceed the total needed by the recipient.

Completion of the Personal Care Screening Tool

The provider is required to complete the PCST for a recipient each time PA is requested for that recipient. The PCST must also be completed as often as necessary when preparing a PA amendment for an approved PA. Prior authorization may be granted for varying periods of time, depending on the circumstances, but is never granted for longer than a 12-month period.

Only one agency may have access to a recipient's Web-based PCST record.

The PCST may not be completed more than 60 days before the requested grant date. Wisconsin Medicaid will only authorize requested grant dates that are on or after the PCST completion date.

Transferring Provider Access to Recipient Records

Only one agency may have access to a recipient's Web-based PCST record. To obtain access to the PCST record of a recipient who is changing providers, the new provider is required to request access to the recipient's PCST record from the former provider. Further instructions are available in the "HELP" function of the Web-based PCST.

Additionally, when a recipient changes providers, the previous provider is required to amend and end date their PA and the new provider should submit a new PA request.

Home Health Agencies

Home health agencies providing both home health services (skilled nursing, home health aide, medication management, etc.) and personal care services to the same recipient may either choose to submit all services on the same PA/RF or request services on separate PA/RFs. The provider should be sure to include the required documentation for each type of service requested.

Note: Providers will be required to submit a separate claim for services corresponding to each PA number (i.e., If two PA/RFs are submitted, two claims must also be submitted, one for each PA/RF.)

Provider Questions

Wisconsin Medicaid will provide answers to frequently asked questions pertaining to the new PA process that utilizes the PCST on the Personal Care Provider page of the Wisconsin Medicaid Web site.

Medicaid-certified personal care providers may submit questions about this *Update* to *PCSTquestions@dhfs.state.wi.us*.

Providers may also call Provider Services at (800) 947-9627 or (608) 221-9883.

Information Regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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 *dhfs.wisconsin.gov/medicaid/*.

PHC 1250

ATTACHMENT 1
Personal Care Screening Tool (PCST)
Completion Instructions

(A copy of the Personal Care Screening Tool [PCST] Completion Instructions is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11133A (09/06)

WISCONSIN MEDICAID
PERSONAL CARE SCREENING TOOL (PCST) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The Personal Care Screening Tool (PCST) is an attachment that must be completed for persons who are requesting authorization for Wisconsin Medicaid personal care services. The PCST may be completed using a Web-based format that may be accessed at *https://www.dwd.state.wi.us/desltc/*, or providers may print and complete a paper format (HCF 11133) from the Forms page of the Medicaid Web site.

The use of this form is mandatory when requesting PA for personal care services. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services. If necessary, attach additional pages if more space is needed. Attach additional documentation where requested. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Providers are required to submit either the PCST Summary Sheet, HCF 11137, or a completed paper version of the PCST and other documents as appropriate as directed by Wisconsin Medicaid personal care policy to Wisconsin Medicaid when requesting PA for personal care services. Providers may submit PA documents by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

GENERAL INSTRUCTIONS

The PCST is a tool that collects information on an individual's ability to accomplish activities of daily living (ADL), instrumental ADL, and medically oriented tasks. Whether the provider is submitting the Web-based or paper version, the PCST must be completed based on a face-to-face evaluation of the individual in his or her place of residence. Completion of the PCST must be done by an authorized screener or agency-designated registered nurse (RN). Clerical entry of information into the PCST may be done by users to whom the Division of Disability and Elder Services has granted access; however, the information must be based on the authorized screener or agency-designated RN's face-to-face visit.

Providers should take into account the time it takes an individual to complete a task. If it takes the individual a very long time to complete the task, consideration should be given to the need for assistance to complete the task safely. However, if the extended time it takes an individual to complete a task does not interfere with his or her ability to complete that task safely, the provider should indicate that the individual is able to complete the task "independently."

When completing the elements in the Activities of Daily Living Section, only one response should be selected when indicating the level of help needed (Elements 25-31). The only exception is Element 30 (Toileting); providers should indicate all responses that apply. When completing an element in this section, providers should first determine if assistance is needed with a task, and if so, that assistance is needed at least one third of the time it is performed. If assistance is needed at least one third of the time, the provider should select the most appropriate level of help from the choices listed in the element for that ADL. If the level of help varies, select the level of help needed using the one-third guideline.

Age-Appropriate Responses for Activities of Daily Living
Typically, children age five and younger require the assistance of an adult to complete many ADL. For those tasks that have an age range associated with them (i.e., bathing, dressing, grooming, eating, mobility, toileting, and transfers), the "age appropriate" response should be selected when appropriate. If the age-appropriate response is selected, the task requires more assistance than an adult would typically provide, and the number of units allocated do not meet the recipient's needs, indicate the reason that more assistance is needed in the comment section for that ADL and submit the Personal Care Addendum, HCF 11136, (including the recipient's POC) for manual review by Wisconsin Medicaid.

WEB-BASED PERSONAL CARE SCREENING TOOL DISCLAIMER (WEB-BASED VERSION ONLY)
Providers who wish to use the Web-based version of the PCST are required to read the Web-Based PCST Disclaimer as follows:

The Web-based PCST contains language that is abbreviated from the paper PCST. Instructions for the paper PCST provide guidance to the authorized screener responding to questions in either the paper or the Web-based versions of the PCST. The authorized screener should refer to the paper PCST and to the PCST instructions for complete details. The Web-based PCST should not elicit responses that are different from those that would be obtained if the authorized screener were to use the paper PCST.

By completing the Web-based PCST, you are acknowledging that you have read the above and agreed to the use of the PCST subject to the above terms, and understand the limitations of the Web-based version of the PCST.

SCREENING INFORMATION

Element 1 — Name — Screening Agency
Enter the name of the agency that will complete the PCST for the applicant.

Element 2 — Screen Completion Date
Enter the date of the face-to-face evaluation of the applicant in MM/DD/CCYY format.

Element 3 — Name — Screener
Enter the name of the authorized screener or agency-designated RN completing the PCST for the applicant.

APPLICANT INFORMATION

Element 4 — Name — Applicant
Enter the last name, first name, and middle initial of the Medicaid recipient applying for personal care services.

Element 5 — Gender — Applicant
Check the appropriate box to indicate the applicant's gender.

Element 6 — Social Security Number — Applicant
Enter the applicant's Social Security number.

Element 7 — Address — Applicant
Enter the applicant's address, including street, city, state, and zip code.

Element 8 — Date of Birth — Applicant
Enter the applicant's date of birth in MM/DD/CCYY format.

Element 9 — Telephone Number — Applicant (Optional)
Enter the applicant's telephone number, including area code.

Element 10 — County / Tribe of Residence — Applicant
Enter the name of the county or tribe's borders in which the applicant resides.

Element 11 — County / Tribe of Responsibility — Applicant
Enter the name of the county or tribe that is responsible for the applicant's benefits.

Element 12 — Directions (Optional)
Enter driving directions to the applicant's place of residence.

Element 13 — Medical Insurance
Check all appropriate boxes to indicate the type(s) of insurance the applicant holds.

Element 14 — Race (Optional)
Check all appropriate boxes to indicate the applicant's race.

Element 15 — Ethnicity (Optional)
Check the box if the applicant's ethnicity is Spanish, Hispanic, or Latino.

Element 16 — Interpreter Services (Optional)
Check the appropriate box to indicate if the applicant requires the services of an interpreter. If "Yes" is checked, indicate the language for which the applicant requires interpretation services.

Element 17 — Responsible Party Contact Type (Optional)
Check the box that describes the responsible party's relationship to the recipient. The responsible party is a contact person other than the applicant.

Element 18 — Name — Responsible Party (Optional)
Enter the responsible party's last name, first name, and middle initial.

Element 19 — Telephone Number — Responsible Party (Optional)
Enter the responsible party's telephone number.

Element 20 — Address — Responsible Party (Optional)
Enter the responsible party's address including street, city, state, and zip code.

Element 21 — Comments (Optional)
Enter any comments about the responsible party.

Element 22 — Scheduled Activities Outside Residence
Check the appropriate box to indicate if the applicant regularly attends scheduled activities outside his or her residence. If "Yes" is checked, enter the number of days per week regularly scheduled activities occur. The applicant's complete schedule of regularly attended activities must be included in the applicant's medical file.

Element 23 — Diagnosis Codes
Enter up to three *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) codes that most directly relate to the applicant's need for home care. At least one ICD-9-CM code is required.

Element 24 — Living Situation
Check the box that best describes the applicant's living situation.

ACTIVITIES OF DAILY LIVING

Element 25 — Bathing
"Bathing" means the ability to wash the entire body (excludes grooming, washing hands and face only, and bathing related to incontinence care) in the shower, tub, or with a sponge or bed bath for the purpose of maintaining adequate hygiene. This includes the ability to get in and out of the tub or shower, turning faucets on and off, regulating water temperature, wetting, soaping, and rinsing skin, shampooing hair, drying body, and applying lotion to skin.

Bathing includes all transfers and mobility related to bathing. Examples of included transfers and mobility include the following:
- Applicant needs assistance to ambulate from the bedroom to the bathroom to bathe and back to the bedroom after the bath.
- Applicant needs to be physically transferred to shower chair.
- Applicant needs to be positioned on bath chair.

Select the response, A-F, that best describes the level of function the applicant possesses when bathing. For children age five or younger, select response "F." If the child requires more assistance than an adult would typically provide to a child of that age, explain in the comment section why more assistance is needed.

Indicate how many days per week personal care worker (PCW) assistance is needed with bathing. Do not count days in which other unpaid caregivers will be providing the cares, or when care is provided outside the place of residence.

Examples
A. Applicant is able to bathe him or her self in the shower or tub with or without an assistive device.
   - Applicant requires use of a shower chair but is able to complete bathing safely without any assistance from another person.
   - Applicant is able to bathe him or her self without any assistance from another person.

B. Applicant is able to bathe him or her self in the shower or tub but requires the presence of another person intermittently for supervision or cueing.
- Applicant needs cueing to shower, gather towel, wash, etc., and to turn on water so scalding does not occur. He or she is then safe alone in the shower so person cueing can leave.
- Applicant needs occasional reminders to stay on task.
- Applicant requires supervision intermittently to ensure personal safety. Applicant has a history of falls.

C. Applicant is able to bathe him or her self in the shower or tub but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- Applicant requires continuous cues to complete bath but can bathe him or her self. The caregiver is required to be continually present. If continuous cues were not given, the caregiver would be required to physically assist with the bath.
- Applicant requires continual presence of another person and cannot be left alone as applicant is confused and attempts to climb out of bathtub. If the caregiver was not continually present, the person would require physical assistance to complete the bath.

D. Applicant is able to bathe in shower, tub, or bed with partial physical assistance from another person.
- Applicant is able to complete upper body bathing but needs physical assistance with lower body bathing and application of lotion.
- Applicant needs physical assistance in and out of the tub but can bathe self.
- Applicant requires a bed bath. Applicant is able to bathe upper body but needs physical assistance from another person to complete bathing of the lower body.

E. Applicant is unable to effectively participate in bathing and is totally bathed by another person.
- Applicant is unable to assist with any aspect of bathing.
- Applicant is able to hold washcloth but is unable to effectively participate in washing body.

F. Applicant's ability is age appropriate for a child age 5 or younger.
- Child is 5 years old or younger.

Element 26 — Dressing
"Dressing" means the ability to dress and undress (with or without an assistive device) as necessary and choose appropriate clothing. This includes the ability to put on prostheses, braces, splints and/or, anti-embolism hose (e.g., "TED" stockings) and includes fine motor coordination for buttons and zippers. Difficulties with a zipper or buttons *at the back* of a dress or blouse do not constitute a functional deficit.

Dressing includes all transfers and mobility related to dressing and undressing. Examples of included transfers and mobility include the following:
- Applicant needs assistance to ambulate from the kitchen to the bedroom to get dressed.
- Applicant needs to be transferred from the edge of the bed to the wheelchair after being dressed.
- Applicant needs to be positioned in bed after being changed into sleeping attire.

For both the Upper Body and Lower Body categories, complete the following:
- Select the response, A-F, that best describes the level of function the applicant possesses when dressing. For children age five or younger, select response "F." If the child requires more assistance than an adult would typically provide to a child of that age, explain in the comment section why more assistance is needed.
- Indicate if PCW assistance is needed with placement and removal of a prosthetic, splint, or brace.
- Indicate the time of day when PCW assistance with dressing is needed.
- Indicate how many days per week PCW assistance is needed with dressing. Do not count days in which other unpaid caregivers will be providing the cares, or when care is provided outside the place of residence.

Examples

Upper Body

A. Applicant is able to dress upper body without assistance or is able to dress him or her self if clothing is laid out or handed to the person.
- Applicant is independent in dressing upper body and does not need assistance.
- Applicant is able to dress upper body independently if clothing is placed in front of him or her.
- Applicant is able to dress upper body independently but needs someone to choose appropriate clothes.

B. Applicant is able to dress upper body by him or her self but requires presence of another person intermittently for supervision or cueing.
- Applicant can dress upper body independently but needs someone to remind him or her to button blouse and adjust collar.
- Applicant requires cueing/instructing to fasten buttons on front of shirt.

C. Applicant is able to dress upper body by him or her self but requires presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
   - Applicant requires constant cueing to complete each aspect of dressing upper body. If constant cues were not provided, the applicant would require the physical assistance of another person.

D. Applicant needs partial physical assistance from another person to dress upper body.
   - Person can put on shirt but cannot physically button it.
   - Person needs assistance pulling shirt over head.

E. Applicant depends entirely upon another person to dress upper body.
   - Person needs total assistance with dressing upper body and is unable to effectively assist.

F. Applicant's ability is age appropriate for a child age 5 or younger.
   - Child is 5 years old or younger.

Lower Body

A. Applicant is able to dress lower body without assistance or able to dress him or her self if clothing and shoes are laid out or handed to the person.
   - Applicant is independent in dressing lower body and does not need assistance.
   - Applicant is able to dress lower body without assistance if clothing is placed in front of or handed to him or her.

B. Applicant is able to dress lower body by him or her self but requires presence of another person intermittently for supervision or cueing.
   - Applicant can dress lower body independently but needs to be reminded by another person to button and/or zip pants.
   - Applicant only needs verbal instruction to complete lower body dressing.
   - Applicant requires supervision intermittently to ensure personal safety. Applicant has a history of falls.

C. Applicant is able to dress lower body by him or her self but requires presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
   - Applicant requires constant cueing to complete each aspect of dressing lower body. If constant cues were not given, he or she would require the physical assistance of another person.

D. Applicant needs partial physical assistance to dress lower body.
   - Applicant can pull on pants but cannot button and/or zip them.
   - Applicant needs assistance pulling up pants.

E. Applicant depends entirely upon another person to dress lower body.
   - Applicant needs total assistance with dressing lower body and is not able to effectively assist.

F. Applicant's ability is age appropriate for a child age 5 or younger.
   - Child is 5 years old or younger.

Element 27 — Grooming

"Grooming" means the ability to tend to personal hygiene needs (i.e., washing face and hands, combing or brushing hair, shaving, nail care, applying deodorant, oral or denture care, eyeglass care [including contact lenses], and hearing aid assistance). Grooming includes all transfers and mobility related to grooming.

Select the response, A-G, that best describes the level of function the applicant possesses when grooming. For children age five or younger, select response "G." If the child requires more assistance than an adult would typically provide to a child of that age, explain in the comment section why more assistance is needed.

Indicate the time of day when PCW assistance with dressing is needed. Indicate how many days per week PCW assistance is needed with grooming. Do not count days in which other unpaid caregivers will be providing the cares, or when care is provided outside the place of residence.

Examples

A. Applicant is able to groom him or her self, with or without the use of assistive devices or adapted methods.
   - Applicant needs a chair placed due to being unsteady when standing but can groom self if able to sit during task.
   - Applicant can groom his or her self with specially adapted utensils.

B. Applicant is able to groom him or her self but requires the presence of another person intermittently for supervision or cueing.
   - Applicant needs to be cued to place toothpaste and brush teeth but can physically perform task by him or her self.
   - Applicant needs to be supervised to ensure proper completion of tasks.

C. Applicant is able to groom him or her self but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- Applicant can groom self but needs to be constantly cued to complete all tasks related to grooming. If not constantly cued, the physical assistance of another person would be required.

D. Applicant needs physical assistance to set up grooming supplies but can groom him or her self.
- Applicant needs assistance putting toothpaste on toothbrush but is able to complete other grooming by him or her self.

E. Applicant needs partial physical assistance to groom him or her self.
- Applicant is able to brush teeth and apply deodorant but needs assistance combing hair and shaving.
- Applicant is able to partially complete task but requires assistance to fully complete grooming.
- Applicant is able to initiate tooth brushing but is not able to effectively complete task without assistance of another person.

F. Applicant depends entirely upon another person for grooming.
- Applicant needs total assistance with all aspects of grooming.

G. Applicant's ability is age appropriate for a child age 5 or younger.
- Child is 5 years old or younger.

Element 28 — Eating
"Eating" means the ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew, and swallow food.

Select the response, 0 or A-H, that best describes the level of function the applicant possesses when eating. If the applicant is fed via tube feedings or intravenously, select response "0." If both responses "D" and "E "apply, select response "E." For children age 3 or younger, select response "H." If the child requires more assistance than an adult would typically provide to a child of that age, explain in the comment section why more assistance is needed.

Indicate the meals with which the PCW will assist. Indicate how many days per week PCW assistance is needed for each meal. *Do not mark meals for which the PCW will not be providing assistance.* Do not count days in which other unpaid caregivers will be providing the cares or when care is provided outside the place of residence. For example, an applicant requires partial feeding at lunch and is in a day program for five days per week; because personal care may not be provided outside the place of residence, only two days of PCW assistance with lunch should be marked.

Examples
0. Applicant is fed exclusively via tube feedings or intravenously.
- Check this box only if the applicant receives nutrition through tube feedings or intravenously.

A. Applicant is able to feed him or her self, with or without use of an assistive device or adapted methods.
- Applicant is able to feed him or her self with the use of adapted utensils.
- Applicant is able to feed him or her self.

B. Applicant is able to feed him or her self but requires the presence of another person intermittently for supervision or cueing.
- Applicant is able to feed him or her self but requires occasional cueing to keep on task.
- Applicant needs to be reminded to use portion control as well as what types of food are appropriate for a special diet.
- Applicant needs to be reminded to eat.

C. Applicant is able to feed him or her self but requires the presence of another person throughout the task for constant supervision to ensure completion of the task.
- Applicant needs to be constantly supervised for inappropriate behaviors while eating.

D. Applicant needs physical assistance at meal time to cut meat, arrange food, butter bread, etc.
- Applicant needs assistance to cut meat, arrange food, set-up adaptive utensils.

E. Applicant has recent history of choking or potential for choking based on documentation.
- Applicant needs to be monitored during eating to prevent choking, aspiration, or other serious complications due to a *documented* history of these problems.

F. Applicant needs partial physical feeding from another person.
- Applicant is able to feed self for a short period of time before no longer able to due so. Assistance is needed to complete eating.

G. Applicant needs total feeding from another person.
- Applicant depends entirely on someone else for feeding.

H. Applicant's ability is age appropriate for a child age 3 or younger.
- Child is 3 years old or younger.

Element 29 — Mobility in the Home
"Mobility in the home" means the ability to move between locations in the applicant's living environment including the kitchen, living room, bathroom, and sleeping area. *This excludes basements, attics, yards, and any equipment used outside the place of residence.* This category excludes mobility related to bathing, dressing, grooming, and toileting.

Select the response, 0 or A-F, that best describes the level of function the applicant possesses when moving between locations in the place of residence. If the applicant remains bedfast, select response "0." For children age 18 months or younger, select response "F." If the child requires more assistance than an adult would typically provide to a child of that age, explain in the comment section why more assistance is needed.

Indicate how many days per week PCW assistance is needed with mobility in the home. Do not count days in which other unpaid caregivers will be providing the cares, or when care is provided outside the place of residence.

Examples
0. Applicant remains bedfast.
- Check this box only if the applicant remains bedfast.

A. Applicant is able to ambulate by him or her self, with or without an assistive device.
- Applicant is able to ambulate independently with the use of a cane or walker.
- Applicant is able to move wheelchair independently.

B. Applicant is able to ambulate by him or her self, with or without an assistive device but requires presence of another person intermittently for supervision or cueing.
- Applicant needs to be reminded to stand up straight when using walker.
- Applicant needs to be cued to move wheelchair to a specific location.

C. Applicant is able to ambulate by him or her self, with or without an assistive device but requires presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of task.
- Applicant needs constant supervision due to history of falls but does not need physical assistance with ambulation.

D. Applicant needs the physical help of another person to negotiate stairs or home ramp within the applicant's living environment.
- Applicant needs physical assistance to ascend stairs to upper level bedroom.
- Applicant needs assistance moving manual wheelchair up ramp to another level within the place of residence but person can move his or her own chair on flat surfaces. (Do *not* count times when applicant needs assistance with negotiating stairs or ramps outside the place of residence.)

E. Applicant needs constant physical help from another person. (Includes total dependence with moving wheelchair.)
- Applicant needs physical assistance with moving a manual wheelchair within his or her home.
- Applicant needs physical assistance of one person plus a gait belt to assist with ambulation.
- Applicant needs hands-on physical assistance when ambulating.

F. Applicant's ability is age appropriate for a child 18 months or younger.
- Child is 18 months old or younger.

Element 30 — Toileting
Toileting includes transferring on and off the toilet, cleansing of self, changing of personal hygiene product, emptying an ostomy or catheter bag, and adjusting clothes. Toileting includes all transfers and mobility related to toileting.

Select the responses, A-G, that best describe the level of function the applicant possesses when toileting. **Select all responses that apply.**

For children age four or younger, select response "G." If the child requires more assistance than an adult would typically provide to a child of that age, explain in the comment section why more assistance is needed.

Both responses "D" and "E" should be selected if the applicant is toileted and is incontinent.

If responses “C,” “D,” “E,” or “F” are selected, also include the frequency per day of the situation described in which the PCW will provide assistance. If the frequency varies, record the higher of the frequencies. For example, a recipient requires assistance with toileting and the PCW assists her six times a day on average. However, the recipient attends a day program five days per week and on those days the PCW assists with toileting four times per day. The frequency entered in the PCST would be six times per day.

Indicate how many days per week PCW assistance with toileting is needed. Do not count days in which other unpaid caregivers will be providing the cares, or when care is provided outside the place of residence.

Examples

A. Applicant is able to toilet him or her self or provide his or her own incontinence care, with or without an assistive device.
   - Applicant needs a raised toilet seat and with its use can toilet self.
   - Applicant is incontinent but can change his or her own incontinence product.

B. Applicant is able to toilet him or her self or provide his or her own incontinence care, with or without an assistive device but requires the presence of another person intermittently for supervision or cueing.
   - Applicant needs to be reminded to wipe him or herself and wash his or her hands, but can toilet him or her self.
   - Applicant requires cueing/instruction to pull his or her pants up after toileting.
   - Applicant needs to be supervised while in the bathroom to ensure proper completion of toileting.

C. Applicant is able to toilet him or her self or provide his or her own incontinence care but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
   - Applicant requires constant cueing to complete each aspect of toileting. Another person needs to be continually present.

   When estimating frequency, if the applicant is both constantly supervised during toileting and provided incontinence care during the same episode, then the episode should be counted under the incontinence frequency total. Do not total both constant supervision with toileting and incontinence care during the same episode.

   For example, the applicant is constantly supervised during toileting generally six times per day. On average the applicant is found incontinent twice during a toileting episode. The frequency should be indicated as constant supervision four times per day and incontinent two times per day.

D. Applicant needs physical help from another person to use toilet and/or change personal hygiene product.
   - Applicant needs assistance pulling up and buttoning his or her pants.
   - Applicant needs assistance with pulling down his or her pants, wiping, and washing his or her hands.
   - Applicant needs physical assistance to change personal hygiene product (such as Depends or a feminine hygiene product.)
   - Applicant has stress incontinence and needs physical help changing personal hygiene product.

   When estimating frequency, if the applicant is both toileted and provided incontinence cares during the same episode, then the episode should be counted under the incontinence frequency total. Do not total both toileting and incontinence care during the same episode.

   For example, the applicant requests to be toileted but was also incontinent. This would be totaled as one episode of incontinence. In another example, the applicant is generally toileted six times a day but may be discovered to be incontinent twice during being toileted. This would be totaled as four episodes of toileting and two episodes of incontinence.

E. Applicant needs physical help from another person for incontinence care. (Does not include stress incontinence.)
   - Applicant needs assistance changing incontinence product, providing peri-care, and assisting with an occasional change of clothes.

   When estimating frequency, if the applicant is both toileted and provided incontinence cares during the same episode, then the episode should be counted under the incontinence frequency total. Do not total both toileting and incontinence care during the same episode.

F. Applicant needs physical help from another person to empty ostomy or catheter bag.
   - Applicant is unable to release clamp on ostomy bag and needs physical assistance to empty bag.

   When estimating frequency, determine how many times per day the PCW will be assisting with emptying ostomy or catheter bag. Do not count episodes in which the PCW will not be needed to provide the cares.

G. Applicant’s ability is age appropriate for a child age 4 or younger.
   - Child is 4 years old or younger.

Element 31 — Transferring
"Transferring" means the physical ability to move between surfaces (e.g., from bed/chair to wheelchair or walker), the ability to get in and out of bed or usual sleeping place, and the ability to use assistive devices for transfers. Transferring excludes transfers related to bathing, dressing, grooming, and toileting.

Select the response, A-F, that best describes the level of function the applicant possesses when transferring. For children age three or younger, select response "F." If the child requires more assistance than an adult would typically provide to a child of that age, explain in the comment section why more assistance is needed.

Indicate how many days per week PCW assistance with transferring is needed. Do not count days in which other unpaid caregivers will be providing the cares or when care is provided outside the place of residence.

Examples

A. Applicant is able to transfer him or her self, with or without an assistive device.
- Applicant is able to transfer him or her self to a wheelchair with the use of an assistive device.
- Applicant is able to transfer him or her self with the use of crutches.

B. Applicant is able to transfer him or her self, with or without an assistive device but requires the presence of another person intermittently for supervision or cueing.
- Applicant needs to be reminded not to bear weight on fractured foot.

C. Applicant is able to transfer him or her self, with or without an assistive device but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- Applicant is able to transfer him or her self with the use of a walker. Constant supervision is required to ensure safety.

D. Applicant needs physical help of another person but is able to participate (e.g., applicant can stand and bear weight).
- Applicant is able to bear weight and assist with a pivot transfer with the physical assistance of another person.

E. Applicant needs constant physical help from another person and is unable to participate (e.g., applicant is unable to stand and pivot or unable to bear weight).
- Applicant requires the assistance of another person with the use of a gait belt and person is unable to effectively participate.
- Applicant requires a two-person transfer.

F. Applicant needs help from another person with the use of a mechanical lift (e.g., Hoyer) when transferring.
- Applicant needs a Hoyer lift to be transferred.

G. Applicant's ability is age appropriate for a child age 3 or younger.
- Child is 3 years old or younger.

MEDICALLY ORIENTED TASKS

Element 32 — (Part I) Medication Assistance
Select the option that best describes the applicant's need for assistance with his or her medication(s).

Indicate how many days per week PCW assistance is needed with medication assistance. Do not count days in which other unpaid caregivers will be providing the cares, or when care is provided outside the place of residence.

Examples

0. Not applicable.
- Applicant has no medications.

A. Independent with medications with or without the use of a device.
- Applicant is able to self-administer medications.
- Applicant is independent with medications with the use of a pill box.

B. Needs reminders.
- Applicant is able to self-administer medications but requires another person or a device (e.g., electronic medication dispenser) to provide reminders.
- Applicant requires instructions on how to take the medication (e.g., cueing him or her to place the medication in the mouth, take a drink, and swallow.)

C. Needs the physical help of another person.
- A family member or friend assists applicant with taking his or her medications. (The PCW does not perform this task.)

D. Needs the physical help of a PCW.
- Applicant requires assistance from a PCW to take medications.
- Applicant requires PCW to place medication in his or her hand or mouth.

If response "D" is selected, indicate the number of times per day a PCW needs to assist the applicant with his or her medications.

Element 33 — (Part II) Tasks to be Performed by a PCW
Select the tasks to be completed by a PCW. If no PCW assistance is needed for a task, leave that task blank.

Indicate how many times per day and days per week each task will be performed by a PCW. If the number of times per day varies, indicate the frequency that occurs most often. Do not count days in which other unpaid caregivers will be providing the cares or when care is provided outside the place of residence.

Glucometer Readings. Allowed only when medical history supports the need for ongoing, frequent monitoring and the physician has established parameters on reporting readings. High blood sugars due to the noncompliance of a competent adult do not justify glucometer tests as medically necessary tasks.

Vital Signs. Allowed only when medical history supports the need for ongoing frequent monitoring and the physician has established parameters at which point a change in treatment may be required. Vital signs include temperature, blood pressure, pulse, and respiratory rates.

Skin Care. Skin care is the application of legend solutions, lotions, or ointments that are ordered by the physician due to skin breakdown, rashes, etc. Pro re nata (PRN) or "as needed" or prophylactic skin care is an ADL task that is covered under bathing. If the PCW will be providing prescribed skin care, the name of the drug and frequency prescribed must be indicated.

Catheter Site Care. Cleaning a catheter site may be marked if the applicant requires PCW assistance with "site care" provided to a *suprapubic catheter* (drainage tube that extends from a small hole in the skin just above the pubic bone). "Site care" means that special care is given to the area where the catheter goes into the abdomen. Site care usually involves cleansing this area with soap and water and covering with dry gauze. Do not check this area for routine catheter care for an indwelling catheter. Routine catheter care usually involves soap and water as a normal part of bathing. Do not confuse site care for a suprapubic catheter with catheter care for an indwelling catheter.

Check Other under Other Program in Element 34 if the PCW will be providing irrigation of the catheter, changing and/or replacing the catheter, or "in & out" catheterization.

Gastrointestinal Tube Site Care. Cleaning a gastrostomy site may be marked if the applicant requires PCW assistance with site care provided to a gastrostomy or jejunostomy site (tube that extends from a small hole in the skin from the abdomen). "Site care" means that special care is given to the area where the tube goes into the abdomen. Site care is usually cleansing this area with soap and water and covering with dry gauze.

Complex Positioning. This is specialized positioning, including positioning required to change body positions while at a specific location for the purpose of maintaining skin integrity, pulmonary function, and circulation. When determining frequency, the positioning related to the tasks of bathing, dressing, and toileting are accounted in the times allotted for each specified task and are not to be counted separately.

Element 34 — (Part III) Tasks to Be Performed by a PCW — Medicaid Review and Manual Approval May Be Required
Complete this section for tasks the registered nurse (RN) will be delegating to a PCW. Tasks in this element will not be assigned time if they are not delegated by an RN. If no PCW assistance is needed for a task, leave that task blank.

Indicate how many times per day and days per week each task will be performed by a PCW. Do not count days in which other unpaid caregivers will be providing the cares, or when care is provided outside the place of residence.

For tasks indicated in this element, manual review of the PA request will be required only when the total amount of time computed by the PCST is insufficient for a personal care worker also to provide the delegated medical tasks identified in this element *and* additional time is being requested for those delegated medical tasks. Include the Personal Care Addendum (including the recipient's plan of care) and other documentation as directed when submitting the PA request.

Daily Tube Feedings. Administration of tube feedings is the process of giving nutrition via a tube inserted into a person's body. This may include a gastrostomy tube (g-tube), jejunostomy tube (j-tube), or a nasogastric tube (NG tube). Select this option when the applicant requires a PCW to administer a tube feeding. Do not select this option if the PCW is only monitoring the feeding while it is in progress. Administering includes starting and stopping the tube feeding and all tasks involved with starting or stopping a feeding such as preparing the feeding, flushing the tube, hanging the bag, etc.

Continuous Feeding. Select continuous feeding if the applicant is receiving a continuous feeding and requires a PCW to administer it. A continuous feeding is a feeding that is not given intermittently throughout the day or given by bolus.

For example, an applicant receives continuous feeding; the PCW sets up the formula, flushes the tube, hangs the feeding bag and starts the feeding. The PCW does this once per day, three days per week. On the other days of the week, a family member administers the feeding. PCW frequency per day = 1, PCW frequency per week = 3.

Intermittent (Bolus) *Feeding*. Select intermittent (bolus) feeding if the applicant receives feedings at various times during the day and requires a PCW to administer them.

For example, an applicant receives bolus feedings (50cc each time) three times a day. The PCW will be administering the feeding two times per day, seven days per week. PCW frequency per day = 2, PCW frequency per week = 7.

Respiratory Assistance. Assistance needed with suctioning, chest physiotherapy (CPT), nebulizer treatments or tracheostomy-related care. Check all that apply.

Tracheostomy Care. Select tracheostomy care if the applicant requires cleaning of the tracheostomy site, changing of the tracheostomy tube, and/or changing of the tracheostomy straps or ties that hold the tube in place and assistance of the PCW is needed.

Note: In the comments section at the end of this element, specify the cares that the PCW will be providing.

Suctioning. Select suctioning if the applicant requires suctioning of the oral cavity, the nasal cavity, the nasopharyngeal cavity, or of a tracheostomy and a PCW is performing the task.

Note: In the comments section at the end of this element, specify the type of suctioning the PCW will be performing.

Chest Physiotherapy (CPT). Select CPT if the applicant requires postural drainage or chest percussion and the PCW is performing the task.

Nebulizer. Select nebulizer if the applicant requires a PCW to administer respiratory treatment via a nebulizer.

Bowel Program. A bowel program is a regimen prescribed by a physician to develop proper bowel evacuation. A bowel program may include the use of suppositories, enemas, or digital stimulation. Indicate which task or tasks are being performed by the PCW as well as the frequency for each task. Each task indicated in this section must be performed by the PCW at least once per week.

Note: In the comments section, specify the specific bowel program the PCW will be providing.

Examples
- The PCW inserts a suppository, waits 30 minutes, and then provides digital stimulation to promote proper evacuation of the colon. This is completed every three days.
- The PCW gives the applicant a warm water enema once a week.

Wound or Decubiti Care (excludes basic skin care). A wound or decubitus requiring dressing and care. "Wound" is defined as a wound from a serious burn, traumatic injury, or a serious infection. Select this response if the applicant has documentation of a wound or a decubitus and requires a PCW to provide wound cleaning and/or dressing. This does not include ostomy care.

For example, the applicant has a wound on the outer aspect of their ankle measuring 1 cm by 1 cm, red in color, and draining serosanguinous drainage. The wound is cleansed daily with NS and simple dry dressing (2x2) applied. The PCW will be providing wound care once per day, seven days per week. Frequency per day = 1, frequency per week = 7.

Note: In the comments section, include a description of the wound or decubitus and explain the wound care the PCW will be performing.

Therapy Program. Assistance with activities that are directly supportive of skilled therapy services. This includes activities that do not require the skills of a therapist to be safely and effectively performed. Activities may include routine maintenance exercises, e.g., range of motion (ROM) exercises and repetitive speech routines. *In order to be medically necessary, the activities must be ordered in conjunction with an active therapy program or as a result of a therapy evaluation signed by a therapist.* The therapist may screen the client and recipient as often as medically necessary to verify the continuing medical necessity of activities supportive of therapy, such as ROM, repetitive speech drills, and other routine exercise programs. A full therapy evaluation by a therapist is needed when there is a change in client condition or when the home exercise program is not accomplishing its goals.

For example, the applicant has seen a physical therapist and the therapist has written a passive ROM program that the person needs physical assistance completing.

Note: When submitting the PA request, a copy of the active therapy program **must** be submitted.

Other. Describe other medically oriented tasks prescribed by a physician and not included in this list that will be delegated by an RN and performed by a PCW. Examples include catheter irrigations, catheter insertions, and ostomy appliance changes.

INCIDENTAL SERVICES

Element 35
Services incidental to the activities of daily living and medically oriented tasks include changing the applicant's bed, cleaning medical equipment, laundering the applicant's bed linens and personal clothing, light cleaning in essential areas of the home used during personal care services, purchasing food, preparing the applicant's meals, and cleaning the applicant's dishes. (Refer to the Covered Services Section of the Personal Care Handbook.) Indicate if services incidental to the activities of daily living and medically oriented tasks will be performed by the PCW.

BEHAVIORS AND MEDICAL CONDITIONS

Element 36 — Behaviors
Indicate if the applicant exhibits behavior on at least a weekly basis that makes activity of daily living tasks more difficult and more time consuming for a PCW to complete. If "Yes" is checked, list the behavior.

Examples
- Applicant hits and kicks PCW while trying to complete the activities of bathing, dressing, and grooming.
- Applicant is physically resistive to all cares completed by the PCW.

Element 37 — Medical Conditions
Indicate if the applicant has any medical conditions that make ADL tasks more difficult and more time consuming for a PCW to complete and are expected to result in a long-term need for extra care. If "Yes" is checked, list the medical condition(s) and describe how it interferes with the ability of the PCW to complete the ADL tasks.

Examples
- Applicant has severe contractures and additional time is needed to safely complete personal care tasks without injuring him or her.
- Applicant experiences severe shortness of breath due to chronic obstructed pulmonary disease (COPD) and requires additional time for completion of tasks.

Element 38 — Seizures
If the applicant has a diagnosis of seizures, indicate the time frame of the last seizure. Specify the seizure type, frequency, and the date of the last seizure. Specify if the PCW will provide seizure interventions, and list the interventions he or she will perform.

MEDICAL APPOINTMENTS

Element 39 — Accompanying Applicant to Medical Appointments
Indicate if a PCW will accompany the applicant to medical appointments.

BILLING PROVIDER INFORMATION (PAPER VERSION ONLY)

Element 40 — Name — Billing Provider
Enter the name of the Medicaid-certified provider billing services provided to the recipient.

Element 41 — Billing Provider's Medicaid Provider Number
Enter the Medicaid-certified billing provider's eight-digit Medicaid provider number.

Element 42 — Address — Billing Provider
Enter the billing provider's address, including street, city, state, and zip code.

SIGNATURE (PAPER VERSION ONLY)

Element 43 — SIGNATURE — Authorized Screener
The authorized screener completing this PCST is required to sign this form.

Element 44 — Date Signed — Authorized Screener
Enter the date the authorized screener completing this PCST signed the form.

PCST SUMMARY SHEET INSTRUCTIONS (WEB-BASED VERSION ONLY)

The PCST Summary Sheet will be produced for Web-based users after all information is entered into the PCST. This summary will contain the allocation of units for the applicant and other important alerts and information for the provider about PA submission.

At the bottom of the PCST Summary Sheet, enter the following information:

- Billing provider name.
- Billing provider address.
- Billing provider's Medicaid provider number.

Also, select the statement that describes any case sharing for this applicant's care.

ATTACHMENT 2
Personal Care Screening Tool (PCST)

(A copy of the Personal Care Screening Tool [PCST] is located on the following pages.)

WISCONSIN MEDICAID
PERSONAL CARE SCREENING TOOL (PCST)

Instructions: Print or type clearly. Refer to the Personal Care Screening Tool (PCST) Completion Instructions, HCF 11133A, for information on completing this form.

SCREENING INFORMATION

1. Name — Screening Agency	2. Screen Completion Date
3. Name — Screener	

APPLICANT INFORMATION

4. Name — Applicant (Last, First, Middle Initial)

5. Gender — Applicant ❑ Male ❑ Female	6. Social Security Number — Applicant
7. Address — Applicant (Street, City, State, Zip Code)	8. Date of Birth — Applicant
	9. Telephone Number — Applicant (Optional)
10. County / Tribe of Residence — Applicant	11. County / Tribe of Responsibility — Applicant

12. Directions (Optional)

13. Medical Insurance

Check all that apply.

- ❑ Medicare (Specify Identification Number) _____.
  - ❑ Part A Effective Date (If Known) _____.
  - ❑ Part B Effective Date (If Known) _____.
  - ❑ Medicare Managed Care.
- ❑ Medicaid (Specify Recipient Identification Number) _____.
- ❑ Private Insurance (Includes Employer-Sponsored [Job Benefit] Insurance).
- ❑ Private Long Term Care (LTC) Number.
- ❑ Railroad Retirement (Specify Number) _____.
- ❑ Other Insurance.
- ❑ No medical insurance at this time.

Continued

APPLICANT INFORMATION (Continued)

14. Race (Optional)

Check all boxes that apply.

❑ Black or African American ❑ Asian or Pacific Islander
❑ White ❑ American Indian or Alaskan Native
❑ Other _____

15. Ethnicity (Optional)

❑ Spanish / Hispanic / Latino

16. Interpreter Services (Optional)

Is an interpreter required? ❑ Yes ❑ No

If so, in what language?

❑ 01 American Sign Language ❑ 04 Hmong ❑ 07 A Native American Language
❑ 02 Spanish ❑ 05 Russian
❑ 03 Vietnamese ❑ 06 Other _____

17. Responsible Party Contact Type (Optional)

❑ Adult Child ❑ Power of Attorney
❑ Ex-spouse ❑ Sibling
❑ Guardian of Person ❑ Spouse
❑ Other Parent / Stepparent ❑ Other Informal Caregiver / Support _____

18. Name — Responsible Party (Last, First, Middle Initial) (Optional)

19. Telephone Number — Responsible Party (Optional)

20. Address — Responsible Party (Street, City, State, Zip Code) (Optional)

21. Comments (Optional)

22. Scheduled Activities Outside Residence (Include a schedule of activities in the applicant's medical file.)

Does the applicant attend scheduled activities outside the residence? ❑ Yes ❑ No

If yes, how many days per week do regularly scheduled activities occur? _____

23. Diagnosis Codes

List up to three *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) codes that most directly relate to the applicant's need for home care. At least one ICD-9-CM code is required.

ICD-9-CM Code 1_____

ICD-9-CM Code 2_____

ICD-9-CM Code 3_____

Continued

APPLICANT INFORMATION (Continued)

24. Living Situation (Indicate where the applicant currently lives.)

Own Home or Apartment
- ❑ Alone. (Includes person living alone who receives in-home services.)
- ❑ With Spouse / Partner / Family.
- ❑ With Nonrelative / Roommates.
- ❑ With Live-in Paid Caregiver(s). (Includes service in exchange for room and board.)

Someone Else's Home or Apartment
- ❑ Family.
- ❑ Nonrelative.
- ❑ Paid Caregiver's Home (e.g., one to two-bed adult family home or child foster care).
- ❑ Home / Apartment for Which Lease Is Held by Support Services Provider.

Apartment with Services
- ❑ Residential Care Apartment Complex.
- ❑ Independent Apartment Community-Based Residential Facility (CBRF).

Group Residential Care Setting
- ❑ Licensed Adult Family Home (three to four-bed home).
- ❑ Community-Based Residential Facility with 1-20 Beds.
- ❑ Community-Based Residential Facility with More than 20 Beds.
- ❑ Children's Group Home.

Health Care Facility / Institution
- ❑ Nursing Home.
- ❑ Intermediate Care Facility for Mental Retardation (ICF-MR/FDD).
- ❑ Developmental Disability Center / State Institution for Developmental Disabilities.
- ❑ Mental Health Institute / State Psychiatric Institution.
- ❑ Other Institution for Mental Disease.
- ❑ Child Caring Institution.
- ❑ No Permanent Residence (e.g., a homeless shelter).

Other
- ❑ Specify (e.g., jail). _____

ACTIVITIES OF DAILY LIVING

25. Bathing

"Bathing" means the ability to wash the entire body (excludes grooming, washing hands and face only, and bathing related to incontinence care) with shower, tub, sponge, or bed bath for the purpose of maintaining adequate hygiene. This includes the ability to get in and out of the tub or shower, turning faucets on and off, regulating water temperature, wetting, soaping, and rinsing skin, shampooing hair, drying body, and applying lotion to skin. Bathing includes all transfers and mobility related to bathing.

Select the response, A-F, that best describes the level of function the applicant possesses when bathing.

- ❑ A. Applicant is able to bathe him or her self in the shower or tub with or without an assistive device.
- ❑ B. Applicant is able to bathe him or her self in the shower or tub but requires presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to bathe him or her self in shower or tub but requires presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of task.
- ❑ D. Applicant is able to bathe in shower, tub, or bed with partial physical assistance from another person.
- ❑ E. Applicant is unable to effectively participate in bathing and is totally bathed by another person.
- ❑ F. Applicant's ability is age appropriate for a child age 5 or younger.

Indicate how many days per week personal care worker (PCW) assistance is needed with bathing. _____

Comments _____

Continued

ACTIVITIES OF DAILY LIVING (Continued)

26. Dressing

"Dressing" means the ability to dress and undress (with or without an assistive device) as necessary and choose appropriate clothing. This includes the ability to put on prostheses, braces, splints, and/or anti-embolism hose (e.g., "TED" stockings), and includes fine motor coordination for buttons and zippers. Difficulties with a zipper or buttons **at the back** of a dress or blouse do not constitute a functional deficit. Dressing also includes all transfers and mobility related to dressing and undressing.

Upper Body
Select the response, A-F, that best describes the level of function the applicant possesses when dressing his or her upper body.

- ❑ A. Applicant is able to dress upper body without assistance or is able to dress him or her self if clothing is laid out or handed to the person.
- ❑ B. Applicant is able to dress upper body by him or her self but requires presence of another person intermittently for supervision of cueing.
- ❑ C. Applicant is able to dress upper body by him or her self but requires presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of task.
- ❑ D. Applicant needs partial physical assistance from another person to dress upper body.
- ❑ E. Applicant depends entirely upon another person to dress upper body.
- ❑ F. Applicant's ability is age appropriate for a child age 5 or younger.

Indicate whether or not PCW assistance is needed with placement and removal of an upper body prosthetic, splint, or brace.

❑ Yes ❑ No

Indicate when PCW assistance with dressing the upper body is needed.

❑ AM ❑ PM ❑ Both

Indicate how many days per week PCW assistance is needed with dressing the upper body. _____

Comments _____

Lower Body
Select the response, A-F, that best describes the level of function the applicant possesses when dressing his or her lower body.

- ❑ A. Applicant is able to dress lower body without assistance or is able to dress him or her self if clothing is laid out or handed to the person.
- ❑ B. Applicant is able to dress lower body by him or her self but requires presence of another person intermittently for supervision of cueing.
- ❑ C. Applicant is able to dress lower body by him or her self but requires presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of task.
- ❑ D. Applicant needs partial physical assistance from another person to dress lower body.
- ❑ E. Applicant depends entirely upon another person to dress lower body.
- ❑ F. Applicant's ability is age appropriate for a child age 5 or younger.

Indicate whether or not PCW assistance is needed with placement and removal of a lower body prosthetic, splint, or brace.

❑ Yes ❑ No

Indicate when PCW assistance with dressing the lower body is needed.

❑ AM ❑ PM ❑ Both

Indicate how many days per week PCW assistance is needed with dressing the lower body. _____

Comments _____

Continued

ACTIVITIES OF DAILY LIVING (Continued)

27. Grooming

"Grooming" means the ability to tend to personal hygiene needs (i.e., washing face and hands, combing or brushing hair, shaving, nail care, applying deodorant, oral or denture care, eyeglass care [including contact lenses], and hearing aid assistance). Grooming includes all transfers and mobility related to grooming.

Select the response, A-G, that best describes the level of function the applicant possesses when grooming.

- ❑ A. Applicant is able to groom him or her self, with or without the use of assistive devices or adapted methods.
- ❑ B. Applicant is able to groom him or her self but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to groom him or her self but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- ❑ D. Applicant needs physical assistance to set up grooming supplies but can groom him or her self.
- ❑ E. Applicant needs partial physical assistance to groom him or her self.
- ❑ F. Applicant depends entirely upon another person for grooming.
- ❑ G. Applicant's ability is age appropriate for a child age 5 or younger.

Indicate when PCW assistance with grooming is needed.

❑ AM ❑ PM ❑ Both

Indicate how many days per week PCW assistance is needed with dressing the upper body. _____

Comments _____

28. Eating

"Eating" means the ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew, and swallow food.

Select the response, 0 or A-H, that best describes the level of function the applicant possesses when eating. If both responses "D" and "E" apply, select response "E".

- ❑ 0. Applicant is fed exclusively via tube feedings or intravenously.
- ❑ A. Applicant is able to feed him or her self, with or without use of assistive device or adapted methods.
- ❑ B. Applicant is able to feed him or her self but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to feed him or her self but requires the presence of another person throughout the task for constant supervision to ensure completion of the task.
- ❑ D. Applicant needs physical assistance at meal time to cut meat, arrange food, butter bread, etc.
- ❑ E. Applicant has recent history of choking or potential for choking based on documentation.
- ❑ F. Applicant needs partial physical feeding from another person.
- ❑ G. Applicant needs total feeding from another person.
- ❑ H. Applicant's ability is age appropriate for a child age 3 or younger.

Indicate the meals for which PCW assistance is needed.

❑ Breakfast ❑ Lunch ❑ Dinner

Indicate how many days per week PCW assistance is needed for each meal.

Breakfast _____ Lunch _____ Dinner _____

Comments _____

Continued

ACTIVITIES OF DAILY LIVING (Continued)

29. Mobility in the Home

"Mobility in the home" means the ability to move between locations in the applicant's living environment, including the kitchen, living room, bathroom, and sleeping area. **This excludes basements, attics, yards, and any equipment used outside the home.** This category excludes mobility related to bathing, dressing, grooming, and toileting.

Select the response, 0 or A-F, that best describes the level of function the applicant possesses when moving between locations in the home.

- ❑ 0. Applicant remains bedfast.
- ❑ A. Applicant is able to ambulate by him or her self, with or without an assistive device.
- ❑ B. Applicant is able to ambulate by him or her self, with or without assistive device but requires presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to ambulate by him or her self, with or without assistive device but requires presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of task.
- ❑ D. Applicant needs the physical help of another person to negotiate stairs or home ramp within the applicant's living environment.
- ❑ E. Applicant needs constant physical help from another person. (Includes total dependence with moving wheelchair.)
- ❑ F. Applicant's ability is age appropriate for a child 18 months or younger.

Indicate how many days per week PCW assistance is needed with mobility in the home. _____

Comments _____

30. Toileting

Toileting includes transferring on and off the toilet, cleansing of self, changing of personal hygiene product, emptying an ostomy or catheter bag, and adjusting clothes. Toileting includes all transfers and mobility related to toileting.

Select the responses, A-G, that best describe the level of function the applicant possesses when toileting. **Select all options that apply.** Both options "C" and "D" should be selected if the applicant is toileted and is incontinent. If options "C," "D," "E," or "F" are selected, also include the frequency of the situation described.

- ❑ A. Applicant is able to toilet him or her self or provide his or her own incontinence care, with or without an assistive device.
- ❑ B. Applicant is able to toilet him or her self or provide his or her own incontinence care, with or without an assistive device but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to toilet him or her self or provide his or her own incontinence care but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.

  Estimate frequency per day that PCW assistance is needed with toileting. _____
- ❑ D. Applicant needs physical help from another person to use toilet and/or change personal hygiene product.

  Estimate frequency per day that PCW assistance is needed with toileting. _____
- ❑ E. Applicant needs physical help from another person for incontinence care. (Does not include stress incontinence.)

  Estimate frequency per day that PCW assistance is needed with toileting. _____
- ❑ F. Applicant needs physical help from another person to empty ostomy or catheter bag.

  Estimate frequency per day that PCW assistance is needed with toileting. _____
- ❑ G. Applicant's ability is age appropriate for a child age 4 or younger.

Indicate how many days per week PCW assistance is needed for toileting. _____

Comments _____

Continued

ACTIVITIES OF DAILY LIVING (Continued)

31. Transferring

"Transferring" means the physical ability to move between surfaces (e.g., from bed/chair to wheelchair or walker), the ability to get in and out of bed or usual sleeping place, and the ability to use assistive devices for transfers. Transferring excludes transfers related to bathing, dressing, grooming, and toileting.

Select the response, A-F, that best describes the level of function the applicant possesses when transferring.

- ❑ A. Applicant is able to transfer him or her self, with or without an assistive device.
- ❑ B. Applicant is able to transfer him or her self, with or without an assistive device but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to transfer him or her self, with or without an assistive device but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- ❑ D. Applicant needs physical help of another person but is able to participate (e.g., applicant can stand and bear weight).
- ❑ E. Applicant needs constant physical help from another person and is unable to participate (e.g., applicant is unable to stand and pivot or unable to bear weight).
- ❑ F. Applicant needs help from another person with the use of a mechanical lift (e.g., Hoyer) when transferring.
- ❑ G. Applicant's ability is age appropriate for a child age 3 or younger.

Indicate how many days per week PCW assistance is needed with transferring. _____

Comments _____

MEDICALLY ORIENTED TASKS

32. (**Part I**) Medication Assistance

Select the appropriate response.

- ❑ 0. Not applicable.
- ❑ A. Independent with medications with or without the use of a device.
- ❑ B. Needs reminders.
- ❑ C. Needs the physical help of another person.
- ❑ D. Needs the physical help of a PCW.

  Frequency per day. _____

Indicate how many days per week PCW assistance is needed with medication assistance. _____

Comments _____

33. (**Part II**) Tasks to be Performed by a PCW

Select the tasks to be completed by a PCW. Indicate the frequency per day and days per week each task will be performed.

- ❑ Glucometer Readings (Allowed when medical history supports the need for frequent ongoing monitoring and the physician has established parameters.)
  PCW Frequency Per Day _____ PCW Days Per Week _____

- ❑ Vital Signs (Allowed when medical history supports the need for frequent ongoing monitoring and the physician has established parameters.)
  PCW Frequency Per Day _____ PCW Days Per Week _____

Continued

MEDICALLY ORIENTED TASKS (Continued)

33. (**Part II**) Tasks to be Performed by a PCW (Continued)

❑ Skin Care (Application of prescription ointments.)

Name of prescription medication _____

Frequency prescribed _____

PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Catheter Site Care

PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Gastrointestinal Tube Site Care

PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Complex Positioning

PCW Frequency Per Day _____ PCW Days Per Week _____

Comments _____

34. (**Part III**) Tasks to Be Performed by a PCW **—** Medicaid Review and Manual Approval May Be Required

Select the tasks to be completed by a PCW as delegated by the registered nurse. Indicate the frequency per day and days per week each task will be performed. For tasks indicated in this element, manual review of the prior authorization (PA) request will be required only when the total amount of time computed by the PCST is insufficient for a PCW also to provide the delegated medical tasks identified in this element *and* additional time is being requested for those delegated medical tasks. Include the Personal Care Addendum, HCF 11136, (include the recipient's plan of care) and other documentation as directed when submitting the PA request.

Daily Tube Feedings (Nasogastric or Gastrostomy)

❑ Continuous Feeding PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Intermittent (Bolus) Feeding PCW Frequency Per Day _____ PCW Days Per Week _____

Respiratory Assistance (Check all that Apply.)

❑ Tracheostomy Care PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Suctioning PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Chest Physiotherapy (CPT) PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Nebulizer PCW Frequency Per Day _____ PCW Days Per Week _____

Bowel Program (Check all that Apply.)

❑ Suppository PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Enema PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Digital Stimulation PCW Frequency Per Day _____ PCW Days Per Week _____

Continued

MEDICALLY ORIENTED TASKS (Continued)

34. (**Part III**) Tasks to Be Performed by a PCW **—** Medicaid Review and Manual Approval May Be Required (Continued)

Other Program (Check all that apply.)

❑ **Wound or Decubiti Care (Excludes Basic Skin Care)** PCW Frequency Per Day _____ PCW Days Per Week _____

❑ **Therapy Program (Therapy plan prescribed by a physical therapist, occupational therapist, or speech-language pathologist within the last 12 month period.)**

PCW Frequency Per Day _____ PCW Days Per Week _____

❑ **Other (Specify all tasks that apply.)**

_____ PCW Frequency Per Day _____ PCW Days Per Week _____

_____ PCW Frequency Per Day _____ PCW Days Per Week _____

Comments _____

INCIDENTAL SERVICES

35. Will services incidental to the activities of daily living (ADL) and medically oriented tasks be performed by the PCW?

Incidental services include changing the applicant's bed, cleaning medical equipment, laundering the applicant's bed linens and personal clothing, light cleaning in essential areas of the home used during personal care services, purchasing food, preparing the applicant's meals, and cleaning the applicant's dishes. (Refer to the Covered Services Section of the Personal Care Handbook.)

❑ Yes ❑ No

BEHAVIORS AND MEDICAL CONDITIONS

36. Behaviors

Does the applicant exhibit behavior that makes ADL tasks more difficult for a PCW to complete?

❑ Yes ❑ No

If "Yes," list the behavior(s).

37. Medical Conditions

Does the applicant have any medical conditions that make ADL tasks more difficult for a PCW to complete?

❑ Yes ❑ No

If "Yes," list the medical condition(s) (e.g., severe contractures, hemiplegia, severe shortness of breath) and describe how the condition(s) makes the ADL tasks more difficult for the PCW to complete.

Continued

BEHAVIORS AND MEDICAL CONDITIONS (Continued)

38. Seizures

Does the applicant have a diagnosis of seizures? ❑ Yes ❑ No

If "Yes," complete the following.

Date of last seizure was

- ❑ A. 0-90 days ago.
- ❑ B. 91-180 days ago.
- ❑ C. more than 180 days ago.

Specific Seizure Type _____

Frequency of Seizures _____

Date of Last Seizure _____

Does PCW provide interventions? ❑ Yes ❑ No

If "Yes," list interventions.

MEDICAL APPOINTMENTS

39. Accompanying Applicant to Medical Appointments

Does a PCW need to accompany the applicant to medical appointments?

❑ Yes ❑ No

BILLING PROVIDER INFORMATION

40. Name — Billing Provider	41. Billing Provider's Medicaid Provider Number

42. Address — Billing Provider (Street, City, State, Zip Code)

SIGNATURE

As the authorized screener completing this PCST, I confirm the following: All information entered on this form is complete and accurate, and I am familiar with all of the information entered on this form.

43. **SIGNATURE** — Authorized Screener	44. Date Signed — Authorized Screener

ATTACHMENT 3
Personal Care Prior Authorization Provider Acknowledgement

(A copy of the Personal Care Prior Authorization Provider Acknowledgement is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11134 (09/06)

WISCONSIN MEDICAID
PERSONAL CARE PRIOR AUTHORIZATION PROVIDER ACKNOWLEDGEMENT

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The Personal Care Prior Authorization Provider Acknowledgement, HCF 11134, states that the *supervising registered nurse (RN)* will perform *each* of the following tasks *before* personal care services are provided for the claims submitted to Wisconsin Medicaid:

- Obtain physician's signed and dated orders.
- Conduct an assessment at the recipient's place of residence.
- Develop the plan of care (POC).

The use of this form is mandatory when requesting prior authorization (PA). Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers are required to submit the Personal Care Prior Authorization Provider Acknowledgement and other documents as appropriate as directed by Wisconsin Medicaid personal care policy to Wisconsin Medicaid when requesting PA for personal care services. Providers may submit PA documents by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

Instructions: Type or print clearly.

Name — Wisconsin Medicaid-Certified Personal Care Services Provider	Wisconsin Medicaid Provider Number

Name — Recipient

Recipient Medicaid Identification Number	PA Number

As the authorized representative of the billing provider, I will assure that the supervising RN completes the following tasks before personal care services are provided for the claims submitted to Wisconsin Medicaid: the physician's signed and dated orders for this recipient will be obtained, an assessment at the recipient's place of residence will be conducted, and a POC will be completed for this recipient.

SIGNATURE — Authorized Representative of the Billing Provider	Date Signed **—** Authorized Representative of the Billing Provider

ATTACHMENT 4
Personal Care Addendum Completion Instructions

(A copy of the Personal Care Addendum Completion Instructions is located on the following pages.)

(This page was intentionally left blank.)

WISCONSIN MEDICAID
PERSONAL CARE ADDENDUM COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The Personal Care Addendum, HCF 11136, is a form that may be completed to supply additional information when requesting PA or for Wisconsin Medicaid recipients requesting an amendment to a PA request. The information on this form is mandatory. The use of this form is voluntary and providers may develop their own form as long as it includes all of the components requested on this form. If more space is needed, attach additional pages. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Retain the original, signed Personal Care Addendum. Attach a copy of the Personal Care Addendum to a copy of the recipient's plan of care (POC), any additional supporting materials that justify or explain the requested changes, and other documents as appropriate as directed by Wisconsin Medicaid personal care policy. Providers may submit PA documents to Wisconsin Medicaid by fax at (608) 221-8616 or by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — Name — Provider
Enter the name of the Medicaid-certified personal care agency providing services to the recipient.

Element 2 — Wisconsin Medicaid Provider Number
Enter the Medicaid-certified personal care agency's eight-digit Medicaid provider number.

SECTION II — RECIPIENT INFORMATION

Element 3 — Name — Recipient
Enter the recipient's last and first names, and middle initial.

Element 4 — Recipient Medicaid Identification Number
Enter the recipient's Medicaid identification number.

SECTION III — GENERAL ASSESSMENT

Element 5 — Skilled Visits Required by Recipient
Enter an "X" next to all visits required by the recipient.

If the recipient is eligible for Medicare, cannot reasonably obtain services outside the residence, and requires a skilled service, Medicare must be maximized before claims may be submitted to Wisconsin Medicaid, including disposable medical supplies and durable medical equipment. However, providers should request PA for all Medicaid-covered services, including those billed to other payers.

Element 6 — Communication Capability
Enter an "X" next to the statement that most closely matches the manner in which the recipient makes his or her needs known.

Element 7 — Hearing Aide Usage
Enter an "X" to indicate whether or not the recipient wears a hearing aide.

If the recipient wears a hearing aide, enter an "X" next to the statement that most closely matches his or her ability to hear while using the hearing aide.

Element 8 — Vision Correction
Enter an "X" to indicate whether or not the recipient wears corrective lenses.

If the recipient wears corrective lenses, enter an "X" next to the statement that most closely matches his or her ability to see while using the corrective lenses.

Element 9 — Orientation
Enter an "X" next to the statement that most closely describes the recipient's orientation awareness to the present environment in relation to time, place, and person.

Element 10 — Medications
Enter all medications prescribed for the recipient. Include the dosage, frequency, route, and start and stop dates for each medication listed.

This information is required regardless of which provider or agency administers or assists with administration of the medications.

Element 11 — Supporting Rationale for Requested Increase of Units
Document the specifics and supporting rationale for the increase in requested units. Attach additional pages if necessary.

SECTION IV — SOCIAL INFORMATION

Element 12 — Social / Economic / Cultural Factors
Identify and explain any social, economic, and/or cultural factors of the recipient that may impact the need for personal care services or how the services are provided.

Element 13 — Scheduled Activities Outside Residence
Enter an "X" to indicate if the recipient attends regularly scheduled activities outside his or her place of residence.

If the recipient attends regularly scheduled activities outside his or her residence, provide the weekly schedule for these activities. Specify the times of day each activity takes place (e.g., 8 a.m.-3 p.m., school).

SECTION V — HISTORY OF CONDITION

Element 14 — Condition / Past and Present Problems Affecting Personal Care
Enter the recipient's condition and any past or present problems that directly affect the provision of personal care services.

SECTION VI — STAFFING SCHEDULE

Element 15 — Staffing Schedule of Each Agency or Provider Providing Services
Enter the scheduled times that each agency or provider provides services to the recipient and indicate the funding source. Staffing may vary on a day-to-day basis at the convenience of the recipient. Agencies/providers may not vary schedule times without the approval of the recipient. Specify the times of day each provider provides services. If the schedule varies, enter the schedule that most closely resembles the services usually provided (e.g., PCW 8am-10am, HHAide 10am-2pm, PCW 6pm-8pm).

Element 16 — Other Information
Document any other information that supports the need for personal care services and the justification for the time that is required to provide the services. Attach additional pages if necessary.

SECTION VII — SIGNATURE

Element 17 — SIGNATURE — Authorized Nurse Completing Form
The registered nurse (RN) completing this Personal Care Addendum is required to sign this form.

Element 18 — Date Signed — Authorized Nurse Completing Form
Enter the date that the RN completing this Personal Care Addendum signed the form.

Element 19
This element serves as a reminder that the recipient's POC must be submitted with the Personal Care Addendum.

ATTACHMENT 5
Personal Care Addendum

(A copy of the Personal Care Addendum is located on the following pages.)

(This page was intentionally left blank.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11136 (09/06)

WISCONSIN MEDICAID
PERSONAL CARE ADDENDUM

Instructions: Print or type clearly. Refer to the Personal Care Addendum Completion Instructions, HCF 11136A, for information on completing this form.

SECTION I — PROVIDER INFORMATION

1. Name — Provider	2. Wisconsin Medicaid Provider Number

SECTION II — RECIPIENT INFORMATION

3. Name — Recipient	4. Recipient Medicaid Identification Number

SECTION III — GENERAL ASSESSMENT

5. Skilled Visits Required by Recipient (Check all that apply.)

- ❑ Registered Nurse
- ❑ Licensed Practical Nurse
- ❑ Home Health Aide
- ❑ Physical Therapist
- ❑ Occupational Therapist
- ❑ Speech-Language Pathologist

6. Communication Capability (Check one.)

- ❑ Communicates needs.
- ❑ Communicates with difficulty but can be understood.
- ❑ Communicates with sign language, symbol board, written messages, gestures, or interpreter.
- ❑ Communicates inappropriate content, makes garbled sounds.
- ❑ Does not communicate needs.
- ❑ Child with age-appropriate communication.

7. Hearing Aide Usage

Does the recipient wear a hearing aide? ❑ Yes ❑ No

If Yes, what is the recipient's ability to hear with the hearing aide, if customarily worn? (Check one, if applicable.)

- ❑ No hearing impairment.
- ❑ Hearing difficulty at level of conversation.
- ❑ Hears and understands only very loud sounds (e.g., person speaking to recipient must yell to be heard.)
- ❑ No useful hearing, including unable to interpret audible sounds.
- ❑ Not determined.

8. Vision Correction

Does the recipient wear corrective lenses? ❑ Yes ❑ No

If Yes, what is the recipient's ability to see with corrective lenses if customarily worn? (Check one, if applicable.)

- ❑ Has no impairment of vision.
- ❑ Has difficulty seeing at level of print but may be able to read large or thick print.
- ❑ Has difficulty seeing obstacles in environment.
- ❑ Has no useful vision.
- ❑ Not determined.

Continued

SECTION III — GENERAL ASSESSMENT (continued)

9. Orientation (Check one.)

- ❑ Oriented
- ❑ Minor forgetfulness of the following (Check all that apply.)
  - ❑ Time
  - ❑ Medications
  - ❑ Place
  - ❑ Meals
  - ❑ Person
- ❑ Partial or intermittent periods of disorientation in the following (Check all that apply.)
  - ❑ AMs
  - ❑ Consistently
  - ❑ PMs
  - ❑ Inconsistently
  - ❑ Two Hours or Less
- ❑ Totally disoriented — does not know time, place, or identity
- ❑ Comatose
- ❑ Not determined

10. Medications

Medication Name	Dosage / Frequency	Route	Start Date	End Date

11. Supporting Rationale for Requested Increase of Units

Continued

SECTION IV — SOCIAL INFORMATION

12. Social / Economic / Cultural Factors

13. Scheduled Activities Outside Residence

Does the recipient attend regularly scheduled activities outside his or her residence? ❑ Yes ❑ No

If yes, specify in the following table the times of day for each activity.

Scheduled Activity	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
School							
Work							
Day Program							
Other (Specify) _____							
Other (Specify) _____							

SECTION V — HISTORY OF CONDITION

14. Condition / Past and Present Problems Affecting Personal Care

Continued

SECTION VI — STAFFING SCHEDULE

15. Staffing Schedule of Each Agency or Provider Providing Services

Specify the times of day each provider provides services.

Level of Care	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Skilled Nursing Services							
Home Health Aide Services							
Personal Care Worker Services							
Case Sharing (Specify agenc[ies]) _____							
Other (Specify, e.g., Home and Community-Based Waiver Services Worker) _____							

16. Other Information

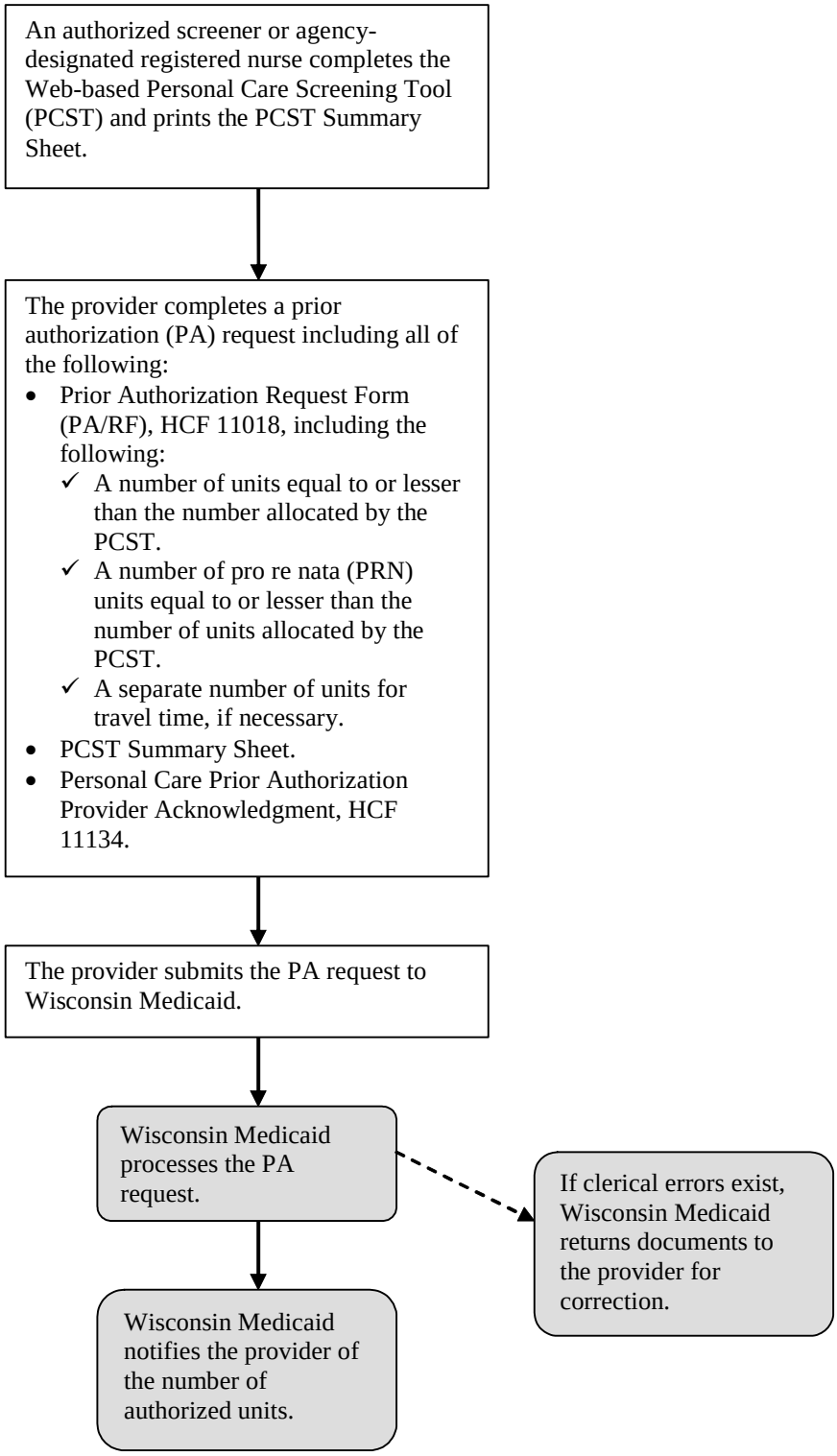
SECTION VII — SIGNATURE

17. **SIGNATURE —** Authorized Nurse Completing Form	18. Date Signed — Authorized Nurse Completing Form

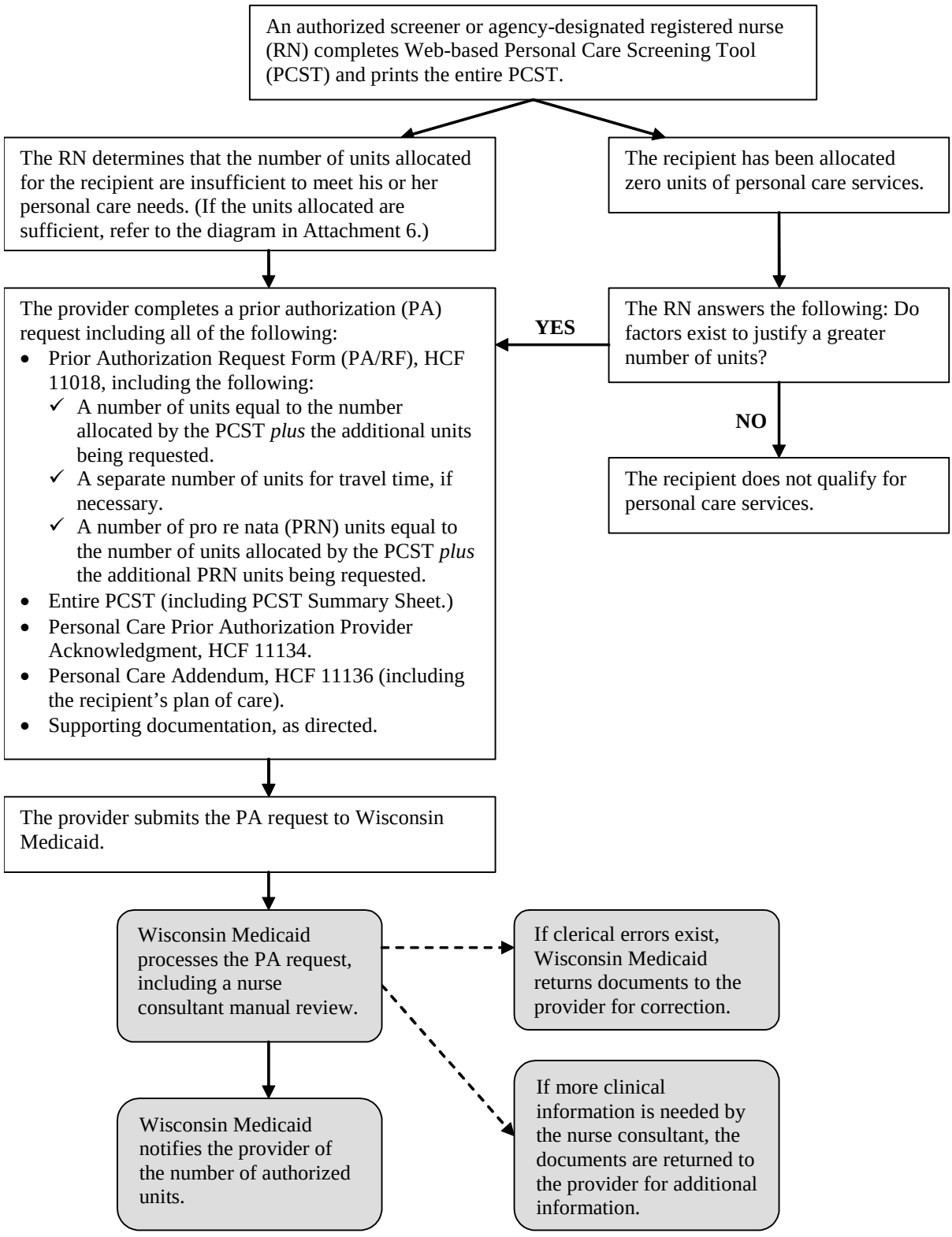
19. The recipient's plan of care is attached to this Personal Care Addendum.

❑ Yes

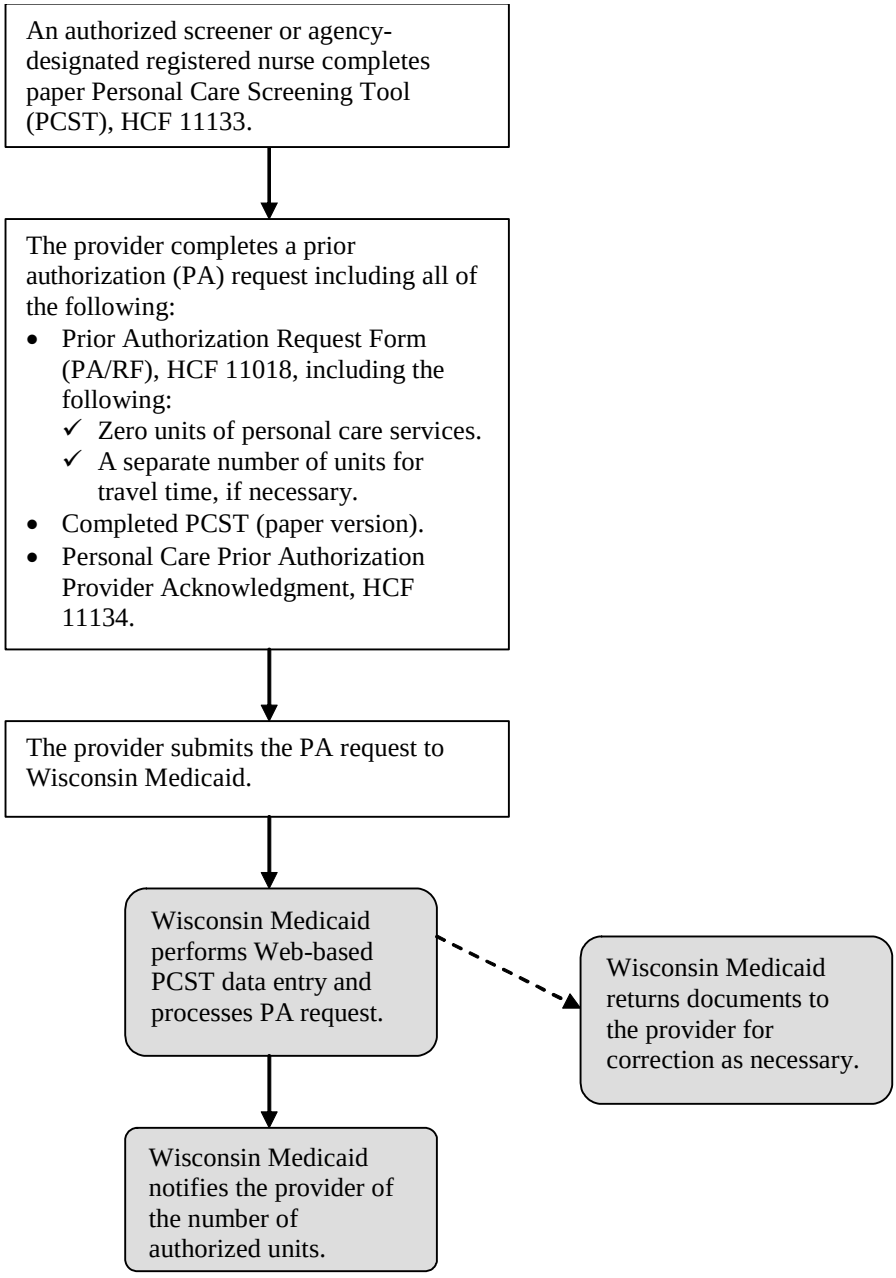
ATTACHMENT 6
Basic Submission of Prior Authorization Requests Using the Web-Based Personal Care Screening Tool (PCST)



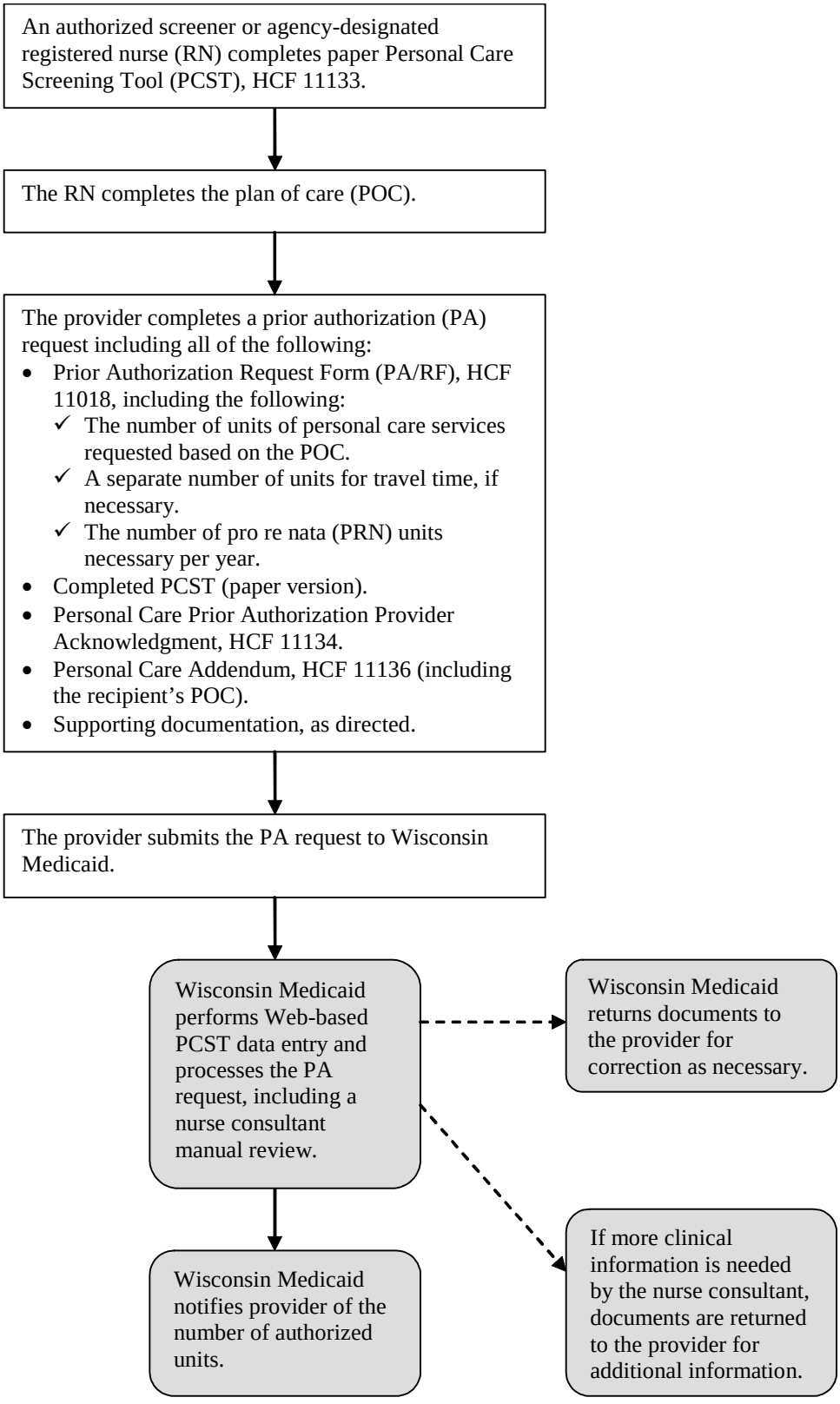
ATTACHMENT 7
Submitting Prior Authorization Requests Using the Web-Based Personal Care Screening Tool (PCST) When Insufficient Units Are Computed



ATTACHMENT 8
Basic Submission of Prior Authorization Requests Using the Paper Personal Care Screening Tool (PCST)



ATTACHMENT 9
Submitting Prior Authorization Requests with Additional Documentation Using the Paper Personal Care Screening Tool (PCST)



ATTACHMENT 10
Prior Authorization Amendment Request Completion Instructions

(A copy of the Prior Authorization Amendment Request Completion Instructions is located on the following pages.)

(This page was intentionally left blank.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11042A (07/06)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION AMENDMENT REQUEST COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the service.

Providers may use the Prior Authorization Amendment Request, HCF 11042, to request an amendment to a PA. The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization Amendment Request to the Prior Authorization Request Form (PA/RF), HCF 11018, and physician's orders, if applicable, (within 90 days of the dated signature) and send it to Wisconsin Medicaid. Providers may submit the Prior Authorization Amendment Request to Wisconsin Medicaid by fax at (608) 221-8616 or by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — **Original PA Number**
Enter the unique seven-digit PA number from the PA/RF to be amended.

Element 2 — **Processing Type**
Enter the processing type of the PA/RF to be amended that is used to identify the category of service.

Element 3 — **Recipient Medicaid Identification Number**
Enter the recipient's Medicaid identification number as indicated on the PA/RF to be amended.

Element 4 — **Name** — **Recipient**
Enter the name of the recipient as indicated on the PA/RF to be amended.

SECTION II — PROVIDER INFORMATION

Element 5 — **Billing Provider's Medicaid Provider Number**
Enter the billing provider's Medicaid provider number as indicated on the PA/RF to be amended.

Element 6 — **Name** — **Billing Provider**
Enter the name of the billing provider as indicated on the PA/RF to be amended.

Element 7 — **Address** — **Billing Provider**
Enter the address of the billing provider (include street, city, state, and zip code) as indicated on the PA/RF to be amended.

SECTION III — AMENDMENT INFORMATION

Element 8 — Requested Start Date
Enter the date that the requested amendment should start.

Element 9 — Requested End Date (If Different from End of Current PA)
Enter the date that the requested amendment should end if the end date is different than the start date.

Element 10 — Reasons for Amendment Request
Indicate the elements of the PA/RF that will be amended. Check all that apply.

Element 11 — Description and Justification for Requested Change
Enter the specifics and supporting rationale of the amendment request related to each box indicated in Element 10.

Element 12 — Are Attachments Included?
Indicate if attachments are included. If Yes, specify all attachments included.

Element 13 — Signature — Requesting Provider
Enter the signature of the provider from the agency or facility that originally requested the PA.

Element 14 — Date Signed — Requesting Provider
Enter the date this amendment was signed by the requesting provider in MM/DD/YYYY format.

ATTACHMENT 11
Prior Authorization Amendment Request

(A copy of the Prior Authorization Amendment Request is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11042 (07/06)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION AMENDMENT REQUEST

Providers may submit prior authorization (PA) requests with attachments to Wisconsin Medicaid by fax at (608) 221-8616 or by mail to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Refer to the Prior Authorization Amendment Request Completion Instructions, HCF 11042A, for detailed information on completing this form.

SECTION I — RECIPIENT INFORMATION

1. Original PA Number	2. Processing Type	3. Recipient Medicaid Identification Number

4. Name — Recipient (Last, First, Middle Initial)

SECTION II — PROVIDER INFORMATION

5. Billing Provider's Medicaid Provider Number	6. Name — Billing Provider

7. Address — Billing Provider (Street, City, State, Zip Code)

SECTION III — AMENDMENT INFORMATION

8. Requested Start Date	9. Requested End Date (If Different from End of Current PA)

10. Reasons for Amendment Request (Check All That Apply)

- ❑ Change Billing Provider Number
- ❑ Add Procedure Code / Modifier
- ❑ Change Procedure Code / Modifier
- ❑ Change Diagnosis Code
- ❑ Change Grant or Expiration Date
- ❑ Discontinue PA
- ❑ Change Quantity
- ❑ Other (Specify)_____

11. Description and Justification for Requested Change

12. Are Attachments Included? ❑ Yes ❑ No
If Yes, specify attachments below.

13. **SIGNATURE** — Requesting Provider	14. Date Signed — Requesting Provider

ATTACHMENT 12
Submitting Personal Care Amendments for Personal Care Services

Using the new prior authorization (PA) process, providers may submit amendments to Wisconsin Medicaid for prior authorized personal care services. The first table in this attachment outlines some of the reasons for which a provider may submit a PA amendment. The steps to be completed and the package of documentation that must be submitted in each situation are listed. The second table lists the specific forms and information included in each package of documentation.

Reason for Requesting a Prior Authorization Amendment	Does a Personal Care Screening Tool (PCST) need to be completed again?	Is a prior authorization amendment required?	Should the current prior authorization be end-dated?	Which documents should be submitted to Wisconsin Medicaid?
To increase pro re nata (PRN) time.	No	Yes	No	Package B
The provider has received an adjudicated PA request, but the registered nurse determines that the units allocated by the PCST and approved by Wisconsin Medicaid are insufficient to meet the recipient's needs. (There has been no change in informal supports or the recipient's condition.)	No	Yes	No	Package B
There is a short-term change in informal supports or the recipient's condition. More units are required. (Short-term changes are anticipated to persist for three months or less.)	No	Yes	No	Package B
There is a long-term change in informal supports or the recipient's condition. More units are required. (When the *new* PCST is completed, units allocated are *sufficient* to meet recipient's personal care needs.)	Yes	Yes	No	Package A
There is a long-term change in informal supports or the recipient's condition. More units are required. (When the *new* PCST is completed, units allocated are *insufficient* to meet recipient's personal care needs.)	Yes	Yes	No	Package B
The PA request is discontinued.	No	Yes	Yes	Package C

Documentation Package to be Submitted for Prior Authorization Amendment	Documentation Included in Package
Package A	• Copy of the PA/RF, HCF 11018. • Copy of completed Web-based PCST and PCST Summary Sheet or the completed paper PCST. • Prior Authorization Amendment Request, HCF 11042, form.
Package B	• Copy of the PA/RF. • Copy of completed Web-based PCST and PCST Summary Sheet or the completed paper PCST. • Prior Authorization Amendment Request Form. • Personal Care Addendum, HCF 11136 (including recipient's plan of care.) • Supporting documentation, as directed.
Package C	• Copy of the PA/RF. • Prior Authorization Amendment Request Form.

ATTACHMENT 13
Sample Personal Care Screening Tool (PCST) Summary Sheet

ABC Personal Care Agency

Personal Care Screening Tool Summary Sheet

Applicant Information: Smith, Laura
123 W. Main St
Madison, WI 53706

Medicaid Number: 3213213212

Date of Birth: 11/27/1978

		Annual (53 weeks)	**Weekly**
Allocation:	**ADLs/Med Oriented Tasks** (includes incidental services and added time for behaviors, medical conditions and/or seizures)	2,968 units	56 units
	Accompany to Medical Appointments (PRN)	96 units	n/a

TOTAL ANNUAL ALLOCATION (53 weeks) 3,064 units

Manual Review Alert: You checked one or more boxes in Part 3 of the Medically Oriented Tasks section of the Web-based PCST. Manual review of your prior authorization request will be required only when the total amount of time computed by the PCST is insufficient for a personal care worker also to provide the delegated medical tasks identified in Part 3 *and* you are requesting additional time for those delegated medical tasks. Be sure to include the plan of care and other documentation as directed when submitting the PA request.

Manual Review Alert: The applicant is a child age 5 or younger. The prior authorization request may require manual review. Manual review of your prior authorization request will be required only when the total amount of time computed by the PCST is insufficient *and* it is determined that more assistance is needed than an adult would typically provide. Be sure to include the plan of care and other documentation as directed when submitting the PA request.

Screener Name: IM Screener **Screen Date:** 5/15/2006

Note: The PCST does not constitute prior authorization for the provision of Wisconsin Medicaid personal care services. Refer to Wisconsin Medicaid publications for more information on obtaining prior authorization.

Provider must complete the following before submitting to Wisconsin Medicaid

Billing Provider Name: _____

Billing Provider Address: _____

WI MA Certified Provider Number: _____

Please check one of the following statements:

☐ The recipient will be served by other providers under a **case share arrangement**.

☐ The recipient will **not** be served by other providers under a case share arrangement.

Note: The Personal Care Screening Tool (PCST) Summary Sheet will contain the information displayed in this sample, however the layout may differ slightly when using the live Web-based PCST.