HSCSN

HSCSN Internal Policy

POLICY NAME: Long-Term Care Services and Supports **POLICY ID:** UM_20

DEPARTMENT: Utilization Management

POLICY EFFECTIVE DATE: 10/24/2025 **POLICY LAST UPDATED DATE:** 10/24/2025

I. PURPOSE

This policy supports governance of HSCSN's delivery of quality services to its enrollees while ensuring compliance with regulations and implementation of industry-specific standards.

II. POLICY STATEMENT

Summary

Health Services for Children with Special Needs, Inc. (HSCSN) coordinates long-term care services and supports (LTSS), defined below, for CASSIP enrollees who need support for chronic physical and behavioral health conditions that limit their abilities to care for themselves. LTSS can be provided in a person's home, in another community-based setting, or by a long-term care facility. LTSS provide assistance with activities of daily living such as eating, bathing, grooming, dressing, walking, using the toilet, getting up or down from a chair or the bed, and preparing meals.

In accordance with 42 CFR 438.210 (a)(5)(ii)(D), HSCSN administers LTSS services in a manner that gives enrollees the opportunity to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

HSCSN has contracted with Liberty Healthcare to perform independent LTSS assessments and reassessments using the InterRAI tool, a nationally recognized and accepted, standardized instrument for assessing the support needs of people with disabilities. LTSS assessments are used by HSCSN Care Management (CM) staff in the development of enrollee care plans and are used by Utilization Management (UM) staff when making determinations regarding enrollee eligibility and level of care for LTSS services.

Currently, enrollees are referred by HSCSN Utilization Management to Liberty Healthcare for an LTSS assessment based on one of the following:

- A complete and valid request from a physician or nurse practitioner for initiation of personal care aide (PCA) services submitted to UM at HSCSN
- A complete and valid request from a physician or nurse practitioner for an increase in PCA services submitted to UM at HSCN
- An enrollee receiving PCA services is due for annual LTSS assessment

- HSCSN Care Manager request for LTSS assessment of an enrollee
- Determination by UM Staff that there has been a significant change in enrollee status that warrants an LTSS assessment
- Referral for an LTSS assessment from a District Agency

In the future, HSCSN will determine which additional services require an LTSS assessment including skilled nursing facility admission, intermediate care facility (ICF-IDD) admission, respite care, , and adaptive equipment. For authorization of these other LTSS services, please refer to their respective policies.

A request for initiation of PCA services triggers a request for an LTSS assessment. Enrollees receiving PCA services will have an LTSS assessment at least annually. The LTSS assessments are used by HSCSN Utilization Management staff for determining eligibility for PCA services and for approval of hours. The LTSS assessments are shared with HSCSN Care Managers so that they can be incorporated into enrollee care plans.

The determination of eligibility and approval of PCA hours is based on clinical criteria in accordance with the CASSIP definition of medical necessity and is consistent with generally accepted medical standards and incorporates the LTSS assessment for individuals 4 years of age and older.

Per the CASSIP Contract section C.5.144, A service is Medically Necessary if a physician or other treating health Provider, exercising prudent clinical judgment, would provide or order the service for an Enrollee for the purpose of evaluating, diagnosing or treating illness, injury, disease, physical or mental health conditions, or their symptoms, and the provision of the service is in compliance with 1905(a) of the Act, 42 U.S.C. § 1396d(a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan. Medically Necessary services shall be:

- No more restrictive than those used in the Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in District statutes and regulations, the State Plan, and other District policy and procedures;
- Services and benefits that promote normal growth and development and prevent, diagnose, detect, treat, ameliorate the effects or a physical, mental, behavioral, genetic, or congenital condition, injury, or disability for CASSIP Enrollees;
- Provided in accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Enrollee's illness, injury, disease, or physical or behavioral health condition;
- Not primarily for the convenience of the Enrollee or treating physician, or other treating healthcare Providers, and more cost effective than an alternative service or sequence of services, and at least as likely to produce equivalent therapeutic or diagnostic results with respect to the diagnosis or treatment of that Enrollee's illness, injury, disease or physical or mental health condition; and
- Specific to the Enrollee and shall take into account available clinical evidence, as well as recommendations of the treating clinician and other clinical, educational, and social services professionals who treat or interact with the Enrollee.

For enrollees under 21 years of age, services should be appropriate for the age and developmental status of the child, adolescent or young adult; take into account the

setting that is appropriate to the specific needs of the child, adolescent or young adult, and family; and reflect current bioethical standards. Medically Necessary interventions must be reasonably expected to produce the intended results for children and to have expected benefits that outweigh potential harmful effects. In making determinations of medical necessity of services for an Enrollee, HSCSN shall consider the individual circumstances specific to the Enrollee and shall take into account available clinical evidence as well as opinion of the treating clinician and other clinical, educational, and social services professionals who treat or interact with the Enrollee.

According to the American Academy of Pediatrics (AAP) Guidelines for Pediatric Home Care, no universal, clear guidelines have been established to determine the number of home care hours for children. The AAP Guidelines recommend that home care decisions include consideration of a variety of factors including child factors, need for assistance with activities of daily living, family factors, school and other services provided, the daily schedule, and the availability of informal supports.

III. PROCEDURE

Definitions

Care Coordination [C.3.29]: Services and activities that ensure all Medicaid Enrollees gain access to necessary medical, social, and other health-related services (including education-related health services) as described in section C.5.146.

Care Management [C.3.31]: Refers to the deliberate, planned, and consistent set of activities intended to improve Enrollee care and reduce the need for unnecessarily accessed medical services by enhancing coordination of care (clinical and administrative), eliminating duplication, and helping Enrollees and their caregivers more effectively manage health conditions. The goals of Care Management are to improve quality, have dedicated supportive services, and control costs for Enrollees with complex conditions.

Case Management Services [C.3.33]: Case Management services are comprehensive services furnished to assist Enrollees, eligible under the State Plan with access to needed medical, social, educational, and other services including all the following per (42 C.F.R. § 440.169(d).

Child and Adolescent Supplemental Security Income Program (CASSIP) [C.3.36]: The Medicaid managed care program specifically designed to provide comprehensive primary, specialty, in-patient, behavioral health, and long-term care to SSI or SSI-eligible children and adolescents.

Department of Health Care Finance (DHCF) [C.3.67]: The Agency within the District of Columbia Government responsible for administering all Medicaid services under Title XIX (Medicaid) and Title XXI (CHIP) of the Act, for eligible beneficiaries, including the DC Medicaid Managed Care Program and oversight of its managed care Contractors, as well as the Alliance and including all agents and Contractors of DHCF. For purposes of the contract, the Contract Administrator shall be authorized to act on behalf of DHCF unless other individuals are specifically otherwise noted.

Enrollee [C.3.92]: An individual who is currently enrolled in CASSIP. Enrollee also refers to the parent, legal guardian, or personal representative of the Enrollee in cases where the Enrollee is a minor or incapacitated as determined by a court.

Family-Centered Care [C.3.102]: Best practice principles for the provision of medical, therapeutic, and mental health care for children with Special Health Care or developmental needs. Family-Centered Care establishes parents as the central beneficiaries of a team of professionals that plan and implement services needed to address a child's needs; build upon the strengths of the family; recognize and address the impact of a child with Special Health Care Needs on caregivers, siblings, and other family members; and arrange for services to be provided in the home or other natural settings whenever possible.

Home Care Agency or Home Heath Services Agency: A home care agency is a business licensed to provide in-home or community-based services such as skilled nursing, private-duty nursing, physical therapy, occupational therapy, speech-language pathology, intravenous therapy, medical social services, home health aide or personal care aide services. A home care agency must be licensed in the jurisdiction where the services are rendered.

Informal Supports: Unpaid assistance provided to an enrollee by the enrollee's family or another individual who is unrelated to the enrollee.

Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID) [C.3.150]: Under 42 CFR § 435.1010, an institution that meets federal Conditions of Participation (CoP) and has as its primary purpose the provision of health or rehabilitation services to individuals with an intellectual disability or related conditions receiving care and services under the Medicaid program. The ICF/ID CoP recognizes the developmental, social, and behavioral needs of individuals with intellectual disability who live in residential settings by requiring that each individual both require and receive active treatment for the ICF/IID care to be eligible for Medicaid funding. Services include a protected residential setting, ongoing evaluation, diagnosis, treatment, planning, twenty-four (24) hour supervision, coordination, and integration of health or rehabilitative services to help each function at his/her greatest ability.

Long-Term Care: Medicaid Long Term Care Services provide coverage through several vehicles and over a continuum of support settings for adults with disabilities to enable them to have choice, control, and access to a full array of quality services that assure optimal outcomes. This includes institutional care and home and community-based long-term services and supports.

Long-Term Services and Supports (LTSS) [C.3.156]: Services and supports provided to enrollees of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the enrollee to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional settings. At present, HSCSN considers Personal Care Aide (PCA) Services to be an LTSS service and requests for PCA trigger an LTSS assessment. Other covered services that may be considered broadly as LTSS include Private-Duty Nursing (PDN), Home Modifications, Respite Care, Skilled Nursing Facility (SNF), and Intermediate Care Facility (ICF) services.

LTSS Assessment: An LTSS assessment is done to evaluate an individual enrollee's functional status, need for assistance with activities of daily living and LTSS services. An

LTSS assessment is completed in-person or virtually by a trained clinician using a standardized instrument.

Medically Necessary [C.3.174]: Services for individuals that promote normal growth and development and prevent, diagnose, detect, treat, ameliorate the effects or a physical, mental, behavioral, genetic, or congenital condition, injury, or disability and following generally accepted standards of medical practice, including clinically appropriate, in terms of type, frequency, extent, site, and duration and considered effective for the Enrollee's illness, injury, disease, or physical or mental health condition.

Personal Care Aide [C.3.198]: An individual who provides services through a Provider Agency to assist the patient in activities of daily living, bathing, dressing, toileting, ambulation, or eating. In the District of Columbia, home care agencies may offer home health or personal care aide services and shall employ or contract with qualified home health or personal care aides to perform those services. A home health aide or personal care aide shall be qualified by completing seventy-five (75) hours of classroom and supervised practice training, with at least sixteen (16) hours devoted to supervised practical training, and by passing a competency evaluation.

Personal Care Aide (PCA) services: PCA services are health-related services that are provided to individuals who are unable to perform one or more activities of daily living (ADL) such as bathing, dressing, grooming, toileting, ambulation, or feeding oneself, as a result of medical condition or physical or cognitive impairment, causing substantial disability. In order to be eligible for PCA services, the enrollee needs to have a disability and require significant assistance in order to perform activities of daily living (ADLs) compared to other individuals of the same age.

Prior Authorization or Preauthorization (Authorization) [C.3.214]: The process used to determine whether to approve a treatment request involving services covered under the Contract. (See also "Service Authorization")

Private-Duty Nursing (PDN): Private-Duty Nursing services are nursing services for technology-dependent enrollees who require long-term and more individualized and continuous care than is available from a visiting nurse under the Skilled Nursing Home Health Services benefit [DCMR 29-947]. PDN is for technology-dependent enrollees who require continuous monitoring and/or frequent skilled nursing interventions on at least a daily basis, necessitating shifts of nursing care.

Recommended Hours: The hours of PCA services or other LTSS services that are recommended on the Assessment Completion Report after an LTSS assessment. Recommended hours are calculated using an algorithm that assigns hours of assistance based on the enrollee's level of dependence (as judged on the interRAI) for each activity of daily living.

Requesting Provider: The Requesting Provider is either a treating physician or advanced practice registered nurse (APRN or nurse practitioner) who is appropriately licensed and has had a prior professional relationship with the enrollee that included an examination(s) done in a hospital, primary care or other physician's office, nursing facility, or in the enrollee's home prior to the order for the personal care aide services or LTSS.

Respite [C.3.226]: A CASSIP covered benefit designed to offer a short-term, intermittent period of relief for a parent, other non-paid caregivers, or person(s) who normally provide the primary care for and lives with a CASSIP Enrollee that has or is suspected of having needs that require constant monitoring, assistance with activities of daily living, and/or intense in-person supports.

Skilled Nursing Services: Medicaid reimbursable Skilled Nursing services are part-time or intermittent skilled nursing care services that are needed by an enrollee due to an illness or injury, and are furnished by a licensed nurse (LPN or RN) in accordance with the enrollee's home health plan of care and through a licensed home care agency [DCMR 29-9901].

Utilization Management [C.3.270]: An objective and systematic process for planning, organizing, directing, and coordinating health care resources to provide Medically Necessary, timely, and quality health care services in the most cost-effective manner.

Utilization Review Criteria [C.271]: Detailed standards, guidelines, decision algorithms, models, or informational tools that describe the clinical factors to be considered relevant to making determinations of medical necessity including, but not limited to, level of care, place of service, the scope of service, and duration of service.

Details

1) Long-Term Care Services and Supports (LTSS) Overview

A. LTSS services are designed to assist persons with a range of services and supports including assistance with basic tasks of everyday life over an extended period of time [DCMR 989.2]

B. The HSCSN Care Manager is responsible for assessing enrollee needs, developing a Care Plan, and assisting the Enrollee/caregiver with coordinating services, including LTSS [per HSCSN Policy CM_09].
    1. The Care Plan must be developed with Enrollee/Caregiver participation and in consultation with other providers caring for the Enrollee.
    2. The Care Plan should identify long-term supports and services that are needed by the Enrollee.
    3. Development of the Care Plan should use a person-centered (and family-centered) planning process.
    4. When an LTSS assessment is done on an enrollee, the Care Plan is updated to incorporate findings from the LTSS assessment including the InterRAI report and the Assessment Completion Report (ACR).

C. The HSCSN care manager may request that UM refers an enrollee for LTSS assessment based on:
    1. Need to further assess an enrollee's functional impairments or activity limitations
    2. To assist with development of the enrollee Care Plan
    3. To identify needs that may be addressed by LTSS services

2) LTSS Assessment

A. LTSS assessments are performed by Liberty Healthcare which is a subcontractor of HSCSN. Liberty Healthcare is the same organization used by DHCF for LTSS assessments.

B. Utilization Management refers HSCSN enrollees for LTSS assessment to Liberty based on Care Manager request, as part of the UM process for PCA services, or upon request from a District agency.
C. The request for assessment will be submitted to Liberty on the HSCSN LTSS Assessment Request Form (Attachment B) and include supporting documentation.
D. A Registered Nurse (RN) or Licensed Independent Clinical Social Worker (LICSW) employed by Liberty Healthcare shall conduct an initial face-to-face assessment (can be in-person or virtual) following receipt of a request for an LTSS assessment from UM at HSCSN.
E. With the exception of hospital discharge or expedited timelines, the RN or LICSW employed by Liberty Healthcare shall be responsible for conducting a face-to-face assessment of the enrollee using a standardized, needs-based assessment tool within five (5) calendar days of the receipt of a request for an assessment, unless:
    1. The enrollee/caregiver has requested an assessment at a later date;
    2. Liberty is unable to contact the enrollee/caregiver to schedule the assessment after making three (3) attempts to do so within five (5) calendar days of receipt of the assessment request; or
    3. HSCSN determines that an extension is needed due to extenuating circumstances.
F. The assessment shall:
    1. Confirm and document the enrollee's functional limitations, cognitive/behavioral, and skilled care support needs;
    2. Be conducted in consultation with the enrollee and his/her authorized representative and/or support team;
    3. Determine and document the enrollee's unmet need for services, taking into account his/her current utilization of informal supports and other non-Medicaid resources required to meet the enrollee's need for assistance;
    4. Determine if the enrollee meets eligibility criteria for personal care aide services and recommend a level of care; and
    5. At the option of the individual, be conducted in the presence of one or more members of his/her support team.
G. Liberty Healthcare uses the interRAI Home Care (HC) and InterRAI Child and Youth Pediatric Home Care (PED-HC) for LTSS assessment depending on the age of the enrollee.
    1. InterRAI is a collaborative network of researchers and practitioners in over 35 countries committed to improving care for persons who are disabled or medically complex. Their network strives to promote evidence-informed clinical practice and policy decision-making. Each instrument represents the results of rigorous research and testing to establish the reliability and validity of items, outcome measures, assessment protocols, case-mix algorithms, and quality indicators.
    2. The InterRAI HC is a validated, standardized, needs-based tool for assessing the home and community-based supports needed by adults with disabilities. The InterRAI PED-HC is a validated, standardized, needs-based tool for assessing the home and community-based supports needed by children and adolescents (4 to 20 years of age) with disabilities.
H. Based on the face-to-face assessment using the standardized needs-based assessment tool, Liberty does an Assessment Completion Report (Report) which

summarizes the findings and provides scores used for determination of eligibility and level of care. Using an algorithm, the LTSS assessment is used to calculate a total numerical score (Total Score), which is comprised of three (3) separate scores (Functional Score, Cognitive & Behavioral Score and Skilled Care Score) pertaining to the assessed functional, cognitive/behavioral, and skilled care needs of an individual. The functional assessment includes an assessment and corresponding score correlated to the individual's ability to manage medications. The three (3) separate assessment scores are used to determine eligibility for specific LTSS as follows:

1. For State Plan Personal Care Aide (PCA) services, eligibility is determined based on the Functional Score, without consideration of the medication management score; and
2. For other LTSS, eligibility can be determined based on the sum of the scores for assessed functional, cognitive/behavioral, and skilled care needs, and includes medication management.

I. The total numerical score consists of a value from zero to thirty-one (0-31), which may include a score of up to twenty-three (23) on the functional assessment, a score of up to three (3) on the cognitive/behavioral assessment, and a score of up to five (5) on the skilled care needs assessment.

J. Each face-to-face assessment of an individual using the standardized needs-based assessment tool contains the following components:

1. The functional assessment evaluates the type of assistance required for each of the following activities of daily living (ADLs), based on typical experience under ordinary circumstances within the last three (3) days prior to assessment:
    a. Bathing, which means taking a full-body bath or shower that includes washing of the arms, upper and lower legs, chest, abdomen, and perineal area;
    b. Dressing, which means dressing and undressing, both above and below the waist, including belts, fasteners (e.g., buttons, zippers), shoes, prostheses, and orthotics;
    c. Eating, which means eating and drinking (regardless of skill), including intake of nourishment by a feeding tube or intravenously;
    d. Transferring, which includes moving in and out of the bathtub or shower, and moving on and off the toilet or commode;
    e. Mobility, which means moving, whether by walking or using a wheelchair, between locations on the same floor; and moving to and from a lying position, turning from side to side, and positioning one's body while in bed;
    f. Toileting, which includes using the toilet, commode, bedpan, or urinal and cleaning oneself afterwards, adjusting clothes, changing bed pads, and managing ostomy or catheter care; and
    g. Medication Management, which means how medications are managed, including remembering to take medicines, opening bottles, taking correct dosages, giving injections, and applying ointments. The need for assistance with medication management is not considered in determinations of eligibility for State Plan PCA services.
2. The cognitive/behavioral assessment evaluates the presence of and frequency with which certain conditions and behaviors occur, for example:
    a. Serious mental illness or intellectual disability;

b. Difficulty with receptive or expressive communication;
c. Hallucinations;
d. Delusions;
e. Physical behavioral symptoms directed toward others (*e.g.*, hitting, kicking, pushing, grabbing, sexual abuse of others);
f. Verbal behavioral symptoms directed toward others (*e.g.*, threatening, screaming, cursing at others);
g. Other physical behaviors not directed toward others (*e.g.*, self-injury, pacing, public sexual acts, disrobing in public, throwing food or waste);
h. Rejection of assessment or health care; and
i. Eloping or wandering.

3. The skilled care needs assessment evaluates whether and how frequently certain treatments and procedures were provided during the applicable look- back period, for example:
    a. Chemotherapy;
    b. Dialysis;
    c. Infection Control;
    d. IV Medication
    e. Oxygen Therapy;
    f. Radiation Therapy;
    g. Suctioning;
    h. Tracheostomy Care;
    i. Transfusion
4. Whether and how frequently certain programs were used during the last three (3) days prior to assessment, for example:
    a. Scheduled toileting program;
    b. Palliative care program; and
    c. Turning/repositioning program.
5. Whether and how frequently (days and total minutes) certain types of formal care were provided during the last seven (7) days prior to assessment, for example:
    a. Home health aides;
    b. Home nurse;
    c. Homemaking services;
    d. Meals;
    e. Physical therapy;
    f. Occupational therapy;
    g. Speech-language pathology and audiology; and
    h. Psychological therapy by any licensed mental health professional.
6. Whether and how frequently certain types of medical visits occurred during the last ninety (90) days prior to assessment, for example:
    a. Inpatient acute hospital visit with overnight stay;
    b. Emergency room visit with no overnight stay; and
    c. Physician visit (includes authorized assistant or practitioner).
7. For individuals in a hospital or nursing facility, whether physical restraints were used during the last three (3) days prior to the assessment.

K. If the RN or LICSW employed by Liberty is unable to conduct or schedule the face-to-face LTSS assessment or reassessment after making three (3) attempts to do so within five (5) calendar days, Liberty will inform HSCSN UM Home Care

Reviewer. HSCSN will have a process for doing outreach to the enrollee and issuing an Administrative Denial to the individual [29 DCMR 989.24].

3) Process for Authorization of Personal Care Aide Services

A. To request Personal Care Aide (PCA) services, a Requesting Provider completes the HSCSN Order for Home Health Services form (Attachment A) and submits it to Utilization Management at HSCSN along with medical records including records for a visit with the requesting provider within 90 days of the order.
B. HSCSN Utilization Management follows standard timeframes for review of the PCA request as per UM_09. Once it has been determined that the request is complete and valid, a request for LTSS Assessment is submitted to Liberty Healthcare using the HSCSN LTSS Assessment Request Form (Attachment B).
    1. LTSS assessments are not used for children under 4 years of age, as they were not validated in this population.
    2. For requests for PCA for children under 4 years of age, once the request is found to be complete and valid, it should be directed to a medical director (without an LTSS assessment) for a determination.
C. After the LTSS Assessment has been completed, Liberty Healthcare sends it to UM at HSCSN within two (2) business days.
D. After the LTSS Assessment has been received by UM at HSCSN, the initial documents and LTSS Assessment are sent to a medical director for review and determination of eligibility and hours.
E. An authorization decision is made and communicated to the enrollee/caregiver and the requesting practitioner as per UM_09 and UM_08.
F. After an LTSS assessment, for eligible enrollees, PCA services are authorized for one year , unless the medical director specifies a shorter duration.
G. If/when PCA services are authorized, the UM Home Care Reviewer works with the HSCSN Care Manager, enrollee and caregiver to identify a home care agency to accept the enrollee for services, develop a Home Health Plan of Care, and provide the authorized services.
H. The accepting Home Care Agency is responsible for submitting re-authorization requests to UM at HSCSN every year and/or prior to the expiration of the last authorization period.
I. Orders signed by the Requesting Provider are required annually and for any change or update to the Home Health Plan of Care.
J. An LTSS assessment is requested for each enrollee receiving PCA services at least annually prior to expiration of the last authorization period.
K. An LTSS assessment is requested for any significant change in health or functional status or after a request for an increase in PCA hours is received.

4) Utilization Review for Personal Care Aide Services

A. An enrollee/caregiver who refuses to participate in an LTSS assessment or cannot be reached in order to schedule an LTSS assessment, does not meet criteria for PCA services and cannot be authorized for PCA services. This will result in an administrative denial.
B. Initial Authorization Requests or Requests for an Increase in Level of Care
    1. A UM case is opened in the HSCSN IT system which includes the order from the Requesting Provider, supporting medical records, the InterRAI assessment, and the Assessment Completion Report. After the LTSS assessment is received, the case is sent to an HSCSN Medical Director for review and an authorization decision.

C. Re-Authorization Requests
    1. A UM case is opened in the HSCSN IT system which includes the Home Health Plan of Care, nursing progress notes and supervisory nursing notes.
    2. The UM Home Care Reviewer reviews each re-authorization request. The enrollee will need an LTSS assessment, then the UM Reviewer determines if there has been significant change in health or functional status since the last review, and if there has been no change in status, then authorizes the PCA services at the same level of care.
    3. If the enrollee is due for an annual LTSS assessment or there has been a significant change in health or functional status, then the UM reviewer requests an LTSS assessment.
    4. After the LTSS assessment is received, the case is sent to a Medical Director for review.

D. Medical Director Review
    1. An enrollee is generally considered to be eligible for PCA services with a Functional Score of 4 or higher as per the Assessment Completion Report.
    2. Liberty provides a calculation of Recommended Hours of LTSS services based on the need for assistance with activities of daily living reported in the interRAI and an algorithm used to calculate hours of support needed for each activity of daily living.
    3. For adults (21 years of age and older), the medical director reviews the case and generally approves the Recommended Hours as either hours per day or global hours per week.
        a. In some cases, the Recommended Hours may be more than were ordered by the Requesting Provider. In those cases, the hours of PCA services that were ordered are approved and the HSCSN Care Manager and enrollee/caregiver are informed that additional hours are available based on the LTSS assessment.
        b. There may be enrollees for whom the recommended hours are less than ordered or previously authorized. For those enrollees, the Medical Director reviews the entire case to determine if the hours requested are medically necessary based on a variety of factors including the LTSS assessment, need for assistance with activities of daily living and supervision, informal supports available for caregiving, disability of the enrollee, other services being provided, safety and risk to the enrollee. The Medical Director may approve additional hours on a case- by-case basis and based on principles of medical necessity as described above.
    4. For children and adolescents, (4 years through 20 years of age), the medical director reviews the case including HSCSN Order for Home Health Services, medical records, interRAI report, Assessment Completion Report and Recommended Hours. The medical director may also obtain additional information from the HSCSN Care Manager about the enrollee and family and uses other information that is available in making a determination of hours.
        a. When making a determination regarding PCA services for a child, the medical director considers the enrollee's age, need for assistance with activities of daily living and supervision compared to other children of the same age, informal supports available for

caregiving, disability of the enrollee, other services being provided, the enrollee's daily schedule, safety and risk to the enrollee.

b. PCA services are not for day care/childcare. Parent/caregiver work hours cannot be used as a justification for PCA services for children under 10 years of age. If PCA is being used to cover hours while a parent works, other options for childcare should first be exhausted before referring for PCA services.
c. PCA services are not primarily for behavior management or supervision of the enrollee. If the enrollee is under 10 years of age, the family is expected to provide needed supervision through informal supports and childcare. If the justification for PCA services is not primarily assistance with activities of daily living, then PCA services may denied or reduced.
d. For cases when the Requesting Provider does not specify hours, the Recommended Hours will be reviewed by the Medical Director. After considering all of the information available, the medical director will determine if the Recommended Hours need to be adjusted. Based on the age of the enrollee, daily schedule, and other services being provided, it may be appropriate to approve fewer or more hours than recommended by the algorithm.
e. For cases when the Recommended Hours are higher than ordered by the Requesting Provider, the hours of PCA services that were ordered are approved.
f. For cases when the Recommended Hours are lower than ordered by the Requesting Provider or previously authorized, the Medical Director evaluates the case. The Medical Director determines if the hours requested are medical necessary based on factors listed above.
g. The Medical Director will document reasons for the decision in the UM Case in the HSCSN IT system.
h. If a determination of hours is less than requested, then an adverse benefit determination will be issued according to UM/08.

5. For children under 4 years of age, the presumption is that parents/guardians and other informal supports will meet their routine need for assistance with daily living. All children under 4 years of age need some assistance with activities of daily living. Typically, children under 4 years of age are not eligible for PCA services. The medical necessity of PCA services can be evaluated on a case-by-case basis considering the age of the enrollee, the need for assistance with activities of daily living and supervision compared to other children of the same age, informal supports available for caregiving, disability of the enrollee, other services being provided, the enrollee's daily schedule, safety and risk to the enrollee.
6. If the enrollee meets criteria for PCA services, but the approved hours are 3 hours or less per day, then the enrollee will be eligible for one short shift per day (a PCA visit of 3 hours or less billed at a flat rate).
7. Hours can be approved as hours per day or global hours per week.
8. If PCA services are denied, suspended, terminated or reduced, the UM Home Care Review Nurse follows the process for adverse benefit

determination (Policy UM/08 Notification of Adverse Benefit Determinations).

9. Authorization decisions are communicated to the enrollee/caregiver and Requesting Provider as per UM_09.
10. The Home Care Review Nurse faxes/e-mails a copy of the completed authorization to the enrollee's Home Health Care Agency of choice indicating:
    a. the approved service;
    b. the number of hours for which the enrollee has been approved to receive and
    c. the date span in which the services are to be provided.
11. The UM Home Care Review Nurse attaches all documents to the enrollee's record in the HSCSN IT system, including orders from the Requesting Provider, medical records, documents from a Home Care Agency, LTSS assessment, authorization decision, and letters.

IV. ACCOUNTABLE EXECUTIVE(S) AND REVIEWER(S)

A. Accountable Executive(s): Levey, Eric

B. Committee(s) Responsible for Review: Benefits and Utilization Management Committee

V. APPROVAL

Approved by:

_____ _____

Levey, Eric Date

VI. REFERENCES

Dates:
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References:
CASSIP Contract Sections: C.3.156, C.5.1.3, C.5.49.5, C.5.144
Federal Regulations: 42 CFR §438.210 (a)(5)(ii)(D)
District Regulations: Title 29 (Public Welfare) of DCMR, Chapter 9, Section 989
Transmittals: N/A
Internal Policies: CM_09

Internal Documents: N/A
Committees: Benefits and Utilization Management Committee (BUMC)