Clinical Policy: Personal Care Worker Services

Reference Number: WI.CP.MP.500 Coding Implications
Date of Last Revision: 2/26 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The purpose of this policy is to outline how the plan will consistently and effectively authorize personal care worker services in accordance with State regulations and clinical guidelines established by the MCO.

Policy/Criteria

I. It is the policy of MHS to authorize personal care worker (PCW) services for members meeting the medical necessity/ clinical criteria for the Medicaid covered service. Personal care services are medically oriented tasks (MOTs) related to assisting a recipient with activities of daily living necessary to maintain the recipient in his or her place of residence in the community. The services shall be provided upon written orders of a physician by a provider certified under DHS 105.1, by a personal care worker employed by the provider or under contract to the provider who is supervised by a registered nurse according to a written plan of care with an authorization duration no longer than 6 months. The personal care worker is limited to performing only those tasks and services as assigned for each recipient and for which he or she has been specifically trained.

II. Procedure

The clinical review for PCW services will ensure that all services being requested are a State approved, Personal Care Worker service and time requested are appropriate and are supported by the clinical documentation.

III. New Requests

A. Required forms are:
   1. MHS Prior Authorization Request Form – *Outpatient Medicaid Prior Authorization*
   2. Current signed Home Health Certification and Plan of Care (Attachment B-HCFA Form 485)
      a. Valid for 60 days per CMS 42 CFR 409.43
   3. Wisconsin Medicaid Personal Care Screening Tool (PCST) (Attachment C-HCFA Form 11133 completed by supervisory RN
   4. Ordering provider office notes within the last 3 months documenting the diagnosis, deficits/ weakness or other physical limitations indicating the need for PCW service.
      a. Documentation of the status of the deficit e.g. fixed and will not improve with additional therapies or temporary and able to be addressed with other modalities.
      b. All members require a completed PT/OT evaluation unless documentation states deficit could not be improved with therapy.

5. Documentation of therapy (as applicable) including anticipated duration of deficit, potential for resolution with assistive devices or durable medical equipment (DME) and a minimum of 6 weeks of therapy notes, using the DME or assistive device, if applicable.
6. If the member has identified DME needs, the DME must be present at the time of the PNA.

B. Travel Time- If travel time is requested, include appropriate documentation (see section "PCW Travel Time")
C. Newly enrolled member continuity of care requirements apply
D. Personal Needs Assessment (PNA) to be performed as per the following protocol.
   1. Upon receipt of new referrals, change in member condition or at the time of renewal, the PCW provider will request a PNA be performed by a contracted provider.
   2. PNA is referred to a provider who is not affiliated with the servicing PCW agency of the affected member.
   3. PNA is documented on the Wisconsin Medicaid Personal Care Screening Tool (PCST) or similar document.
   4. Newly enrolled with MHS/NHP will need a PNA completed within the 90-day continuity of care period during which the member will continue to receive the same level of services.
   5. The PNA will be submitted with the PCW request for review and used as part of the documentation for the authorization determination.

IV. Renewals

A. Required forms are:
   1. MHS Prior Authorization request form – Outpatient Medicaid Prior Authorization
   2. Current signed Home Health Certification and Plan of care (HCFA Form 485)
      a. Valid for 60 days per FH Admin Code DHS 105.16(1)
   3. Wisconsin Medicaid Personal Care Screening Tool (PCST) (Attachment C – HCFA Form 11134) completed by supervisory RN.
   4. Prior Authorization Amendment Request Form, if applicable (HCFA Form 11042 6/03)
   5. Recent signed plan of care (POC).
   6. Relevant ordering provider office notes within the last 6 months documenting the diagnosis, deficits/ weakness or other physical limitations indicating the need for PCW service.
      a. Documentation of the status of the deficit e.g. fixed and will not improve with additional therapies or temporary and able to be addressed with other modalities.
      b. All members require a completed PT/OT evaluation unless documentation states deficit could not be improved with therapy.
   7. Documentation of PT/OT notes, if applicable.
   8. If there is no change since original request to physical limitations of the member, documentation indicating that no changes have occurred is required.
   9. Documentation of DME present at the time of assessment, if applicable.
   10. Recent PCW notes – 4 weeks required.

B. Travel Time- If travel time is requested, include appropriate documentation (see section "PCW Travel Time").
C. Failure to obtain updated Personal Needs Assessment, at least every six months, as requested by the health plan may result in the denial of authorization if it is not completed prior to the renewal date and subsequent authorization submission.

V. Post Hospitalization / Change in Condition

A. For members with current PCW authorization, who are post hospitalization, that do not require any change in services, the prior PCW authorization will resume with the previous units and services.
B. For members with a current PCW authorization, where additional PCW units are required after hospitalization, a new PCST and PNA must be completed.
    1. Agency will be responsible for submitting an updated PCST tool and PNA within fourteen (14) days of discharge from an inpatient hospital stay. PCST tool will be completed by a supervisory RN. Updated PCST and PNA will be reviewed and determination for continuation or adjustment of medically necessary PCW services will be made.
    2. Supervisory visit will be added to a current authorization if one is on file.
C. For members requiring new PCW services for post hospital discharge needs, those requests will be reviewed on a case-by-case basis. The PCW provider will be required to submit a PCST, PNA and clinical documentation to substantiate medical necessity.

VI. Liability of Relatives & Enforcement

A. Parents are responsible for care of children under 18 years unless they are themselves unable to do so.
B. Grandparents are responsible for the care of all minor children and grandchildren if the parents of grandchild is also a minor.
C. See Non-Covered Services section of this document for information related to Wisconsin Administrative Code 49.90.

VII. Ad Hoc requests for PCW adjustments prior to an expired authorization:

A. **Personal Needs Assessments (PNAs)**
    1. Ad hoc PNA may be requested on renewals in which an increase of two (2) or more hours are requested or at nurse discretion. Ad hoc evaluations will be used to clarify and provide more detailed information on the members' needs related to PCW services. The PNA will be provided at the health plan's expense.

VIII. Supervisory Registered Nurse (RN) Visits

A. Personal care providers are required to have the RN supervisor supervise the PCW at least once every 60 days. Per Wis. Admin. Code § DHS 105.17(1n)(d)1, the RN supervisory visit must be "conducted at a time when the personal care worker will be directly observed providing personal care services to the client in the client's home." During the visit to supervise the PCW, the RN supervisor may also review and evaluate the member's condition. However, the RN supervisor is not required to complete the review and evaluation of the member's condition during the same visit used to supervise the PCW.
B. Per Forward Health Topic 2464, reimbursement for supervisory visits is limited to one PCW supervisory visit every 60 days per provider, per member.
C. To allow for flexibility, supervisory visits can be scheduled every 50 – 60 days per provider, per member.

D. For exceptional circumstances, ad hoc requests for additional visits are approvable to assess the care being provided as well as provide training to the PCW provider. For reimbursement, the provider is required to document in the medical record the medical necessity for more frequent visits to supervise the PCW.

IX. PCW Travel Time

A. Travel time must be included in the PA request.
B. MHS does not have a default travel time, thus the travel time must be part of the PA request.
C. Travel time cannot be submitted by PCW workers who live in the same home as the member.
D. Requested travel time will be validated by verification of the caregiver (name and address) and client address. The requesting agency is expected to provide the necessary supporting documentation (i.e. MapQuest).
E. Travel time includes traveling to and from the recipient's residence and one of the following locations:
    1. The previous or following personal care appointment
    2. The PCW's residence
    3. The agency
F. Requests for travel time to and from the provider's office are approved as needed (submitted as an "amendment", but not prior to the time of service).
G. The information listed above is on the Forward Health website, Handbook Area: Personal Care and the Wisconsin Administrative Code. Schedule PCW visits to maximize travel time so that the service is delivered in a cost-effective manner. Bill travel time only for dates that the PCW actually provided person care services to the member.

X. Non-Covered Services

A. Under DHS 107.112(4), Wisconsin Administrative Code, Wisconsin Medicaid does not cover the following:
    1. Personal care services provided in a hospital, nursing home or in a community-based residential facility, as defined in S.50.01(1) States with more than twenty (20) beds.
    2. Homemaking services and cleaning areas not used during personal care services activities, unless directly related to the care of the person and essential to the recipient's health.
    3. Personal care services not documented in the plan of care.
    4. Personal care services not provided by a responsible relative under S.49.90, Stats.
    5. Personal care services provided in excess of 250 hours per calendar year without prior authorization.
    6. Services other than those listed in subs (1)(b) and (2)(b);
    7. Skilled nursing services, including:
        a. Insertion and sterile irrigation of catheters
        b. Giving injections
        c. Application of dressings involving prescription medication and use of aseptic techniques
        d. Administration of medication that is not usually self-administered

e. Therapy services

B. Under DHS 49.90, Wisconsin Administrative Code, the Liability of Relatives is as follows:

1. (1) the parent and spouse of any dependent person who is unable to maintain himself or herself shall maintain such dependent person, so far as able, in a manner approved by the authorities having charges of the dependent, or by the board in charge of the institution where such dependent person is; but no parent is required to support a child 18 years of age or older.
2. (2) Except as provided under the subs (11) and (13)(a), the parent of a dependent person under the age of 18 shall maintain a child of the dependent person so far as the parent sis able and to the extent that the dependent person is unable to do so. The requirement under the subdivision does not supplant any requirement under the subd.1. and applies regardless of whether the court has ordered maintenance by the parent of the dependent person or established a level of maintenance by the parent of the dependent person.
    a. (b) For purposes of this section those persons receiving benefits under federal Title XVI or under S.49.377 shall not be deemed dependent persons.
    b. (c) For the purpose of determining the ability of a parent or spouse to maintain a dependent person, the ability of a parent to support the child of his or her dependent child under the age of 18, credit granted such subch. VIII of Ch. 71 shall not be considered.
    c. (1m) Each spouse has an equal obligation to support the other spouse as provided in this chapter and support the child of the dependent person as provided under sub (1)(a)2.

XI. Pediatric Members

A. For pediatric members requesting PCW services, the following criteria must be met:

1. The member is less than 18 years of age
2. The member meets the current PCW clinical requirements, including supporting documentation from their pediatrician identifying the members deficits that would benefit from PCW support
3. Documentation of parental inability to assist with ADLs provided by the PCW benefit that are being requested for the pediatric member
4. All pediatric PCW cases to be reviewed by the medical director for medical necessity and review of any parental inability submitted in the clinical documentation.
5. Under the WI Admin code, 107.112 (4) (d) regarding non-covered services, PCW benefit is a non-covered service when provided by a responsible relative under s. 49.90 stats
    a. 49.90 WI Admin Code Liability of relatives; enforcement "1. The parent and spouse of any dependent person who is unable to maintain himself or herself shall maintain such dependent person, so far as able, in a manner approved by the authorities having charge of the dependent, or by the board in charge of the institution where such dependent person is; but no parent shall be required to support a child 18 years of age or older."

XII. PRN Time

A. PRN Time is reviewed in accordance with the Forward Health (FH) requirements and regulations contained within FH Topic #3176. Details on the documentation requirements for requesting PRN time on the PCW PA can be found on the FH Portal at www.forwardhealth.wi.gov.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
T1019	Personal Care Worker Services
99509	Registered Nurse Supervisory Visits
99499	Personal Needs Assessment

Reviews, Revisions, and Approvals	Revision Date	Approval Date
New policy creation in response to PCW program revision and approval criteria	N/A	1/25
Ad Hoc - Added language to the RN supervisory section. Added language to general policy statement about auth duration Corrected typos	3/25	3/25
Ad Hoc - Added section for Pediatric PCW members	8/25	8/25
Ad Hoc - Updated language in Supervisory RN visits section #1 to align with FH language	10/25	10/25
Annual review – formatting/grammar	11/25	11/25
Ad Hoc – formatting and additional language on PRN time added	2/26	2/26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical

practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria

set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.