

Medica Health Plans (“Medica”) Administrative Requirements for Participating Agencies for the Provision of Personal Care Assistance (PCA) Services

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Capitalized terms in this document are defined as set forth in Minnesota Statutes, Chapter 256B, and the Personal Care Assistance provider participation agreement with Medica, unless otherwise defined herein. “Personal Care Assistance” means assistance for those services set forth in Minnesota Statutes, §256B.0659, Subd.2. For more information, see the Medica Utilization Management policy regarding Personal Care Assistance services at [Medica.com](#).

Non-compliance with Medica Administrative Requirements, including without limitation those provided in this document, is considered a material breach and grounds for contract termination with Medica. All Personal Care Assistance Administrative Requirements described in this document must be met.

Introduction

We value our relationships with our Personal Care Assistance contracted provider network and the efforts our providers make to be in compliance with the Medica Administrative Requirements. It is because of our dedication to Medica members that we have high standards for our Personal Care Assistance providers to ensure quality services and safeguard against abuse of the Personal Care Assistance program.

Medica wishes to thank its Personal Care Assistance contracted providers for all their great work and for their collaborative efforts with Medica to help people live as safely in the community as possible!

I. Personal Care Assistant (“PCA”) Employee Oversight

As a Medica contracted Personal Care Assistance Provider Agency, it is your responsibility to ensure that the services for which you bill Medica are in fact performed by your employees and that your employees meet all the requirements necessary to be a PCA. Your responsibility for oversight of Personal Care Assistance services is not limited to Qualified Professional supervisory visits. It is necessary to have monitoring in place to ensure that your employees:

- Stay at work for the entire scheduled time;
- Complete time cards truthfully and accurately; and
- Perform the services they report.

You are also required to have an electronic visit verification (“EVV”) system in place that meets the requirements in Minnesota Statutes §256B.073 and all state and federal monitoring requirements. This includes the electronic documentation of the following:

- Type of service performed;
- Individual receiving the service;
- Date of the service;
- Location of the service delivery;
- Individual providing the service; and
- Time the service begins and ends.

Medica selected the hybrid EVV model offered by HHAEExchange to be the EVV system in Minnesota. Providers may use the Medica provided system or an EVV system that works best for their business. If providers choose another EVV system, it must meet the technical specifications required by the state for all services requiring EVV and it must be able to submit the required data to the state EVV system. Medica will not charge providers to access the state-selected system.

The Minnesota Department of Human Services (DHS) has received Centers for Medicare and Medicaid Services (CMS) approval for the transition of the PCA program to Community First Services and Supports (CFSS) in Minnesota. With this approval, all CFSS workers are required* to complete an individual PCA and CFSS training by June 1, 2024. Per DHS, this new training will help PCA and CFSS staffs prepare for this transition and will help ensure that there are no delays in reimbursement for CFSS services.

*Current individual PCA workers who took the test after April 15, 2020, and have a certificate titled “PCA and CFSS Support Worker Training” do not need to retake the training. Current individual PCA workers who took the test before April 15, 2020, and have a certificate titled “Personal Care Assistance Training” will need to complete the training.

While it is not possible to observe all the work of every PCA, you are required to have a policy and procedure in place that will identify any issues pertaining to the performance of an individual PCA. (See I.G. below for more information on Written Monitoring Procedures.)

Upon federal approval, the DHS shall establish CFSS. CFSS will replace PCA services. DHS intends to

use the same eligibility criteria for CFSS as currently used for PCA services. As a contracted entity with Medica you will be responsible for ensuring the transition to the new state plan in accordance with regulatory guidance, including but not limited to, MN Statute [§256B.85](#).

CFSS has two service delivery models, the agency model and the budget model. Both models allow the person to choose their service providers. In the agency provider model, the person selects an agency that serves as their service workers' employer. This means the agencies will recruit, hire, train, supervise and pay CFSS support workers. In the budget, the person recruits, hires, trains, supervises and pays their support workers.

A. Care Oversight

A Qualified Professional must conduct face-to-face PCA supervised home visits as required in the DHS PCA Manual. This manual can be viewed using the following link: [DHS PCA Manual](#). This is an opportunity to ensure that the PCA records accurately reflect the actual hours worked. Except as noted below, Medica does not reimburse for Qualified Professional supervision conducted over the phone.

Exception to standard requirements:

The Qualified Professional may conduct the required supervision remotely for a person with chronic health conditions or a severely compromised immune system when:

1. The person requests a determination from their primary health care provider.
2. The primary health care provider determines remote supervision is appropriate.
3. The primary health care provider documents their determination of need for remote supervision.
4. The PCA provider agency retains copies of the primary health care provider's documents with all copies of the person's care plan.

The Qualified Professional must still conduct the first Qualified Professional visit in person or complete the initial PCA care plan in person. The person may request to return to in-person Qualified Plan visits at any time.

The agreement between a Care Coordinator and a Personal Care Assistance Provider Agency to provide less PCA supervision than Medica requires, must be documented in the Medica member's file at the agency and will also be documented by the Care Coordinator.

B. Documented Contingency Plan

Every Medica member's Care Plan, as described in Minnesota law, must show evidence of a contingency plan in the event that a PCA does not report to work. Your agency must have a procedure in place to ensure the safety of a Medica member if a PCA does not report to work as scheduled. See Section III. C. for more information on requirements for contingency plans as documented in the Care Plans.

C. Oversight of PCAs

In addition to the supervision visits, the agency must have an electronic visit verification plan in place to ensure that PCAs report to work as scheduled and complete their time cards accurately. For example, Medica suggests making at least one unannounced phone call a week to ensure the PCA reported to work as scheduled. If the PCA is not onsite as expected, the agency's procedure for responding to an unexpected absence must be followed and progressive discipline must be started immediately, as appropriate. This is critical for two reasons. First, once a need for Personal Care Assistance services has been determined, it is the responsibility of your agency to ensure those services occur for the safety of the member.

Second, it is against federal law to bill for Medicaid services that did not occur, and the Personal Care Assistance Provider Agency must have mechanisms in place to ensure services occurred as reported.

Personal Care Assistance provider agencies must develop and implement administrative policies and procedures by which their agency will conduct service verification calls. A service verification call is an

unscheduled telephone call with the services recipient and the PCA worker to verify that an individual PCA worker is present and providing scheduled services. All Personal Care Assistance agencies must develop and implement administrative policies and procedures for conducting service verification calls.

Specific oversight activities must be documented in the Medica member's file.

D. Scheduled Work Time and Time Cards

The hours a PCA works should be planned in advance and should be scheduled at times that will meet the member's needs identified on the Personal Care Assistance Assessment taking into consideration other formal and informal supports in place that also meet a member's needs. Per Minnesota Statutes 256B.0911, the monthly use of Personal Care Assistance services is to be developed by the Medica member, Qualified Professional and PCA and should be documented in the Care Plan. PCAs must work the hours as planned and any change in planned work hours must be approved and documented by your agency management concurrent with the change. Personal Care Assistance Provider Agency involvement in scheduling is required even if the PCA is a family member and lives with the Medica member.

Hours worked should correspond to the functional needs of the Medica member, and the tasks completed must correspond to the Care Plan. For example, if assistance with dressing is needed, the PCA should be working during the time dressing/undressing occurs and the need for this type of assistance must be documented in the Personal Care Assistance Care Plan.

Time cards must reflect actual hours worked. Per Minnesota Statutes §256B.0659 Subd. 12, time cards must include:

- Full name of PCA and individual PCA ID numbers;
- Provider name and telephone number;
- Full name of the Medica member and the Medica member's medical assistance identification number or date of birth;
- Consecutive dates, including, day, month and year and arrival and departure time with a.m. and p.m. notations;
- Signature of Medica member or Responsible Party;
- Personal signature of the PCA;
- Any shared care provided if applicable;
- A notice that it is a federal crime to provide false information on personal care service billings for medical assistance; and
- Dates and locations of Medica member hospitalizations, care facility or incarceration.

Time cards must be documented daily, submitted on at least a monthly basis to the Personal Care Assistance Provider Agency, and never be completed or signed prior to work being performed. The Qualified Professional supervising the PCA should have confidence that the work was performed before approving a time card. In lieu of a signature, by paying the PCA and billing Medica, the agency assumes responsibility for the accuracy of the time card.

PCAs must be able to communicate effectively with the Medica member and the Personal Care Assistance Provider Agency and be able to maintain daily written records. If the Medica member and/or the PCA does not speak English, it is the responsibility of your agency to provide for a translated time card. The

Provider Tip:

Examples of Vulnerable Adult Maltreatment that must be reported:

1. Sexual Assault should be immediately sent to the Office of Health Facility Complaints ("OHFC") and the police. The police should also be contacted immediately so that evidence can be collected and appropriate exams completed.
2. Physical abuse by staff, relatives, visitors.
3. Unexplained injuries, such as fractures, large skin tears, and bruises, especially those that are in unusual areas, such as the perineum, breasts, upper inner thigh, should be forwarded to OHFC promptly.
4. Staff taking or using credit cards, checks, and/or money from Medica members.
5. Neglect: Obtain information about the nature of the neglect, e.g., was there failure to follow the resident's Care Plan, physician's order, etc.

time card must be in English, as well as the language spoken by the PCA and Medica member. It is acceptable to use a time card with universal symbols in lieu of translation.

E. Vulnerable Child and Adult Maltreatment

Children. Minnesota law requires professionals and their delegates who work with children to make a child protection report if they know of or have reason to believe a child is being neglected or abused, or has been neglected or abused within the preceding three years. Mandated reporters do not meet their duty to report child maltreatment by using MAARC, as required for adult reporting and defined below. To report concerns about child abuse, neglect or sexual abuse, contact the county or tribal social service agency where the child lives during business hours. If the child is in immediate risk of harm, contact your local law enforcement agency or dial 911. For more information on child maltreatment reporting refer to the Minnesota Department of Human Services website [by clicking here](#).

Adults. All care givers are mandatory reporters of maltreatment or suspected maltreatment of vulnerable adults under Minnesota law. Your Personal Care Assistance Provider Agency must have a training program for all agency employees that includes details about the Minnesota Adult Abuse Reporting Center (MAARC) at 1-844-880-1574 which is the statewide common entry point for accepting reports of suspected maltreatment of vulnerable adults. For all Medica members receiving Personal Care Assistance services, the assessment has shown a need for services.

Therefore, once the need for services has been determined, if a PCA fails to provide needed services--for example, if the PCA does not report to work as scheduled--the Medica member's safety could be at risk. If situations like this put the health of a Medica adult member in jeopardy, they must be reported to MAARC. Additionally, Minnesota law requires that a referral be made to MAARC if any Responsible Party fails to provide the support needed by the Medica adult member. For more information on vulnerable adult reporting refer to the Minnesota Department of Human Services website [by clicking here](#).

F. Responsible Party

The Responsible Party has responsibility for oversight of the work of PCAs. The Responsible Party's signature on the time card attests to knowledge that the PCA performed all work reported on the time card.

Minnesota law defines "Responsible Party" as an individual who is capable of providing the support necessary to assist the person receiving Personal Care Assistance services to live in the community. The *Personal Care Assistance Assessment and Service Plan* will indicate if a Medica member needs a Responsible Party and will identify who is the Responsible Party. A Personal Care Assistance assessment cannot be conducted without a Responsible Party if one is needed. In accordance with law, the Responsible Party **cannot** also be the:

- the member's PCA;
- the Qualified Professional assigned to the member's case;
- home care provider agency owner or manager;
- home care provider agency staff, unless staff who are not listed above are related to the recipient by blood, marriage, or adoption; or
- county staff acting as part of employment.

A licensed family foster parent who lives with the recipient may be the Responsible Party as long as the family foster parent meets the other Responsible Party requirements.

A Responsible Party is required when:

- the person is a minor;
- the person is an incapacitated adult resulting in a court-appointed guardian; or
- the Personal Care Assistance Assessment determines that the recipient is in need of a Responsible Party to direct the recipient's care.

Once it has been identified that a Medica member needs a Responsible Party, the Personal Care Assistance Provider Agency and Responsible Party enter into a written agreement (DHS form #5856, which can be accessed on DHS's [eDocs page](#)) regarding the Responsible Party's duties. It is the responsibility of the Personal Care Assistance Provider Agency to ensure that the appointed Responsible Party carries out the duties as listed in the [DHS PCA Program Manual](#).

Under Minnesota law, failure to carry out the Responsible Party duties results in a referral to MAARC for adults and the county or tribal social service agency for children (refer to Section E regarding vulnerable adult maltreatment and child neglect or abuse). Personal Care Assistance Provider Agency compliance with Responsible Party requirements will be included in the Medica audits of Personal Care Assistance Provider Agencies.

G. Written Monitoring Procedures

Your Personal Care Assistance Provider Agency must have a written policy and procedure for monitoring Personal Care Assistance services. In addition to the other activities listed in this section, Medica encourages you to include the following in your policy and procedure:

- A confidential process for Medica members and employees to report possible violations of Minnesota law and Medica policies; and
- A process for conducting a satisfaction survey offered to Medica members and their Responsible Parties.

H. Maximum Hours Worked

In accordance with law, Minnesota Statute 256B.0659, subdivision 11(a)(10), in no case is it appropriate that an individual PCA work more than 310 hours in a given month for one or more agencies. Medica will enforce this policy via a retrospective review process. What this means is that Medica will initially pay a claim for services after receiving it, but then, if upon retrospective review it is found that an individual PCA worked more than 310 hours in a given month, Medica will take back payment for hours in excess of 310.

Your agency is free to develop the procedures that it deems most effective to ensure the services billed to Medica are in fact performed.

Provider Tip: There is oversight of PCAs that your Personal Care Assistance Provider Agency will need to do as a business need or in order to meet Medicare certification requirements, which is beyond what is billed to Medica for supervisory visits by a Qualified Professional in accordance with Minnesota law and DHS requirements. The cost of this oversight for business or Medicare certification purposes is in part funded by the Personal Care Assistance rate your agency already receives. Additionally, your efforts to ensure that your billed services were in fact performed are a standard part of doing business and are not separately reimbursable.

II. Authorizations

The most recent authorization a Personal Care Assistance Provider Agency receives from Medica is the authorization the PCA should use to provide services. An agency may receive an authorization with an end date a year from now. If in two months Medica sends a new authorization increasing the amount of Personal Care Assistance services to be provided, with the same end date as the previous authorization, the PCA should provide the level of Personal Care Assistance indicated on the most recent authorization received from Medica for the date spans indicated on the most recent authorization. The most recent authorization generated by Medica supersedes any previous authorizations in place.

For all Medica members 65 years of age and older, you must contact the assigned Care Coordinator for

authorization of Personal Care Assistance services and to request Personal Care Assistance assessments.

Seniors	Contact the Medica member's Care Coordinator. Obtain the name of the Care Coordinator from the Medica member or call the Provider Service Center (PSC) at 1-800-458-5512.
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Before Medica can complete an authorization, re-authorization or a change in authorization, the Personal Care Assistance Provider Agency may be asked to provide key documentation to the Medica Care Coordinator. The information requested can vary, but may include request for submission of:

- The Referral for Reassessment for Personal Care Assistance Services (DHS 3244P). Click [here](#) to obtain a copy of this form;
- A copy of the last completed Personal Care Assistance Assessment;
- Two weeks of PCA notes for existing Medica members; and
- The most recent Care Plan for existing Medica members.

Additional documentation may be requested by Medica, including additional medical records, Care Plans for the past year, or additional PCA notes.

A. New Authorizations

Per changes made during the 2012 legislative session, Personal Care Assistance Provider Agencies are not allowed to request an initial Personal Care Assistance Assessment. DHS defines initial assessment as a request made when there is not an active Personal Care Assistance authorization in place. When a Personal Care Assistance Provider Agency learns of a Medica member interested in a PCA who does not have a current authorization, members should contact their Care Coordinator.

To expedite service delivery for Medica members, services can be started based on a verbal authorization from the Care Coordinator pending written authorization. Medica suggests that the Personal Care Assistance Provider Agency document the name of the person who verbally authorized the service, date of discussion and amount of time or units verbally authorized to ensure payment.

B. Re-Authorizations

It is required that the Personal Care Assistance Provider Agency request a re-authorization of services a minimum of 60 days in advance of the end of an authorization. Providers should contact the member's Care Coordinator to request a re-authorization. The purpose of this requirement is to ensure that there are no disruptions in services to Medica members. Claims without authorization will be disallowed as provider liability and cannot be billed to the Medica member. Reauthorization requests will not be accepted from an out of network PCA provider.

C. Authorization Needed Due to Transition to Medica

When a Medica member transfers to Medica with a current Personal Care Assistance service authorization in place, the amount and type of Personal Care Assistance services will remain in effect for the duration of the authorization unless the service needs change, at which time a new assessment would be warranted. In those instances, Medica will continue to authorize Personal Care Assistance services at the previous level authorized until the new assessment is processed and a new authorization is generated. Refer to the table listed above under "II. Authorizations" for details.

D. Changes in Authorizations

If you feel there needs to be a change in the Personal Care Assistance authorization for Medica members with a Care Coordinator, you should encourage the Medica member, or the Responsible Party, to contact the Care Coordinator to discuss this.

E. Change of Personal Care Assistance Provider Agency

Medica members may choose from any Medica participating Personal Care Assistance Provider Agencies for their Personal Care Assistance services. The new agency is responsible for the following actions:

- Obtaining approval from the Medica member or Responsible Party for the change of agency;
- Contacting the current agency to notify it of the change to a new agency and obtaining documentation of the amount of flexible Personal Care Assistance services that had been used in the current authorization span. (Medica requires the current agency to give this information to the new agency or Medica upon request); and
- Submitting to Medica the documentation received from the current agency indicating the amount of flexible Personal Care Assistance services that have been used so that Medica can generate an updated authorization for the new agency.
- Completed [PCA Technical Change Request Form](#) (DHS 4074A) used to document the requirements above for change in Provider Agency should be sent directly to the Care Coordinator.

It is important to include the Care Coordinator in agency change planning. The Care Coordinator may pursue verification from the Medica member that the Medica member wishes to change agencies. The Care Coordinator will also need to enter a new authorization. Therefore, Personal Care Assistance Provider Agencies must include the Care Coordinator in agency change plans to ensure payment of Personal Care Assistance services.

Please note: The new agency must coordinate a future effective date for the change from the current agency to the new agency. It is the responsibility of the new agency to ensure that a new authorization is in place. Medica will not pay for retroactive authorizations due to a change of agency.

Personal Care Assistance Provider Agencies may not limit a Medica member's right to choose service providers. Personal Care Assistance Provider Agencies may not have or enforce any agreements, requirements or non-compete clauses prohibiting, limiting or restricting an individual PCA from working with a Medica member or different Personal Care Assistance Provider Agency **after leaving a Personal Care Assistance Provider Agency, regardless of the date the agreement was signed.**

Provider Tip: Minnesota law provides that the Personal Care Assistance Provider Agencies are only permitted to market agency services through printed information in brochures and on websites. Agencies *may not* engage in any agency-initiated direct contact or marketing in person, by phone, or other electronic means to potential Medica members, guardians or family members.

F. The Right Service at the Right Time

It is important that Personal Care Assistance Provider Agencies and PCAs recognize that their role is not to inappropriately steer or direct a Medica member towards services. This may constitute a violation of state and federal law and, therefore, may be grounds for termination of a contract between the Personal Care Assistance Provider Agency and Medica.

Medica members have an assigned Care Coordinator. It is the role of the Care Coordinator to discuss service needs and the overarching service plans. Please keep in mind that Personal Care Assistance is only one service on a large menu of other service options with which your agency may be involved and the Care Coordinator, in collaboration with the Medica member, puts together a larger plan on how medical, psychosocial and environmental needs are to be met. If the Medica member has concerns about the service plan, the most appropriate thing to do is to direct the Medica member back to the Care Coordinator to discuss the concerns. Medica would like to see increased partnerships between Personal Care Assistance Provider Agencies and Care Coordinators, but decisions about which services are most appropriate to meet all of the Medica member's needs should be between the Medica member and the Care Coordinator.

III. Development of Care Plans

Thoughtful development of Care Plans consistent with Minnesota law is a key part of ensuring that

Medica member needs are met by your PCA employee. Both Medicare-certified agencies and non-Medicare-certified agencies are expected to have Care Plans in the member's agency file. For Medicare-certified agencies, you must have all required plan of care data elements (as found on the 485 Care Plan form) contained in a readily identifiable location within the member's agency file. Non-Medicare-certified provider Care Plans must meet the requirements set forth by DHS, located [here](#).

Development and updates of Care Plans must be based on face to face meetings with Medica members. The Care Plan must be completed within seven days of starting Personal Care Assistance services. Care Plans must be updated when there is a change in condition or, at a minimum, on an annual basis. Each Personal Care Assistance Provider Agency is required to provide the Medica member with a current Care Plan that is consistent with the needs identified on the *Personal Care Assistance Assessment and Service Plan*. Updated copies of the Care Plan must be kept in the Medica member's home and the Medica member's file at the Personal Care Assistance Provider Agency.

A. Employee Oversight

While conducting PCA supervision visits, the Qualified Professional should document review of the PCA documentation, whether the Personal Care Assistance services are meeting the goals outlined in the Care Plan and review the month-to-month plan for use of Personal Care Assistance services. The Qualified Professional is also responsible for documenting any changes in the Medica member's needs (would result in the Care Plan needing to be updated), all communication that occurred with Medica member and staff and any hands-on training provided to ensure proper care of the Medica member. This review and supervision ensures that the PCA is able to provide appropriate care and should support the PCA's time submitted on the time cards. Keep copies of the supervisory visit documentation at the Personal Care Assistance Provider Agency in the Medica member's and PCA's file, and at the Medica member's home.

As part of the supervisory visit the Qualified Professional must verify a copy of the Home Care Bill of Rights was provided to the member, or their responsible party before services are started. This documentation must be retained as part of the member's record.

A copy of the Home Care Bill of Rights must also be presented to the member at least ten calendar days' prior to the termination of a service by a home care provider. This clause does not apply in cases where:

- The client engages in conduct that significantly alters the terms of the service plan with the home care provider;
- The client, person who lives with the client, or others create an abusive or unsafe work environment for the person providing home care services; or
- An emergency or a significant change in the client's condition has resulted in service needs that exceed the current service plan and that cannot be safely met by the home care provider.

Medica requires that all PCA supervisory visits be conducted in person. Medica values the professional oversight the Qualified Professional provides to the PCA and requires that at least every other supervisory visit include direct observation of the PCA's work.

In addition to ensuring the Medica member is receiving the appropriate care, the Qualified Professional is required to inquire about the Medica member's satisfaction with the assigned PCA. Medica encourages the Qualified Professional to facilitate privacy for some of the supervision visits allowing the Medica member an opportunity to openly discuss potential dissatisfaction, vulnerability or abuse issues.

Medica expects Personal Care Assistance Provider Agencies to pursue additional background checks during employment if there is reason to believe something has occurred that may place the individual PCA at risk for not passing. Pursuing these additional background checks is part of your Personal Care Assistance Provider Agency employee oversight responsibility.

B. Flexible Use

Though Medica may enter Personal Care Assistance authorizations for 12-month time frames, it is expected that the Personal Care Assistance Provider Agency will divide this 12-month service authorization time frame into two six-month periods. Medica expects the Personal Care Assistance Provider Agency to ensure that no more than 75% of the total authorized Personal Care Assistance units in a 12-month time period be used in any six-month time period in accordance with Minnesota law.

The month-to-month plan for utilization of flexible Personal Care Assistance services must be documented in the Care Plan. If the Medica member is at risk of exceeding the Personal Care Assistance services prior to the end of a six-month period, the Personal Care Assistance Provider Agency must notify the Medica member and the appropriate Medica contact in writing of this in a timely fashion. The Medica member's Personal Care Assistance agency record must include documentation of notice to the Medica member and Medica that the member's use of Personal Care Assistance services was approaching or exceeded the number of hours authorized.

It is expected that the Personal Care Assistance Provider Agency will notify the Care Coordinator with any changes in condition, even if there are sufficient Personal Care Assistance service units available due to the flexible schedule to accommodate short-term changes in condition (e.g., hospitalizations).

The Personal Care Assistance Provider Agency must monitor the use of flexible Personal Care Assistance services closely to assure proper utilization. Personal Care Assistance services are to be medically necessary. Just because a Medica member may have "stored up" Personal Care Assistance hours does not mean that a higher level of Personal Care Assistance services should be provided for the sole purpose of using the "extra" hours. Providing increased Personal Care Assistance hours is appropriate when there has been a change in condition, or to accommodate medical appointments or alternating schedules that result in increased needs (e.g., increased Personal Care Assistance for a child who is out of school in the summer). It is the responsibility of the Personal Care Assistance Provider Agency to make sure flexible Personal Care Assistance is used correctly.

The Personal Care Assistance Provider Agencies are required to complete the Flexible PCA Verification Form when received from a Medica representative. Failure to complete and send this form as instructed may result in breach of contract.

C. Documented Contingency Plan

Every Medica member's chart must show evidence of a contingency plan (also known as a risk management plan). This is critical for the safety of the Medica member as well as for oversight of the PCAs. There should be an appropriate plan in place for back-up coverage appropriate to the needs of the Medica member. If a PCA does not report to work as scheduled, the PCA must contact the agency to report the absence and the contingency plan, as documented in the Care Plan, will then be executed. The best business practice is for the PCA to be required to contact the agency as soon as he or she is aware of the need for a change in the schedule and no later than 30 minutes before scheduled work time, and the agency to have a plan in place to send a replacement PCA and ensure the Medica member's Personal Care Assistance needs are met. You should develop a contingency plan to meet the stated needs. Here are further details about contingency planning:

Provider Rule:

Contingency Plan: The Personal Care Assistance Provider Agency should write a contingency plan and maintain it in the Medica member's file as part of the Care Plan. Depending on what your agency's approach to contingency planning is, some of the points listed on the following page may be included in the contingency plan you develop for your Medica members.

Suggested Contingency Plan Components:

- Documentation that the regularly scheduled PCA will inform the agency within a certain amount of time (a minimum of 30 minutes) of the inability to perform at the scheduled time.
- Documentation that the Personal Care Assistance Provider Agency will inform the Medica member within a certain number of hours of the PCA's regularly scheduled time that the PCA will not be available, and that a substitute PCA is available, if requested.
- Documentation of the name of the substitute PCA.
- Documentation that the Contingency Plan, including the substitute PCA, has been agreed to by the Medica member.
- Documentation that the substitute PCA has received training on the Medica member's Care Plan prior to the Contingency Plan being implemented.

IV. Billing Requirements**A. Billing for Supervision**

All Qualified Professional supervision services billed to Medica must be for services provided in person and specifically related to a Medica member's care. The Personal Care Assistance Provider Agency should use its agency number to bill for supervision services. Any training other than the individualized training required to provide care for the specific Medica member is NOT billable Qualified Professional time. Any supervision requirements that are provided beyond what Medica requires and beyond what the member's needs require (e.g., additional supervision required as a result of being a Medicare certified agency) are NOT billable Qualified Professional time.

The frequency of a Qualified Professional supervisory visit, beyond what Medica requires, is determined by the complexity of care and is not covered unless medically necessary. The necessity for each visit must be documented in the Personal Care Assistance agency record. Although Medica does not currently require authorizations for Qualified Professional supervision, the Personal Care Assistance Provider Agency must not automatically bill 2 hours/8 units for each visit unless that entire time is used and needed. For stable, non-complex Medica members, it is unlikely that a Qualified Professional supervisory visit would require 2 full hours since Medica requires Qualified Professional supervision to occur more frequently than DHS. Medica will be auditing this. If the Qualified Professional supervision does require the full 2 hours, the documentation of tasks completed and supervision provided should support billing for 2 hours of time. Supervision that is billable to Medica includes:

- Care Plan development;
- Review of medications;
- Evaluation of the quality of Personal Care Assistance services being provided, including any action taken to correct deficiencies;
- Communication of changes in Medica member needs to the physician, Care Coordinator or others;
- Orientation of PCAs to personal care and needs; and
- Training PCAs to provide hands-on assistance with special health care tasks.

Employee oversight or training that may not be billed to Medica includes:

- Training that is not specific to the care of the Medica member; for example, CPR or HIPAA privacy training;
- Unannounced phone calls to the Medica member to ensure the PCA reported to work as scheduled; including service verification calls;
- Time spent at a Medica member's home for the purpose of training a new PCA on how to complete paperwork or agency time cards;
- Time spent at the Personal Care Assistance Provider Agency by a new PCA for the purpose of enrolling into the agency system and completing new hire paperwork;

- Direct professional nursing tasks that could be assessed and authorized as skilled nursing tasks, which need to be billed only by a contracted home health agency;
- Group trainings at the Personal Care Assistance Provider Agency on universal issues that the agency may pursue for business needs in an effort to be a better agency and provider; and
- Additional supervisory visits that are required by Medicare related to being a Medicare certified home care agency.

B. Billing for PCA and Relative Caregiver Payments

For each individual PCA and the Medica member(s) for whom they provide services, Medica requires all Personal Care Assistance Provider Agencies to identify, document and report individual PCA and Medica member relationships for all Personal Care Assistance services, including the extended Personal Care Assistance services. “Related” means the individual PCA is related to the recipient (parent, sibling, adult child, grandparent or grandchild) by blood or through a legal adoption process. Failure to maintain required documentation may result in a \$500 fine to the Personal Care Assistance Provider Agency.

Provider Tip: Your employed PCA may start providing Personal Care Assistance services to Medica members after passing the background check *and* obtaining a DHS provider number even if the PCA does not have a Medica PCA number yet assigned. The Medica standard for timely filing applies to claims submitted for services provided to Medica members regardless of whether they had the Medica PCA number or not.

C. Billing for PCA Enhanced Rate

Providers shall only bill for the PCA enhanced rate when the individual personal care assistant meets DHS requirements AND are providing services to a qualifying member. The rate enhancement applies to PCA services when the member is eligible for ten(10) or more hours of PCA a day or is an EN home care rating AND are provided by an individual PCA who has met all the requirements designated by DHS. The enhanced rate does not apply to supervision of PCA services.

D. Enrolling and Terminating PCA Employees

Before enrolling a PCA with Medica, the PCA **must** be enrolled with DHS, be assigned an individual treating provider number and be affiliated with all agencies in which they are employed.

In addition, Medica requires that the Personal Care Assistance Provider Agency notify Medica of **terminated employees**. Notification to Medica should be via the Medica provider portal.

E. Excluded Personal Care Assistance Provider Agencies; Individual PCAs/Disclosure of Ownership; Disclosure of Certain Business Transactions; and Compliance Training

- (a) General Requirements. Personal Care Assistance Provider Agencies must comply with Medica requirements pertaining to fraud, waste and abuse as set forth in the Medica Administrative Requirements document. Agencies and their Subcontractors and employees, including without limitation PCAs, must not have been: (i) convicted of a criminal offense related to involvement in any federally funded government program; (ii) debarred, suspended or otherwise excluded from participation in any federally funded government program, in accordance with applicable federal law; or (iii) sanctioned by the U.S. Department of Health and Human Services Office of Inspector General (“OIG”). To this end, **the agencies must monthly check** the following lists for potential names of their employees, officers, directors, agents, Subcontractors and Persons with an Ownership or Control Interest as defined below: (i) the OIG List of Excluded Individuals/Entities; (ii) the System for Award Management (“SAM”) (formerly the General Services Administration Excluded Parties List System); and (iii) the DHS Provider Enrollment File (this can be checked by clicking [here](#)). This should also occur prior to pursuing the DHS individual PCA enumeration process. Additionally, pursuant

to Minnesota Statutes §245C.15, Personal Care Assistance Provider Agencies must not employ or enter into a business relationship with an individual PCA who has been convicted of a felony, including, but not limited to, “crimes of violence” as that term is defined under Minnesota Statutes §624.712 Subd. 5. If an employed PCA is subsequently convicted of a felony, the individual PCA must be terminated immediately.

- (b) **Excluded Entities and Individuals.** Personal Care Assistance Provider Agencies are not allowed to have agreements with an excluded entity or individual for the provision of items or services related to Medica obligations for Personal Care Assistance services under the Medica contract with DHS. Under law, neither DHS nor Medica will pay for any services provided by an individual found on the above noted exclusion lists. Medica requires Personal Care Assistance Provider Agencies to ask potential PCAs if they are terminated (as a service provider) from performing services under a government program prior to assigning the PCA to any Medica members. If Medica identifies any individual PCA that is terminated as a service provider for reasons provided in this Section D, the agency will be notified that the PCA cannot continue to provide services to any Medica member. Any such individual PCA that Medica has terminated as an individual PCA is not permitted to provide Personal Care Assistance services or any other type of home care services to a Medica member during the period of termination. Prior to employment or entering into a business relationship with a PCA, Personal Care Assistance Provider Agencies must make best efforts to confirm the identity of the prospective PCA.

Therefore, agencies should ask for former names and maiden names of prospective PCAs, and check the appropriate data bases, including checking of the Social Security Administration’s Death Master File.

- (c) **Disclosure of Ownership Information.** Before entering into a contract with Medica, on an annual basis, and within 35 days of any request by Medica, Personal Care Assistance Provider Agencies must provide written disclosure to Medica of certain information regarding Managing Employees, and information regarding the corporate ownership of agency and any Subcontractor as required by this paragraph (c). In addition, Personal Care Assistance Provider Agencies must notify Medica within 10 business days of the date an agency knows, or has reason to know, of any update or change in such ownership. Personal Care Assistance Provider Agencies’ disclosure to Medica shall include, but not be limited to, the following information:

1. The name, social security number, date of birth and address of Managing Employees, and each Person with an Ownership or Control Interest in Personal Care Assistance Provider Agency, or any Subcontractor in which agency has direct or indirect ownership of 5% or more;
2. Whether any Person with an Ownership or Control Interest identified in the preceding paragraph is related to any other Person with an Ownership or Control Interest as spouse, parent, child or sibling; and
3. The name of any other organization in which a Person with an Ownership or Control Interest in Personal Care Assistance Provider Agency also has an ownership or control interest in that other organization.

- (d) **Disclosure of Business Transactions.** Within fifteen (15) days of a request by CMS or DHS, the Personal Care Assistance Provider Agency shall disclose to Medica information related to business transactions in accordance with 42 C.F.R. §455.105(b). The Personal Care Assistance Provider Agency’s disclosure to Medica shall include the following information:

1. The ownership of any Subcontractor with whom the agency has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and

2. Any Significant Business Transactions between the agency and any wholly owned supplier, or between the agency and any Subcontractor, during the 5-year period ending on the date of the request.
- (e) Compliance Training. The Personal Care Assistance Provider Agency must annually provide compliance training that meets the guidelines set by CMS from time to time (“Compliance Training”), to all of its personnel and/or employees (as required by CMS) responsible for the administration or delivery of Personal Care Assistance services to Medica members. To the extent required by CMS, such Compliance Training will include such other applicable compliance and/or fraud, waste, and abuse training directed by CMS. For Downstream Entities responsible for the administration or delivery of services to Medica members, an agency must within ninety (90) calendar days of contracting with its Downstream Entities and annually thereafter: (i) communicate general compliance information to its Downstream Entities; and (ii) provide fraud, waste and abuse training directly to its Downstream Entities or provide appropriate fraud, waste and abuse training materials to its Downstream Entities.

An agency shall provide, at Medica’s request, an attestation that the agency has fulfilled the required Compliance Training for its personnel, employees, and Downstream Entities (to the extent required or instructed by CMS) in compliance with this section. Upon reasonable written notice from Medica to the Personal Care Assistance Provider Agency, the Personal Care Assistance Provider Agency shall permit Medica personnel to review the agency’s policies and procedures, including without limitation Compliance Training program materials and methods of distribution to Downstream Entities, related to agency’s Compliance Training provided under this paragraph (e).

- (f) For purposes of this Section D, the following definitions apply.

“Downstream Entities” are any parties that enter into an acceptable written agreement below the level of the arrangement between Medica and the Personal Care Assistance Provider Agency. These written arrangements continue down to the level of the ultimate provider of Personal Care Assistance services.

“Managing employee” means an individual (including a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity or part thereof, or who directly or indirectly conducts the day to day operations of the entity or part thereof as defined in federal regulations.

“Person with an Ownership or Control Interest” means a person or corporation that: (a) has an ownership interest, directly or indirectly, totaling 5% or more in a Personal Care Assistance Provider Agency; (b) has a combination of direct and indirect ownership interests equal to 5% or more in a Personal Care Assistance Provider Agency; (c) owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by a Personal Care Assistance Provider Agency, if that interest equals at least 5% of the value of the property or assets of the agency; or (d) **is an officer or director of a Personal Care Assistance Provider Agency.**

“Significant Business Transaction” is any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and 5% of agency’s total operating expenses.

“Subcontractor” means an individual, agency or organization to which a Personal Care

Assistance Provider Agency has contracted (or a person with an employment, consulting or other arrangement with the agency) for the provision of items and services that are significant and material to the Personal Care Assistance Provider Agency's contract with Medica and Medica's obligations under its contract with DHS.

F. Claim Form

To adhere to the guidelines set by the Minnesota Administrative Uniformity Committee (AUC) and to be consistent with Minnesota law to standardize electronic healthcare transactions, Minnesota providers are required to submit all claims electronically. Personal Care Assistance Provider Agencies must bill for Personal Care Assistance services using an 837- Professional (837P). All Personal Care Assistance services, including extended hours of Personal Care Assistance Services and shared care, must be billed on the 837P for electronic claims.

Other participating providers may submit claims to Medica by paper or electronically. Go to medica.com at this location for details about submitting claims: [Electronic Transactions](#)

- Paper claims must be submitted on the CMS-1500 Claim Form—established by the American Medical Association (AMA) or the invoice accepted by the Minnesota Department of Human Services for professional services and, for facility services, claims must be submitted on the UB-04 claims form established by the National Uniform Billing Committee (NUBC).
- Electronic claims are accepted through various vendor systems. (Please check with vendors to determine if they have a direct connection with Medica). Go to medica.com at Providers > Administrative Resources > [Claim Tools](#) for the following information on Electronic Claims Submission:
 - AUC Initiative
 - Delta Dental of Minnesota
 - HIPAA 5010 FAQ

Additional information is located at Providers>Administrative Resources>Billing and Reimbursement>[Electronic Transactions](#)

All paper Medica claims go to:

Medica
PO Box 30990
Salt Lake City, UT 84130

Medica electronic payer ID: 94265

If your agency has multiple PCAs meeting the Medica member's Personal Care Assistance needs, you must submit individual claims for each PCA.

Note: You must bill for services with one line per date of service in accordance with the DHS requirement.

G. Timeliness of Billing

While Medica contracts allow for a period of 180 days from the date of service for billing Medica, Medica expects timely billing for services. Medica monitors the billing timeliness of Personal Care Assistance Provider Agencies. The [Medica Timely Filing and Late Claims Policy](#) is located on medica.com at Providers>Administrative Resources> Claim Tools.

V. Subcontracting

A Personal Care Assistance Provider Agency contract with Medica permits the agency to enter into subcontracts with others for the purpose of performing Personal Care Assistance services only with the

express prior written approval of Medica. All employees for which an agency bills must be W-2 employees of the agency, unless the agency has the express written approval of Medica.

Medica considers “Supplemental Staffing” a form of subcontracting. “Supplemental Staffing” (e.g. using temporary agencies or other Personal Care Assistance Provider Agencies), whether they are participating with Medica or not, is not acceptable without Medica’s prior written approval.

If the agency bills for services performed by subcontractors and there is no prior written approval from Medica on file, Medica will recover the payment. Moreover, billing for services performed by a subcontractor as defined above, without the prior written approval of Medica, is considered a material breach and grounds for terminating an agency’s contract with Medica. An agency may not bill Medica members to recover payments for inappropriately subcontracted services.

Subcontracts must be submitted to the Medica Network Management Department no later than June 1 of each year. All subcontract information must be sent via e-mail to NetManQuest@medica.com. This e-mailbox will only accept subcontract information; all other inquiries must be made to the proper Medica department.

VI. Documentation in Medica Member / Personal Care Assistance File

Personal Care Assistance Provider Agencies are required to keep specific documentation on file for each Medica member it serves. *Agencies will be audited for compliance with these requirements.* Agencies must keep specific documentation on each Medica member for a minimum of 10 years or a longer period of time as required by law. The following provides a list of examples of what Medica expects to see in agency files. Other documents may be included in agency files.

Agency files:

- Documentation of orientation and training of the PCA specific to the Medica member’s needs (training on the Care Plan);
- Criminal Background Check for the PCA;
- Background check of the Qualified Professional;
- Documentation that all agency employees are being checked monthly against the following lists:
 - (a) OIG List of Excluded Individuals/Entities (or the Medicare Exclusion Database)
 - (b) General Services Administration (“GSA”) Excluded Parties List System within the Health & Human Services System for Award Management
 - (c) DHS Provider Enrollment File
 - (d) National Plan and Provider Enumeration System
 - (e) Social Security Death Master Index
 - (f) Excluded Provided Lists maintained by the State
- Copies of the Qualified Professional’s current license as appropriate;
- Individual PCA Acknowledgement Form;
- Attendance of required PCA trainings;
- Authorization record from Medica;
- Care Plans;
- Documentation of the Qualified Professional visits;
- Documentation of service verification calls;
- Time cards/daily work records;
- Verification of all required staff having attended the *DHS Steps for Success* training;
- Authorization record from Medica;
- Contingency Plan;
- Documentation that flexible use hours are being tracked, and if the Medica member is at risk of exceeding the use of authorized hours, documentation that the Medica member or the Medica

- member's Responsible Party has been so notified;
- Documentation that the Home Care Bill of Rights notice was provided to the member;
 - Documentation that a PCA receiving the Enhanced PCA rate for services has met the [DHS Requirements](#); and
 - Per Minnesota Statutes 256B.0659, Subd. 12:
 - (a) Personal Care Assistant services for a recipient must be documented daily by each Personal Care Assistant, on a time sheet form approved by the commissioner. All documentation may be web-based, electronic, or paper documentation. The completed form must be submitted on a monthly basis to the provider and kept in the recipient's health record.
 - (b) The activity documentation must correspond to the Personal Care Assistance Care Plan and be reviewed by the Qualified Professional.
 - (c) The Personal Care Assistant time sheet must be on a form approved by the commissioner documenting time the Personal Care Assistant provides services in the home. The following criteria must be included in the time sheet:
 - (1) Full name of Personal Care Assistant and individual provider number;
 - (2) Provider name and telephone numbers;
 - (3) Full name of recipient and either the recipient's medical assistance identification number or date of birth;
 - (4) Consecutive dates, including month, day, and year, and arrival and departure times with a.m. or p.m. notations;
 - (5) Signatures of recipient or the responsible party;
 - (6) Personal signature of the Personal Care Assistant;
 - (7) Any shared care provided, if applicable;
 - (8) A statement that it is a federal crime to provide false information on personal care service billings for medical assistance payments; and
 - (9) Dates and location of recipient stays in a hospital care facility, or incarceration.

VII. Quality Assurance

Medica has the ability to be selective with whom it contracts. This allows Medica to ensure quality services for its members and increases its ability to work collaboratively with Personal Care Assistance Provider Agencies, while ensuring that they maintain strong business practices. Medica does have a high standard of performance for its Personal Care Assistance Provider Agencies and has a variety of efforts underway to measure provider performance as well as to offer training and educational opportunities.

A. Medica Provider College Trainings

The Medica Provider College provides online training through live webinars. These training sessions are available to all of the Medica Personal Care Assistance Provider Agencies and are optional. Additional information can be accessed on Medica.com at Providers>Training>[Provider Training](#). Materials are distributed prior to the webinar and the teaching style is interactive. Past topics have included Personal Care Assistance, Home Health Care, Minnesota Health Care Programs, Resources for Helping Yourself and skills training for Nursing Facilities and Care Coordinators, to name a few.

B. Special Investigations Unit (SIU)

The Medica Special Investigations Unit ("SIU") is part of the Medica corporate compliance department. Among other responsibilities, SIU works with Medica staff in public programs and is responsible for prevention, detection, investigation, reporting and when possible, recovery of funds paid to individuals or entities who have engaged in Fraud, Waste or Abuse. In furtherance of these objectives, SIU may, among other things, request records for review, perform onsite audits, and interview providers or their staff

regarding the issue under review.

Should you be contacted by SIU, it is expected that you will cooperate completely with any requests in a timely manner.

C. DHS ‘Steps for Success’

This is a three-day workshop offered by DHS to Personal Care Assistance Provider Agencies to meet the [Provider Training Requirements](#) when enrolling or maintaining enrollment as a Personal Care Assistance Provider Agency. Agencies may attend the “Steps for Success” workshop either in person or through their own internet connection, as a webinar session.

D. Provider Newsletter and Alerts

The *Medica Connections*[®] newsletter is an electronic newsletter sent out monthly by e-mail to a variety of Medica-contracted providers, including Personal Care Assistance Provider Agencies. This newsletter includes notices of contract and administrative requirement changes and, therefore, Personal Care Assistance Provider Agencies should review it. Provider Alerts are similar notifications sent to the Medica provider network on an urgent basis, as needed. [Sign up for both at Medica.com](#).

PCA PROVIDER AGENCY RESOURCES	
MEDICA RESOURCES	
TOPIC	LOCATION
Authorizations	For Medica Choice Care SM and Medica MinnesotaCare members, call 1-800-458-5512. For MSHO/MSC+, contact the Medica member’s Care Coordinator. If you do not know who the care coordinator is, contact the Medica Provider Service Center at 1-800-458-5512.
Coding Guidelines	Medica.com at Providers>Administrative Resources>Supplementary Contracting and Regulatory Requirements> Personal Care Assistance <ul style="list-style-type: none"> • Procedure Codes for Personal Care Assistance Services
Fraud Hotline	Call 952-992-2237 or 1-866-821-1331. Messages can be left confidentially.
How to find a Member’s Assigned Care Coordinator	Call Medica Provider Service Center (PSC) at 1-800-458-5512
Medica Administrative Manual	Medica.com at Providers>Administrative Resources> Administrative Manual
Care Coordination/ Non-Participating PCA Providers	Medica.com at Providers>Administrative Resources>Supplementary Contracting and Regulatory Requirements> Personal Care Assistance <ul style="list-style-type: none"> • Non-Participating PCA Provider Billing Process for MSHO (Medica DUAL Solutions) and MSC+ (Medica ChoiceCare) Members
Medica Claims Tools & Forms and Timely Filing Policy	Medica.com at Providers>Administrative Resources> Claim Tools
Medica Connections Newsletter and Provider Alerts	If you would like to receive <i>Medica Connections</i> and Provider Alerts via email, subscribe here .
Medica Contact Information	Medica.com at Providers> Contact Medica
Referral for Reassessment for Personal Care Assistance Services (DHS 3244P)	Click here for a copy of this form.

PCA Technical Change Request Form (DHS 4074A)	Click here for a copy of this form.
Medica Medical Policy on Personal Care Assistance and Related Services	Medica.com at Providers>Policies and Guidelines> UM Policies & Prior Authorization >then look under the Home Care heading for the following: <ul style="list-style-type: none"> • Extended Hours Home Care (Skilled Nursing Services) (III-HOM.01) • Home Health Aide (III-HOM.02) • Medicaid Home Care Nursing (HCN) Services (III-HOM.05) • Medicaid Home Health Aide (III-HOM.04) • Personal Care Assistance (III-HOM.03)
Medica Product Information	Medica.com at Providers>Administrative Resources>Product Portfolio> Product Information
Medica Provider Training Opportunities/Medica Provider College	Medica.com at Providers>Training> Provider Training
Member Customer Service	Refer to the back of the Member ID card.
Network Contracting	Medica.com at Providers>Administrative Resources>Medica Administrative Manual>Network Operation and Support Services> Credentialing and Demographics
Provider Demographic Online Tool (PDOT) (for Primary/Secondary Administrators)	Medica.com at Providers>Administrative Resources>Billing and Reimbursement>Electronic Transactions> User Guide for Provider Demographic Update Online Tool (PDOT)
Provider Service Center	Call 1-800-458-5512
Personal Care Assistance Provider Troubleshooting Guide	Medica.com at Providers>Administrative Resources>Supplementary Contracting and Regulatory Requirements>Personal Care Assistance> PCA Provider Troubleshooting Guide
Home Health Agency Prior Authorization Request Form	Not to be used for PCA. Medica.com at Providers>Policies and Guidelines> UM Policies and Prior Authorization >under Prior Authorization, view and print the " Prior Authorization Request Form for Home Health Agency "

Non-compliance with Medica Administrative Requirements, including without limitation those provided in this document, is considered a material breach and grounds for termination of your contract with Medica. You are responsible for ensuring that you meet all the standards described in this document.