wisconsin Medicaid update
and BadgerCare

May 2007 ● No. 2007-37

Wisconsin Medicaid and BadgerCare Information for Providers

To:

Home Health Agencies

Personal Care Agencies

HMOs and Other Managed Care Programs

Significant Changes to the Personal Care Screening Tool

Wisconsin Medicaid is making changes to the Personal Care Screening Tool (PCST). This *Wisconsin Medicaid and BadgerCare Update* includes the following changes, effective in June 2007:

- Revised PCST and Personal Care Addendum instructions.
- Revised policies and procedures for prior authorization submission for both the Web-based and the paper PCST.

The revised Web-based PCST will be available beginning June 30, 2007. Providers are to begin using the revised Web-based PCST for prior authorization (PA) requests received after 1 p.m. Central Daylight Time (CDT), June 29, 2007, and the revised paper PCST for PA requests received after 1 p.m. CDT, June 22, 2007.

Wisconsin Medicaid Personal Care Screening Tool

This *Wisconsin Medicaid and Badger Care Update* replaces the August 2006 *Update* (2006-71), titled "Wisconsin Medicaid Announces Release of Personal Care Screening Tool."

Together, the Division of Disability and Elder Services (DDES) and the Division of Health Care Financing have developed the Wisconsin Medicaid Personal Care Screening Tool (PCST) to assist providers in determining the number of units to request for prior authorization (PA) of medically necessary personal care (PC) services that are to be provided by a personal care worker (PCW). The PCST bases the allocation of PC units on the information entered by the provider about the recipient's needs for assistance from a PCW.

The Department of Health and Family Services implemented the PCST to streamline the process for requesting and authorizing Wisconsin Medicaid fee-for-service personal care. The PCST improves consistency in determining recipient needs for medically necessary PC services. The PCST is a

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companion screen to the adult Long Term Care Functional Screen (LTC FS), which determines an applicant's eligibility for home and community-based waiver services.

Providers may choose to complete either the Web-based or paper PCST. Either version may be used for a recipient who requires PC services. The PCST should be completed based on the recipient's needs for medically necessary PC services provided in the recipient's home by a PCW. The frequencies indicated on the PCST should reflect the frequencies per week that the agency providing PC services will provide. Revised completion instructions for the PCST are included in Attachment 1 of this *Update.* These instructions are to be used for the Web-based and paper PCST.

Web-Based Personal Care Screening Tool

By completing the Web-based version of the PCST, providers can determine the maximum number of units of PC services that may be authorized without submitting additional supporting clinical documentation. The PCST Summary Sheet displays the number of units allocated and information pertinent to the determination. Refer to Attachment 14 for a sample PCST Summary Sheet.

Providers are encouraged to utilize the Web-based version to *immediately* identify the number of units that may be indicated on the PA request. Providers who have been granted user access may enter the Web-based PCST at *https://www.dwd.state.wi.us/desltc/*.

Paper Personal Care Screening Tool

Providers may choose to complete the paper PCST rather than using the Web-based PCST. To avoid delays, providers are required to enter information on the paper form for all required elements as stated in the completion instructions. After Wisconsin Medicaid receives the paper 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 then be communicated to the provider on the paper Prior Authorization Request Form (PA/RF), HCF 11018 (10/03), or the Web-based PA/RF, HCF 11018e (10/03), when the request is adjudicated. The revised paper PCST may be downloaded and printed from the Forms page of the Wisconsin Medicaid Web site or photocopied from Attachment 2 of this *Update*.

Providers are encouraged to utilize the Web-based version to *immediately* identify the number of units that may be indicated on the PA request.

Deadlines for Submitting Prior Authorization Requests to Wisconsin Medicaid

Web-based Personal Care Screening Tool

For PA requests and amendment requests received on and after June 30, 2007, providers are required to attach reports based on the revised Web-based PCST. The reports consist of the Full PCST, HCF 11133E (05/07), and the PCST Summary Sheet, HCF 11133SS (05/07). The revised Web-based PCST will be available for use after June 29, 2007.

Wisconsin Medicaid will return PA requests and amendment requests accompanied by a September 2006 Web-based PCST report (Full PCST, HCF 11133E [09/06] or Summary Sheet, HCF 11133SS [09/06]) received after 1 p.m. Central Daylight Time (CDT) June 29, 2007. The June 29, 2007, deadline also applies to PA requests and amendment requests that were previously returned to providers to correct and resubmit.

Refer to the implementation calendar in Attachment 3 for more information.

Paper Personal Care Screening Tool

On June 25, 2007, Wisconsin Medicaid will begin accepting the revised *paper* Personal

Care Screening Tool, HCF 11133 (05/07). The deadline for Wisconsin Medicaid to receive PA requests and amendments accompanied by the September 2006 *paper* PCST is 1 p.m. CDT June 22, 2007. The June 22, 2007, deadline also applies to PA requests and amendment requests that were previously returned for providers to correct and resubmit. Prior authorization requests and amendments accompanied by the Personal Care Screening Tool, HCF 11133 (09/06) will be returned to providers if received by Wisconsin Medicaid after the deadline.

Refer to the implementation calendar in Attachment 3 for more information.

To obtain PA for PC services, providers are required to submit documents to Wisconsin Medicaid that accurately and completely demonstrate the need for the requested PC services.

Process for Requesting Prior Authorization

To obtain PA for PC services, providers are required to submit documents to Wisconsin Medicaid that accurately and completely demonstrate the need for the requested PC 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.

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. Also, the PCST is required to be completed as often as necessary when preparing a PA amendment for an adjudicated 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.

The PCST may not be completed more than 90 days before the requested PA start date. Wisconsin Medicaid will authorize the requested start date only when the requested start date is on or after the PCST completion date and all other requirements are met.

Minimum Documentation That Providers Are Required to Submit

To request PA for PC services, providers are required to submit the following documents to Wisconsin Medicaid:

- PA/RF.
- Personal Care Prior Authorization Provider Acknowledgement, HCF 11134 (05/07).
- One of the following:
  - ✓ A copy of the PCST Summary Sheet (when using the Web-based PCST).
  - ✓ A copy of the completed PCST (when using the paper PCST).

Documentation Providers Are Required to Maintain on File

Providers *are required* to maintain all of the following on file to support their reimbursement for PC services:

- Copies or the originals, as appropriate, of all documents submitted with the PA request to Wisconsin Medicaid. (Providers are required to maintain the Full PCST on file, not just the PCST Summary Sheet.)
- The plan of care (POC). For more information on the POC, refer to the Personal Care Handbook and other Wisconsin Medicaid publications.
- Signed and dated physician orders reflecting the number of hours per day and days per week that PC services are to be provided. Physician orders are required to be expressed as hours per day, days per week.
- The nursing assessment. Standards of Practice for Registered Nurses and Licensed Practical Nurses, chapter N6.03(1)(a), Wis. Admin. Code, defines the nursing assessment as the "systematic and continual collection and analysis of data

about the health status of a patient culminating in the formulation of a nursing diagnosis." Nursing assessment forms are created by the provider. Wisconsin Medicaid does not prescribe a format for nursing assessments.
- The record of all PCW assignments for the recipient, and the record of the registered nurse (RN) supervisory visits.
- The time and activity records of all visits by PCWs, including observations and assigned activities, completed and not completed.
- Documentation of travel time if claimed for reimbursement.
- The list of the recipient's medications, regardless of the involvement with medication administration assistance.
- The list of the recipient's regularly scheduled activities outside the home.
- The copy of written agreements between the PC provider and RN supervisor, if applicable.
- The clinical rationale making the services medically necessary must be clearly documented.

Refer to the Personal Care publications for other documentation requirements.

When the Personal Care Screening Tool Allocates More Time Than Ordered by the Physician

The provider may request only the number of units that are supported by the physician's order and the POC even if the PCST allocates more time than needed.

For example, if the physician's order and the POC support the need to provide 56 units/week (not including travel time) and the PCST allocates 70 units/week, then the number of units the provider may request may not exceed 56 units/week (not including travel time).

Requesting Home Health and Personal Care Services

Home health agencies providing both home health services (skilled nursing, home health aide, medication management, etc.) and PC services to the same recipient may choose either 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: Services authorized under multiple PAs should be billed under separate claims with their respective PA numbers. Wisconsin Medicaid will accept only one PA number per claim.

Wisconsin Medicaid requires providers to submit the completed Personal Care Prior Authorization Provider Acknowledgement with each request for PA.

Other Forms for Requesting Prior Authorization

Wisconsin Medicaid developed the Personal Care Prior Authorization Provider Acknowledgement and the Personal Care Addendum, HCF 11136 (05/07), to be used with PA requests for personal care.

Personal Care Prior Authorization Provider Acknowledgement

The Personal Care Prior Authorization Provider Acknowledgement indicates that the *supervising RN* will perform *each* of the following tasks *before* PC services are provided to a Medicaid recipient:
- Obtain physician's signed and dated orders.
- Conduct an assessment at the recipient's home.
- Develop the POC.

Wisconsin Medicaid requires providers to submit the completed Personal Care Prior Authorization Provider Acknowledgement with each request for PA. The form is available in fillable Adobe® Portable Document Format (PDF) and fillable Microsoft® Word format. The instructions and form may be downloaded

and printed from the Forms page of the Wisconsin Medicaid Web site or photocopied from Attachment 4.

Personal Care Addendum

The Personal Care Addendum is to be completed as directed for PA requests and with PA amendment requests.

Wisconsin Medicaid requires the POC to be submitted with every Personal Care Addendum. When completing the Personal Care Addendum, rather than repeating information that has been included in the POC, providers may refer to specific locations (e.g., page and item numbers) in the POC as long as the referenced item in the POC contains all of the required components. Stating "See POC" is too general. Wisconsin Medicaid requires providers to include all of the requested Personal Care Addendum components.

Before a Medicaid-certified PC provider may use the Web-based PCST, the provider is required to register and be approved for user access.

Providers may obtain the Personal Care Addendum Completion Instructions and the Personal Care Addendum from the Forms page of the Wisconsin Medicaid Web site. The form is available in fillable Adobe® PDF and fillable Microsoft® Word formats. The completion instructions and form are also available in Attachments 5 and 6.

Discontinued Forms

The Home Care Assessment Form and the Home Care Assessment Update Form are obsolete. Prior authorization requests that include these forms will be returned to the provider.

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

Providers should contact the DDES (not Wisconsin Medicaid Provider Services) for assistance with registration for the Web-based PCST.

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

An authorized representative of the Medicaid-certified PC 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/forms1/DDES/DDE0418.doc* or in Adobe® PDF from *dhfs.wisconsin.gov/forms1/DDES/DDE0418.pdf*. Providers who are unable to download the form from the Web site may also call the DDES at (608) 267-2455 to request a copy.

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 related to the provider's and screener's registration, the provider is responsible for contacting the DDES to update information on those persons who require user access.

Using the Web-Based Personal Care Screening Tool

Only an agency-designated RN or authorized LTC FS screener may complete the PCST. For an individual other than an RN to become an authorized PCST screener, the screener should meet all the following requirements:

- Be authorized to complete the PCST by the agency authorized to complete the LTC FS.
- Be a DDES-certified LTC FS screener.

Not all the recipients receiving PC services will have an LTC FS. For recipients with or without an existing LTC FS, the requesting provider can initiate the PCST. Providers should carefully check the recipient's identifying information, especially the Social Security number, to verify that an LTC FS or another PCST does not exist for the recipient.

Initial Screen and Edit

Two entry paths exist to complete the PCST, "Initial screen" and "Edit." Each path is designated for specific purposes.

The screener may select "Initial screen" for any of the following purposes:

- To enter information about a new applicant that previously has not been screened for PC services.
- To enter information as a result of a long-term change in the recipient's condition *and* based on a face-to-face visit in the recipient's home.
- To complete the PCST in order to request PA for PC services for a subsequent PA period.

The screener may select "Edit" for any of the following purposes:

- To *correct* information entered for the "Initial screen."
- To change medical insurance information.
- To update "optional" fields.

Personal Care Screening Tool Instructions

The PCST instructions are abbreviated in the Web-based PCST application prompts. Screeners should be familiar with the PCST instructions and should not rely solely on the prompts provided with the Web-based PCST. Before beginning the Web-based PCST, the screener is instructed to read the following message on the Basic Information page of the Web-based PCST:

Only an agency-designated RN or authorized LTC FS screener may complete the PCST.

> 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 the paper and the Web-based PCST formats. The authorized screener should refer to the paper PCST and to the PCST instructions for complete details. The responses selected when completing the Web-based PCST should not be different from those that would be selected if the authorized screener were to complete the paper PCST.
>
> By completing the Web-based PCST, you are acknowledging that you have read the above, understand the limitations of the Web-based PCST, and agree to the use of the PCST subject to the above terms.

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

1. The agency-designated RN or authorized LTC FS completes all information requested on the PCST and prints the Full PCST Report.

2. The provider completes the following documentation:
   - ✓ PA/RF.
   - ✓ Personal Care Prior Authorization Provider Acknowledgement.
3. The provider submits all documentation to Wisconsin Medicaid including a copy of the PCST Report Summary Sheet.
4. Wisconsin Medicaid adjudicates the PA request.
5. The provider is notified of the number of authorized units on the adjudicated PA request.

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

The PA/RF should include the following information listed separately:

- The number of weekly and annual units equal to or less than the number of weekly and annual units allocated by the PCST.
- If needed, the number of pro re nata (PRN) units equal to or less than the number of annual units allocated by the PCST.
- If needed, the number of weekly and annual units requested for travel time.

Refer to Attachment 7 for a diagram illustrating how to request PA using the Web-based PCST. Refer to Attachments 15, 16 and 17 for examples demonstrating how to complete the PA/RF when the RN determines the PCST allocated a sufficient number of units.

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 PC services, the RN should identify the factors present to justify a greater allocation of units than computed by the PCST.

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

If the RN determines that a greater allocation of units is justified for the recipient and the provider requests PA for more units than computed by the PCST, Wisconsin Medicaid requires providers to submit the following documents:

- PA/RF.
- Personal Care Prior Authorization Provider Acknowledgement.
- A copy of the Full PCST report, including the Summary Sheet.
- The Personal Care Addendum.
- The POC.
- Supporting documentation, as directed in the PCST instructions.

The PA/RF should include the following information listed separately:

- The number of weekly and annual units requested.
- If needed, the number of annual PRN units requested.
- If needed, the number of weekly and annual units requested for travel time.

Note: When the provider wants to communicate more information to Wisconsin Medicaid than the Web-based PCST comment section can hold, the provider may include the additional information with the addendum. The provider should *not submit* the paper PCST with the PA request.

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

Refer to Attachment 8 for a diagram illustrating how to request PA using the Web-based PCST

when the units computed for the recipient are insufficient. Refer to Attachments 15, 17, and 18 for examples demonstrating how to complete the PA/RF when the RN determines the PCST allocated an insufficient number of units.

Printing and Submitting Full and Summary Sheet Reports

Providers should print the Full PCST and Summary Sheet reports as needed for submission with PA requests. The Full PCST and Summary Sheet selections can be found under the heading "Reports." The report selections are located on the left side of the Web-based PCST and are generated in PDF format. The Full PCST displays only the responses that the screener selected for each completed element of the PCST. The Full PCST includes the Summary Sheet.

When the provider requests more time than is allocated by the PCST, the provider is required to submit a copy of the Full PCST with the PA/RF. When the provider requests an amount equal to or less than the time allocated on the PCST, the provider is required to submit a copy of the PCST Summary Sheet with the PA/RF. Providers should not submit the paper PCST used to collect information during the face-to-face visit.

Using the Paper Personal Care Screening Tool

Only an agency-designated RN or authorized LTC FS screener may complete the PCST. For an individual other than an RN to become an authorized PCST screener, the screener should meet all the following requirements:

- Be authorized to complete the PCST by the agency authorized to complete the LTC FS.
- Be a DDES-certified LTC FS screener.

Before submitting the paper PCST to Wisconsin Medicaid for data entry, providers should carefully check the recipient's identifying information, especially the Social Security number.

If during data entry, Wisconsin Medicaid discovers the recipient has already been screened by another provider, the PA request including the paper PCST will be returned.

Providers should print the Full PCST and Summary Sheet reports as needed for submission with PA requests.

Requesting Zero Units

When requesting PA for PC services using the paper PCST, the basic steps to complete include the following:

1. The agency-designated RN or authorized LTC FS screener completes all information requested on the paper PCST. (To avoid delays in processing, the agency-designated RN or authorized LTC FS screener should respond to all required elements as stated in the completion instructions.)
2. The provider completes the following documentation:
   - ✓ PA/RF.
   - ✓ Personal Care Prior Authorization Provider Acknowledgement.
3. The provider submits all of the above documentation to Wisconsin Medicaid.

The PA/RF should include the following information listed separately:

- Zero weekly and annual units of PC services (expressed as .01 when completing the Web PA/RF).
- If needed, zero annual units of PRN (expressed as .01 when completing the Web PA/RF).
- If needed, the number of weekly and annual units requested for travel time.

Wisconsin Medicaid will enter the information from the paper PCST into the Web-based PCST and adjudicate the PA according to the

number of PC units allocated by the Web-based PCST. Wisconsin Medicaid will notify the provider of the number of authorized units and include a copy of the Full PCST when the adjudicated PA request is returned to the provider.

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

The data on the LTC FS and PCST screen should be consistent.

Refer to Attachment 9 for a diagram illustrating how to request PA using the paper PCST. Refer to Attachments 15 and 19 for examples demonstrating how to complete the PA/RF when requesting zero units.

Requesting a Quantity Greater Than Zero

When requesting PA for PC services using the paper PCST and if requesting a specific quantity of units greater than zero, the basic steps to complete include the following:

1. The agency-designated RN or authorized LTC FS completes all information requested on the paper PCST. (To avoid delays in processing, the agency-designated RN or authorized LTC FS screener should respond to all required elements as stated in the completion instructions.)
2. The provider completes the following documentation:
   - ✓ PA/RF.
   - ✓ Personal Care Prior Authorization Provider Acknowledgement.
   - ✓ Personal Care Addendum.
   - ✓ POC.
   - ✓ Supporting documentation, as directed in the PCST instructions.
3. The provider submits all of the prior documentation to Wisconsin Medicaid.

The PA/RF should include the following information listed separately:

- The number of weekly and annual units requested.
- If needed, the number of annual PRN units requested.
- If needed, the number of weekly and annual units requested for travel time.

Wisconsin Medicaid will enter the information from the paper PCST into the Web-based PCST and adjudicate the PA. The documentation submitted is used to adjudicate the PA when the provider requests a number of units in excess of the number of units the Web-based PCST allocates. Wisconsin Medicaid will notify the provider of the number of authorized units and include a copy of the Full PCST when the adjudicated PA is sent to the provider.

Refer to Attachment 10 for a diagram illustrating how to request PA using the paper PCST and additional documentation. Refer to Attachment 16 for an example demonstrating how to complete the PA/RF when requesting a quantity greater than zero.

Long Term Care Functional Screen Creates Error Message on the Personal Care Screening Tool

The data on the LTC FS and PCST screen should be consistent. During the Web PCST data entry, a message may appear advising the screener that the response entered into the PCST element is inconsistent with information provided in the adult LTC FS.

In order to remove the error message, it is necessary for the PCST screener to reach an agreement with the authorized LTC FS screener. The authorized LTC FS screener

contact information is located on the Basic Information page of the Web-based PCST.

If the authorized LTC FS screener does not agree with the PCST screener to change the LTC FS response, then the PCST screener will not be able to calculate the allocation.

When Wisconsin Medicaid enters data from a paper PCST into the Web-based PCST and an error message appears, Medicaid will return the PA request to the provider to resolve the conflict. The LTC FS screener contact information will be included with the returned PA request.

Pro Re Nata Time

Pro re nata (as needed) units may be requested when time is needed to accompany the recipient to medical appointments and for short duration episodes of acute need for services from a PCW.

Although the weekly and annual amounts allocated by the PCST should be sufficient to meet the needs for weekly scheduled services from a PCW, there may be instances (such as a short term need) in which a deviation might occur in the recipient's weekly needs for services from a PCW. For the occasional deviation in the recipient's needs for services from a PCW, PRN units may be requested. The PCST allocates time for PRN when the screener indicates in the PCST both of the following:

- The recipient has a need for PRN services.
- The recipient has a need for a PCW to provide activities of daily living (ADL) services.

Requests for PRN should be recorded on a separate line of the PA/RF. The amount of PRN time allocated by the PCST (96 units per year) should be adequate to meet most annual PRN needs.

As required with any other PA request for PCW services, the submitted documentation should describe medically necessary covered PC services, and that all informal supports (such as family and friends) have been exhausted. The reason for PRN units should be indicated on the physician's orders. Personal care worker service units authorized to be used PRN may be used only for services covered under HFS 107.112(1)(b) and (2)(b), Wis. Admin. Code. In addition, PRN units should be requested as a specific number of units over the length of the entire PA period. Refer to Attachments 16 and 17 for examples of PA/RFs with a request for PRN services.

Pro re nata (as needed) units may be requested when time is needed to accompany the recipient to medical appointments and for short duration episodes of acute need for services from a PCW.

Requesting Pro Re Nata Time on the Prior Authorization Request

Providers should take the following steps when making a request for PRN time:

1. Obtain a physician's order for PRN hours. Physician orders must be based on the recipient's weekly needs for scheduled PCW services and must indicate the circumstances in which the PRN hours may be used.
2. Indicate the annual PRN units being requested in Element 19 on the PA/RF (this would include PRN units for accompanying to medical appointments and PRN units for use when there is a deviation in the recipient's weekly needs for regularly scheduled PCW services).

If the annual number of PRN units being requested exceeds 96 units, Wisconsin Medicaid requires the following additional completed items to be included with the PA/RF:

- The POC.
- The Personal Care Addendum form.
- Justification for the need for annual PRN to exceed 96 units.

Amending for Additional Pro Re Nata Time

If the PRN units granted on the current PA have been used and there is reason to expect that more PRN units may be needed before the current PA expires, the provider may take the following steps:

1. Obtain an updated physician's order specifying the number of and reason for additional PRN hours.
2. Complete the Prior Authorization Amendment Request, HCF 11042 (05/07) and include documentation indicating why previously granted PRN time was needed, how it was used, and why more is needed.

Wisconsin Medicaid requires documentation of PRN units to be maintained in the medical record.

Refer to Attachment 13 regarding the appropriate paperwork to submit when requesting an amendment to a current PA.

Documentation of Pro Re Nata Time in the Medical Record

Wisconsin Medicaid requires documentation of PRN units to be maintained in the medical record. Refer to Wisconsin Medicaid PC publications for required documentation related to PRN use.

Correcting Errors Entered into the Personal Care Screening Tool

The provider may correct errors in the information entered into the PCST.

When completing the Web-based PCST, screeners are cautioned against using the computer's mouse scroll function. Using the scroll function may change the selections in the drop-down menus. Before calculating the allocation, the screener should carefully review the selections for each element in the PCST.

With limited exceptions, Wisconsin Medicaid expects that once the screener becomes familiar with the PCST, the screener will not have to edit the screen after the allocation is determined and before the PA request is submitted for adjudication. The screener is encouraged to review PCST responses *before* proceeding to the allocation screen.

Wisconsin Medicaid has the ability to monitor screen editing activities. Refer to the "Using the PCST" section for more information about creating initial screens and editing screens.

Correcting the Personal Care Screening Tool After Prior Authorization Has Been Adjudicated

If the provider discovers that he or she has entered an incorrect response into the PCST after submitting the PA request, he or she should edit the screen and compare the amount that is allocated after the PCST screen is edited to the amount that was prior authorized. The provider's actions depend on the results of the comparison.

When the prior authorized amount is *less than* the amount of the revised allocation, then the provider may send in an amendment request only if more time is needed than has been authorized.

When the prior authorized amount is *equal to or more than* the amount of the revised allocation, the provider is not required to submit an amendment. However, the provider may not use amounts in excess of the revised PCST allocation. Payments for services provided are subject to recoupment if the services were authorized as a result of provider error when completing the PCST. Prior authorization does not constitute a guarantee or promise of payment. Furthermore, Wisconsin Medicaid will reimburse providers only for medically necessary services that are provided, ordered by the physician, and supported by the POC.

If, after editing the PCST, the amount allocated is less than the amount authorized and the RN determines that the PCST has not allocated a sufficient number of units, the provider may request more time. Refer to the "Prior Authorization Amendments" section of this *Update* for more information on amendments.

Components Requiring Manual Review by Wisconsin Medicaid

The PCST does not allocate time in the following situations:

- The medically oriented tasks listed in Part III of the Medically Oriented Tasks (MOTs) section (Element 34) are marked on the PCST.
- The "age appropriate" response is selected in the Activities of Daily Living section. (Typically, children ages five and younger require the assistance of an adult to complete many ADL.)

When requesting more units than the PCST allocated, the provider is required to submit the Personal Care Addendum, the POC, and other supporting documentation, as directed in the PCST Completion Instructions.

Medically Oriented Tasks

When MOTs listed in Part III of the Medically Oriented Tasks section are identified on the PCST, Wisconsin Medicaid nurse consultants adjudicate the PA requests based on PA/RF, Full PCST, *and* other information required to be submitted. A Wisconsin Medicaid nurse consultant manual review of the PA request will be required only when the total amount of time computed by the PCST is insufficient for a PCW to provide the delegated tasks identified *and* additional time is being requested for those delegated tasks.

Age-Appropriate Assistance

The provider may request more units when the age appropriate response is selected if the RN determines the task requires more assistance than an adult would typically provide to a child that age and the PCST allocated an insufficient number of units to meet the recipient's weekly needs for PCW services. When requesting more units than the PCST allocated, providers are required to indicate the reason that more assistance is needed in the comment section for that ADL and submit the Personal Care Addendum (including the POC).

When requesting more units than the PCST allocated, the provider is required to submit the Personal Care Addendum, the POC, and other supporting documentation, as directed in the PCST Instructions.

Services Incidental to Activities of Daily Living and Medically Oriented Tasks

When the screener indicates on the PCST that the recipient needs services incidental to the ADL and that the PCW will provide those services, the PCST automatically calculates the maximum amount of time to allocate for services incidental to the ADL and MOTs.

Wisconsin Medicaid covers the following services that are incidental to ADL and MOTs:

- Changing the recipient's bed and laundering the recipient's bed linens and personal clothing.
- Light cleaning in essential areas of the home used during PC activities.
- Care of eyeglasses and hearing aids.
- Meal preparation, food purchasing, and meal service.

The weekly amount of PC time prior authorized for the recipient combines the amount of time prior authorized for ADL, MOTs, and for services incidental to the ADL and MOTs. Neither travel time nor PRN time qualifies to have time added for services incidental to ADL and MOTs.

Calculating Time for Prior Authorization of Services to the Recipient Living Alone

For the recipient living "alone," as indicated in PCST Element 24, the time for services incidental to ADL and MOTs is calculated in an amount equal to one-third of the time allocated for the ADL and MOT services. For example, if the PCST allocates 900 weekly minutes for ADL and MOTs, it adds 300 minutes to bring the weekly allocation to a total of 1200 minutes. In allocating units, the PCST divides the total weekly minutes by 15 minutes and rounds up. In this example, the PCST allocated 80 units per week because the PCST calculated the weekly number of minutes to be between 1,186 and 1,200 minutes.

Wisconsin Medicaid requires that the weekly amount of time billed for ADL and/or MOTs represents at least 75 percent of the weekly amount of time billed for PCW services.

Billing for Services Provided to the Recipient Living Alone

Wisconsin Medicaid requires that the weekly amount of time billed for ADL and/or MOTs represents at least 75 percent of the weekly amount of time billed for PCW services. In order to bill for services incidental to ADL and MOTs on the date of service (DOS), the provider is required to bill at least one ADL and/or MOT service.

For example, if the weekly amount billed for ADL and/or MOTs adds up to 900 minutes, then the weekly amount of time billed for services incidental to ADL and MOTs may be equal to or less than 300 minutes. The provider may bill up to 1,200 minutes weekly of PCW services for ADL, MOTs, and services incidental to ADL and MOT activities combined as long as the number of minutes billed for services incidental to ADL is equal to or less than 25 percent of the amount of time billed.

When billing Wisconsin Medicaid, the provider is to bill for each DOS and only for the actual time used to provide prior authorized services. Refer to the July 2003 *Update* (2003-69), titled "Changes to local codes, paper claims, and prior authorization for personal care services as a result of HIPAA," for rounding guidelines when converting minutes of service provided into billing units.

Calculating Time for Prior Authorization of Services to the Recipient Not Living Alone

When a living arrangement *other* than "alone" is checked in PCST Element 24, then the time for services incidental to ADL and MOTs is calculated in an amount equal to one-fourth of the time allocated for the ADL and MOT services. For example, if the PCST allocates 1,120 weekly minutes weekly for ADL and MOTs, it adds 280 minutes to bring the weekly allocation to a total of 1,400 minutes. In allocating units, the PCST divides the total weekly minutes by 15 minutes and rounds up. In this example, the PCST allocated 94 units per week because the PCST calculated the total weekly number of minutes to be between 1,396 and 1,410 minutes.

Billing for Services Provided to the Recipient Not Living Alone

Wisconsin Medicaid requires that the weekly amount of time billed for ADL and/or MOTs represents at least 80 percent of the weekly amount of time billed for PCW services. In order to bill for services incidental to ADL and MOTs on the DOS, the provider is required to bill at least one ADL and/or MOT service.

For example, if the weekly amount billed for ADL and/or MOTs adds up to 1,120 minutes, then the weekly amount of time billed for services incidental to ADL and MOTs may be equal to or less than 280 minutes. The provider may bill up to 1,400 minutes of PCW services weekly for ADL, MOTs, and services incidental to ADL and MOT activities combined as long as the number of minutes billed for

services incidental to ADL MOTs is equal to or less than 20 percent of the amount of time billed.

When billing Wisconsin Medicaid, the provider is to bill for each DOS and only for the actual time used to provide prior authorized services. Refer to the July 2003 *Update* (2003-69), titled "Changes to local codes, paper claims, and prior authorization for personal care services as a result of HIPAA," for rounding guidelines when converting minutes of service provided into billing units.

Determining Allocations for Amounts Authorized During Manual Review

When Wisconsin Medicaid authorizes services requiring nurse consultant review of the PCST, the nurse consultant manually calculates the additional time for services incidental to those services. Nurse consultants calculate the time using the previously described methods for determining the amounts allocated for the recipient that is living alone or is in a living situation other than alone.

Prior Authorization Amendments

Providers may submit an amendment to change or update an approved or modified PA. Situations in which providers may decide to submit amendment requests include, but are not limited to, the following:

- To request more PRN units when previously authorized units are exhausted.
- To request PRN units when PRN services were not included on the PA/RF requesting PA for PC services.
- 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.
- To discontinue PA. Refer to the Prior Authorization section of the Personal Care Handbook for a list of reasons PA may be discontinued.
- To add or increase travel time.

Providers may submit an amendment to change or update an approved or modified PA.

Complete a Prior Authorization Amendment Request describing the specific change requested and the reason for the request. Provide sufficient detail for Wisconsin Medicaid to determine the medical necessity of the requested covered PC service.

The amendment request should include the number of additional units being requested. Additional units are required to be requested in units per week (per year for PRN) on the Prior Authorization Amendment Request.

Refer to Attachment 13 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

Wisconsin Medicaid requires the use of the Prior Authorization Amendment Request when the provider amends an approved or modified PA for PC services. 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 11 and 12.

Case Sharing

Case Sharing Only for Personal Care Services

If the recipient requires more PC services than one provider can deliver, the provider may case share to meet the recipient's needs for a PCW. It may be convenient for the agencies involved if the agency planning to provide most of the PC services for the recipient completes the PCST. The provider that completes the PCST is responsible for *coordinating and leading* the case sharing activities; however, each agency is required to complete and submit its own PA and amendment requests.

If the recipient requires more PC services than one provider can deliver, the provider may case share to meet the recipient's needs for a PCW.

When screening the recipient for PC services to be provided by more than one provider, the screener is to complete the PCST based on the recipient's comprehensive weekly needs for the assistance of a PCW. The screener must not include assistance provided in or out of the home by informal supports or unpaid caregivers. Only one provider is permitted to complete the PCST (either the Web-based or paper PCST) for the recipient. Providers sharing the case should develop a system to share required information needed for each provider to submit their PA request. Information needed by each provider includes the Full PCST.

Wisconsin Medicaid PA requires each provider sharing the case do one of the following:

- Check "case share" on the PCST Summary Sheet when completing the Web-based PCST and include on the PA/RF the names of the other agencies sharing the case.
- Check "case share" in paper PCST Element 40 and include in Element 40 the names of the other agencies that are sharing the case.

Each provider needing travel time should separately add weekly units of travel time to its PA/RF for the recipient.

Combined Units Requested Are Less Than or Equal to the Number of Units Allocated

When sharing a case for which the combined number of units requested by all providers is less than or equal to the number of units allocated by the PCST, Wisconsin Medicaid requires *each* provider to submit the following documents:

- The PA/RF including:
  - ✓ The number of units per week the agency will provide.
  - ✓ The number of units per year of PRN the agency will provide.
  - ✓ The combined number of units to be provided by *all* case sharing providers.
- The Personal Care Prior Authorization Provider Acknowledgement Form.
- A copy of the PCST Summary Sheet report.
- The staffing schedule, including the days of week and times of day that each agency will provide care. Providers may use Element 15 of the Personal Care Addendum to record the staffing schedule.
- The POC.

Combined Units Requested Are Greater Than the Number Allocated

Wisconsin Medicaid PA requires each provider sharing the case to submit the following documents when the combined number of units requested exceeds the number of units allocated by the PCST:

- The PA/RF including:
  - ✓ The number of units per week the agency will provide.
  - ✓ Then number of units per year of PRN the agency will provide.

- ✓ The combined number of units to be provided by *all* case sharing providers.

- The Personal Care Prior Authorization Acknowledgement Form.
- A copy of the Full PCST Report.
- The completed Personal Care Addendum.
- The POC.
- Supporting documentation, as directed in the PCST instructions.

Physician Orders for the Shared Case

Wisconsin Medicaid PA requires that the physician orders contain the combined number of hours reflecting the recipient's need for PC services by a PCW and the number of hours that each provider will be providing care. The number of physician-ordered hours of PC services are then to be shared among the providers on the case. For example, if the PCST allocates 196 units per week for the recipient and providers "A" and "B" are to share the recipient's case, the physician orders for providers "A" and "B" are to be written as follows:

"PCW services 49 hours per week. Provider 'A' to provide cares for 4 hours per day, 7 days per week. Provider 'B' to provide cares for 3 hours per day, 7 days per week."

Amendment

When it is necessary to amend PA for a shared case, only as many providers as needed should prepare amendments requesting additional units. See the "Prior Authorization Amendments" section of this *Update* for required documentation.

Case Sharing Personal Care Worker and Home Health Aide Services

Wisconsin Medicaid requires the PCST screener to do the following only when the provider is case sharing PCW and home health aide services:

- Either check "case share" on the PCST Summary Sheet when completing the Web-based PCST and include on the PA/RF the names of the other agencies sharing the case or, when using the paper PCST, check "case share" in Element 40 and include the names of the other agencies that are case sharing.
- Submit the Personal Care Addendum with specific attention paid to Element 15.
- Submit the POC, which includes the orders for PC services.

If a case is shared with a home health agency providing home health aide visits, the home health agency is expected to include routine PC tasks in addition to medically oriented tasks, thereby lessening the need for PCW activity.

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 agency listed in the Basic Information page of the Web-based PCST.

Upon the official request for a screen transfer, the provider with control of the electronic screen is required to transfer the screen without delay. Failure to transfer the screen immediately could affect the recipient's access to care. The provider controlling the electronic screen does not have the authority to interfere with a Wisconsin Medicaid recipient's access to PC services from another provider.

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 agency listed in the Basic Information page 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. Instructions on how to transfer the PCST are available in the "HELP" function of the Web-based PCST.

Provider Questions

Providers with questions may 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

TABLE OF CONTENTS
Attachments

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.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11133A (05/07)

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 must 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.

Wisconsin Medicaid requires persons who are requesting authorization for personal care services to complete and submit the Personal Care Screening Tool (PCST) as instructed. 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 the 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 (PC) services. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services. If more space is needed than is provided in the comment section, include the additional information on the Personal Care Addendum, HCF 11136 (09/06). 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 directed by Medicaid personal care policy 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 in number 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 (IADL), medically oriented tasks (MOT), and the recipient's needs for personal care worker (PCW) assistance with these activities. The screener may not include services provided to the applicant by informal, unpaid supports such as family or friends. Whether the provider is using the Web-based or paper PCST, the PCST must be completed based on a face-to-face evaluation of the individual in his or her home. Only an authorized Adult Long Term Care Functional Screen (LTC FS) screener or agency-designated registered nurse (RN) may complete the PCST. 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 should be based on the authorized LTC FS 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 PCW 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 ADL 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 on at least a weekly basis. If assistance is needed at least weekly, 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 that represents the level most often needed.

When completing the frequencies in Elements 25-34 and 38, the screener should enter frequencies that represent only the PCW services that the provider will provide. When one or more agencies will be sharing the case, the screener should enter frequencies that represent only the PCW services the case-sharing providers will provide.

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) and the child's age falls within the stated range, the "age appropriate" response should be selected. If it is determined that the task requires more assistance than an adult would typically provide to a child of that age, *and* the weekly number of units allocated do not meet the total needs, submit the following to Wisconsin Medicaid for nurse consultant review:

- An explanation in the comment section for the reason that more assistance is needed with that ADL.
- The Personal Care Addendum, HCF 11136 (including the plan of care [POC]).

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

The Web-based Personal Care Screening Tool (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 the paper and the Web-based PCST formats. The authorized screener should refer to the paper PCST and to the PCST instructions for complete details. The responses selected when completing the Web-based PCST should not be different from those that would be selected if the authorized screener were to complete the paper PCST.

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

SCREENING INFORMATION

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

Element 1b — Telephone Number
Enter the telephone number when submitting the paper PCST.

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

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

Element 3b — Qualifications — Screener
Check the box identifying the screener's qualifications.

APPLICANT INFORMATION

Element 4 — Name — Applicant
Enter the last name, first name, and middle initial of the Medicaid applicant being screened 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 home.

Element 13 — Medical Insurance
Check all appropriate boxes to indicate the type(s) of insurance the applicant holds. *The applicant's Wisconsin Medicaid identification number is required when submitting a request for prior authorization.*

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 applicant. 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 Numbers — Responsible Party (Optional)
Enter the responsible party's telephone number(s) and best time(s) to call.

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 of his or her residence. If "Yes" is checked, enter the number of days per week that 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 personal 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, applying lotion to skin, and routine catheter care.

Bathing includes all transfers related to bathing. Examples of transfers include the following:

- Applicant needs to be physically transferred to a shower 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 PCW assistance is needed with bathing. Do not count days in which unpaid caregivers will be providing the care, or when care is provided outside of the home.

Examples

A. Applicant is able to bathe him- or herself 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 herself without any assistance from another person.

B. Applicant is able to bathe him- or herself in the shower or tub but requires the presence of another person intermittently for supervision or cueing.
- Applicant needs intermittent 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 the person cueing can leave.
- Applicant needs occasional reminders to stay on task.
- Applicant requires supervision intermittently to ensure personal safety.

C. Applicant is able to bathe him- or herself 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 herself. The caregiver is required to be continually present. If continuous cues were not provided, the caregiver would be required to physically assist with the bath.
- Applicant requires continual presence of another person and cannot be left alone as the applicant is confused and attempts to climb out of the 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 and provide routine care of an indwelling catheter.

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 five or younger.
- Child is five years old or younger.

Element 26 — Dressing

"Dressing" means the ability to dress and undress (with or without an assistive device) as necessary. This 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.

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 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 unpaid caregivers will be providing the care, or when care is provided outside of the home.

Examples

Upper Body

A. Applicant is able to dress upper body without assistance or is able to dress him- or herself 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 herself, but requires the 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 the blouse and adjust the collar.
- Applicant requires cueing/instructing to fasten buttons on front of shirt.

C. Applicant is able to dress upper body by him- or herself, 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 dressing the upper body, but can dress him- or herself. The applicant requires the full attention of the caregiver throughout the dressing activity. If continuous cues were not provided, the caregiver would be required to physically assist with dressing the upper body.

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

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

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

Lower Body

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

B. Applicant is able to dress the lower body by him- or herself, but requires the presence of another person intermittently for supervision or cueing.
- Applicant can dress the lower body independently but needs to be reminded intermittently by another person to button and/or zip pants.
- Applicant only needs intermittent 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 the lower body by him- or herself, 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 the lower body, but can dress him- or herself. The applicant requires the full attention of the caregiver throughout the dressing activity. If continuous cues were not provided, the caregiver would be required to physically assist with dressing the lower body.

D. Applicant needs partial physical assistance to dress the 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 the lower body.
- Applicant needs total assistance with dressing the lower body and is not able to effectively assist.

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

Prosthetics, Braces, Splints, and/or Anti-Embolism Hose
- Select "yes" if applicant needs assistance with placement or removal of a prosthetic, brace, splint, and/or anti-embolism hose. If the applicant does not need assistance, select "no." Do *not* check "yes" for if the applicant needs assistance with placement or removal of any of the following items: hearing aids, eyeglasses, or dentures.
- Indicate the number of days per week PCW assistance is needed with placement and/or removal of a prosthetic, brace, splint, and/or anti-embolism hose. Do not count days and times of day in which unpaid caregivers will be providing the care, or when care is provided outside of the home.

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, and oral or denture care).

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

Examples

A. Applicant is able to groom him- or herself, 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 the task.
- Applicant can groom him- or herself with specially adapted utensils.

B. Applicant is able to groom him- or herself, 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 herself.
- Applicant needs to be supervised intermittently to ensure proper completion of tasks.

C. Applicant is able to groom him- or herself, but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- Applicant needs constant cueing to complete all tasks related to grooming, but can groom him- or herself. The caregiver is required to be continually present. If continuous cues were not provided, the caregiver would be required to physically assist with grooming.

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

E. Applicant needs partial physical assistance to groom him- or herself.
- Applicant is able to brush teeth and apply deodorant, but needs assistance combing hair and shaving.
- Applicant is able to partially complete the task, but requires assistance to fully complete grooming.
- Applicant is able to initiate tooth brushing, but is not able to effectively complete the task without the 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 five or younger.
- Child is five 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 exclusively via tube feedings or intravenously, select response "0." If a recipient is fed orally *and* via tube feedings, select the most appropriate response A through G (also complete daily tube feedings under Element 34, as appropriate). For children age three 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 unpaid caregivers will be providing the cares or when care is provided outside of the home. For example, an applicant requires partial feeding at lunch and is in a day program for five days per week; because PC may not be provided outside of the home, 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 if the applicant receives nutrition only through tube feedings or intravenously and is not fed orally.

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

B. Applicant is able to feed him- or herself, but requires the presence of another person intermittently for supervision or cueing.
- Applicant is able to feed him- or herself, 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 needs physical assistance at meal time to cut meat, arrange food, butter bread, etc.
- Applicant needs assistance to cut meat, arrange food, or set up adaptive utensils.

D. Applicant is able to feed him- or herself, but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- Applicant needs to be constantly supervised for inappropriate behaviors while eating, but can feed him- or herself. The applicant requires the full attention of the caregiver throughout the eating activity. If continuous supervision was not provided, the caregiver would be required to physically assist with eating.

E. Applicant has a recent history of choking or the potential for choking, based on documentation.
- Applicant needs to be constantly 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 him- or herself for a short period of time before being no longer able to do so. Assistance is needed to complete eating.
- Applicant is able to drink from an adapted cup by him- or herself, but requires someone to feed him or her solid foods.

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 three or younger.
- Child is three years old or younger.

Element 29 — Mobility in the Home
"Mobility in the home" means the ability to move between locations (i.e., ambulate) 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 of the home.*

Select the response, 0 or A-E, that best describes the level of function the applicant possesses when moving between locations in the home, with or without help from an assistive device. Assistive devices include, but are not limited to, canes, crutches, walkers scooters, and wheelchairs. If the applicant remains bedfast, select response "0." For children age 18 months or younger, select response "E." 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 unpaid caregivers will be providing the care, or when care is provided outside of the home.

Examples
0. Applicant remains bedfast.
- Check this box only if the applicant remains bedfast and does not get out of bed.

A. Applicant is able to ambulate by him- or herself.
- 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 herself, but requires presence of another person intermittently for supervision or cueing.
- Applicant needs to be reminded to stand up straight when using a walker.
- Applicant needs to be cued to move a wheelchair to a specific location.

C. Applicant is able to ambulate by him- or herself, but requires the constant presence of a PCW to provide immediate physical intervention.
- Applicant needs constant supervision, but does not need physical assistance with ambulation. The applicant requires the full attention of the caregiver throughout ambulatory activities. If continuous supervision were not provided, the caregiver would be required to provide physical assistance with mobility.

D. Applicant needs physical help from another person.
- Applicant needs physical assistance with moving a manual wheelchair within his or her home.
- Applicant needs physical assistance from one person plus a gait belt to assist with ambulation.
- Applicant needs hands-on physical assistance when ambulating.

E. 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 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.

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.

When toileting assistance is needed *only* for the bowel program, the screener should indicate assistance needed with the bowel program in Element 34, and not in the toileting section.

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

Examples

A. Applicant is able to toilet him- or herself 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 herself 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 herself.
   - Applicant requires cueing/instruction to pull his or her pants up after toileting.
   - Applicant needs to be intermittently supervised while in the bathroom to ensure proper completion of toileting.

C. Applicant is able to toilet him- or herself 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, but can toilet him- or herself. The applicant requires the full attention of the caregiver throughout the toileting activity. If continuous cues were not provided, the caregiver would be required to physically assist with toileting activities.

   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 two out of the six toiletings. 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 a personal hygiene product (such as Depends or a feminine hygiene product.)
   - Applicant has stress incontinence and needs physical help changing a personal hygiene product.

   When estimating frequency, if the applicant is both toileted and provided incontinence care 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 two out of the six toiletings. 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 care 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 two out of the six toiletings. This would be totaled as four episodes of toileting and two episodes of incontinence.

F. Applicant needs physical help from another person to empty an 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 an ostomy or catheter bag. Do not count episodes in which the PCW will not be needed to provide the care.

G. Applicant's ability is age appropriate for a child age four or younger.
- Child is four 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, and toileting.

Select the response, A-G, that best describes the level of function the applicant possesses when transferring. For children age three 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 how many days per week PCW assistance with transferring is needed. Do not count days in which unpaid caregivers will be providing the care or when care is provided outside the home.

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

B. Applicant is able to transfer him- or herself, 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 a fractured foot.

C. Applicant is able to transfer him- or herself, 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 requires constant supervision when transferring, but is able to transfer him- or herself. The applicant requires the full attention of the caregiver throughout the transfer activities. If continuous supervision was not provided, the caregiver would be required to physically assist with transfers.

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

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 three or younger.
- Child is three years old or younger.

MEDICALLY ORIENTED TASKS (MOTs)

Element 32 — (Part I) Medication Assistance
Select the option that best describes the applicant's need for assistance with his or her medication(s). Medication assistance includes assistance with oral medications, topical patches, eye drops, ear drops, nasal spray, inhalers, medications administered via a gastrostomy tube, and suppositories not related to a bowel program. When assistance is needed with the application of legend skin care, indicate the need in Element 33. When assistance is needed with nebulizer treatments, indicate the need in Element 34.

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

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 the frequency per day and days per week each task will be performed by a PCW. If the frequency per day varies, indicate the higher frequency. Do not count days in which other unpaid caregivers will be providing the care or when care is provided outside of the home.

Glucometer Readings. Allowed only when medical condition 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 does not support the need for assistance of a PCW.

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. If the applicant has more than one prescription ointment, indicate the one that occurs most frequently. Document other prescription ointments on the comment line. Prescription ointments related to wound care should be indicated in Element 34 under wound care.

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 RN is 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 the frequency per day and days per week each task will be performed by a PCW. Do not count days in which unpaid caregivers will be providing the care, or when care is provided outside of the home.

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 PCW to provide the delegated tasks identified in this element *and* additional time is being requested for those delegated tasks. Include the Personal Care Addendum, HCF 11136 (05/07), the POC, 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 days 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 days 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 care 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. 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. Assistance with a bowel program includes assistance with related hygiene needs. 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 and requires assistance with post task hygiene.

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 normal saline and simple dry dressing (2x2) applied. The PCW will be providing wound care once per day, seven days per week. Frequency per day = 1, number of days 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 a therapy program or as a result of a therapy evaluation and ordered by the physician.* The therapist may screen the 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 therapy program developed by a therapist **must** be submitted and the activities must be included in the physician orders.

Range of Motion. Assistance with ROM that is not directly supportive of skilled therapy services. Do not select this if you have selected ROM under Therapy Program. A physician's order is required along with documentation supporting the medical necessity for ROM. The need for ROM must be directly supported by the recipient's diagnosis and medical condition (e.g., ROM to the left side due to left hemiparesis following a cerebrovascular accident). Typically, ROM that is not part of a prescribed therapy program should be able to be completed during routine ADL. If ROM is unable to be completed during routine ADL, the documentation must include information as to why it cannot be completed during these activities. Documentation must also include a description of the ROM the PCW will be assisting with (e.g., ROM to all four extremities once a day) and an explanation as to why the ROM activities cannot be completed without the physical assistance of a PCW.

For example, the applicant has chronic contractures of the upper extremities and requires passive ROM to prevent further decline. In this situation, the ROM is ordered by a physician, but it is neither directly supportive of skilled therapy services nor is it part of an active therapy program that has been prescribed by a therapist.

Note: When submitting a PA request for more time than the PCST has allocated and ROM has been selected, a Personal Care Addendum, HCF 11136 (05/07) must be completed and submitted and include a description of the ROM with which the PCW will be assisting, the reason the recipient cannot complete ROM during routine ADL, and the reason the recipient cannot complete ROM without the physical assistance of a PCW. The POC with the physician's order for ROM by a PCW must also be submitted with the PA request.

Vital Signs. Allowed only when medical condition support 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.

Other. List the medically oriented tasks prescribed by a physician that are not included among the other MOT listed in the PCST. The tasks listed in "Other" are RN-delegated tasks to be performed by a PCW. Examples could include catheter irrigations, catheter insertions, and ostomy appliance changes. Do not select "other" if applicant uses a mechanical lift for transfers. If a mechanical lift is needed for assistance with transfers, refer to Element 31 and select response "F."

Note: When submitting a PA request for MOT listed in "Other", include a detailed description of the MOT to be provided by the PCW.

INCIDENTAL SERVICES

Element 35

Services incidental to the ADL and MOT include changing the applicant's bed, laundering the applicant's bed linens and personal clothing, care of eyeglasses (also contact lenses) and hearing aids, light cleaning in essential areas of the home used during PC 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 ADL and MOT will be performed by the PCW.

BEHAVIORS AND MEDICAL CONDITIONS

Element 36 — Behaviors

Indicate if the applicant exhibits more often than once per week behavior that makes ADL tasks more time consuming for the PCW to complete. If "Yes" is checked, list the behavior(s) and describe how the behavior(s) make the ADL and MOT tasks more time consuming for the PCW to complete.

Examples

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

Element 37 — Medical Conditions

Indicate if the applicant has any medical conditions that make ADL and MOT tasks 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 increases the amount of time for the PCW to complete the ADL and MOT 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 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.

PRO RE NATA, INCLUDING MEDICAL APPOINTMENTS

Element 39 — Pro Re Nata Including Time to Accompany Applicant to Medical Appointments

Time needed for PRN includes time to accompany the applicant to medical appointments and/or time for short duration episodes of acute need for PC services. Indicate if PRN is needed for a PCW to accompany the applicant to medical appointments and/or to provide PC services during short duration episodes of acute need for PC services.

BILLING PROVIDER INFORMATION (PAPER PCST ONLY)

Element 40 — Name — Billing Provider

Enter the name of the Medicaid-certified provider billing services provided to the recipient. Providers sharing the case are required to indicate that the case is shared and to include on the PA/RF the names of the agencies sharing the case. Check the box to indicate that the applicant will be served by other providers under a case-sharing arrangement.

Element 41 — Billing Provider's Provider ID Number

Enter the Medicaid-certified billing provider's provider identification number.

Element 42 — Address — Billing Provider

Enter the billing provider's address, including street, city, state, and ZIP code.

SIGNATURE (PAPER PCST 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 PCST 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 provider identification number.
- Case sharing arrangements. (Providers sharing the case are required to indicate that the case is shared and to include on the PA/RF the names of the agencies sharing the case.)

ATTACHMENT 2
Personal Care Screening Tool (PCST)

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

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11133 (05/07)

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

1a. Name — Screening Agency

1b. Telephone Number

2. Screen Completion Date

3a. Name — Screener

3b. Qualifications — Screener ❑ Registered Nurse ❑ Certified Adult LTC Functional Screener ❑ Other

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

17. Responsible Party Contact Type (Optional)

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

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

19. Telephone Number(s) — Responsible Party (Optional)
Home:
Work:
Cell:
Best time to call:

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

21. Comments (Optional)

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

Does the applicant regularly 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 personal 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 includes dormitory, convent, or other communal setting.
- ❑ With Live-in Paid Caregiver(s) includes service in exchange for room and board.

Someone Else's Home or Apartment
- ❑ Family.
- ❑ Nonrelative.
- ❑ 1-2 Bed Adult Family Home (Certified) or Other.
- ❑ Paid Caregiver's Home.
- ❑ Home / Apartment for Which Lease is Held by Support Services Provider.

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

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 includes rehabilitation facility.
- ❑ Intermediate Care Facility for Mental Retardation.
- ❑ Developmental Disability Center / State Institution for Developmental Disabilities.
- ❑ Mental Health Institute / State Psychiatric Institution.
- ❑ Other Institution for Mental Disease.
- ❑ Child Caring Institution.
- ❑ Hospice
- ❑ 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) 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, applying lotion to skin, and routine catheter care. Bathing includes all transfers 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 herself in the shower or tub, with or without an assistive device.
- ❑ B. Applicant is able to bathe him- or herself in the shower or tub, but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to bathe him- or herself in 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.
- ❑ 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 five or younger.

Indicate how many days per week personal care worker 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. This 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.

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 the upper body without assistance or is able to dress him- or herself if clothing is laid out or handed to him or her.
- ❑ B. Applicant is able to dress the upper body by him- or herself, but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to dress the upper body by him- or herself, 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 partial physical assistance from another person to dress the upper body.
- ❑ E. Applicant depends entirely upon another person to dress the upper body.
- ❑ F. Applicant's ability is age appropriate for a child age five or younger.

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: _____

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 the lower body without assistance or is able to dress him- or herself if clothing is laid out or handed to him or her.
- ❑ B. Applicant is able to dress the lower body by him- or herself, but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to dress lower body by him- or herself, 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 partial physical assistance from another person to dress the lower body.
- ❑ E. Applicant depends entirely upon another person to dress the lower body.
- ❑ F. Applicant's ability is age appropriate for a child age five or younger.

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: _____

Prosthetics, Braces, Splints and/or Anti-Embolism Hose

Indicate whether or not PCW assistance is needed with placement and/or removal of a prosthetic, brace, splint, or anti-embolism hose:

❑ Yes ❑ No

Indicate how many days per week PCW assistance is needed with placement and/or removal of a prosthetic, brace, splint, or anti-embolism hose: _____

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, and oral or denture care).

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 herself, with or without the use of assistive devices or adapted methods.
- ❑ B. Applicant is able to groom him- or herself, but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to groom him- or herself, 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 herself.
- ❑ F. Applicant depends entirely upon another person for grooming.
- ❑ G. Applicant's ability is age appropriate for a child age five or younger.

Indicate when PCW assistance with grooming is needed:

❑ AM ❑ PM ❑ Both

Indicate how many days per week PCW assistance is needed with grooming: _____

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 recipient is fed orally *and* via tube feedings, select the most appropriate response A through F for the oral feedings. Complete the daily tube feedings under Element 34 as appropriate.

- ❑ 0. Applicant is fed exclusively via tube feedings or intravenously.
- ❑ A. Applicant is able to feed him- or herself, with or without use of assistive device or adapted methods.
- ❑ B. Applicant is able to feed him- or herself, but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant needs physical assistance at meal time to cut meat, arrange food, butter bread, etc.
- ❑ D. Applicant is able to feed him- or herself, but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- ❑ 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 three or younger.

Indicate the meals for which PCW assistance is needed:

❑ Breakfast ❑ Lunch ❑ Dinner ❑ None

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

Breakfast _____ Lunch _____ Dinner _____ ❑ Not Required

Comments _____

Continued

ACTIVITIES OF DAILY LIVING (Continued)

29. Mobility in the Home

"Mobility in the home" means the ability to move between locations (i.e., ambulate) 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.**

Select the response, 0 or A-E, that best describes the level of function the applicant possesses when moving between locations in the home with or without an assistive device. Assistive devices include, but are not limited to, canes, crutches, walkers, scooters, and wheelchairs.

- ❑ 0. Applicant remains bedfast.
- ❑ A. Applicant is able to ambulate by him- or herself.
- ❑ B. Applicant is able to ambulate by him- or herself, but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to ambulate by him- or herself, but requires the constant presence of PCW to provide immediate physical intervention.
- ❑ D. Applicant needs physical help from another person.
- ❑ E. 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 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* and, as requested, include the frequency per day.

- ❑ A. Applicant is able to toilet him- or herself or provide his or her own incontinence care, with or without an assistive device.
- ❑ B. Applicant is able to toilet him- or herself 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 herself 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.

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

  _____Estimated 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.)

  _____Estimated frequency per day that PCW assistance is needed with incontinence care.
- ❑ F. Applicant needs physical help from another person to empty an ostomy or catheter bag.

  _____Estimated frequency per day that PCW assistance is needed with ostomy or catheter care.
- ❑ G. Applicant's ability is age appropriate for a child age four 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 and toileting.

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

- ❑ A. Applicant is able to transfer him- or herself, with or without an assistive device.
- ❑ B. Applicant is able to transfer him- or herself, 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 herself, 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 the 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 is 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 three 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, not a PCW.
- ❑ 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 condition supports the need for ongoing, frequent 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 (Only for suprapubic catheters.)

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, the 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 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 _____

❑ **Range of Motion (Ordered by a physician, but not part of a prescribed therapy program.)**

PCW Frequency Per Day _____ PCW Days Per Week _____

❑ **Vital Signs (Allowed when medical condition supports the need for ongoing, frequent monitoring, and the physician has established parameters.)**

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 ADL and MOTs, be performed by the PCW?

Incidental services include changing the applicant's bed, laundering the applicant's bed linens and personal clothing, care of eyeglasses (also contact lenses) and hearing aides, 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 more often than once per week behavior that makes ADL and MOTs more time consuming for the PCW to complete?

❑ Yes ❑ No

If "Yes," list the behavior(s) and describe how the behavior(s) makes the ADL and MOTs more time consuming for the PCW to complete:

Continued

BEHAVIORS AND MEDICAL CONDITIONS (Continued)

37. Medical Conditions

Does the applicant have any medical conditions that make ADL and MOTs more time consuming 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 and MOTs more time consuming for the PCW to complete.

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 the PCW provide interventions? ❑ Yes ❑ No

If "Yes," list interventions:

PRO RE NATA, INCLUDING MEDICAL APPOINTMENTS

39. Pro Re Nata (PRN), Including Time to Accompany Applicant to Medical Appointments

Does the applicant need PRN for a PCW to accompany him or her to medical appointments and/or for assistance during short duration episodes of acute need for PC services?

❑ Yes ❑ No

BILLING PROVIDER INFORMATION

40. Name — Billing Provider

❑ Check if case sharing. Names — Other Agencies Sharing the Case:

41. Billing Provider's Provider ID 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
Deadlines for Submitting Prior Authorization Requests to Wisconsin Medicaid

JUNE/JULY 2007						
SUNDAY	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**SATURDAY**
17	18	19	20	21	22 Last day, 1 p.m. Central Daylight Time (CDT), that Wisconsin Medicaid will accept Prior Authorization Request Forms (PA/RFs) and amendments with paper Personal Care Screening Tool (PCST) dated 9/06.	23
24	25 First day Wisconsin Medicaid will begin accepting PA/RF and amendments with paper PCST dated 5/07.	26	27	28	29 Last day, 1 p.m. CDT, that Wisconsin Medicaid will accept PA/RFs and amendments with Web-based PCST Reports based on 9/06 instructions.	30
1	2 First day Wisconsin Medicaid will begin accepting PA/RF and amendments with Web-based PCST Reports based on 5/07 instructions.	3	4	5	6	7

ATTACHMENT 4
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 (05/07)

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, 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 Prior Authorization Provider Acknowledgement, HCF 11134, states that the *supervising registered nurse (RN)* will perform *each* of the following tasks *before* personal care (PC) 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 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 directed by Wisconsin Medicaid PC policy to Wisconsin Medicaid when requesting PA for PC 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	Provider Identification Number

Name — Recipient

Recipient Medicaid Identification Number	Prior Authorization Number

As the authorized representative of the billing provider, I will assure that the supervising RN completes the following tasks before PC 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

ATTACHMENT 5
Personal Care Addendum Completion Instructions

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

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 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 plan of care, any additional supporting materials that justify or explain the requested changes, and other documents as directed by Wisconsin Medicaid personal care (PC) 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 PC agency providing services to the recipient.

Element 2 — Provider Identification Number
Enter the Medicaid-certified PC agency's provider identification 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 Aid Usage
Enter an "X" to indicate whether or not the recipient wears a hearing aid.

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

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 PC 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 of 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 PC 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 PC 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
Enter the date that the RN completing this Personal Care Addendum signed the form.

ATTACHMENT 6
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 (05/07)

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. Provider Identification 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 verbally.
- ❑ Communicates verbally 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 Aid Usage

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

If yes, what is the recipient's ability to hear with the hearing aid, 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; 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
  - ❑ Place
  - ❑ Person
  - ❑ Medications
  - ❑ Meals
- ❑ Partial or intermittent periods of disorientation in the following (Check all that apply.)
  - ❑ a.m.
  - ❑ p.m.
  - ❑ Two Hours or Less
  - ❑ Consistently
  - ❑ Inconsistently
- ❑ 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.

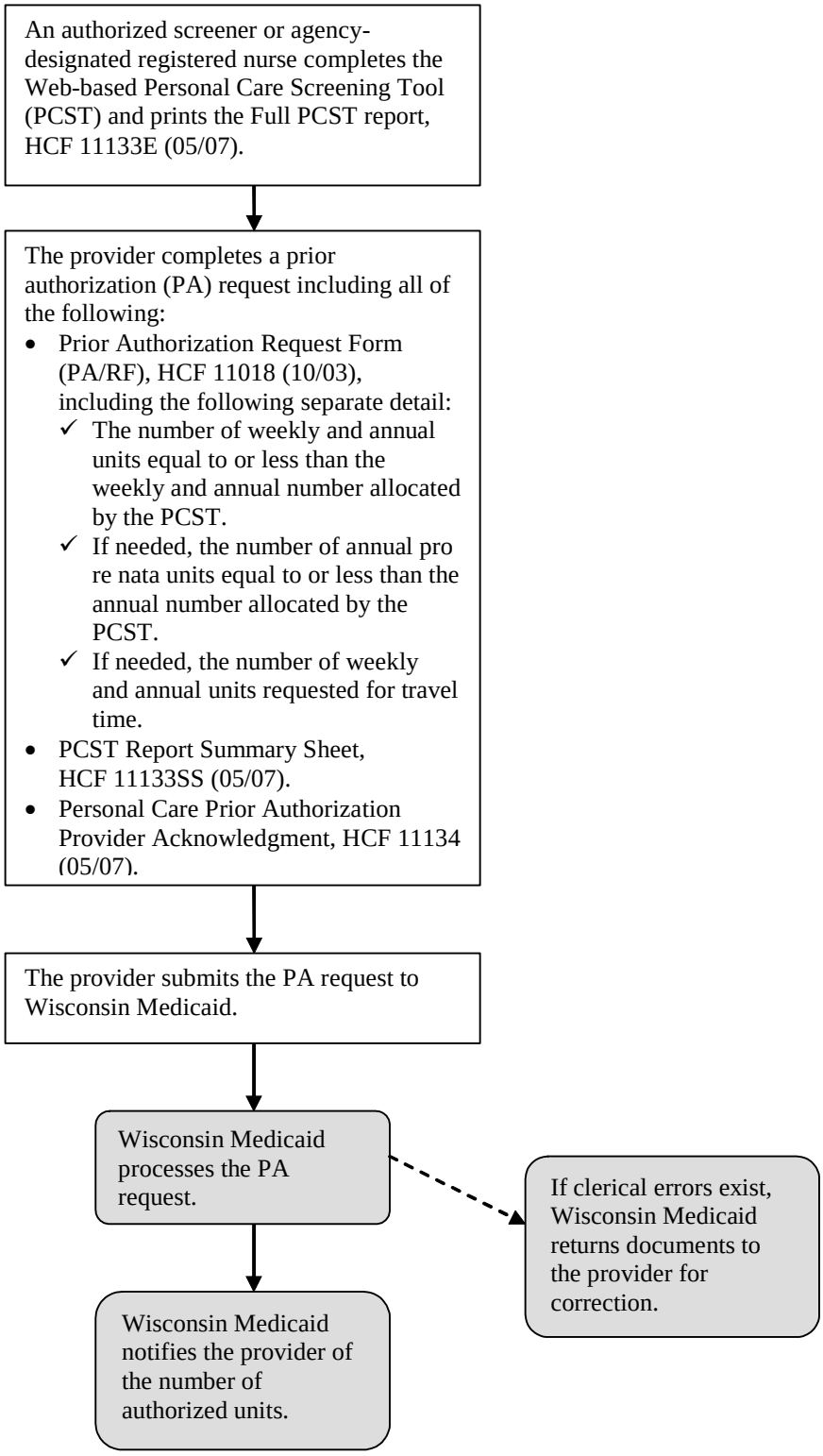
Level of Care	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Skilled Nursing Services							
Home Health Aide Services							
Personal Care Worker Services							
Case Sharing (Specify agency[ies]) _____							
Other (Specify, e.g., Home and Community-Based Waiver Services Worker) _____							

16. Other Information

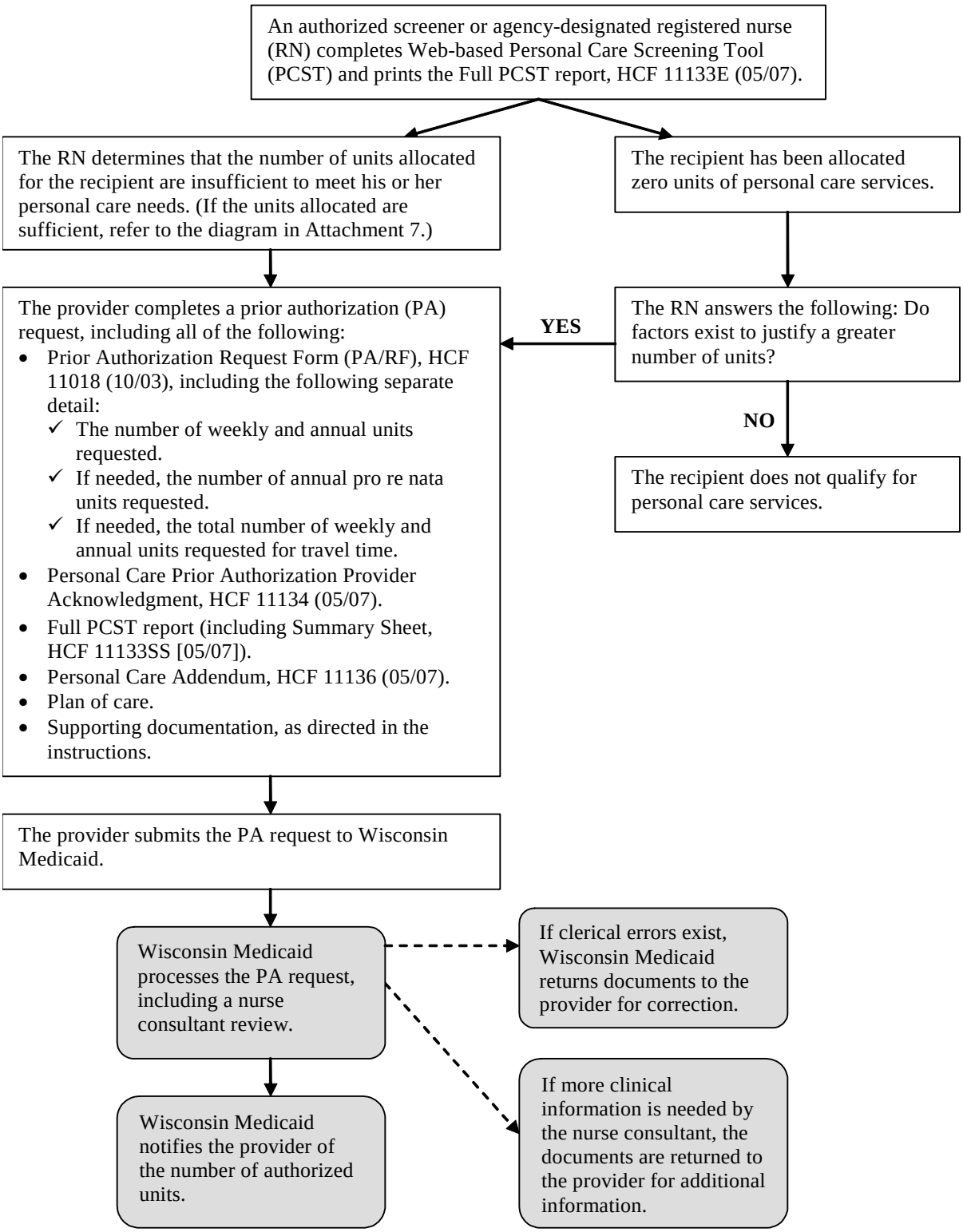
SECTION VII — SIGNATURE

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

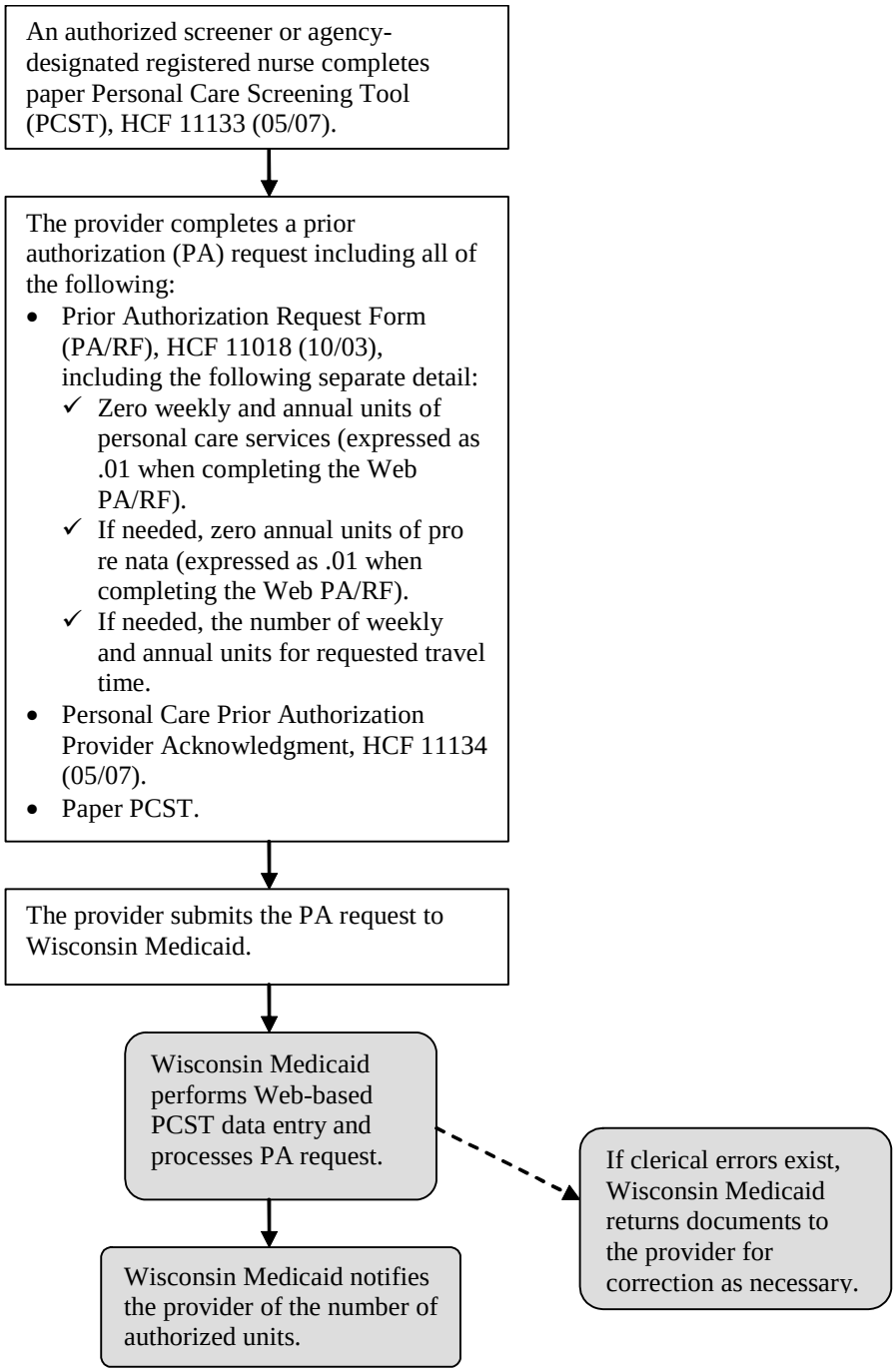
ATTACHMENT 7
Requesting Prior Authorization Using the Web-Based Personal Care Screening Tool



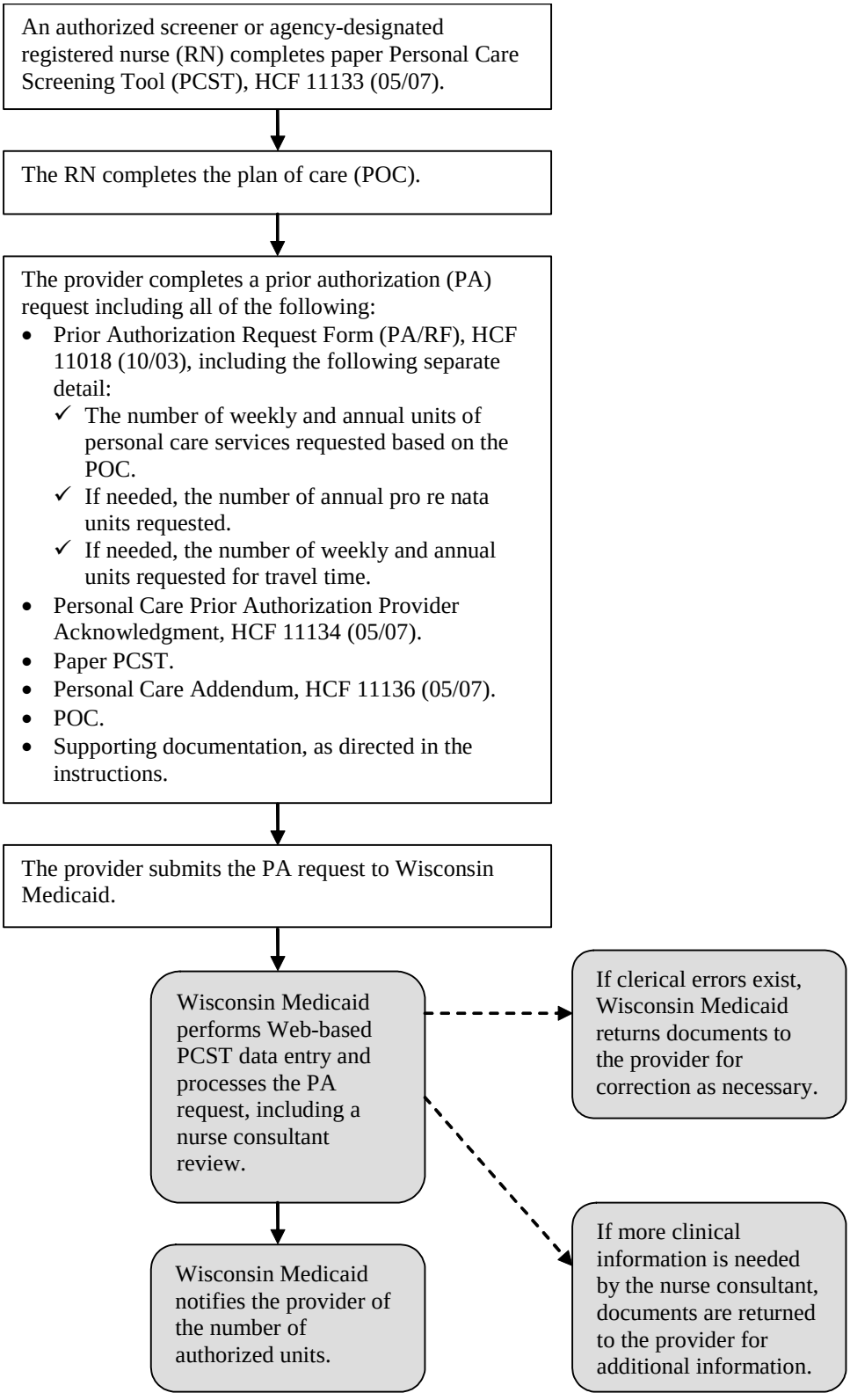
ATTACHMENT 8
Requesting Prior Authorization Using the Web-Based Personal Care Screening Tool When Insufficient Units Are Computed



ATTACHMENT 9
Basic Prior Authorization Requests Using the Paper Personal Care Screening Tool — Requesting Zero Units



ATTACHMENT 10
Requesting Prior Authorization Using the Paper Personal Care Screening Tool — Requesting Quantity Greater Than Zero



ATTACHMENT 11
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.)

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 of 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 Prior Authorization Number**
Enter the unique seven-digit PA number from the PA/RF to be amended.

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

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 Provider Identification Number**
Enter the billing provider's provider identification 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 the 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 current end 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/CCYY format.

ATTACHMENT 12
Prior Authorization Amendment Request

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

(This page was intentionally left blank.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11042 (05/07)

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 Prior Authorization Number	2. Processing Type	3. Recipient Medicaid Identification Number

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

SECTION II — PROVIDER INFORMATION

5. Billing Provider's Provider Identification 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 Identification 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 13
Submitting Prior Authorization Amendment Requests for Personal Care Services

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

Documentation package to be submitted for Prior Authorization Amendment	**Documentation included in package**
Package A	• Copy of the Prior Authorization Request Form (PA/RF), HCF 11018 (10/03). • Copy of Personal Care Screening Tool (PCST) Summary Sheet, HCF 11133SS (05/07), or the paper PCST, HCF 11133 (05/07).* • Prior Authorization Amendment Request, HCF 11042 (05/07). • Plan of care (POC).
Package B	• Copy of the PA/RF. • Copy of Web-based Full PCST report including the Summary Sheet or the paper PCST.* • Prior Authorization Amendment Request. • Personal Care Addendum, HCF 11136 (05/07). • POC. • Supporting documentation, as directed in the PCST instructions.
Package C	• Copy of the PA/RF. • Prior Authorization Amendment Request.
*Note: If using the Web-based PCST and required to create an initial screen, submit a copy of the newly created Full PCST report including the Summary Sheet. When *not* required to create an initial screen, submit the current version of the Full PCST report and Summary Sheet. If using the paper PCST and required to create an initial screen, submit a copy of the newly created paper PCST. When *not* required to create an initial screen, submit a copy of the current paper PCST.	

Reason for Requesting a Prior Authorization Amendment	Does an initial PCST need to be completed again?	Should the current PA be end-dated?	Which documents should be submitted to Wisconsin Medicaid?
To request pro re nata (PRN) time up to 96 units per year and not previously requested on the PA/RF.	Yes	No	Package A
To request additional PRN time over the amount previously approved.	No	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 for personal care worker services.	No	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	No	Package B
There is a long-term change in informal supports or the recipient's condition. More units are required.	Yes	No	Package A (If the *newly* created PCST allocates units *sufficient* to meet the recipient's needs for a PCW.)
	Yes	No	Package B (If the *newly* created PCST allocates units *insufficient* to meet the recipient's needs for a PCW.)
The PA request is discontinued.	No	Yes	Package C
To request travel time or to request additional travel time.	No	No	Package C

ATTACHMENT 14
Sample Personal Care Screening Tool Summary Sheet

(A sample “Personal Care Screening Tool Summary Sheet” is located on the following page.)

Personal Care Screening Tool

7/05/2007 - 8:38:39AM

Summary Sheet

Screen Number: Current Screen , Version Number: Current Version

Personal Care Allocation Information

Allocation Calculated By Agency: Personal Care Agency
Recipient's Information: Recipient, Ima
999 Any Street
Anytown, WI 55555
Medicaid Number: 5557799900
Date of Birth: 12/01/1980

		Annual (53 weeks)	**Weekly**
Allocation:	**ADLs / Med Oriented Tasks** (includes incidental services and added time for behaviors, medical conditions and / or seizures)	1,643.00 units	31.00 units
	Pro Re Nata (includes time to accompany to medical appointments and/or for short duration episodes of acute need for PC services)	96.00 units	N/A
TOTAL ALLOCATION (53 weeks)		1,739.00 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.

Screener: Screener, Ima **Screen Completion Date:**07/02/2007

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.

ATTACHMENT 15
Prior Authorization Request Form Samples

When completing the Prior Authorization Request Form (PA/RF), HCF 11018 (Rev. 10/03), the way in which the provider requests prior authorization for personal care units depends on a number of factors.

Following are four basic situations providers are likely to encounter. Attachments 16 through 19 illustrate how to complete the PA/RF for the situation described. The PA/RF examples are based on the Personal Care Screening Tool (PCST) allocation example:

ALLOCATION EXAMPLE

ADLs/Medically Oriented Tasks = 63 units/week for a subtotal of 3,339 annual units

Accompany to Medical Appointments (PRN) = 96 units/year

Total Annual Allocation (53 weeks) = 3,435 units

Situation 1: The registered nurse (RN) determines that the number of units allocated by the PCST is sufficient to meet the recipient's needs. *Attachment 16* of this *Update* illustrates how to request an amount up to the amount allocated by the PCST.

Situation 2: The RN determines that the number of weekly units allocated by the PCST is sufficient to meet the recipient's needs, but the number of annual pro re nata (PRN) units allocated to accompany the recipient to medical appointments is not enough. *Attachment 17* illustrates how to request an amount that includes the number of units allocated by the PCST plus the additional number of PRN units needed.

Situation 3: The RN determines that the number of weekly units is not sufficient to meet the recipient's needs and the number of annual PRN units allocated to accompany the recipient to medical appointments is sufficient. *Attachment 18* illustrates how to request an amount that includes the number of units allocated by the PCST plus the additional number of units needed.

Situation 4: The provider is completing the PA/RF to accompany the basic (no specific quantity requested) paper-based PCST. *Attachment 19* illustrates how to request zero units.

ATTACHMENT 16
Sample Prior Authorization Request Form — Situation 1

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 10/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616, or providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
		1234567

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
I.M. Provider **10 W. Williams** **Anytown, WI 55555**	**(555) 123-4567** 4. Billing Provider's Medicaid Provider Number **87654321**	**121**

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number	6. Date of Birth — Recipient (MM/DD/YY)	7. Address — Recipient (Street, City, State, Zip Code)
1234567890	**MM/DD/YY**	**609 Willow** **Anytown, WI 55555**
8. Name — Recipient (Last, First, Middle Initial) Recipient, Im A.	9. Sex — Recipient ❑ M ■ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
401.9 hypertension NOS		
13. Diagnosis — Secondary Code and Description	14. Requested Start Date	
250.02 diabetes mellitus type II (NIDDM)	**MM/DD/YY**	

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
	T1019					**12**	**Personal Care Services** **63 units/wk x 53 weeks**	**3,339**	**XXX.XX**
	T1019					**12**	**PRN Personal Care Services** **96 units/yr**	**96**	**XXX.XX**
	T1019	**U3**				**12**	**Personal Care Travel Time** **28 units/wk x 53 weeks**	**1,484**	**XXX.XX**

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

22. **Total Charges**	**XXXX.XX**

23. **SIGNATURE** — Requesting Provider	24. Date Signed
I.M. Requesting	**MM/DD/YY**

FOR MEDICAID USE Procedure(s) Authorized: Quantity Authorized:

❑ Approved _____ Grant Date _____ Expiration Date

❑ Modified — Reason:

❑ Denied — Reason:

❑ Returned — Reason:

_____ **SIGNATURE** — Consultant / Analyst _____ Date Signed

ATTACHMENT 17
Sample Prior Authorization Request Form — Situation 2

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 10/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616, or providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
		1234567

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
I.M. Provider **10 W. Williams** **Anytown, WI 55555**	**(555) 123-4567**	**121**
	4. Billing Provider's Medicaid Provider Number **87654321**	

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number	6. Date of Birth — Recipient (MM/DD/YY)	7. Address — Recipient (Street, City, State, Zip Code)
1234567890	**MM/DD/YY**	**609 Willow** **Anytown, WI 55555**
8. Name — Recipient (Last, First, Middle Initial)	9. Sex — Recipient	
Recipient, Im A.	❑ M ■ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
401.9 hypertension NOS		
13. Diagnosis — Secondary Code and Description	14. Requested Start Date	
250.02 diabetes mellitus type II (NIDDM)	**MM/DD/YY**	

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
	T1019					**12**	**Personal Care Services** **63 units/wk x 53 weeks**	**3,339**	**XXX.XX**
	T1019					**12**	**PRN Personal Care Services** **192 units/yr**	**192**	**XXX.XX**
	T1019	**U3**				**12**	**Personal Care Travel Time** **28 units/wk x 53 weeks**	**1,484**	**XXX.XX**

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

22. **Total Charges**	**XXXX.XX**

23. **SIGNATURE** — Requesting Provider	24. Date Signed
I.M. Requesting	**MM/DD/YY**

FOR MEDICAID USE Procedure(s) Authorized: Quantity Authorized:

❑ Approved _____ Grant Date _____ Expiration Date

❑ Modified — Reason:

❑ Denied — Reason:

❑ Returned — Reason:

_____ **SIGNATURE** — Consultant / Analyst _____ Date Signed

ATTACHMENT 18
Sample Prior Authorization Request Form — Situation 3

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 10/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616, or providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
		1234567

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
I.M. Provider **10 W. Williams** **Anytown, WI 55555**	**(555) 123-4567** 4. Billing Provider's Medicaid Provider Number **87654321**	**121**

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number	6. Date of Birth — Recipient (MM/DD/YY)	7. Address — Recipient (Street, City, State, Zip Code)
1234567890	**MM/DD/YY**	**609 Willow** **Anytown, WI 55555**
8. Name — Recipient (Last, First, Middle Initial) **Recipient, Im A.**	9. Sex — Recipient ❑ M ■ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
401.9 hypertension NOS		
13. Diagnosis — Secondary Code and Description	14. Requested Start Date	
250.02 diabetes mellitus type II (NIDDM)	**MM/DD/YY**	

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
	T1019					**12**	**Personal Care Services** **77 units/wk x 53 weeks**	**4,081**	**XXX.XX**
	T1019					**12**	**PRN Personal Care Services** **96 units/yr**	**96**	**XXX.XX**
	T1019	**U3**				**12**	**Personal Care Travel Time** **28 units/wk x 53 weeks**	**1,484**	**XXX.XX**

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

22. **Total Charges** **XXXX.XX**

23. **SIGNATURE** — Requesting Provider	24. Date Signed
I.M. Requesting	**MM/DD/YY**

FOR MEDICAID USE Procedure(s) Authorized: Quantity Authorized:

❑ Approved _____ Grant Date _____ Expiration Date

❑ Modified — Reason:

❑ Denied — Reason:

❑ Returned — Reason:

_____ **SIGNATURE** — Consultant / Analyst _____ Date Signed

ATTACHMENT 19
Sample Prior Authorization Request Form — Situation 4

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 10/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616, or providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
		1234567

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
I.M. Provider **10 W. Williams** **Anytown, WI 55555**	**(555) 123-4567**	**121**
	4. Billing Provider's Medicaid Provider Number **87654321**	

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number	6. Date of Birth — Recipient (MM/DD/YY)	7. Address — Recipient (Street, City, State, Zip Code)
1234567890	**MM/DD/YY**	**609 Willow** **Anytown, WI 55555**
8. Name — Recipient (Last, First, Middle Initial)	9. Sex — Recipient	
Recipient, Im A.	❑ M ■ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
401.9 hypertension NOS		
13. Diagnosis — Secondary Code and Description	14. Requested Start Date	
250.02 diabetes mellitus type II (NIDDM)	**MM/DD/YY**	

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
	T1019					**12**	**Personal Care Services** **0 units/wk x 53 weeks**	**.01**	**XXX.XX**
	T1019					**12**	**PRN Personal Care Services** **0 units/yr**	**.01**	**XXX.XX**
	T1019	**U3**				**12**	**Personal Care Travel Time** **28 units/wk x 53 weeks**	**1,484**	**XXX.XX**

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

22. **Total Charges**	**XXXX.XX**

23. **SIGNATURE** — Requesting Provider	24. Date Signed
I.M. Requesting	**MM/DD/YY**

FOR MEDICAID USE

Procedure(s) Authorized:

Quantity Authorized:

❑ Approved

_____ Grant Date

_____ Expiration Date

❑ Modified — Reason:

❑ Denied — Reason:

❑ Returned — Reason:

_____ **SIGNATURE** — Consultant / Analyst

_____ Date Signed