

Clinical Policy: Personal Care Services

Reference Number: WA.UM.42

Effective Date: 01/18

Last Review Date: 6/18

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

The purpose of this guideline is to provide guidelines and outline the process for authorizing personal care services. Medical Personal Care is a program that provides assistance with activities of daily living to individuals who meet the eligibility requirements with authorization from Home and Community Services. HCS assesses need by use of the CARE assessment tool. They are available in a member's home, adult family home, or DDA group home. These services include personal care, relief care, cluster care, nurse delegation training by an individual provider to continue providing personal care or member responsibility reimbursement. Services must not duplicate services Coordinated Care is required to provide.

Process for Authorization

1. HCS requests for personal care services will be received in the WA Behavioral Health Utilization Management Email box.
2. The following criteria must be met to approve personal care services:
 - a. The member must have IMC/BHSO coverage *and*
 - b. The need for personal care is based solely on a psychiatric disability *and*
 - c. The services requested or needs of the member could not be met through provision of other available Behavioral Health services.
 - i. For example: group homes may already have staff who provide transportation, medication management, act as payee etc...
 - ii. Services may also be provided by other entities or programs such as PACT, day treatment, Case Management etc...
3. The UM clinician will respond back to HCS with a completed authorization form within 5 business days of the original request unless there is mutual agreement in writing to extend the five (5) business day requirement.
4. If services do not meet criteria **and** the individual's diagnosis is psychiatric:
 - a. A plan must be developed by Coordinated Care and implemented to meet the service needs identified in the CARE assessment. A written response must be provided to HCS or its designee and must include the reason for the determination and alternative services available; if needed authorize those services that will be used to meet the personal care needs identified in the CARE assessment. A plan must be developed by Coordinated Care and implemented to meet the service needs identified in the CARE assessment.
5. If the client's eligibility for Personal Care services is not based on a solely psychiatric disability that will be documented on the HCS form.

Reviews, Revisions, and Approvals	Date	Approval Date
Policy created	1/18	1/18
Policy Review		6/18

References

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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

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

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

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

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

©2016 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene® and Centene Corporation® are registered trademarks exclusively owned by Centene Corporation.