CHAPTER 500–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PERSONAL CARE SERVICES

– CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 516.1 change procedure code T2010 to T1001; Section 516.2 change procedure code T1001 to T1002	Sec 516 Procedure Code Correction	Sept 11, 2003	Sept 1, 2003
Form: Nursing Plan of Care – 31 days Form: Personal Care Daily Log Sheet Form: Personal Care Standards	Form Replacement		
Form: Personal Care Standards	Form Change	Oct 20, 2003	Sept 1, 2003

PERSONAL CARE SERVICES
SEC 516 PROCEDURE CODE CORRECTION
9/11/2003

Introduction: The procedure codes listed in Sections 516.1 and 516.2 were entered incorrectly.

Directions: Replace these two sections with the correct procedure codes.

Change: Section 516.1 Change procedure code T2010 to T1001; Section 516.2 Change procedure code T1001 to T1002.

PERSONAL CARE SERVICES
FORM REPLACEMENT
9/12/2003

Introduction: New forms have been created for Nursing Plan of Care – 31 days, Personal Care Daily Log Sheet, Personal Care Standards.

Directions: New forms have been inserted into manual. Print out the "Working Forms file"

Change: Replace old forms with new forms.

PERSONAL CARE SERVICES
FORM REPLACEMENT
10/20/2003

Introduction: On the Personal Care Standards form; under Personal Hygiene/Grooming, Toileting: Assistance on and off the commode, bedpan, toilet, change Partial Assistance Level II from "up to 5 minutes per day" to "up to 5 minutes per incident"

Directions: New forms have been inserted into manual. Print out the "Working Forms file"

Change: Replace old forms with new forms.

CHAPTER 500–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PERSONAL CARE SERVICES

500 INTRODUCTION

The West Virginia (WV) Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible beneficiaries. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all state and federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise by the Bureau for Medical Services (BMS).

This chapter sets forth the BMS requirements for payment of personal care services provided to eligible West Virginia Medicaid beneficiaries.

The policies and procedures set forth herein are promulgated as regulations governing the provision of personal care services by personal care providers in the Medicaid Program administered by the West Virginia Department of Health and Human Resources (DHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia.

501 DEFINITIONS

As used in the Personal Care Program**:**

Bureau for Medical Services (BMS) - The single state agency responsible for all regulations and policies for all Medicaid reimbursable services.

Employment - Competitive work of at least forty (40) hours per month that occurs in an integrated setting for which a wage at or above the federal minimum wage is received.

Job Seeking - A process of obtaining employment which may continue for no more than twelve (12) months, not necessarily consecutive, without reaching employment (as defined above); and which is indicated by documentation of registration with the individual's local job service and one of the following:

- Development of an individual job search agreement with the recipient's service provider agency; or
- Documentation of job readiness from the Division of Rehabilitation Services; or
- Documentation of participation in a TWWIIA Employment Network.

Medically Necessary - those activities indicated on the Physician's order (PAS 2000) that are determined to be needed services for clients.

Nursing Plan of Care - A service-specific and standardized document completed by a registered nurse that identifies the tasks to be provided to meet the client's assessed needs.

Disability: The definition of disability for medical purposes is the same as those used by Social Security Administration (SSA) in determining eligibility for Social Security Insurance (SSI) or Social Security Disability Insurance (SSDI) based on disability.

As used by the Social Security Administration:

Individual Age 18 or Over

An individual who is age 18 or over is considered to be disabled if he is unable to engage in any substantial gainful activity due to any medically determined physical or mental impairment, which has lasted or can be expected to last for a continuous period of not less than 12 months, or can be expected to result in death.

Individual Under Age 18

The child who is under age 18 is considered to be disabled if he/she has a physical or mental impairment which can be expected to last for at least 12 months and which severely interferes with his process of maturation. Maturation refers to skills and emotional and social development.

An Individual Under Age 18 is Not Considered a Child if He/She:

$ Is legally married, or
$ Is divorced, or
$ He/she is living in a common household with a member of the opposite sex, and they are holding themselves out of the community in which they reside, as husband and wife, or
$ He/she is over age 16 and has been emancipated by a court of law.

Blindness: To Meet the Definition of Blindness, an Individual Must Have:

$ Central visual acuity of 10/200 or less in the better eye with corrective glasses, or
$ A limited visual field of 20 degrees or less in the better eye with the use of eyeglasses.

Consideration of Medical and Social Factors in Determining Disability:

$ In determining whether or not an individual is disabled, medical and social factors and the relationship between the two must be considered.

$ If the medical information indicates that the individual has an impairment which has lasted or can be expected to last the required length of time, social factors must be examined to determine the effect of the impairment on the individual.

$ When a case is referred to Medical Review Training (MRT) for a disability decision, the worker completes form OFS-RT-1, Social Summary Outline. This form is designed to provide the social

information used by the worker to make a presumptive decision and also for the MRT to make the final disability decision.

502 PROVIDER PARTICIPATION REQUIREMENTS

Providers of Personal Care Services participating in the Medicaid program must fully meet the standards established by the Secretary of the U. S. Department of Health and Human Services, all applicable State and Federal laws governing the provision of their services, and all regulations contained herein. Providers of personal care services must meet certification standards before they can be enrolled in the Medicaid program.

503 COMPREHENSIVE AGREEMENT

In addition to the agreement on the claim form, providers of Personal Care Services shall be required to enter into a comprehensive agreement with BMS stipulating the conditions of participation. The agreement shall continue in effect until it is terminated for cause or mutual agreement of the parties.

504 PROVIDER CERTIFICATION REQUIREMENTS

Only agencies certified by the BMS may serve as personal care providers. Certification is dependent upon the agency's ability to satisfy the following performance standards:

A. Have a valid Certificate of Need (CON) and a valid license, if licensure is applicable to a said agency;

B. Have demonstrated fiscal soundness, fiscal management capability and a system that provides documentation of services and costs. Fiscal soundness must be documented indicating 2 months of operating capitol. In addition, agency must demonstrate a source of income other than sole reliance on Medicaid reimbursement for personal care services. Agencies must demonstrate a sliding fee schedule to accommodate private pay or other third party sources of payment and maintain records of invoicing and other revenue of non-Medicaid clients;

C. Document, at the time of application, the agency's experience in service delivery to the target population to be served, including the number of clients being served and geographic area. The document must include the agency's organizational chart with the names of the members on the Board of Directors and a list of staff, which includes their licensure and/or qualifications;

D. Be able to provide personnel who meet minimum criteria for providers of personal care services and who meet applicable licensure and/or other credential requirements;

E. Have appropriate insurance coverage to cover both personal injury, $100,000 per person and $500,000 per occurrence. They must produce evidence of said coverage at the time of application to BMS;

F. Have approved BMS training curriculum for personal care staff and provide an ongoing staff training program which must include OSHA blood borne pathogens training. The agency must also provide a plan of monitoring the assignments of employees providing personal care services to assure that individuals are in compliance with the training requirements and services are provided according to the plan of care and the recipient's needs are appropriately met. Documentation of a BMS approved training program must accompany the application;

G. Maintain records that indicate payments made for services are supported by documentation; that the services were authorized, and that time spent in the provision of the services to each individual recipient is documented. Services must be provided in accordance with a registered nurse's plan of care;

H. Must identify each county in which they will operate. Must have a permanent staffed office if not in each county then in 8 connecting counties and must have available a roster of trained staff available for services in each county of the provider's designated service area.

The West Virginia Specialized Family Care Medley-at-Risk Program administered by the Bureau for Children and Families, Department of Health and Human Resources, is exempt from the provisions of this section (504).

505 REQUIREMENTS FOR COUNTY OFFICE

All personal care agencies wishing to provide personal care services must meet the following requirements for all offices which cover 8 contiguous counties:

A. Have a business license issued by the state and a federal tax identification number.

B. Have a physical facility. A post office box or commercial mailbox will not suffice.

1. The facility must be located within West Virginia.
2. The facility must have at least one entrance that is handicapped accessible to the public and accessible from the street and/or parking lot. Handicapped parking must be available.
3. The physical facility must be open to the public at least 40 hours per week.
4. The facility also must contain secure space for maintaining beneficiary records.

C. Maintain a telephone that is listed under the name of the business locally, or if long distance, a toll free number for assistance. Exclusive use of a beeper number, answering service, pager, facsimile machine, car phone, cell phone or an answering machine does not constitute a primary business telephone but may be used for after hours or emergency calls.

D. Appropriate medical documentation on each individual must be kept by the Medicaid provider in the office that represents the county where services were provided and made available to the West Virginia Department of Human Resources and/or United States Department of Health and Human Services, Centers for Medicare and Medicaid Services upon request.

To meet the federal requirements of utilization review and quality control, the provider must keep a file on each Medicaid recipient for who the Department of

Health and Human Resources is billed. This file must contain original documentation supporting the medical necessity for the services provided to the recipient.

506 APPLICATION FOR ENROLLMENT AS A PROVIDER

Any agency with an approved Certificate of Need which meets the certification requirements in Section 504 is eligible to apply as a provider of personal care services. The agency must apply to BMS and is required to complete an enrollment application. Apply to:

Department of Health and Human Resources
BUREAU FOR MEDICAL SERVICES
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3707

Any agency which demonstrates compliance by its application and the required accompanying documentation then has an on-site review within 90 days of submission to ensure compliance with program rules and regulations. Upon satisfactory completion of the written application and the on-site review, the applicant is enrolled and certified as a provider of Medicaid personal care services. An agency is not permitted to provide personal care services until this process is complete.

507 STAFF QUALIFICATIONS AND TRAINING

Each provider must assure that there is adequate staff in number and qualifications to care for the number of recipients served. Staff must meet one of the following categories of qualifications:

Administrative: Any staff who performs administrative duties related to personal care services must possess experience, education, and training necessary to discharge the function of his/her position.

Nursing: Any staff that develop, review, monitor, and oversee a nursing plan of care must be currently licensed as a registered nurse in West Virginia.

Direct Care: Any staff that provides hands-on care or other services to a recipient, according to an approved nursing care plan, must be certified by an approved training program which meets the requirements of this chapter.

507.1 Documentation of Staff Qualifications

All documentation of staff qualifications, such as licenses, transcripts, certificates, references,

trainings, etc., must be maintained on file by the provider. The provider must have a review process to insure that employees providing personal care services possess the minimum qualifications outlined in this chapter. Minimum credentials must be verified for new employees, and, thereafter, annually to assure that credentials/licenses remain valid.

507.2 Basic and Annual Training Requirements

Each provider agency must have an approved basic training curriculum which prepares non-licensed staff for direct care and service. Such provider training curriculum shall be reviewed and approved by the BMS or its designee to assure that it meets the Basic Training Requirements specified in Section 507.3. An agency must comply with applicable provisions of WV Code § 15-2C-1 on Central Abuse Registry.

507.3 Basic Training Requirements

New non-licensed direct-care staff who have no training or experience must receive 8 hours of basic training before rendering care or unsupervised service to an eligible individual. Within 12 months of the beginning date of employment, the above identified individuals must receive at least 24 hours of additional training, for a total of 32 hours. The components marked with an asterisk (*) are mandatory training for the initial 8 hour basic training. The training must cover:

A *Orientation to the agency, community, and services:
B. How to work with specific populations including the elderly, persons with behavioral disorders, distinct categories of physical or cognitive disabilities;
C. Body mechanics;
D *Personal care skills including, but not limited to (a) bathing; (b) grooming; (c) feeding; (d) toileting; (e) transferring; (f) positioning; (g) ambulation; and (h) vital signs (physician's order is required in addition to this training before non-licensed direct care staff can take vital signs);
E. Care of the home and personal belongings;
F. * Safety and accident prevention;
G. Food, nutrition, meal preparation;
H. Occupational safety and health administration standards related to blood-borne pathogens;
I. *Cardiopulmonary resuscitation; and
J. First aid training.

507.4 Substitution of the Basic Training Requirements

The requirements for basic training for non-licensed direct care staff may be waived (components of Section 507.3 marked with an asterisk cannot be waived) if they meet one of the following substitution requirements:

A. Documentation of successful completion of one of the following related training courses: certified nurse aid; home health aide; homemaker aid or other institutional or home-based

skill course which has been reviewed and approved as comparable by licensed personnel of the provider agency. Documentation of completion by the training course provider must be maintained in personnel records. Provider agencies must make copies of their training records available upon request by direct care staff.

B. One year of experience with the type of population being served by the provider. Verification of this requirement must be met by written reference checks and kept in the personnel file.

C. A competency demonstration review conducted by the provider's licensed staff, a portion of which must be conducted in a supervised home-based setting. The registered nurse must document this review in the personnel file with a description of the demonstration provided, the date, and the location.

507.5 Annual In-service Training Requirement

There is no substitution for the 8 hour annual in-service requirement. In meeting this requirement, providers must consider the following:

A. Each individual providing personal care services must be provided with additional training to develop specialized skills or an opportunity to review and enhance skills or review information learned in basic training.

B. On-the-job training must be provided as needed to instruct the caregiver in specific skills or techniques for individual clients.

C. Assistance in resolving problems in particular case situations may also be used as a training opportunity.

D. A criteria and methodology for evaluating the overall job performance of each person providing personal care services must be established. The supervising registered nurse for personal care or Family Based Care Specialist in the Medley-at-Risk Program is responsible for performance evaluation of non-licensed direct care staff and must consider evaluation outcomes when developing in-service training for all staff or those individuals with skill deficiencies.

508 DISCHARGE POLICIES AND PROCEDURES

The following policies and procedures for discontinuing personal care services must be followed. Discontinuing services for a client still in need of assistance must occur only after appropriate conferences with BMS, the client and client's family. In these cases in which there is still a need for services to be provided, the conference can be a telephone call, fax, or letter. Services for a client are discontinued by a provider agency under the following circumstances:

A. When the client loses Medicaid eligibility and the client's case is closed by DHHR; services must be discontinued immediately upon notification.

B. When the provider learns of circumstances that require the closure of a case for reasons including, but not limited to, death, entry into a nursing home, or services are no longer needed. In these circumstances, the provider must notify BMS in writing and request that the client services be discontinued. Services should be discontinued upon notification;

C. When the client is noncompliant with the agreed upon plan of care, including failure to follow through with the job search agreement or failure to provide the required documentation for services outside the home. Noncompliance requires persistent actions by the client or family which negate the services provided by the agency. After all alternatives have been explored and exhausted, the provider must notify BMS in writing of the noncompliant acts and request that the client's services be discontinued. The provider must continue services for 21 days or until notified by BMS;

D. When the client or client's family threatens or abuses the personal care aide or other agency staff or creates an unsafe physical environment, i.e.... the staff's welfare is in jeopardy and corrective action has failed. The provider must notify BMS of the threatening or abusive acts or other endangering circumstances and may request that the service authorization be discontinued. Continuation of service for the 21 days is not required;

E. When a provider is unable to continue to meet the needs of a client. The provider must notify the state agency in writing and request that the client's service be discontinued or assigned to another provider. The provider must also provide written notice of discharge to the client's family at least 21 days prior to the date of discharge. During the 21 day period, BMS must assist in making appropriate arrangements with the client for transfer to another agency, institutional placement, or other appropriate care. All such arrangements must continue to assure that the eligible individual retains free and unrestricted choice of willing, qualified providers. Regardless of circumstances, the personal care provider must continue to provide services in accordance with the plan of care for the 21 days or until alternate arrangements are made by BMS, whichever occurs first.

509 RECIPIENT APPEAL PROCESS

Refer to Common Chapter 700.

510 PERSONAL CARE SERVICES

Personal care services are medically necessary activities or tasks ordered by a physician, which are implemented according to a Nursing Plan of Care developed and supervised by a registered nurse**.** These services enable people to meet their physical needs and be treated by their physicians as outpatients, rather than on an inpatient or institutional basis. Personal care services are provided in the recipient's residence, except that services may be provided outside the home when those services are necessary to assist eligible individuals obtain and retain competitive employment of at least 40 hours per month. Services are designed to assist an individual with a disability as defined by SSA program, (see Section 501) perform daily activities on and off the job that the individual would typically perform if he/she did not have a disability. Assistance is in the form of hands-on assistance,

as in actually performing a personal care task for a person. Services include those activities related to personal hygiene, dressing, feeding, nutrition, environmental support functions, and health-related tasks. Personal care services can be provided on a continuing basis or on episodic occasions. Services must be:

- Prescribed by a physician on a PAS-2000;
- Necessary to the long term maintenance of the recipient's health and safety;
- Provided pursuant to a plan of care developed by a registered nurse and periodically monitored by a registered nurse; and
- Rendered by an individual who has met the basic training requirements of this manual and is not a member of the recipient's family.

511 LOCATION OF SERVICES

Eligible individuals receive personal care services in their residence, except that services may be provided outside the home when such services are necessary to assist the eligible individual to obtain and retain competitive employment of at least forty hours per month. Locations for obtaining employment may include employment agencies, human resource offices, accommodation preparation appointments, and job interview sites. Personal care services cannot be provided in a hospital, nursing facility, ICF/MR, or any other settings in which nursing services are provided.

511.1 Personal Care/Residential Board & Care Homes (Assisted Living)

Agency care providers are agencies that provide personal care to 3 or more individuals but are not the custodial caregiver agency for those individuals. A custodial caregiver agency is one that provides room, board and other personal care type services to 3 or more individuals residing in a common residence or living arrangement. In order to avoid conflict of interest and self-referral, custodial caregiver agencies cannot be providers of, or reimbursed for personal care services rendered to their own Medicaid eligible residents.

The following is intended to clarify Medicaid policy regarding the provisions of Medicaid reimbursable personal care services in personal care or residential board and care homes and assisted living facilities:

A. Medicaid personal care services must not duplicate or replace those services for which a provider is required by law or regulation to provide.

B. Personal care homes, residential board and care homes, and homes licensed under the behavioral health 24 hour residential services, by definition, must provide a certain level of personal care services. A personal care home and a residential board and care home is defined as:

> *.... any institution, residence, or part thereof that advertised, offered, maintained or operated.... for the express or implied purpose of providing accommodations and*

personal assistance and supervision, for a period of more than twenty-four hours, to four or more persons who are dependent upon the services of others by reason of physical or mental impairment who may require limited and intermittent nursing care... WV Code §16-5D; §16-15H-2.

C. Personal assistance is defined as meaning "personal services including, but not limited to, the following: Help in walking, bathing, dressing, feeding, or getting in and out of bed, or supervision required because of the age or mental impairment of the resident." WV Code §16-5D; §16-15H-2.

D. The fee that individuals pay to residential board and care and personal care homes includes this level of personal assistance. Therefore, Medicaid will not and cannot reimburse for these services.

E. If a Medicaid certified personal care provider is requested to render services to Medicaid recipients in personal care or residential board and care homes (assisted living facility), said homes must provide a detailed itemization of all personal care services provided to recipients and an explanation of what services the home cannot provide and why additional services are required. This itemization of services must accompany the PAS-2000 assessment. Medicaid will not reimburse for personal care services that are the responsibility of the personal care home or residential board and care homes (assisted living facility) or are duplicative services.

512 SERVICES AND/OR COSTS NOT ELIGIBLE FOR REIMBURSEMENT UNDER PERSONAL CARE SERVICES

A. Room and Board Services: Room and board is defined as the provision of food and shelter including private and common living space; normal and special diet food preparation; linen, bedding, laundering, and laundry supplies; housekeeping duties and lavatory supplies; maintenance and operation of buildings and grounds including fuel, electricity, water supplies and parts, tools to repair and maintain equipment and facilities and the salaries and other costs related to the items listed above. Room and board services, as listed above, apply to those individuals and agency providers that have individuals residing in a common residence or living arrangement and for whom these individuals, or agencies representing those individuals, provide reimbursement to the provider for these services. Medicaid personal care services must not duplicate or replace services for which a provider is required by law or regulation to provide.

B. Personal care services which have not been certified by a physician on a PAS-2000 or are not in the approved plan of medically necessary care developed by the registered nurse.

C. Hours that exceed the 60 hours per recipient per month limitation that have not received prior

authorization.

D. Services that are provided by a recipient's spouse, parents of a minor child, child of an adult recipient or legal guardian who is the trustee for a trust that can be used to pay for health care of the personal care recipient, and services provided by a custodial caregiver in the absence of an approved waiver of these requirements granted by BMS.

E. Supervision and other activities that are considered normal child care appropriate for children of that age.

513 FAMILY MEMBER RESTRICTION

The following family relationships to the recipient exclude an individual from providing personal care services for purposes of reimbursement by Medicaid:

(1) Spouse
(2) Parents or stepparent.
(3) Adopted child or adoptive parent
(4) Adult sibling (including step-sibling) of a minor child
(5) Adult child of an adult recipient
(6) Adult sibling residing with adult sibling recipient
(7) Parents of an adult child.

513.1 Waiver of Family Member Restriction

In some circumstances, BMS (or its designee) may waive the restrictions on family members based on the following hardship criteria. **NOTE:** These waivers are not available to a legally responsible family member. This includes spouses of recipients, parents; stepparents, or adoptive parents of a minor child, parents of an adult child (numbers 1, 2, 3 and 7 of the family member definition).

A. **Geographic inaccessibility:** Recipients who reside in remote or extremely rural areas where access is limited by rugged terrain or natural barriers and the family member is the only individual willing to serve the recipient.

B. **Financial:** The family member providing services resigns or takes a leave of absence from a full time job to provide personal care services to the recipient.

C. **Mental Status:** The recipient's mental status is such that he/she may present a risk to anyone other than the family member providing personal care services.

513.2 Requesting a Waiver

Requests for hardship waivers must be in writing and submitted to the appropriate office as indicated below, accompanied by relevant supporting documents. Approval must be received prior to the

initiation of services. Supporting documents include, at a minimum, letters from the family member, provider agency, and nurse doing the initial assessment.

Department of Health and Human Resources
BUREAU FOR MEDICAL SERVICES
Office of Behavior and Alternative Health Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3707
Phone: (304) 558-1700

514 DETERMINATION OF MEDICAL NEED FOR PERSONAL CARE SERVICES

Each client accessing personal care services must have a completed valid PAS-2000.

514.1 Medicaid Review Team Review for Social Security Disability Determination

For persons who are applying for employment and are not SSI, or SDI eligible, the client or other representatives must request a disability evaluation through BMS by contacting the Office of Behavioral and Alternative Health Care at (304) 558-6002.

514.2 Medical Assessment – PAS-2000

A pre-admission screening assessment PAS-2000, (Attachment 2), designated by the BMS is used to certify an individual's medical need for personal care service. This medical assessment must be signed and dated by a physician, and becomes the physician's order and certification for personal care services for this individual. The assessment PAS-2000 must be completed upon application by the patient for personal care services and at least annually thereafter. In addition, a standardized Personal Care Nursing Assessment, (Attachment 6), must be completed at least once each 6 months. However, nursing assessments may be completed more often when a client's condition changes or at 90 day intervals with appropriate documentation of need.

514.3 Nursing Review of PAS-2000

Upon request for personal care services, a registered nurse must review the pre-admission assessment information to determine that the medical and physical care needs of the applicant meet the medical needs criteria of BMS for reimbursement by Medicaid for personal care services. An annual recertification, utilizing the PAS-2000, is required for individuals who require ongoing services. The annual recertification PAS-2000 must be signed and dated by the physician attesting to the continued need for services.

A registered nurse must sign and date the PAS-2000 as directed on the form on page 6, number 42. This signature means that the registered nurse verifies by direct observation and assessment that the applicant has met the medical level of care criteria set forth in this manual as necessary for certification/recertification.

515 MEDICAL ELIGIBILITY CRITERIA FOR PERSONAL CARE SERVICES

An individual with 3 or more deficits at the appropriate level in the following functional areas qualifies for personal care services. Individual with 4 or more deficits may be considered candidates

for personal care services if their care and safety needs can be met within the service limits for personal care service.

The following are the minimum ratings considered as deficits in activities of daily living for the personal care services:

ACTIVITY	OBSERVED LEVEL
Eating	Level II or higher (physical assistance or more)
Bathing	Level II or higher (physical assistance)
Grooming	Level II or higher (physical assistance)
Dressing	Level II or higher (physical assistance)
Continence	Level II/III (occasional or regular incontinence)
Orientation	Level III or higher (totally disoriented; comatose)
Transferring	Level III or higher (1or 2 person assist)
Walking	Level III or higher (1or 2 person assist)
Wheeling	Level III or higher (situational/total assistance)

An individual may also qualify for personal care level service if he/she has 2 functional deficits identified as listed above, (items refer to PAS-2000) and any one or more of the following conditions indicated on the PAS-2000:

- Pressure-sores rated at Stage 3 or 4 (Item #24)
- Emergency Capabilities (Item #25): It is indicated that, in the event of any emergency, the individual is physically incapable of vacating a building.
- Professional/Technical Care needs (item #27): The individual has professional or technical care needs which are provided by the individual himself or by a family member for one or more of the following services itemized under #27; (g) suctioning; (h) tracheostomy; (i) ventilator; (k) parenteral fluids; (l) sterile dressings; or (m) irrigations.
- Medication Administration (item #28) indicates that the individual is not (c) capable of administering his/her own medications.

515.1 Recertification of Personal Care Services

For individuals who receive personal care on an ongoing basis, recertification by completion of the PAS-2000 is required at least annually. In addition, a personal care nursing assessment must be completed at least every 6 months.

516 COVERED SERVICES

The following are descriptions of personal care services and activities which are reimbursable by

Medicaid:

516.1 T1001 - Initial RN Assessment/Recertification

Procedure Code: T1001
Service Unit: Event
Limit: 1 per year
Prior Authorization: No

This service includes the following activities, all of which must be completed before the code is billed.

- Nurse's review of MD signed and dated PAS-2000: This is done to verify client eligibility for the program.

- Initial or annual client nursing assessment: This is to be completed in the home with documentation to include the Personal Care Services Nursing Assessment Form

- Development of the nursing plan of care. This is to be initiated in the home with client participation. This includes the 7-day plan of care or 31-day plan of care and provider daily log. If the nurse feels increased service hours are needed at this time, the required information needed for prior authorization is prepared and included with this billing code.

- Personal care provider introduction to the client, review of the client's nursing plan of care with the personal care aide, as well as supervision and monitoring of the implementation of the plan of care by the personal care aide is also included with the billing code.

If the client's condition changes at a later date and a need for increased service time is warranted, a prior authorization request could be initiated and that activity would be billed under procedure code T1001, which is currently capped at 6 units per month.

516.2 T1002-Ongoing Assessment and Care Planning

Procedure Code: T1002
Service Unit: 15 minutes
Limit: 6 units per month
Prior Authorization: No

This service includes the following activities which must be performed by a registered nurse:

A. The required 6 month assessment and any other assessment that the client's condition indicates with documentation to justify the event. Assessment must include face-to-face, hands-on activity and direct observation of the individual who is being assessed. The nursing assessments must be signed and dated by the registered nurse and client. Assessments must include an employment appraisal at least once a year when both residential and employment settings are indicated in the nursing plan of care yearly.

B. Development and modification of nursing care plans, either a 7-day or a 31-day care plan at the discretion of the registered nurse writing the plan. (Exception: Prior Authorization requests require both a 7-day and a 31-day care plan.) Nursing care plans must consider any support from family or community support which is available to address care needs. The care plan addresses the client needs identified in the assessment. Plans must be modified as necessary to account for progress, decline or other changes in the client's condition. Since it is a mandatory activity that the nurse reviews and sign the 7-day or 31-day personal care daily log sheets, time spent for this activity is reimbursable by Medicaid. Time spent should be documented in actual minutes.

C. Supervision and monitoring of the implementation of the nursing care plan by non-licensed staff: In this activity, the nurse assesses the quality and appropriateness of care and activity by non-licensed direct care staff and assures that it is provided according to the care plan. This nurse must also assure that environmental support activity does not exceed one third of the total care activity allotted by the care plan. In unique circumstances, one-on-one training of the direct care provider by the registered nurse is also reimbursable. The purpose of the one-on-one training must be to instruct the attendant in a specific skill or technique, or to assist the attendant in resolving medically related problems in the individual case situation.

Although the goal is to provide assistance to an individual who cannot carry out activities of daily living, when assessing and care planning, the nurse assures that this goal is balanced with the goal of promoting independence and encouraging the highest possible level of function for the individual.

516.3 Documentation

The following standardized documents, which must be signed by a registered nurse, are required to substantiate personal care services:

- Pre-admission Screen (PAS-2000): Initial and annual recertification
- Nursing Plan of Care: 7-day or 31-day
- Nursing Assessment: Initial, 6-month assessment, and other assessments as necessary with documentation of need.
- Personal Care Daily Log Sheet: Documentation requires the following: Clients name, caregiver's signature and registered nurse's signature, verifying activities completed as written from the plan of care. If there is more than one caregiver, each individual must sign the log and place their initials in the blocks where they provided services.

516.4 T1019 - Hands on Direct Care Services

Procedure Code:	T1019
Service Unit:	15 Minutes
Service Limit:	60 hours per month
Prior Authorization:	Yes, any services beyond 60 hours per month and services to obtain and retain employment which exceed the one third limit for environmental support tasks.

516.5 Definition:

This service is defined as hands-on, medically necessary activities and supportive tasks described in the nursing care plan which are implemented by qualified and trained staff as defined under 507.2 and 507.3. Services are provided in the recipient's residence, except that services may be provided outside the home when those services are necessary to assist eligible individuals to obtain and retain competitive employment of at least 40 hours per month (see 516.7 below). Staff may provide assistance with such activities as dressing, personal hygiene, feeding, assistance with self-administration of medications, and assist with environmental support tasks such as housecleaning, laundry, bed changing. Environmental support tasks must not exceed one third of the allotted activity on the plan of care.

516.6 Covered Environmental Support

Environmental support includes light housecleaning, laundry, ironing and mending, bed changing or making, dishwashing, grocery and/or pharmacy shopping, and bill paying.

516.7 Additional Covered Service Settings

Personal care services outside the home may be provided during all employment-related activities and during job seeking activities. These activities and tasks enable individuals with physical and/or mental disabilities as defined by SSA program to carry out activities of daily living on and off the job that the individual would typically perform if he/she did not have a disability. These activities include:

- Researching employment opportunities
- Employment applications
- Interviewing
- Pre-employment assessments
- Pre-employment observation periods
- Periods of employment of less than 40 hours per month if working toward goal of at least 40 hours per month.

516.8 Documentation:

The documentation required for Procedure Code T1019 includes the Personal Care Daily Log. (Attachment 5) This form must be signed by the registered nurse or Family Based Care Specialist in the Medley-at-Risk Program; it must have the original signature of the person providing direct care to the client.

When the nursing plan of care identifies the need for personal care services outside the home, it is the responsibility of the service provider agency to verify and maintain documentation of employment of at least forty hours per month or documentation of job seeking. Appropriate documentation of employment may be in the form of a pay stub or substitute form signed by the employer which

indicates the hourly wage, number of hours worked in a specific time period and location of employment. (See Wage and Hour Report, Attachment 13) Documentation of registration with the individual's local job service must also include one of the following:

- Development of an individual job search agreement with the recipient's service provider agency;
- Documentation of job readiness from the Division of Rehabilitation Services; or
- Documentation of participation in a TWWIIA Employment Network.

The appropriate documentation must be resubmitted to the service provider agency at least once every 3 months and may be submitted via mail, fax, or in person. Copies of this documentation must be maintained by the recipient's case manager or supervising nurse in a specific employment section of the recipient's permanent record.

517 NON-COVERED SERVICES

Personal care services can only be reimbursed when the nursing plan of care spells out the specific need and incorporates it in planned time. The following services are not covered and/or billable as personal care services:

- Professional skill care such as tube feeding, Foley catheter irrigations, sterile dressings, or other procedures requiring sterile techniques are neither to be performed by non-licensed personal care staff, nor will they be considered reimbursable as personal care services.
- Activities such as training, travel time before or after providing services to an eligible individual, or administrative tasks are not reimbursable as separate activities.
- Environmental Services which are provided as part of the room and board provisions of residential settings are not reimbursable. These residential settings include behavioral heath supervised residential homes.
- The registered nurse cannot bill or be reimbursed for telephone calls and preparation of medication boxes.

518 PRIOR AUTHORIZATION FOR SERVICES ABOVE THE LIMIT

The following are standardized forms which make up the information and define the process of requesting personal care service beyond 60 hours per month to a maximum of 210 hours per month.

518.1 Required Prior Authorization Packet

- Prior Authorization Cover Sheet (Attachment 1)
- Pre-admission Screen - PAS-2000 (Attachment 2)
- Nursing Plan of Care - 7-day (Attachment 3)
- Nursing Plan of Care - 31-day (Attachment 4)
- Nursing Assessment (Attachment 6)

Personal Care Daily Log Sheets (Attachment 5) are not required as a part of the prior authorization

Packet

518.2 Prior Authorization Time Frames

Prior authorization request for clients receiving services above the limits may be approved for a maximum of 6 months. Example, a client who was prior authorized for a total of 90 hours of service per month from July through December and who requires 3 more months at this level will submit the prior authorization request no later than November 30. All prior authorization requests are reviewed and approved within 30 days for all packets with required documents and complete information provided.

Providers may request prior authorization for new clients for whom they are initiating services at any time. The same is true for clients who may have an acute episode which increases care needs.

518.3 Prior Authorization Denials/Returns

Prior authorization packets which have the following incomplete or inaccurate information will be returned.

- Incorrect Medicaid recipient number;
- No provider number listed;
- Lack of appropriate signatures and/or date;
- Packets found to be incomplete due to missing one of the required forms listed in Section 518.1; and/or
- Not meeting medical need criteria.

ATTACHMENT 1

PRIOR AUTHORIZATION COVER SHEET

INSTRUCTIONS

It must be filled out completely - no blank spaces.

It must have correct Medicaid number.

It must specify beginning and ending period of request.

It must contain the number of hours per month.

It must have total number of hours for the time period of the request.

It must be sent to correct address depending on the target population.

It must indicate if this is a first time request.

MEDICAID
Personal Care Services
Prior Authorization Cover Sheet

Agency Name: _____
Agency Address:_____
Provider Number:_____
Contact person: _____
Telephone Number: _____
Client Name:_____
Correct Medicaid Number : _____-_____-_____
Total Units per month previously approved: _____
Service Period for this request:
_____ to _____
(Beginning) (Ending)
Requesting _____ units per month Submission Date:_____

Total Number of Units for this period: _____
Submit to:

Personal Care Services Prior Authorizations
Bureau for Medical Services
Attn: Pam Pushkin, RN
350 Capital Street, Room 251
Charleston, West Virginia 25301-3707
OR
Bureau of Senior Services
Attn: Libby Boggess, RN
1900 Kanawha Boulevard East, Building 10
Charleston, WV 25305

Please note:

If form is <u>not correctly completed,</u> it will be returned for completion. For purposes of new format changes, please submit the information listed below:

I. A copy of this cover sheet;
II. A copy of signed Pre-Admission Screening Form (PAS-2000);
III. Nursing Plan of Care, 7-day and 31-day Personal Care Plan;
IV. Current Nusing Assessment; and
V. Any other information that you feel will help justify your reports.

ATTACHMENT 2

PRE-ADMISSION SCREENING (PAS-2000)

INSTRUCTIONS

Must be signed and dated by physician (no physician's assistant).

Must be signed and dated by a registered nurse.

Each item must be completed. If not applicable, put N/A.

Section IV (page 5) must be completed in full.

A physician's order for activities requiring such order must be on the PAS-2000 (page 5 item 38) or attached.

Client or client designee must sign section 18. Name of client on file is acceptable.

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES PRE-ADMISSION SCREENING

Reason for Screening:
Check Only One

A. Nursing Home Only 9 Initial 9 Transfer
B. Nursing Home waiting Waiver 9 yes
C. A/D Waiver Only 9 Initial 9 Re-Evaluation
D. Personal Care 9 Initial 9 Re-Evaluation

Facility/Agency/Person making referral:

NAME:
ADDRESS:

CONTACT PERSON:
_____PHONE:(___) ____ - _____

FAX: (___) _____ -

1. DEMOGRAPHIC INFORMATION

1. Individual's Full Name	2. Sex		3. Medicaid Number	4. Medicare Number
	F	M		

5. Address (Including Street/Box, City, State & Zip	6. Private Insurance

7. County	8. Social Security Number	9. Birthdate (M/D/Y)	10. Age	11. Phone #

12. Spouse's Name	13. Address (If different from above)

14. Current living arrangements, including formal and informal support (ie. family, friends, other services)

15. Name and Address of Provider if applicable

16. Medicaid Waiver Recipient A 9 Yes B 9 No C 9 Aged/Disabled D 9 MR/DD

17. Has the option of Medicaid Waiver been explained to the applicant? A 9 Yes B 9 No

18. For the purpose of determining my need for appropriate services, I authorize the release of any medical information by the physician to the Department of Health and Human Resources of its representative.

Ξ_____ □ _____ □

SIGNATURE - Applicant or Person acting for Applicant Relationship Date

19. Check if Applicant has any of the following:

a 9 Guardian d 9 Power of Attorney g 9 Other _____b 9 Committee e 9 Durable Power of Attorney

c 9 Medical Power of Attorney f 9 Living Will

Name & Address of the Representative
Phone (___) ___-

PAS-2000

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DATE:_____

II. MEDICAL ASSESSMENT

NAME:_____

20. Health Assessment - Include infectious diseases, nutritional needs, prior treatments, degenerative conditions, recent hospitalization(s), and/or surgery(ies) with dates - Date of most recent office visit. (Attach most recent Hospital Discharge Summary and Physical, if available)

21. Normal Vital Signs for the individual

a. Height	b. Weight	c. Blood Pressure	d. Temperature	e. Pulse	f. Respiratory Rate

22. Check if Abnormal

a 9 Eyes g 9 Breasts m 9 Extremities s 9 Musculo-Skeletal
b 9 Ears h 9 Lungs n 9 Abdomen t 9 Skin
c 9 Nose i 9 Heart o 9 Hernia(s) u 9 Nervous System
d 9 Throat j 9 Arteries p 9 Genitalia-male v 9 AllergiesSpecify)
e 9 Mouth k 9 Veins q 9 Gynecological
f 9 Neck l 9 Lymph Syst. r 9 Ano-Rectal

Describe Abnormalities and treatment

23. Medical Conditions/Symptoms: [Please Grade as : (1) - Mild, (2) - Moderate, (3) - Severe]

a 9 Angina-rest ___ e 9 Paralysis ___ i 9 Diabetes
b 9 Angina-exertion ___ f 9 Dysphagia ___ j 9 Contracture(s)
c 9 Dyspnea___ g 9 Aphasia ___ k 9 Mental Disorder(s)
d 9 Significant Arthritis___ h 9 Pain ___ l 9 Other (Specify)

24. Decubitus a 9 Yes b 9 No If yes, check the following:

A. Stage _____ B. Size _____ C. Treatment

Location

a 9 Left Leg c 9 Right Leg e 9 Left Hip g 9 Right Hip
b 9 Left Arm d 9 Right Arm f 9 Left Buttock h 9 Right Buttock

Other _____ Developed at: a 9 Home b 9 Hospital c 9 Facility

25. In the event of an emergency, the individual can vacate the building: (Check only one)

a 9 Independently b 9 With Supervision c 9 Mentally Unable d 9 Physically Unable

PAS-2000

DATE: _____

NAME:_____

26. Indicate individual's functional ability in the home for each item with the level number 1, 2, 3, 4, or 5. Nursing care plan must reflect functional abilities of the client in the home.

Item	Level 1	Level 2	Level 3	Level 4
a__Eating_(Not_a_Meal Prep)	Self/Prompting	Physical Assistance	Total Feed	Tube Fed
b__ Bathing	Self/Prompting	Physical Assistance	Total Care	
c__ Dressing	Self/Prompting	Physical Assistance	Total Care	
d__ Grooming	Self/Prompting	Physical Assistance	Total Care	
e__ Cont./Bladder	Continent	Occas. Incontinent*	Incontinent	Catheter
f__ Cont./Bowel	Continent	Occas. Incontinent*	Incontinent	Colostomy
g__ Orientation	Oriented	Intermittent Disoriented	Totally Disoriented	Comatose(L5)
h__ Transferring	Independent	Supervised/Assistive Devise	1 Person Assistance	2 Person Asst
i__ Walking	Independent	Supervised/Assistive Devise	1 Person Assistance	2 Person Asst
j__ Wheeling	No Wheelchair	Wheels Independently	Situational Asst (Doors,etc.)	Tot Asst
k__ Vision	Not Impaired	Impaired /Correctable	Impaired/Not Correctable	Blind
l__ Hearing	Not Impaired	Impaired/Correctable	Impaired/Not Correctable	Deaf
m__ Communication	Not Impaired	Impaired/Understandable	Understandable with Aids	Inappropriate /None
		*less than 3 X p/wk		

27. Professional and technical care needs - check all that apply.

a 9 Physical Therapy
b 9 Speech Therapy
c 9 Occupational Therapy
d 9 Inhalation Therapy
e 9 Continuous Oxygen
f 9 Ostomy
g 9 Suctioning
h 9 Tracheostomy
i 9 Ventilator
j 9 Dialysis
k 9 Parenteral Fluids
l 9 Sterile Dressings
m 9 Irrigations
n 9 Special Skin Care
o 9 Other _____

28. Individual is capable of administering his/her own medications (check only one). A 9 Yes B 9 With Prompting/Supervision C 9 No Comment:_____

29. Current Medications	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

DATE:_____

III. MI/MR ASSESSMENT NAME:_____

30. Current Diagnoses - Check all that apply

a 9 None
b 9 Mental Retardation
c 9 Autism
d 9 Seizure Disorder (Age at onset _____)
e 9 Cerebral Palsy
f 9 Other Developmental Disability (Specify _____
g 9 Schizophrenic Disorder
h 9 Paranoid Disorder
i 9 Major Affective Disorder
j 9 Schizoaffective Disorder
k 9 Affective Bipolar Disorder
l 9 Tardive Dyskinesia
m 9 Major Depression
n 9 Other related conditions

Date of last PASARR Level II Evaluation _____ (Specify_____)

31. Has an individual ever received services from an agency serving persons with mental retardation/developmental disability and/or mental illness? Yes ___ No ___ If yes, specify agency Name_____ Address_____
Admission Date _____ Discharge Date _____

32. Has the individual received any of the following medications on a regular basis within the last two years? Yes ___ No ____
33. Was this medication used to treat a neurological disorder? Yes ___ No ___

Chlorpromazine	- Thorazine	Perphenazine	- Trilafon	Haloperidol	- Haldol
Promazine	- Sparine	Fluphenazine	- Prolixin	Molindone	- Moban
Triflupromazine	- Vesprin	Fluphenazine HCI	- Permitil	Loxapine	- Loxitane
Thioidazine	- Mellaril	Trifluphenazine	- Stelazine	Clozapine	- Clozaril
Mesoridazine	- Serentil	Chlorprothixene	- Taractan	Procholorperazine	- Compazine
Actiphenazine	- Tindal	Thiothixene	- Navane		

Medication	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

34. Clinical and Psychosocial Data - Please check any of the following behaviors which the individual has exhibited in the past two years.

a 9 Substance Abuse (Identify)
b 9 Combative
c 9 Withdrawn/Depressed
d 9 Hallucinations
e 9 Delusional
f 9 Disoriented
g 9 Bizarre Behavior
h 9 Bangs Head
i 9 Sets Fires
j 9 Displays Inappropriate Social Behavior
k 9 Seriously Impaired Judgment
l 9 Suicidal Thoughts, Ideations/Gestures
m 9 Cannot Communicate Basic Needs
n 9 Talks About His/Her Worthlessness
o 9 Unable to Understand Simple Commands
p 9 Physically Dangerous to Self and Others, if Unsupervised
q 9 Verbally Abusive
r 9 Demonstrates Severe Challenging Behaviors
s 9 Specialized Training Needs
t 9 Sexually Aggressive

Does the individual have Alzheimer's, multi-infarct, senile dementia, or related condition? Yes__ No__
Other (Specify)

PAS-2000

DATE: _____

IV. PHYSICIAN RECOMMENDATION

NAME:_____

35. Prognosis - Check one only: a____ Stable b____ Improving c_____ Deteriorating d Terminal
Other _____

36. Rehabilitative Potential - Check one only: a ___ Good b ___ Limited c___ Poor

37. Diagnosis:
a.Primary

b.Secondary

c. Other medical conditions requiring services

38. Physician Recommendations

A. FOR NURSING FACILITY PLACEMENT ONLY

On the basis of present medical findings, the individual may eventually be able to return home or be discharged.

a ___ Yes b___ No

If yes, check one of the following:

a 9 Less than 3 months
b 9 3-6 months
c 9 Over 6 months
d 9 Terminal illness

B. I recommend that the services and care to meet these needs can be provided at the level of care indicated.

a 9 Nursing Home
b 9 Nursing Home waiting A/D Waiver
c 9 A/D Waiver
d 9 Personal Care

39. To the best of my knowledge, the patient's medical and related needs are essentially as indicated above (Must be signed by M.D. or D.O.)

_____
_____

Physician's Signature **MD/DO**

_____
____

Date This Assessment Completed:

TYPE OR PRINT Physician's name/address below:

_____
_____
_____
_____
_____

DISCLAIMER: Approval of this form does not guarantee eligibility for payment under the State Medicaid Plan

NOTE: Information gathered from this form may be utilized for statistical/data collection.

DATE: _____

V. ELIGIBILITY DETERMINATION

NAME: _____

DEPARTMENT USE ONLY
LEVEL I (Medical Screen)

Medical and other professional personnel of the Medicaid Agency or its designees MUST evaluate each individual's need for admission by reviewing and assessing the evaluations required by regulation.

Exemptions from requirements for Level II Assessment

40. Does the individual have or require:

a. Diagnosis of dementia (Alzheimer's or related disorder)?	**9 Yes**	**9 No**
b. Thirty Day Respite Care?	**9 Yes**	**9 No**
c. Serious Medical Condition?	**9 Yes**	**9 No**

41. Medical Eligibility Determination:

a 9 Nursing Facility Services **b 9 Aged/Disabled Waiver**
c 9 Personal Care Services **d 9 No Services Needed**

42. PASARR Determination:

a 9 Level II required **b 9 Level II not required**

_____ _____
Nurse Reviewer's Signature - Title **Date** **Control Number**
Printed Name_____

DEPARTMENTAL USE ONLY
LEVEL II (MI/MR Screen)
(Completed by PASARR Provider)

43. DETERMINATION:

a 9 Nursing facility services needed - Specialized services not needed.
b 9 Nursing facility services needed - Specialized services needed.
c 9 Alzheimer's or related disorder identified.
d 9 Thirty day Respite care needed.
e 9 Terminal illness identified.
f 9 Serious illness identified.
g 9 Nursing facility services not needed.

44. RECOMMENDED PLACEMENT:

a 9 Nursing Facility Services
b 9 Aged/Disabled Waiver
c 9 Psychiatric Hospital (21 years or under)
d 9 ICF/MR or MR/DD Waiver
e 9 Other - Identify

PASARR Reviewer's Signature **Title** **Printed Name**

_____ _____
Agency Name **Date**

PAS-2000 A COPY OF THIS FORM MUST BE IN THE INDIVIDUAL'S MEDICAL RECORDS

ATTACHMENT 3

NURSING PLAN OF CARE - 7 DAY

INSTRUCTIONS

RN has choice of 7-day or 31-day plan if no prior authorization (P.A.) is needed.

If prior authorization is needed, both plans need to be completed to submit for P.A.

Both the 7 & 31 Day Plan of Care must include total amount of time plan justifies and marked for total or partial assistance.

RN signature and provider's name must be on both forms.

Activities which are non-billable in personal care should not appear on the plan of care .

Personal care standards and terms should be used when writing a plan of care.

Plan of care should reflect how client is rated on the PAS-2000.

NURSING PLAN OF CARE

Agency:	Agency #:	90-Day Review Date:
Client Name:		Medicaid #:
Client Address:		
R.N. Signature:		Date:

PERSONAL CARE ACTIVITIES	Level of Services to be Provided		Daily Planned Time							Date Service Started
	Part Assist	Total Assist	Mon	Tue	Wed	Thur	Fri	Sat	Sun	
PERSONAL HYGIENE/GROOMING										
A. Grooming										
B. Bathing										
C. Toileting										
D. Dressing										
E. Laundry (incontinent)										
NON-TECH PHYSICAL ASSISTANCE										
A. Repositing/Transfer										
B. Walking										
C. Medical Equipment										
D. Assistance with Medication										
E. ROM (Per Phys. order)										
F. Vitals (Per Phys. order)										
G. Other (Per Phys. order)										
NUTRITIONAL SUPPORT										
A. Meal Prep										
B. Feeding										
C. Special Dietary Needs										
ENVIRONMENTAL										
A. Housecleaning										
B. Laundry/Ironing										
C. Making/Changing Bed										
D. Dishwashing										
E. Shopping										
F. Payment of Bills										
TOTAL NUMBER OF MINUTES: _____					TOTAL NUMBER OF UNITS: _____					

NOTE: Environmental tasks are incidental to the other tasks identified on the plan of care. The Atimes planned@ on this plan of care are an estimate of the time/services provided to/for the CLIENT. (This excluded time/services normally provided by other members of the household.)18-03 Revised 04/03

ATTACHMENT 4

NURSING PLAN OF CARE 31- DAYS

INSTRUCTIONS

RN has choice of 7-day or 31-day plan if no prior authorization (P.A.) is needed.

If prior authorization is needed, both plans need to be completed to submit for P.A.

Both the 7 & 31 Day Plan of Care must include total amount of time plan justifies and marked for total or partial assistance.

RN signature and provider's name must be on both forms.

Activities which are non-billable in personal care should not appear on the plan of care .

Personal care standards and terms should be used when writing a plan of care.

Plan of care should reflect how client is rated on the PAS-2000.

Nursing Plan of Care 31 Days

Client's name:	Agency & Phone Number:
Provider Name:	Approved Hours for Client:
Medicaid #:	Number of Units:
30 Day Review Completed by: RN (Please Print)	Date:
Signature of Completing RN:	

P - Partial Assistance T - Total Assistance

PERSONAL CARE TASKS

PERSONAL HYGIENE/GROOMING	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes
A. Grooming																																			
B. Bathing																																			
C. Toileting																																			
D. Dressing																																			
E. Laundry (incontinent)																																			
TOTAL																																			

NON-TECH PHYSICAL ASSISTANCE	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes
A. Repositing/Transfer																																			
B. Walking																																			
C. Medical Equipment																																			
D. Assistance with Medication																																			
E. ROM (Per Phys. order)																																			
F. Vitals (Per Phys. order)																																			
G. Other (Per Phys. order)																																			

Nursing Plan of Care 31 Days

TOTAL																																						
NUTRITIONAL SUPPORT	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes
A. Meal Prep																																						
B. Feeding																																						
C. Special Dietary Needs																																						
TOTAL																																						
ENVIRONMENTAL	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes
A. Housecleaning																																						
B. Laundry/Ironing																																						
C. Making/Changing Bed																																						
D. Dishwashing																																						
E. Shopping																																						
F. Payment of Bills																																						
TOTAL																																						
																												TOTAL HOURS										
																												TOTAL UNITS										

ATTACHMENT 5

PERSONAL CARE DAILY LOG SHEETS

INSTRUCTIONS

All Information must be complete and reflect activities as they are written on the plan of care.

i.e., marked partial or total with times filled in on the left hand column.

A registered nurse's signature is required when log is complete.

The provider who is named on the daily log must also sign the log sheet verifying the activities were provided as outlined.

Any variance from the plan must be explained at the bottom of page 2.

Personal Care Daily Logs

Client's Name:	Agency & Phone Number:
Provider Name:	Approved Hours for Client:
Medicaid #:	Number of Units:
30 Day Review Completed by:	Date:
Signature of Completing RN:	

P - Partial Assistance T - Total Assistance

PERSONAL CARE TASKS

PERSONAL HYGIENE/GROOMING	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes
A. Grooming																																			
B. Bathing																																			
C. Toileting																																			
D. Dressing																																			
E. Laundry (incontinent)																																			
TOTAL																																			

NON-TECH PHYSICAL ASSISTANCE	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes
A. Repositing/Transfer																																			
B. Walking																																			
C. Medical Equipment																																			
D. Assistance with Medication																																			
E. ROM (Per Phys. order)																																			
F. Vitals (Per Phys. order)																																			
G. Other (Per Phys. order)																																			
TOTAL																																			

NUTRITIONAL SUPPORT	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes

Personal Care Daily Logs

A. Meal Prep																																				
B. Feeding																																			
C. Special Dietary Needs																																			
TOTAL																																			
ENVIRONMENTAL	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes
A. Housecleaning																																			
B. Laundry/Ironing																																			
C. Making/Changing Bed																																			
D. Dishwashing																																			
E. Shopping																																			
F. Payment of Bills																																			
TOTAL																																			

Total Units	
Total Hours	

COMMENTS ABOUT CLIENT FOR RN TO CHECK. ALSO EXPLAIN ANY VARIANCE FROM PLAN OF CARE:

Provider Signature:_____Date: _____

ATTACHMENT 6

PERSONAL CARE NURSING ASSESSMENT

INSTRUCTIONS

Form must be completed at least every 6 months.

Nursing assessment should reflect client's needs as they are on the PAS-2000.

If client's condition has changed, a new assessment may be needed.

Nursing assessment should justify time shown on plan of care.

Signature of RN and client are required.

PERSONAL CARE NURSING ASSESSMENT

Attachment 6

Name:	Medicaid Number:
Date of Birth ____ / ____ / _____	Sex: ____ F ____ M
Address:	

TYPE OF RESIDENCE

Lives Alone:	Lives w/ Natural Family:
Shares an Apartment:	Group Home:
Other (please specify):	

MEDICATIONS (Including name, dosage, and time)

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

VITAL SIGNS

Height:	Weight:	Blood Pressure:
Temperature:	Pulse:	Respiratory Rate:

PERSONAL CARE NURSING ASSESSMENT

DESCRIBE THE CLIENT'S ABILITY TO PERFORM PERSONAL CARE TASKS

1. Grooming/Skin Care - to include care of hair, mouth, nails, skin and teeth.
   Partial Assistance - what does this entail? _____
   _____
   _____
   Total Assistance - what does this entail? _____
   _____
   _____

2. **Bathing**

Tub ___	Shower ___	Bed Bath ___	Bathe Self ___	Sponge ___

3. **Bladder/Bowel Functions**

Continent ___	Incontinent - How often? ___	Bladder ___	Bowel ___
Wears diapers/protective undergarments ___		Needs assistance for toileting ___	
Colostomy ___	Catheter ___	Other ___	

4. **Non-Technical Physical Assistance**

Ambulates by Self _____	Needs Medical Assistance to ambulate _____	
Uses Wheelchair - please circle one	Manual	Electric
Uses Crutches _____	Uses Cane _____	Uses Walker _____

5. Describe personal care activities which are ordered by the patient's physician as it relates to the medical diagnosis: _____
   _____
   _____
   _____

PERSONAL CARE NURSING ASSESSMENT

DESCRIBE THE CLIENT'S ABILITY TO PERFORM PERSONAL CARE TASKS

1. Grooming/Skin Care - to include care of hair, mouth, nails, skin and teeth.
Partial Assistance - what does this entail? _____
_____
_____
Total Assistance - what does this entail? _____
_____
_____

2. **Bathing**

Tub ___	Shower ___	Bed Bath ___	Bathe Self ___	Sponge ___

3. **Bladder/Bowel Functions**

Continent ___	Incontinent - How often? ___	Bladder ___	Bowel ___
Wears diapers/protective undergarments ___		Needs assistance for toileting ___	
Colostomy ___	Catheter ___	Other ___	

4. **Non-Technical Physical Assistance**

Ambulates by Self _____	Needs Medical Assistance to ambulate _____	
Uses Wheelchair - please circle one	Manual	Electric
Uses Crutches _____	Uses Cane _____	Uses Walker _____

5. Describe personal care activities which are ordered by the patient's physician as it relates to the medical diagnosis: _____
_____
_____
_____

ATTACHMENT 7

PERSONAL CARE EMPLOYMENT SUPPORT RECORD SHEET

Personal Care-Employment Support Record Sheet

(This is intended to be the cover sheet for employment section of the client's file.)

Name: _____ Social Security Number: _____

Medicaid Number: _____ Date: _____

Agency Completing Form: _____

Name/Title of Person Completing Form: _____

_____

Client Personal Care - Employment Support Status

Job Seeking Status

_____ Client has provided documentation of registration wit their local Job Service AND one of the following:

_____ Client has agreed to participate in an Individual Job Search. This Agency will monitor the Job Seeking Agreement. (See Job Seeking Agreement)

_____ Client has provided documentation of eligibility for vocational rehabilitation services from the Division of Rehabilitation Services.

_____ Client has provided documentation of participation in a TWWIIA Employment Network.

Employment Status

_____ **Partial Employment**: Client has obtained partial employment working less than forty (40) hours per month earning at least minimum wage. The client agrees to maintain a CLIENT WAGE and HOUR REPORT Form. (See Employment Status Agreement)

_____ Client is progressing toward full employment of forty (40) hours per month with their current employer within three (3) months.

_____ Client is still job seeking to find full employment of at least forty (40) hours per month and agrees to participate in a Job Seeking Agreement.

_____ **Full Employment:** Client has obtained full employment of at least forty (40) hours per month earning at least minimum wage. The client agrees to maintain a CLIENT WAGE and HOUR REPORT form. (See Employment Status Agreement.)

ATTACHMENT 8

JOB SEEKING AGREEMENT

Job Seeing Agreement

(Agreement to be completed before client begins job seeking.)

Name: _____ SSN: _____

Medicaid Number: _____Date: _____

Provider Number: _____

Name/Title of Person Monitoring Plan: _____

Plan Dates: From: _____To:_____

(Check all applicable categories)

____ I agree to register and maintain active status with my local Job Service AND one of the following:

____ Individual Job Search

I agree to: 1) Contact Job Services when notified of an opening and appear for interviews as schedule. 2) Contact _____ (number) of potential employers per month and record results of an employer contact summary sheet to be reviewed by the agency every three months. 3) Contact at least one half of the employers in person. Or 4) other . (Please describe)_____
_____
_____

_____ Vocational Rehabilitation Services from the Division of Rehabilitation Services

I agree to: 1) Make application at the local Division of Rehabilitation Services Office; 2) Provided documentation of eligibility for Vocational Rehabilitation Services; 3) Provide documentation of continued participation in DRS Vocational services to this agency every three months.

____ Participation in a TWWIIA Employment Network

I agree to: 1) Participate in a TWWIIA Employment Network Program; 2) Provide documentation of eligibility for a TWWIIA Employment Network Program; 3) Provide documentation of continued participation in the TWWIIA Employment Network Program to this agency every three months. (This option is not available at this time.)

Job Seeking Agreement: I understand that personal care services will be provided outside the home ewhen I am employed at least 40 hours per month earning at least minimum wage. Personal care services will be provided for no more than twelve (12) months, not necessarily consecutive, while I am seeking employment or partially employed, working less than fourty (40) hours per month. I agree to adhere to the Job Seeking Agreement and to inform my provider agency of any change in my job seeking status. My provider agency will monitor the Job Seeing Agreement and maintain record of the Agreement in my Medicaid file for review by the Bureau for Medical Services.

Client's Signature:_____ Print Name:_____

Agency: _____ Signature: _____Date:_____

ATTACHMENT 9

EMPLOYMENT STATUS AGREEMENT

Employment Status Agreement
(Agreement to be completed after client becomes employed.)

Name: _____ SSN: _____

Medicaid Number: _____Date: _____

Provider Number: _____

Name/Title of Person Monitoring Plan: _____

Plan Dates: From: _____ To: _____

(Check all applicable categories)

____ I have obtained full employment.
I am working at least forty (40) hours per month at or above minimum wage. I agree to provide this agency documentation of my employment on a CLIENT WAGE AND HOUR REPORT Form every three months.

____ I have obtained partial employment. My employer has indicated he/she will be able to offer full employment at a later date.
I am working less than forty (40) hours per month due to: _____

_____
I expect to be working at least forty (40) hours per month on or about _____. I agree to provide this agency documentation on my employment on a CLIENT WAGE AND HOUR REPORT Form every three (3) months.

_____ I have obtained partial employment. However, my employer has indicated that he/she will <u>not</u> be able to offer full employment.
I am working less than forty (40) hours per month due to : _____

_____
I agree to continue Job Seeking and have entered into a Job Seeking Agreement. I agree to provide this agency documentation of my employment on a CLIENT WAGE AND HOUR REPORT Form every three (3) months.

I understand that personal care services will be provided outside the home when I am employed at least 40 hours per month earning at least minimum wage. Personal care services will be provided for no more than twelve (12) months, not necessarily consecutive, while I am partially employed, working less than forty (40) hours per month. I agree to notify my provider agency immediately of any change in my enrollment status. My provider agency will monitor the Employment Status Agreement and maintain records of the agreement in my Medicaid file for review by the Bureau of Medical Services.

Client's Signature: _____ Print Name: _____

Agency: _____Signature: _____ Date: _____

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ATTACHMENT 10

EMPLOYMENT CONTACT SUMMARY SHEET

Employer Contact Summary Sheets
(Form for client to document employer contacts)

Name: _____ SSN: _____

Medicaid Number: _____ Date:_____

Month: _____

Employer: _____ Phone: _____

Address: _____

Contact Person: _____ Title: _____

Position Applied For: _____

Type of Contact (phone, in-person, follow-up, etc.): _____

Source of Lead (newspaper, phone book, job service, etc.): _____

Results: _____

Employer: _____ Phone: _____

Address: _____

Contact Person: _____ Title: _____

Position Applied For: _____

Type of Contact (phone, in-person, follow-up, etc.): _____

Source of Lead (newspaper, phone book, job service, etc.): _____

Results: _____

ATTACHMENT 11

EMPLOYER FOLLOW-UP SHEET

Employer Follow-up Sheet
(Form for provider agency to document client's employer contact)

Name: _____ SSN: _____

Medicaid Number: _____ Date: _____

Person/Title Completing Follow-up Form: _____

Agency: _____

Employer Name & Address: _____ _____ Person Contacted/Title: _____ Results of Contact with Employer: _____ _____
Employer Name & Address: _____ _____ Person Contacted/Title: _____ Results of Contact with Employer: _____ _____
Employer Name & Address: _____ _____ Person Contacted/Title: _____ Results of Contact with Employer: _____ _____

ATTACHMENT 12

RELEASE OF INFORMATION

(Agency Letter head)

RELEASE OF INFORMATION

Name: _____

Social Security Number: _____ **Date of Birth:** _____

I authorize you to furnish any information regarding my application or employment status with your company to _____

Provider Agency, Address Phone Number)

Signature: _____

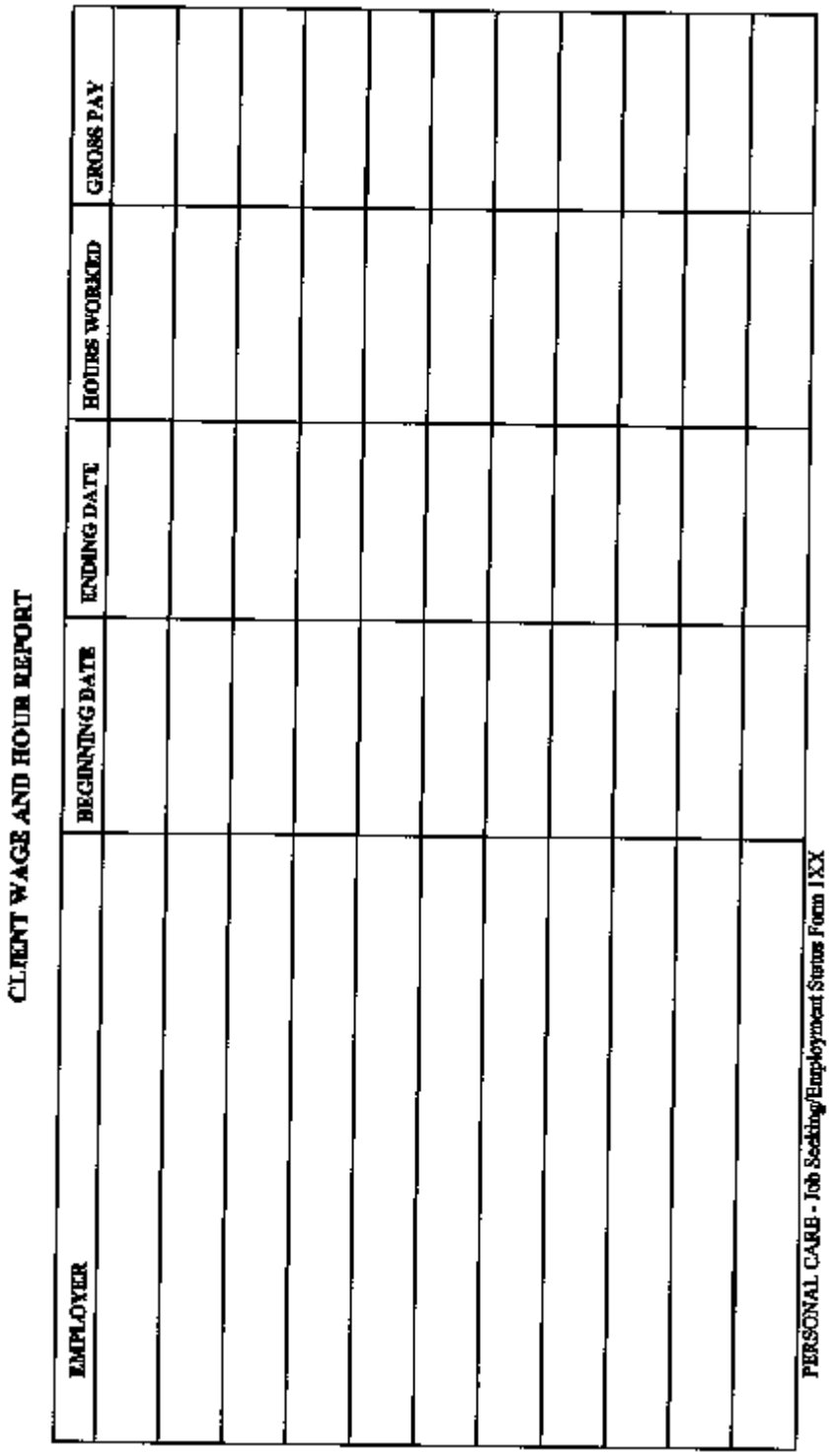
Print Name: _____ Date: _____

Address: _____

_____

ATTACHMENT 13

CLIENT WAGE AND HOUR REPORT



ATTACHMENT 14

NURSING PLAN OF CARE FOR EMPLOYMENT SUPPORT SERVICES

NURSING PLAN OF CARE
EMPLOYMENT SUPPORT SERVICES

PROVIDER: _____Provider # : _____90 Day Review Date:_____

Client Name: _____ Medicaid # : _____

Client Address: _____ R. N. Signature _____

Personal Care Activities	**Level of Services to be provided**		**Daily Planned Time**							**Date Services Started**	**Comments**
	P Part Assist	T Total Assist	Sun	Mon	Tue	Wed	Thu	Fri	Sat		
Grooming											
Toileting											
Reposition/Transfer											
Walking											
Medical Equipment											
Assist w/meds											
Meal Prep											
Feeding											
Special Dietary Needs											

Total Number of Minutes: _____ Total Number of Units: _____

Mode of Transportation: _____

Name of Person Providing the Services: _____

Client's Employer (if applicable) : _____

COMMENTS:

_____

_____

_____

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ATTACHMENT 15

DEFINITIONS OF PERSONAL CARE TERMS
Used with Standards in Development of Plan of Care

DEFINITIONS OF PERSONAL CARE TERMS

(to be considered when a Plan of Care is written)

1. Partial Assistance: Hand-on assistance with an activity; however, the clients can participate to a limited degree.

2. Total Assistance: Hands-on activity where client is incapable of participating in the activity and the provider must perform all services.

3. Medically Necessary: Those services indicated on the Physician's order that must be ordered by the Physician as needed services for client.

Personal Hygiene/Grooming

1. Toileting: Diapering does not apply to babies up to three (3) years old unless extenuating medical circumstances apply.

   Partial Assistance: Hands on assistance such as assisting on and off the toilet, bedpan, commode. Not necessary for provider to clean person.

   Total Assistance: Hands on. Physically placing client on toilet, cleaning after completing elimination and return to chair, bed, etc....

2 Dressing:

   Partial Assistance: Assisting client by laying out clothes, helping client put clothes on. Can dress themselves but needs some hands on assistance.

   Total Assistance: Provider must completely dress client from laying out clothes to physically putting on all wearing apparel.

3. Medically Incontinent Laundry:

   Laundry requested beyond normal weekly routine. The only approved laundry for incontinence will be that which is considered "Medically" necessary only. Incontinent Laundry is not appropriate for ages birth to three (3) unless extenuating medical circumstances apply.

4. Skin Care:

   Routine skin care such as applying body lotion after bathing, or application of suntan lotion is not considered medically necessary. Skin care that would be acceptable would be special lotions for psoriasis, skin break-down or other medically recognized skin conditions.

Non-Technical Physical Assistance:

1. Non-skilled Medical Care such as B/P monitoring for a Diagnosis of Hypertension must be "Medically" necessary as prescribed by the physician's order which clearly instructs all specifics necessary to carry out the function.

2. Range of Motion, Nebulizer treatments, or changing of a simple dressing are examples of activities needing a physician's order which specifically describes the activities needed and the number of times per day and length of time per session needed.

Definitions of Personal Care Services

3. Medical Equipment: Use and care of any medical equipment necessary to maintain client's needs in the home. List all equipment and how it pertains to the plan of care.

4. Walking: In order to have billable time for this activity on the Plan of Care, client needs to be rated a Level III on PAS-2000, indicating "hands-on-assistance."

Nutritional Support:

1. Feeding: Is considered normal activity for babies birth to two (2) years old except for extenuating medical circumstances.

   Partial Assistance: In regards to feeding; for example, means cutting up meat on plate or setting up plate.

   Total Assistance: In regards to feeding; for example, placing food on fork/spoon and placing in clients mouth, prompting them to chew and swallow.

   In regards to drinking; for example, holding up of liquid, placing it to their mouth and prompting them to swallow.

2. Meal Preparation: Making preparations of food to be consumed by client.

   Partial Assistance: An example of this is taking a frozen dinner out of the paper carton or assisting the client to carrying food to table.

   Total Assistance: An example of this is the provider may be cutting up, cooking, watching and otherwise preparing an entire meal for the client who is physically/mentally incapable of assisting in the preparations.

In group home settings of three (3) or more clients in one household, meal preparation must be pro-rated across all individuals who will eat the meal. For example, if there are six (6) clients and it takes an hour to prepare a meal, each client maximum of ten (10) minutes per meal. If client participates in day program outside his/her residence, the maximum would be ten (10) minutes two (2) times a is equal to 20 minutes.

Other:

1. Seizure activity - Is limited to protecting a client during or immediately after the seizure. **Monitoring for seizures is not billable.**

2. Room and Board Payments - Monies paid to an individual/agency on a monthly basis, from the clients accounts (SSI) or the Department of Health and Human Resources (DHHR), Bureau of Social Services. Payments of Room and Board from either resource will exclude certain services as listed in the Personal Care Standards.

3. Incident - When an activity states 'per incident' it means each time the activity occurs. An example is taking medications. A client may be on medications hat must be taken five (5) times a day. Each of those five (5) times would be a separate incident.

ATTACHMENT 16

PERSONAL CARE STANDARDS

Personal Care Standards

PERSONAL CARE ACTIVITIES		PARTIAL ASSISTANCE LEVEL II	TOTAL ASSISTANCE LEVEL III	TOTAL MAX. MINUTES/DAY Additional documentation required when using these times.
PERSONAL HYGIENE / GROOMING				
Grooming/Routine Skin Care: Includes care of hair, skin, nails, teeth & mouth		up to 10 minutes per day	up to 15 minutes per day	up to 60 minutes per day
Bathing; in bed, the tub or in the shower		up to 15 minutes per day	up to 30 minutes per day	up to 30 minutes per day
Toileting:	Diapering : Child	N/A	5 minutes per incident	up to 30 minutes per day
	Diapering: Adult	N/A	up to 30 minutes per incident	up to 180 minutes per day
	Assistance on and off the commode, bedpan, toilet	up to 5 minutes per incident	up to 15 minutes per incident	up to 75 minutes per day 24 hrs.
Dressing		up to 15 minutes per incident	up to 30 minutes per day	up to 30 minutes per day
Medically Incontinent Laundry	Urine, feces (drooling)	up to 30 minutes 2 X a week - occasional incontinence	up to 30 minutes per day	up to 30 minutes per day
NON-TECH. PHYSICAL ASSISTANCE				
Repositioning / Transfer; i.e. in & out of bed, on or off seats		5 minutes per incident	5 minutes per incident	up to 1 hour in 24 hours
Walking: with or without assistance of medical equip, in home		N/A	up to 30 minutes per day	up to 30 minutes per day
Medical Equip: list use and care of equipment in the home		15 minutes per day	up to 30 minutes per day	up to 30 minutes per day
Wheelchair: assistance pushing, loading & unloading in vehicle		up to 30 minutes per day	up to 30 minutes per day	up to 30 minutes per day
Range of Motion: assist with active & or passive ROM **(Per P.O.)**		Up to 60 minutes per day	up to 60 minutes per day	up to 60 minutes per day
Assist with Medication: includes prompting at right time, provide liquid & assistance in self-medication. Documentation of who prepares medication.		5 minutes per incident	5 minutes per incident	will depend: based on the number of times medications are ordered in 24 hours
Vital Signs: **(As per Physician's Orders)**		5 minutes per incident	5 minutes per incident	up to 30 minutes in 24 hr. period
Other: As per Physician's orders				

Personal Care Standards

PERSONAL CARE ACTIVITIES	PARTIAL ASSISTANCE LEVEL II	TOTAL ASSISTANCE LEVEL III	TOTAL MAX. MINUTE/DAY Additional documentation required when using these times

**** The Following Standards apply only to those consumers that DO NOT pay for room and board to their provider of service:**

NUTRITIONAL SUPPORT:

Meal Preparation: *Please note: only for those consumers who DO NOT pay for room & board (If a client lives in a group home situation, please refer to definitions.)	up to 15 minutes per meal	up to 15 minutes per meal	up to 45 minutes per day
Feeding	up to 15 minutes per meal	up to 30 minutes per meal	up to 90 minutes per day
Special Dietary Need: Pureed food, extra hydration with documentation	up to 15 minutes	up to 30 minutes	up to 30 minutes per meal

Environments: can count only 1/3 of time spent. ** can only count units for those consumers who DO NOT pay for board and room.

ENVIRONMENTAL:

House cleaning: i.e. dusting & vacuuming rooms consumer uses	up to 10 minutes per day	up to 10 minutes per day	up to 60 minutes per week
Laundry / Ironing & Mending:	up to 60 minutes per week	up to 60 minutes per week	up to 60 minutes per week
Making and Changing Beds:	5 minutes per day	5 minutes per day	15 minutes per day
Dishwashing: This time based on only washing consumer's dishes	up to 10 minutes per meal	up to 10 minutes per meal	up to 10 minutes per meal
Shopping: Time based on shopping for the consumer	up to 60 minutes per week	up to 60 minutes per week	up to 60 minutes per week
Payment of Bills: Only those bills of the consumer	up to 30 minutes per month	up to 30 minutes per month	up to 30 minutes per month
Seizure Activity; this time includes protecting consumer during & right after the seizure **only with supporting documentation**	5 to 30 minutes per incident	5 to 30 minutes per incident	5 to 30 minutes per incident