

# Personal Care Attendant (PCA) Payment Policy

## Policy

This policy applies to The Personal Care Attendant (PCA) Program. The PCA Program is a program available to eligible NaviCare members residing in the community. This program consists of physical assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) provided to the member by a PCA in accordance with the member's authorized evaluation completed by the NaviCare Nurse Case Manager (NCM). This is an integrated program coordinated by NaviCare, Fiscal Intermediaries, and Personal Care Management (PCM) Agencies.

The NaviCare member is the employer of the PCA and is responsible for recruiting, hiring, scheduling, educating and, if necessary, firing PCAs. If the NaviCare member is not capable of performing the duties of an employer, a Surrogate must be obtained by the member with the assistance of the Skills Trainer from the PCM Agency. The member receives an Internal Revenue Service Employer Identification Number as an employer.

The PCA Program eligibility requirements include the need for physical assistance with Activities of Daily Living and Instrumental Activities of Daily Living and that a member does not receive group adult foster care or adult foster care program services. They must also meet the PCA Program eligibility requirements.

NaviCare follows the Commonwealth of Massachusetts MassHealth Provider Manual Series – Personal Care Manual Program Regulations 130 CMS 422.000 – Revision date May 5, 2017 Transmittal Letter PCA 22 when determining eligibility for this service.

The Plan reimburses covered personal care attendant (PCA) services based on the terms of the provider's individual contract and when approved by the Primary Care Team (PCT).

Effective March 12<sup>th</sup>, 2020, in response to the State of Emergency in Massachusetts due to 2019 novel coronavirus (COVID-19), Personal Care Management Agencies agencies are permitted to provide services via telehealth to NaviCare members in accordance with the LTSS guidance issued by EOHHS. Those services are limited to:

- A Personal Care Management Agency may conduct Intake and Orientation and all forms of Functional Skills Training via telehealth (including telephone and live video) in accordance with the standards set forth in the All Provider Bulletin 289
- A Personal Care Management Agency may conduct a reassessment and/or an adjustment to an existing prior authorization for Personal Care Attendant Services via telehealth (including telephone and live video) in accordance with the standards set forth in the All Provider Bulletin 289

Additionally, the following administrative requirements will be waived or amended during the State of Emergency in accordance with the LTSS guidance:

- Personal Care Management Agency may request the continuation of an existing prior authorization prior to the end date of the existing prior authorization. Extension requests will be approved for periods up to 90 days.
- Required physician/nurse practitioner/physician assistant signatures for the purpose of approving Prior Authorization requests are waived until further notice. And clinical staff signatures for the purpose of signing Evaluations and Prior Authorization requests may be waived
- Waiver of the requirement to submit the additional documents listed on the PCA-SD form when requesting a Prior Authorization.

- The Personal Care Management Agency, however, remains obligated to determine other services the member is receiving to ensure there is no duplication of personal care services.
- The Personal Care Management agency must list the other services a member is receiving in the comments section of the PA request, including schedules of those other services and any pertinent information.

## Definitions

Activities of Daily Living (ADLs) - Those specific activities performed by a PCA to physically assist a member to transfer, take medications, bathe or groom, dress and undress, engage in passive range of motion exercises, eat, and toilet.

Administrative Proxy – The member’s legal guardian, a family member or any other person identified in the service agreement who is responsible for performing certain administrative functions related to PCA management that the member is unable or unwilling to perform

Fiscal Intermediary - An entity contracting with the Plan to perform employer-required tasks and related administrative tasks.

Functional Skills Training - Instructional services provided by a personal care agency to assist members who have obtained prior authorization for PCA services and their surrogates, if necessary, in developing the skills and resources to maximize the member’s management of personal health care, personal care services, ADLs, and activities related to the fiscal intermediary.

Holidays - January 1st, July 4th, Thanksgiving Day, December 25th.

Instrumental Activities of Daily Living (IADLs) - Those specific activities that are instrumental to the care of the member’s health and are performed by a PCA, such as meal preparation and clean-up, laundry, shopping, housekeeping, maintenance of medical equipment, transportation to medical providers, and completion of paperwork required for the member to receive personal care services.

NaviCare Nurse Case Manager – A registered nurse employed by the Plan and responsible for determining a member’s clinical eligibility for the program.

Overtime - Activity time performed by a PCA in excess of 40 hours per work-week.

Personal Care Attendant (PCA) - A person who is hired by the member or surrogate to provide PCA services.

Personal Care Attendant Services (PCA Services) - Physical assistance with ADLs and IADLs provided to a member by a PCA in accordance with the member’s authorized evaluation or reevaluation and service agreement

Personal Care Management (PCM) Agency - A public or private agency or entity under contract to provide PCM services in accordance with the PCM services contract.

Personal Care Management (PCM) Services - Services provided by a personal care management agency to a member. PCM services include intake and orientation and functional skills training.

Surrogate - The member’s legal guardian, a family member, or other person as identified in the service agreement, who is responsible for performing certain PCA management tasks that the member is unable to perform. These tasks must be described in the member’s service agreement. These PCA management tasks may include signing and submitting activity forms, hiring, firing, supervising, and otherwise directing the PCA as specified in the member’s service agreement. A member’s surrogate cannot also be the PCA or an employee or a contractor of either the member’s fiscal intermediary or the member’s PCM agency. The surrogate must live in proximity to the member and be readily available to perform the tasks described in the service agreement.

## Reimbursement

The Plan will reimburse personal care services up to the number of approved weekly hours based upon the clinical assessment and evaluation completed by the NaviCare Nurse Case Manager for members who can be appropriately cared for in the home and when all of the following conditions are met:

1. The personal care services are approved by the PCT.
2. The member's disability is permanent or chronic in nature and impairs the member's functional ability to perform ADLs and IADLs without physical assistance.
3. The member, as determined by the Care Team and PCM agency, requires physical assistance with two or more of the following ADLs:
  - mobility, including transfers;
  - medications,
  - bathing/grooming;
  - dressing or undressing;
  - range-of-motion exercises;
  - eating; and
  - toileting
4. The Plan has determined that the PCA services are medically necessary and has granted a prior authorization for PCA services.

PCA services are still reimbursable when a member elects Hospice.

## Referral/notification/prior authorization requirements

Prior authorization is required for PCA services. Please contact the member's PCT/designated navigator prior to rendering services or adding services to the care plan.

**Referral and prior authorization requirements for services delivered via telehealth are the same as services delivered on an in-person basis; as such, telehealth services to NaviCare members may require referral or prior authorization**

Issues and questions can be sent to the following email address:  
NavicarePCAmalbox@FallonHealth.org

## Billing/coding guidelines

When possible, combine all charges for the member for a given timeframe onto one claim. Services billed cannot exceed authorized weekly units.

Services must be billed with the following codes:

Personal Care Management (PCM) Billable Codes	
Code	Description
99456	Work related or medical disability examination by other than the treating physician that includes: completion of a medical history commensurate with the patient's condition; performance of an examination commensurate with the patient's condition; formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; development of future medical treatment plan; and completion of necessary documentation/certificates and report (initial evaluation of a member to determine the need and extent of the need for personal care services) (per evaluation).
99456 - TS	Work related or medical disability examination by other than the treating physician that includes: completion of a medical history commensurate with the patient's condition; performance of an examination commensurate with the patient's condition; formulation of a diagnosis, assessment of capabilities and

	stability, and calculation of impairment; development of future medical treatment plan; and completion of necessary documentation/certificates and report (code with modifier for re-evaluations)
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter (per member per month charge for intake and orientation services provided to a member who does not yet have PA for PCA services) (maximum 3 months)
T2022	Case management, per month (current PA for PCA services required for each member) (per member per month charge for functional skills training)

<b>Personal Care Attendant (PCA) Billable Codes</b>	
<b>Code</b>	<b>Description</b>
T1019	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant) (P.A.) (Use this code to bill for PCA services provided during day or night.)
T1019 – TU	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant) Special payment rate, overtime (P.A.) (Use this code and modifier to bill for premium pay for overtime.)
T1019 – TV	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant) Special payment rate, holidays (PA) (Use this code and modifier to bill for premium pay for holidays.)
T1020	Personal care services, per diem (admin task fee / interest fee).
99509 – U1	Home visit for assistance with activities of daily living and personal care (per 15 minutes) (Use to bill for PCA earned sick time.) (Current PA for PCA services required for each member.)
99509 – U3	Home visit for assistance with activities of daily living and personal care (Use to bill for PCA new hire orientation, per diem, per eligible PCA.)

Modifier 77 – Include with the service codes listed above when billing additional authorized units for a previously submitted date of service (not applicable with code T1020).

**COVID-19 Expended Telehealth billing/coding guidelines:**

Providers should bill the same procedure codes for services delivered via telehealth as appropriate for services delivered face-to-face. Services must be billed using Place of Service code “02” and Modifier 95 to designate them as being rendered via telehealth.

T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter (per member per month charge for intake and orientation services provided to a member who does not yet have PA for PCA services) (maximum 3 months)
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T2022	Case management, per month (current PA for PCA services required for each member) (per member per month charge for functional skills training)
T1020	Personal care services, per diem (admin task fee / interest fee).
99456	Work related or medical disability examination by other than the treating physician that includes: completion of a medical history commensurate with the patient's condition; performance of an examination commensurate with the patient's condition; formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; development of future medical treatment plan; and completion of necessary documentation/certificates and report (initial evaluation of a member to determine the need and extent of the need for personal care services) (per evaluation).
99456 - TS	Work related or medical disability examination by other than the treating physician that includes: completion of a medical history commensurate with the patient's condition; performance of an examination commensurate with the patient's condition; formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; development of future medical treatment plan; and completion of necessary documentation/certificates and report (code with modifier for re-evaluations)

**Service limitations:**

The Plan does not reimburse any of the following as part of the PCA program:

- Social services, including, but not limited to, babysitting, vocational rehabilitation, sheltered workshop, educational services, recreational services, advocacy, and liaison services with other agencies
- Medical services available from other providers, such as physician, pharmacy, or community health center services
- Assistance provided in the form of cueing, prompting, supervision, guiding, or coaching
- PCA services provided to a member while the member is a resident of a nursing facility or other inpatient facility
- PCA services provided to an member during the time an member is participating in a community program including, but not limited to, day habilitation, adult day health, adult foster care, or group adult foster care
- Services provided by a member's spouse, surrogate, or any legally responsible relative is prohibited from receiving payment as a PCA

**Timely filing:**

The filing limit for first-time claim submission to the Plan (claims with or without modifier 77) is 365 days from the date of service. If the contract with the Plan specifies a different time limit, that limit will apply.

Corrected claims and late time sheets must be received within 120 days from the date of the Remittance Advice Summary (RAS). The provider must follow the guidelines outlined in the Plan Provider Manual, *Claims Guidelines and Submission* sections.

**Policy history**

Origination date: 11/01/2016  
 Previous revision date(s): January 2017 – Introduced policy.  
 Connection date & details: May 2017 - Clarified timely filing language, updated the reimbursement section, and added the definition of a nurse case manager.

November 2017 – Changed timely filing from 120 to 365 days

October 2018 – Clarified services are reimbursable during hospice election.

October 2019 – Updated Policy section, clarified definitions and reimbursement.

April 2020 – Annual review. Updated Definitions. Updated Policy, Prior Authorization and Billing and Coding sections related to COVID-19 temporary telehealth coverage.

*The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.*