

Section 3.7 Medicaid Personal Care Program – 2011

This section is applicable to audits of counties and 51 Boards.

Funding: Medical Assistance, CFDA number 93.778. The federal government has identified Medical Assistance as a program of higher risk. Auditors will need to ensure that they meet the federal requirements for testing a major program within the context of also ensuring they meet the requirements from the Department of Health Services.

The Wisconsin Medicaid personal care benefit (MAPC) provides funding through the Medicaid State Plan to assist persons with the performance of their activities of daily living. Recipients need a valid Wisconsin Medicaid card, and a medically necessary need for the service. All hours of care provided in a year, beyond 50 hours, are required to be prior authorized by the Wisconsin Medicaid Program.

Counties that meet the statutory requirements of 46.215, 46.22 or 46.23, Stats., or a county department established under s.51.42 or 51.437, Stats., may become certified personal care providers under Wisconsin Medicaid. Each certified agency is required to submit a plan of operations which meets the requirements of Wisconsin Administrative Code DHS 105.17 and DHS 107.112 in order to bill as a certified provider for the personal care benefit.

The supervisory registered nurse employed or sub-contracted by the county conducts a home care assessment on each recipient who has a medical necessity for assistance with personal care and a valid Wisconsin Medicaid card. The nurse determines the number of hours the recipient needs, obtains physician orders, completes a plan of care which the physician signs, and then requests prior authorization for the care. The prior authorization packet is submitted to the Wisconsin Medicaid Program, and hours of care are prior authorized for up to one year.

All hours and visits billed per recipient must be accounted for in appropriate personnel and recipient records. Counties shall develop a clear audit trail for personal care which shows revenues for each recipient for the care provided under this benefit, separate from other services and benefits being provided under long term care programs (e.g., CBRF costs, adult family home costs, supportive home care costs).

A county will not be reimbursed for services provided to a client who is not eligible for Medicaid funding. The county may choose to use another appropriate funding source or pass on the disallowed service reimbursement to the personal care provider due to non-compliance if this provision is included in the provider/agency contract.

When presenting findings, identify the program and the specific compliance requirement, for example “PC A. Medicaid Audit of Personal Care Services.”

Risk assessment

The Department of Health Services has designated the Medicaid Personal Care Program to be a state major program when the auditee or its contracted providers together receive \$100,000 from the Wisconsin Medicaid program for personal care services billed under the auditee's provider number.

Compliance requirements and suggested audit procedures

Several of the compliance requirements in this section reference the Personal Care Handbook, which is online at <https://www.forwardhealth.wi.gov/WIPortal/Default.aspx>.

A short webcast titled "Introduction to the Online Handbook" is available to assist in navigation and search functions within the handbook. The training can be found online at

<https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/training/OnlineHandbook/OnlineHandbook.htm.spage>

PC A. DHS Audit of Personal Care Services

Compliance requirement(s)

The Office of the Inspector General (formerly the Bureau of Program Integrity) in the Department of Health Services conducts audits of several counties that bill the Wisconsin Medicaid Program for personal care services. Counties are expected to implement corrective action for any audit findings issued as a result of these compliance audits.

Suggested audit procedure(s)

Inquire whether the county has undergone a compliance audit performed by the Office of the Inspector General that resulted in findings requiring corrective action. If such findings exist, determine whether the county has implemented its corrective action for any findings.

PC B. Contracting for Personal Care Services

Compliance requirement(s)

Many counties contract personal care services through provider agencies. In all cases, there must be a formal contract for such services, and the counties must ensure that the contractors are qualified to provide personal care services. In addition, counties must provide their contractors with Medicaid rules, regulations and provider publications from the Wisconsin Medicaid Program that govern how the personal care benefit is administered, and they must monitor the contractor's compliance with these rules.

Suggested audit procedure(s)

If the county contracted for personal care services through other providers, determine whether

- There is a contract between the county and the contractor
- The contractor is qualified to provide personal care services
- The county provided the contractor with Medicaid rules, regulations and publications
- The county monitored the contractor's compliance with the Medicaid rules, regulations and publications

PC C. Personal care case file

Compliance requirement(s)

The recipient's case file must include the following information showing compliance with requirements for Personal Care:

- Evidence that recipient has a valid Medicaid card.
- Copies or originals of the Personal Care Screening Tool (PCST), as appropriate, and of all documents submitted to Wisconsin Medicaid. Most of the PCST information in the Personal Care Handbook is in the Prior Authorization section and Personal Care Screening Tool chapter. (Providers completing the Web-based PCST are required to maintain the entire PCST on file, not just the PCST Summary Sheet.)
- A Plan of Care (POC) that meets guidelines as outlined in the Personal Care Handbook, Topics 2460, 2465, and 10577, including a physician's order indicating medical necessity for assistance with personal care and light housekeeping.
- Personal care services must be provided in a recipient's home, including but not limited to a group home, assisted living, or community based residential facility (CBRF) of less than 20 beds. Personal care cannot be provided in a nursing home, hospital or CBRF of more than 20 beds.
- The housekeeping component of personal care services must not exceed more than one third of the total direct care services provided per week in the recipient's home when the recipient lives alone or other limitations that can be found in the Personal Care Handbook, Topic #3167.
- A prior authorization must be in place if the personal care and personal care travel time exceeds 50 hours in a calendar year as required in the Personal Care Handbook, Topic # 3175, 2485.

Suggested audit procedure(s)

For a sample of personal care case files, determine whether the case file includes the required documentation. See Section 1.6 "SAS 39 and Audit Sampling" for guidance on sample sizes.

PC D. Personal Care and Supportive Home Care

Compliance requirement(s)

Several long term care programs from the Department of Health Services pay for supportive home care services that are similar to personal care services, including meal preparation, housekeeping, assisting with bathing, laundry, changing beds or medication reminders. Counties are expected to ensure that the same units of service are not billed to more than one program, and they need to be especially diligent considering the similarities between supportive home care services and personal care services.

Suggested audit procedure(s)

Determine whether the county has effective procedures to ensure that the same unit of service is not billed to more than one program. Any instance of double billing must be reported as a finding with questioned costs.

PC E. Billings

Compliance requirement(s)

The requirements for billing Medicaid for Personal Care services include:

- Contract providers and providers funded through a fiscal agent may bill the county only for actual hours of personal care services provided, and the county may not bill Medicaid more hours than were actually provided by the county or a sub-contractor.
- Billed hours must not exceed the number of hours approved by the physician and prior authorized.
- Travel time billed to Medicaid must contain the information in the documentation requirements as outlined in Personal Care Handbook, Topics 2510, 2509, 2487 (alternate formats are allowed as long as all of the required information elements are included).
- Billings must be specific to each eligible recipient and correspond to the time sheets showing the date the service was delivered, the in-and-out time, and the individual tasks as required in the Personal Care Handbook, Topics 2500, 2510.
- Recipients must sign each personal care provider's visit sheet as required in the Personal Care Handbook, Topic 2500.
- Reimbursement amounts for contracted services must be in accordance with provider agreements or contracts and recipient case plans.
- Reimbursement amounts for services documented through a fiscal agent must be in accordance with individual provider agreements and recipient case plans.
- Counties must maintain an accounting of personal care that includes revenues received for each recipient for the care provided under this benefit. The accounting of personal care must indicate costs associated with personal care separately from other services provided under other long term care programs and funding sources (see "Personal Care and Supportive Home Care," above).

Suggested audit procedure(s)

For a sample of billings, determine whether the billings were supported by the required documentation. See Section 1.6 "SAS 39 and Audit Sampling" for guidance on sample sizes.

Questions

Please send questions by email to DHSAuditors@Wisconsin.gov and include the identifier for the audit procedure (example - "PC A. Medicaid Audit of Personal Care Services") and the name of the auditee in the message.