Department of Medical Assistance Services
600 East Broad Street
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MEDICAID MEMO

Notice of Implementation of Personal Care Cap — Revised Exception Criteria

Last Updated: 03/09/2022

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Notice of Implementation of Personal Care Cap — Revised Exception Criteria

This memorandum **(which supersedes the memo entitled "Notice of Implementation of Personal Care Cap-Effective September 1, 2011" dated July 8, 2011)** is a ***REVISION to the entire criteria*** in the previous notification of a change in personal care services authorizations for the Elderly or Disabled with Consumer Directed Services (EDCD) and HIV/AIDS Waiver Programs and supersedes all previously issued memorandum and provider policy manuals with respect to personal care services. These changes are effective September 1, 2011 and have been approved by the Centers for Medicare and Medicaid Services (CMS).

This change applies to services provided by personal care providers and facilitated by service facilitators. These changes apply to HCPCS codes T1019 for agency directed personal care and S5126 for consumer directed personal care or a combination of the two. In all instances, effective with dates of service July 1, 2011 and forward, when a request is made for T1019 and/or S5126, the duration of the service authorization will not exceed a 24 month period.

For All Existing and New Prior Authorizations which do not exceed 56 hours per week: Providers do not have to submit any additional documentation or request any changes for existing or any new prior authorizations which do not exceed the 56 hour per week cap.

For All New Admissions, Transfers, or Changes to Current Service Authorizations Submitted to KePRO Effective for Dates of Service On and After September, 1, 2011:

The following criteria will be applied by providers when seeking an exception to the 56 hour per week cap for personal care services (whether the services are agency directed or consumer directed or a combination of agency and consumer-directed services).

The waiver individual must:

- Currently have a minimum level of care of B or C as defined in the EDCD or HIV/AIDS waiver manuals, Chapter IV;

AND have one or more of the following which documents the increase risk of institutionalization:

1. Documentation of dependencies in all of the following activities of daily living: bathing, dressing, transferring, toileting, and eating/feeding, as defined by the current pre-admission screening criteria. (Submitted to KePRO via DMAS-99.); OR
2. Documentation of dependencies in both Behavior and Orientation as defined by the current pre-admission screening criteria. (Submitted to KePRO via DMAS-99.); OR
3. Documentation from the local Department of Social Services that the individual currently has an open case with either Adult Protective Services (APS) or Child Protective Services (CPS) (as described in subdivisions (1) and (2) of this subdivision) and is in need of additional services above the 56 hour per week cap. Documentation can be in the form of a phone log contact or any other documentation supplied. (Submitted to the service authorization contractor via attestation.)
    - For APS: Is defined as a substantiated APS case with a disposition of needs protective services and the adult accepts the needed services.
    - For CPS: Is defined as being open to CPS investigation if it is either founded OR a completed family assessment documents the case with moderate or high risk.

When submitting attestation information, upon post payment review and/or Quality Management Review (QMR), should documentation regarding proof of attestation submitted to KePRO be absent in the clinical record, the provider's reimbursement may be subject to retraction and/or a referral to the Medicaid Fraud Control Unit (MFCU) initiated.

When submitting a request to KePRO for over 56 hours per week for dates of service on and after October 1, 2011, in addition to the current documentation requirements, evidence of the following must be included with the request.

- The completed **DMAS 98** fax cover form requesting services;
- The most recent **DMAS 97A/B** that reflects the current level of care (level of

care B or C, as indicated above)

- The most recent **DMAS 100** that reflects the need for supervision hours;
- The most recent **DMAS 99** that reflects the individual's current functional and medical status, **AND;**
- One or more of the items listed above in items 1-3.

General Information for Providers and Service Facilitators:

Providers and service facilitators are responsible for updating the plan of care as necessary to support the need for the hours over 56 hours per week. Providers are responsible for ensuring that staff providing care are aware of any changes related to service delivery based upon the implementation of the 56 hours per week cap. Service Facilitators are responsible for ensuring that employers and recipients are aware of any changes related to the implementation of the 56 hours per week cap.

Please refer to the EDCD or HIV/AIDS Waiver Provider Manual, Chapter IV for information regarding the level of care determination process. The process for determining the number of hours an individual may need has not changed.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the ACS Web Portal Support Helpdesk, toll free, at 1-866-352- 0496 from 8:00 A.M. to 5:00 P.M. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800- 884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.