



Florida Medicaid

Personal Care Services Coverage Policy

Agency for Health Care Administration



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1.0 Introduction

Florida Medicaid personal care services provide medically necessary assistance in the home or in the community, with activities of daily living (ADL) and age-appropriate instrumental activities of daily living (IADL), to enable recipients to accomplish tasks they would normally be able to do for themselves, if they did not have a medical condition or disability.

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render personal care services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.4) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) website at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent coverage limits than specified in Florida Medicaid policies.

1.3 Legal Authority

Personal care services are authorized by the following:

- Section 1861(m) of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), section 440.167
- Section 409.905, Florida Statutes (F.S.)

1.4 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid Definitions Policy.

1.4.1 Activities of Daily Living (ADL)

As defined in Rule 59G-1.010, F.A.C.

1.4.2 Babysitting

Custodial care, daycare, afterschool care, supervision, or similar childcare unrelated to the services that are documented to be medically necessary for the recipient.

1.4.3 Caretaker Relative

As defined in 42 CFR 435.4.

1.4.4 Claim Reimbursement Policy

A policy document found in Rule Division 59G, F.A.C., that provides instructions on how to bill for services.

1.4.5 Coverage and Limitations Handbook or Coverage Policy

A policy document found in Rule Division 59G, F.A.C., that contains coverage information about a Florida Medicaid service.

1.4.6 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1, F.A.C., containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.4.7 Home Health Services

Medically necessary services that can be safely provided to the recipient in their home or in the community, including home health visits (skilled nursing and home health aide services), family home health services, private duty nursing, and personal care services.

1.4.8 Independent Personal Care Provider

An individual who renders personal care services directly to recipients and does not employ others for the provision of personal care services.

1.4.9 Independent Personal Care Group Provider

An unlicensed group (agency) enrolled to provide personal care services that has one or more staff employed to perform the services.

1.4.10 Instrumental Activities of Daily Living (IADL)

As defined in Rule 59G-1.010, F.A.C.

1.4.11 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.4.12 Provider

The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

1.4.13 Recipient

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

1.4.14 Related Provider

For the purpose of this coverage policy, the term means an individual who is the aunt, brother, brother-in-law, cousin, daughter, daughter-in-law, father, father-in-law, granddaughter, grandfather, grandmother, grandson, great-grandfather, great-grandmother, half-brother, half-sister, husband, mother, mother-in-law, nephew, niece, sister, sister-in-law, son, son-in-law, stepbrother, stepdaughter, stepfather, stepmother, stepsister, stepson, uncle, or wife of the recipient.

2.0 Eligible Recipient

2.1 General Criteria

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive

Florida Medicaid recipients under the age of 21 years requiring medically necessary personal care services. Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance and Copayments

There is no coinsurance or copayment for this service in accordance with section 409.9081, F.S. For more information on copayment and coinsurance requirements and exemptions, please refer to Florida Medicaid's Copayments and Coinsurance Policy.

3.0 Eligible Provider

3.1 General Criteria

Providers must meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid personal care services.

3.2 Who Can Provide

Services must be rendered by providers meeting one of the following:

- Home health agencies licensed in accordance with sections 400.464 and 408.810, F.S., and Rule Chapters 59A-8 and 59A-35, F.A.C.
- Independent personal care providers

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers up to 24 hours of personal care services per day, per recipient, in order to provide assistance with ADLs and age-appropriate IADLs, when the recipient meets the following criteria:

- Has a medical condition or disability that substantially limits their ability to perform ADLs or IADLs and does not have a parent or legal guardian able to provide the required care
- Is under the care of a physician and has an order for personal care services as outlined in 409.905(4), F.S.
- Requires more extensive and continual care than can be provided through a home health visit
- Requires services that can be safely provided in their home or the community

For recipients requiring less than two hours of personal care services per day, please refer to the Florida Medicaid Home Health Visits Coverage Policy.

4.2.1 Parental Responsibility

Florida Medicaid covers personal care services rendered to a recipient whose parent or legal guardian is not able to provide ADL or IADL care, and to supplement care provided by parents and legal guardians. Parents and legal guardians must participate in providing care to the fullest extent possible. Providers must offer training to enable parents and legal guardians to provide care when needed and to confirm that they can safely render services without jeopardizing the health or safety of the recipient.

4.2.2 Services Provided by Independent Personal Care Providers

Personal care services provided by independent personal care providers must be:

- Supervised by the parent or legal guardian, if provided by a non-home health agency, when the recipient is under the age of 18 years
- Supervised by the recipient, or their authorized representative, if the services are provided by a non-home health agency, when the recipient is between the ages of 18 and 21 years with no legal guardian

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a

condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following:

- A skill level other than what is prescribed in the order for services and approved plan of care (POC)
- Assistance with homework
- Babysitting
- Care, grooming, or feeding of pets and animals
- Certification of the POC by a physician
- Companion sitting or leisure activities
- Escort services
- Housekeeping (except light housekeeping to make the environment safe), homemaker, and chore services
- Nursing assessments related to the POC
- Professional development training or supervision of home health staff or other home health personnel
- Respite care to facilitate the parent or legal guardian attending to personal matters
- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by related providers or caretaker relatives as defined in sections 1.4.3 and 1.4.14 of this policy, household members, or any person with custodial or legal responsibility for the recipient (except when a recipient is enrolled in the Consumer-Directed Care Plus Program)
- Services provided in any of the following locations:
 - Hospitals
 - Intermediate care facility for individuals with intellectual disabilities
 - Nursing facilities
 - Prescribed pediatric extended care centers
 - Residential facilities or assisted living facilities when the services duplicate those provided by the facility
- Services rendered prior to the development and approval of the POC
- Travel time to or from the recipient's place of residence
- Yard work, gardening, or home maintenance work

Florida Medicaid may cover some services listed in this section through a different service benefit.

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's Recordkeeping and Documentation Requirements Policy.

6.2 Specific Criteria

Providers must maintain the following, in addition to any general documentation requirements, in the recipient's file:

- Assessments completed in accordance with 42 CFR 484.55 and CFR 440.70(f)(3)-(4)
- Written orders completed in accordance with section 409.905(4), F.S.
- A POC developed in accordance with 42 CFR 484.60 and section 409.905, F.S.

Providers must include any home health services being furnished by another provider in the POC.

Providers must document the methods used to train a parent or legal guardian in the recipient's medical record.

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's Authorization Requirements Policy.

7.2 Specific Criteria

Providers must obtain authorization from the Medicaid contracted Quality Improvement Organization (QIO) every 180 days, or more frequently, if there is a change in the recipient's condition requiring an increase or decrease in authorized services.

Providers must include the following forms, incorporated by reference, and available on the AHCA website at <http://ahca.myflorida.com/Medicaid/review/index.shtml>, when requesting authorization for personal care services, as applicable:

- Parent or Legal Guardian Medical Limitations, AHCA Form 5000-3501, November 2016
- Parent or Legal Guardian Work Schedule, AHCA Form 5000-3503, November 2016
- Parent or Legal Guardian Statement of Work Schedule, AHCA Form 5000-3504, November 2016
- Parent or Legal Guardian School Schedule, AHCA Form 5000-3505, November 2016

7.2.1 Review Criteria

The QIO uses the review criteria specified in section 9.0 for the first level review.

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Claim Type

Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, incorporated by reference in Rule 59G-4.002, F.A.C.

8.3.1 Modifiers

Providers must include the following on the claim form as appropriate:

- TT Services rendered to multiple recipients in the same setting
- UF Services provided by more than one provider in the same setting

8.4 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.5 Rate

For a schedule of rates, incorporated by reference in Rule 59G-4.002, F.A.C., visit the AHCA website at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

8.5.1 Rate Adjustment for Multiple Recipients

Florida Medicaid reimburses providers for services that can be rendered during the same time period by one aide, to two or more recipients who share a dwelling space, as follows:

- One hundred percent of the Florida Medicaid rate for the first recipient
- Fifty percent of the Florida Medicaid rate for the second recipient
- Twenty-five percent of the Florida Medicaid rate for the third and subsequent recipients

9.0 Appendices

- 9.1** Review Criteria for Personal Care Services
- 9.2** Parent or Legal Guardian Medical Limitations Form
- 9.3** Parent or Legal Guardian Work Schedule Form
- 9.4** Parent or Legal Guardian Statement of Work Schedule Form
- 9.5** Parent or Legal Guardian School Schedule Form

REVIEW CRITERIA FOR PERSONAL CARE SERVICES

First level reviewers evaluate all of the following information to ensure requested services are appropriate. Reviewers will approve the frequency and duration of services that are medically necessary.

If the first level reviewer cannot determine medical necessity, or additional hours are requested, the case will be referred to a physician reviewer for final determination.

1. Service Criteria for First Level Reviewers:

All documentation submitted must substantiate the recipient's specific diagnoses and the coverage criteria specified in section 4.0. Providers must include assessments from both the personal care services provider and the treating physician.

All documentation must substantiate one of the following functional impairments:

a. Minimal functional impairment - One of the following indicators must be satisfied:

- ADLs requiring at least minimum assistance
- Ambulates with assist of person or device
- Transfers requiring at least minimum assistance

b. Moderate functional impairment - Two of the following indicators must be satisfied:

- ADLs requiring at least minimum assistance
- Ambulates with assist of person or device
- Transfers requiring at least minimum assistance

c. Maximum functional impairment - All of the following indicators must be satisfied:

- ADLs requiring total assistance
- Non-ambulatory
- Transfers requiring 1-2 person assist

d. Maximum and persistent functional impairment without available parent or legal guardian support - All of the following indicators must be satisfied:

- ADLs requiring total assistance
- Non-ambulatory
- Transfers requiring 1-2 person assist
- Treating physician must certify that all of the above impairments are present

2. Determining Service Duration

First level reviewers will determine whether the amount of services requested will be approved using the following chart:

Personal Care Task	General Time Allowances
Bathing	
Full-body Bath: Tub, shower or sponge/bed bath.	Up to 30 minutes. May rotate with partial bath based on recipient's needs
Partial Bath: A sponge bath includes, at minimum, bathing of the face, hands, and perineum.	15–20 minutes per partial bath
Dressing	
Laying out clothing, handing and retrieving clothing, putting clothes on and taking them off, including handling fasteners, zippers, and buttons.	15 minutes
Application of prosthetic devices or application of therapeutic stockings.	May add 15 minutes for applying hose and/or prosthesis
Grooming and Skin Care	
Brushing teeth, denture care, shaving, washing and drying face and hands. Applying lotion to non-broken skin.	15–30 minutes
Shampoo and comb hair, basic hair care, basic nail care.	15 minutes
Positioning	
Moving recipient to and from a lying position, turning side to side, and positioning recipient in bed.	10 minutes/every 2 hours when medically indicated
Transfers	
Moving recipient into and out of a bed, chair, or wheelchair. May include the use of assistive devices.	15 minutes/every 2 hours when medically indicated
Toileting and Maintaining Continence	
Includes transfer on or off the toilet, bedside commode, urinal, or bedpan. Includes cleaning the perineum and cleaning after an incontinent episode. Includes taking care of a catheter or colostomy bag or changing a disposable incontinence product.	15–45 minutes
Eating	
Taking in food by any method. Extra time may be allowed for preparing a special diet.	30 minutes per meal
Delegated Medical Monitoring and Activities	
Non-skilled medical tasks that are delegated to the aide by the RN, in accordance with Florida laws and practice acts. The tasks include, but are not limited to, assisting recipient with pre-poured medications, monitoring vital signs, and measurement of intake/output.	15–30 minutes day for all monitoring tasks performed

PARENT OR LEGAL GUARDIAN MEDICAL LIMITATIONS

This form must be completed by the parent or legal guardian's physician.

Date: _____

Patient's Name: _____

Physician's Name: _____

Physician's Address: _____

Physician's Telephone Number: () _____

Please describe any medical limitation or disability that the above named individual may have that would limit their ability to participate in the care of a patient with complex medical needs (e.g. lifting restrictions, developmental disorder, bed rest for pregnancy, etc.):

If limitation/disability is temporary, please document the expected timeframe for resolution.

Signature of Physician: _____

National Provider Identifier: _____

By my signature, I am allowing release of this information to be used for the purpose of determining authorization for my child.

Signature of Parent/Legal Guardian: _____

PARENT OR LEGAL GUARDIAN WORK SCHEDULE

This form must be completed by a supervisor at the place of employment.

Parent/Legal Guardian's

Name: _____

Name of Employer: _____

Address: _____

Work Schedule:

(Include work hours for each day)

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Sunday: _____

If employee works a variable work schedule, please indicate the average number of hours per week, this employee works: _____

Supervisor Name: _____

Title: _____

Telephone Number: () _____

Signature: _____

Date: _____

PARENT OR LEGAL GUARDIAN STATEMENT OF WORK SCHEDULE

This form must be completed by the parent or legal guardian.

Parent/Legal Guardian's
Name: _____

Statement of Work Schedule

Name of Employer: _____

Address: _____

Work Schedule:

(Include work hours for each day)

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Sunday: _____

Parent/Legal Guardian
Signature: _____

Date: _____ Telephone Number: (____) _____

PARENT OR LEGAL GUARDIAN SCHOOL SCHEDULE

This form must be completed by a school advisor or representative.

Parent/Legal Guardian's Name: _____

Name of School: _____

Address: _____

Current School Term: Fall Spring Summer Year: _____

Term Start Date: _____ Term End Date: _____

School Schedule:

(Include school hours for each day)

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Sunday: _____

Name of School Representative: _____

Title: _____

Telephone Number: () _____

Signature: _____

Date: _____