A Review of Medicaid Personal Care Services

Liberty Healthcare Corporation of North Carolina

June 2017
What is Personal Care Services (PCS)?

The PCS program is designed to provide personal care services to qualifying individuals that need assistance in their effort to perform their activities of daily living (ADL) that include bathing, dressing, mobility, toileting and eating.
Personal Care Services (PCS) are provided in the Medicaid beneficiary’s living arrangement by paraprofessional aides employed by licensed home care agencies, licensed adult care homes, or home staff in supervised living homes.

The amount of prior-approved service is based on an assessment conducted by an independent entity (Liberty Healthcare) to determine the beneficiary’s ability to perform Activities of Daily Living (ADLs).

The five qualifying ADLs for the purposes of this program are: Bathing, Dressing, Mobility, Toileting, and Eating.
Covered Services Include:

- Assistance to help with qualifying ADL;
- Assistance with medications that treat medical conditions that effect the qualifying ADL; and
- Assistance with devices directly linked to the qualifying ADL.
Non Covered Services Include:

- Skilled nursing by LPN or RN
- Respite care
- Care for pets or animals
- Yard work

- Medical or non-medical transportation
- Financial Management
- Errands
- Companion sitting
PCS Eligibility Criteria

- Have active Medicaid;
- Have a medical condition, cognitive impairment or disability that limits them from performing their activities of daily living;
- Be considered medically stable;
- Be under the care of their primary care physician or specialist for the condition causing limitations;
- Have seen their treating physician within the last 90 days;
- Reside in a private living arrangement, or in a residential facility licensed by the State of North Carolina as an adult care home, a combination home, or a group home as a supervised living facility; and
- Not have a family member or caregiver who is willing and able to provide care.
How Many Hours Can A Beneficiary Receive?

60 hours
- EPSDT on the initial assessment hours generation.
- All EPSDT assessments are sent to Division of Medical Assistance for final hour calculation/evaluation

80 hours
- For a beneficiary who does not meet the criteria for Session Law 2013-306

Up to 130 Hours
- For the beneficiary who meets the criteria for Session Law 2013-306
A beneficiary, family or legally responsible person must contact his/her primary care or attending physician and request they complete the ‘Request for Independent Assessment for PCS Form (3051 form) in order to have an assessment for PCS.

- The form can only be completed by a MD, NP, or PA.
- The beneficiary will be required to have seen the referring physician within the last 90 days from the date on the form.
The Assessment

Once the doctor completes a 3051 form and sends it to the IAE (Liberty Healthcare), the PCS assessment will be performed by a Nurse Assessor at the beneficiary’s home or residential facility. The Nurse Assessor will capture the following in their assessment:

- Demonstrations of a beneficiary’s ability to perform their activities of daily living (ADLS)
- Available caregivers
- Daily medicine regimen
- Diagnosis information
- Paid supports/Non Paid supports
- Special assistive tasks
- Exacerbating conditions that impact their ability to perform their ADLs
- Environmental conditions and home safety evaluation
- Beneficiary preferred providers
- Return frequency
How Does The Beneficiary Qualify For Services?

The beneficiary must have:

- 3 of the 5 qualifying ADLs with limited assistance;
- 2 ADLs, one of which requires extensive assistance;
- or
- 2 ADLs, one of which requires assistance at the full dependence level.
# Assistance Levels Defined

<table>
<thead>
<tr>
<th>Assistance Levels</th>
<th>Defined</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Totally Able</strong></td>
<td>Self-perform 100% of the activity with or without assistance of aid or assistive devices and without supervision or assistance to set up supplies and environment for task.</td>
</tr>
<tr>
<td><strong>Verbal Cueing or Supervision</strong></td>
<td>Self-perform 100% of the activity with or without assistance of aid or assistive devices and requires supervision, monitoring or assistance to retrieve or set or supplies or equipment.</td>
</tr>
<tr>
<td><strong>Limited Hands On Assist</strong></td>
<td>Self-perform 50% of the activity and requires hands on assistance to complete remainder of the task.</td>
</tr>
<tr>
<td><strong>Extensive Hands On Assist:</strong></td>
<td>Able to self-perform less than 50% of the activity and requires hands on assist to complete remainder of activity.</td>
</tr>
<tr>
<td><strong>Cannot Do At All:</strong></td>
<td>Unable to perform any of the activity and is totally dependent on another person to perform the activity.</td>
</tr>
</tbody>
</table>
Referral Request is Received

Scheduling Coordinator Schedules Appointment with Beneficiary for Assessment

Assessor visits Beneficiary Home to Complete Independent Assessment

The Selected Provider Accepts Care for the Beneficiary and Initiates Care

The Assessor Submits the Assessment for Review

If Qualified, the Assessor Provides the Beneficiary with a List of Providers, the Beneficiary Selects One
Completing the Request for Independent Assessment for Personal Care Services Form

3051 Form
DMA 3051 – Request for Independent Assessment
DMA 3051 – Key Information

- DMA 3051 has 6 sections: A-F. Requestors are not required to complete all sections each time a request is submitted.
- Only sections that are required for the specific type of request should be completed.
- Sections A-D must be completed by the Primary Care Physician or Attending Physician only.
- Sections E and F must be completed by the beneficiary, caregiver, or PCS provider only.

Completion of all appropriate fields ensures timely processing of the submitted requests. DMA 3051 and instructions are located on the Liberty Healthcare website: [http://nc-pcs.com/Medicaid-PCS-forms/](http://nc-pcs.com/Medicaid-PCS-forms/)
Overview of the DMA 3051 Form
Medical and Non-Medical

- Practitioners: Utilize pages 1 and 2, the Medical portion of DMA 3051.
- Non-Practitioners: (the beneficiary, caregiver or PCS Provider) complete page 3, the Non-Medical portion of the request.
Completing DMA 3051: Practitioners New Referrals

For NEW Referral Requests, a Practitioner must complete the following sections:

- **Section A**
  - Beneficiary Demographics

- **Section B**
  - Beneficiary Conditions that Result in Need for Assistance with ADLs

- **Section C**
  - Practitioner Information
The following fields are required:

- Beneficiary’s Name, Date of Birth, Address and Phone number
- Medicaid ID Number – Only active Medicaid participants are eligible
- The beneficiary’s alternate contacts: parent, guardian or legal representative. A PCS provider cannot be listed as an alternate contact
- Indicate if the beneficiary has an active Adult Protective Services case

**Note:** For beneficiaries residing in an ACH setting, a PASRR is required for PCS approval.

If known, indicating the PASRR# and PASRR date for those in ACH settings will allow for timely processing of the request.
Completing DMA 3051: Practitioners
New Referral: Section B

The following fields are required:

- The medical diagnosis and ICD-10 code(s) that result in the need for assistance with ADLs, along with date of onset. **Incomplete or inaccurate codes may delay the processing of the request.**
- For each diagnosis, indicate if the condition impacts the beneficiary’s ability to perform ADLs. **If ‘Impacts ADLs’ is not indicated, the request will not be processed.**
- Based on clinical judgment, indicate the expected duration of the ADL limitation.
- Indicate if the beneficiary is medically stable and if they require 24-hour caregiver availability.
Completing DMA 3051: Practitioners
New Referral: Section C

The following fields are required:

- Attesting Practitioner’s Name and NPI#
- Practice Name and NPI#
- Practice Contact Name, Address, and Phone. **Note:** Practice stamps are accepted versus completing each of these fields.
- Date of last visit to the Practitioner - The last visit date must have occurred within 90 days of the request date or the request will be denied.
- The 3051 Form for a New Referral MUST be signed by the referring practitioner and credentials indicated along with the date. Acceptable credentials include an MD, NP, or PA. **If credentials are not included and cannot be verified, the request will not be processed.**

**Note:** Signature stamps are not accepted as a substitute for the practitioner’s signature.
The Expedited Request for PCS for Beneficiaries Served through the Transition to Community Living Initiative.
What is the Expedited Request for PCS?

Effective January 2014, the NC Division of Medical Assistance (DMA) approved an expedited assessment process to provisionally approve beneficiaries for Medicaid PCS.

The PCS expedited process determines beneficiary provisional eligibility and the authorized service level pending the completion of the full independent assessment conducted by Independent Assessment Entity (IAE) Assessors.

In July of 2016, expedited requests for PCS assessments became an option for individuals served through the Transitions to Community Living Initiative.
What Beneficiaries Qualify?

In order to be considered for an expedited assessment, a beneficiary must meet the following criteria:

- Be medically stable
- Eligible for Medicaid or pending Medicaid eligibility
- Have an ACH Preadmission Screening and Resident Review (PASRR) number on file*
- In the process of either:
  - Being discharged from hospitalization following a qualifying stay;
  - Being under the supervision of Adult Protective Services (APS);
  - Seeking placement after discharge from a skilled nursing facility; or
  - Be an individual served through the transition to community living initiative.
In order to qualify for an expedited PCS assessment, individuals served through TCLI must be medically stable and eligible for Medicaid or pending Medicaid eligibility.

- If the individual’s Medicaid eligibility is pending, the provisional authorization remains pending until Medicaid eligibility is effective.

- If the individual is not Medicaid eligible within the 60 calendar day provisional period, the individual must request PCS through the standard PCS assessment process.
Who Can Submit It?

In addition to meeting the criteria, an expedited PCS request for individuals served through TCL may only be submitted by the following an approved LME-MCO Transition Coordinator.

Expedited requests submitted by staff members that are not on the approved LME-MCO PCS Expedited Review Contacts List will not be processed.
The Expedited Assessment Completion Process

• If all eligibility requirements are met, the DMA 3051 Request for Independent Assessment for PCS should be sent to Liberty Healthcare via Fax to our Expedited line at 919-322-5942 or toll free at 855-740-0200, followed by a call to LHC-NC at 855-740-1400 by the designated transition coordinator.

• Note: For quick identification, on the DMA 3051, where it indicates ‘Beneficiary Currently Resides’ in section A of the request form, the LME-MCO should indicate ‘TCLI’ on the ‘other line’.
The Expedited Assessment Completion Process

- At the time of the follow up call, LME-MCOs must inform the Customer Service Team Member that the beneficiary is served by the Transitions to Community Living Initiative.
- The Customer Service Team Member will review and immediately approve or deny the expedited assessment based on eligibility requirements only.
PCS Mini Assessment and Provisional Hours

If approved to move forward:

1. The caller will be transferred to a Request Processor who will process the request.

2. Once processed, the Request Processor will transfer the call to a LHC-NC nurse who will conduct a brief telephone assessment comprised of 15 questions directly related to the 5 ADLs.

3. If eligible for PCS based on the mini assessment, the beneficiary will immediately be awarded temporary hours for PCS services and a letter will be sent to the selected PCS Provider.

4. Following the expedited process, LHC-NC will contact the beneficiary within 14 business days to schedule and complete an independent assessment in the beneficiary’s place of residence.
The Expedited Assessment Completion Process

1. APS worker, Discharge Planner or LME-MCO Transition Coordinator faxes the expedited new request to LHC.
2. Expedited request is received and the listed APS worker, Discharge Planner or LME-MCO Transition Coordinator is contacted to confirm the request as expedited. Request is processed.
3. A designated Liberty RN contacts the APS worker, Discharge Planner or LME-MCO Transition Coordinator as listed on the request and conducts a mini assessment by phone.
4. If Qualified, the beneficiary is awarded temporary hours and the provider chosen by the beneficiary will be authorized to begin services.
5. Scheduling Coordinator schedules appointment with beneficiary for full assessment.
6. If Qualified, the assessor provides the beneficiary with a list of providers, the beneficiary selects one.
7. The assessor submits the assessment for review.
8. The selected provider accepts care for the beneficiary and initiates care.
9. Assessor visits beneficiary home to complete full independent assessment.

Assessor visits Beneficiary Home to Complete full Independent Assessment

Assessor visits Beneficiary Home to Complete full Independent Assessment
Things to Remember

• Individuals approved for PCS through the expedited process will receive a **provisional** authorization for up to 60 hours and are subject to a standard PCS assessment within 14 business days.

• Transition coordinators must have a placement address for individuals served through TCLI **prior** to submitting the expedited request for a PCS assessment.
Things to Remember

• Prior to contacting LHC-NC, LME-MCOs must be knowledgeable of the beneficiary’s Activity of Daily Living needs.
  • Refer to Joint Communication Bulletin #J228 and the TCLI Job Aide sent to all LME-MCOs.

• A PCS provider must be identified before the request can be processed.
  • A list of PCS providers can be found at http://nc-pcs.com/search-for-providers/
Things to Remember

- PCS Providers are not required to accept a beneficiary, it may take several tries to find a provider that will be able to service the beneficiary, it is best for staff to attempt to coordinate care prior to requesting the expedited assessment.

- LHC-NC is only authorized to process expedited assessment requests from designated LME-MCO PCS Expedited Review Contacts. Expedited assessment requests from other staff members will not be processed.
Medicaid Personal Care Services Contacts

Division of Medical Assistance (DMA) PCS Program

Phone: 919-855-4360
Fax: 919-715-0102
Email: PCS_Program_Questions@dhhs.nc.gov

Liberty Healthcare Corporation of North Carolina

Request forms and general inquiries should be addressed to:

Liberty Healthcare Corporation-NC PCS Program
5540 Centerview Dr., Suite 114
Raleigh, NC 27606
Call Center: 919-322-5944
or 855-740-1400 (toll free)
Fax: 919-307-8307
or 855-740-1600 (toll free)
Email: NC-IAsupport@libertyhealth.com
Website: www.nc-pcs.com