Personal Care Services (PCS)

Primary Care Practice Webinar

February 11th, 2015

Community Care of North Carolina

Important Housekeeping

- **Webinar will be recorded and posted to the following websites:**
  - CCNC: www.communitycarenc.org
  - DMA: http://www.ncdhhs.gov/dma/pcs/pas.html
  - Liberty Healthcare: http://www.nc-pcs.com/physicians/

- **Please hold your questions until the end of the webinar.**

- **PLEASE MUTE YOUR PHONES AND DO NOT PUT US ON HOLD.**

Agenda

- **Purpose of this Webinar**
  - PCS and Criteria for Receiving the Service
  - Introduction of New Medical Attestation Form for PCS
- **What are Medicaid State Plan Personal Care Services?**
- **PCS Authorization Process**
- **Review of the New PCS Request Form**
- **DMA Policy/Form Changes in 2015**

What is PCS?

- **Medicaid benefit that provides help in the beneficiary's residence with Activities of Daily Living (ADLs)**
- **Beneficiary must have a medical condition, disability or cognitive impairment and an unmet need for hands-on assistance with at least two (usually) of the following ADLs:**
  - Bathing
  - Dressing
  - Mobility
  - Toileting
  - Eating

For Beneficiaries

- **Whose ADL needs are associated with a medical condition(s)**
- **Who have no other caregiver support to address the ADL needs**
- **Who are living in private residences, adult care homes, family care homes or group homes**
- **Whose health conditions are predictable/stable and do not require nursing level judgment/care**

PCS in Numbers

- **Current spending: $460 Million Annually**
- **Growth rate: Average 5% year-over-year growth**
- **Annual Volume: 11,500 new applicants; 40,000 ongoing recipients**
- **Paid Hours: Average of 70 hours/month of services per recipient**
- **Current Hourly Rate: $13.88**
- **Independent Agency Assessment Approval Rate: 86%**

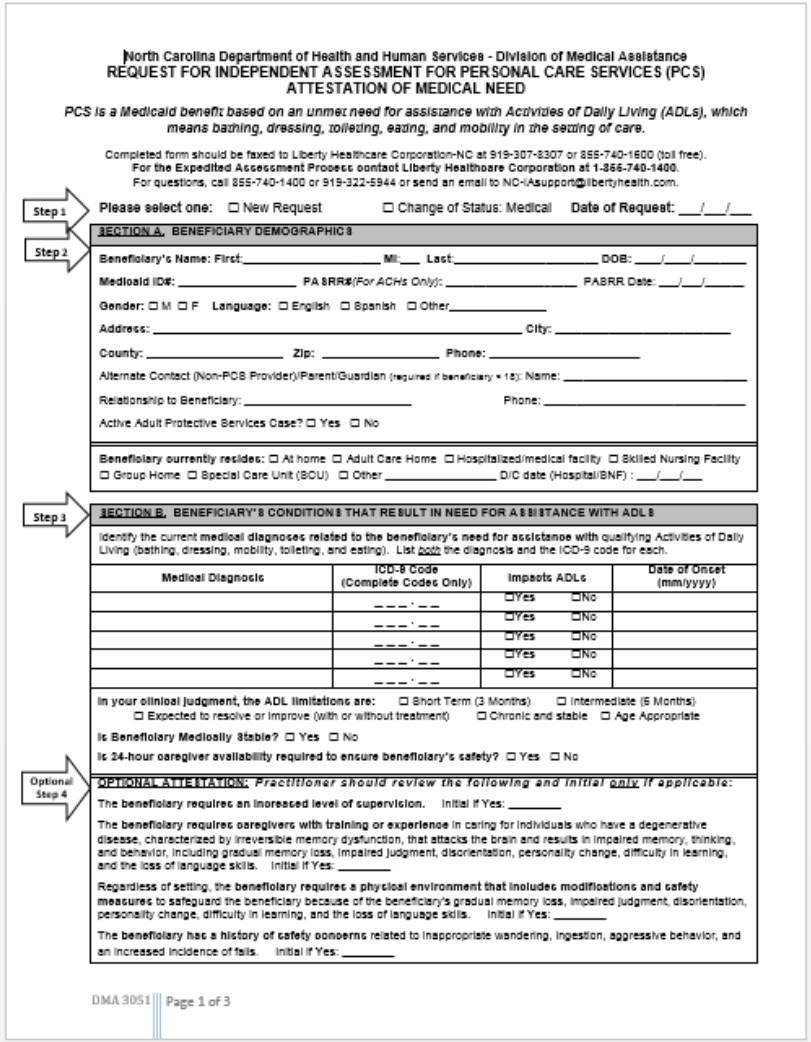
PCS Process

1. **Begins when PCP completes "PCS Request for Assessment/Attestation Form" and submits to Liberty Healthcare (the Independent Assessment Entity or IAE)**
2. **Liberty Healthcare performs the independent assessment of beneficiary's abilities in their setting of care**
3. **VieBridge (IT vendor) approves service hours for beneficiary based on Liberty's assessment (including no service, if deemed appropriate).**
4. **If approved, Liberty authorizes PCS provider (selected by beneficiary) to provide services**
5. **PCS provider begins service**

PCS Request Form

- **CCNC has worked with DMA to revise the PCS Request for Assessment/Attestation form**
- **New form was implemented effective Feb 1st**
- **Old form is no longer accepted**
- **New form reflects major revisions**
  - Important for PCPs to appreciate the revisions to avoid duplicating paperwork
  - Revisions will help avoid inappropriate utilization

PCS Request Form



North Carolina Department of Health and Human Services - Division of Medical Assistance
REQUEST FOR INDEPENDENT ASSESSMENT FOR PERSONAL CARE SERVICES (PCS)
ATTESTATION OF MEDICAL NEED

PCS is a Medicaid benefit based on an unmet need for assistance with Activities of Daily Living (ADLs), which means bathing, dressing, toileting, eating, and mobility in the setting of care.

Completed form should be faxed to Liberty Healthcare Corporation-NC at 919-307-8307 or 855-740-1600 (toll free).
For the Expedited Assessment Process contact Liberty Healthcare Corporation at 1-866-740-1400.
For questions, call 855-740-1400 or 919-322-5944 or send an email to NC-IAsupport@libertyhealth.com.

Step 1 Please select one: ☐ New Request ☐ Change of Status: Medical Date of Request: ___/___/___

Step 2 **SECTION A. BENEFICIARY DEMOGRAPHICS**

Beneficiary's Name: First:_____ MI:___ Last:_____ DOB: ___/___/_____
Medicaid ID#: _____ PASRR#(For ACHs Only): _____ PASRR Date: ___/___/_____
Gender: ☐ M ☐ F Language: ☐ English ☐ Spanish ☐ Other_____
Address: _____ City: _____
County: _____ Zip: _____ Phone: _____
Alternate Contact (Non-PCS Provider)/Parent/Guardian (required if beneficiary < 18): Name: _____
Relationship to Beneficiary: _____ Phone: _____
Active Adult Protective Services Case? ☐ Yes ☐ No

Beneficiary currently resides: ☐ At home ☐ Adult Care Home ☐ Hospitalized/medical facility ☐ Skilled Nursing Facility ☐ Group Home ☐ Special Care Unit (SCU) ☐ Other _____ D/C date (Hospital/SNF) : ___/___/___

Step 3 **SECTION B. BENEFICIARY'S CONDITIONS THAT RESULT IN NEED FOR ASSISTANCE WITH ADLS**

Identify the current **medical diagnoses related to the beneficiary's need for assistance with** qualifying Activities of Daily Living (bathing, dressing, mobility, toileting, and eating). List both the diagnosis and the ICD-9 code for each.

Medical Diagnosis	ICD-9 Code (Complete Codes Only)	Impacts ADLs	Date of Onset (mm/yyyy)
	___.__	☐Yes ☐No	
	___.__	☐Yes ☐No	
	___.__	☐Yes ☐No	
	___.__	☐Yes ☐No	
	___.__	☐Yes ☐No	

In your clinical judgment, the ADL limitations are: ☐ Short Term (3 Months) ☐ Intermediate (6 Months) ☐ Expected to resolve or improve (with or without treatment) ☐ Chronic and stable ☐ Age Appropriate

Is Beneficiary Medically Stable? ☐ Yes ☐ No

Is 24-hour caregiver availability required to ensure beneficiary's safety? ☐ Yes ☐ No

Optional Step 4 **OPTIONAL ATTESTATION:** *Practitioner should review the following and initial only if applicable:*

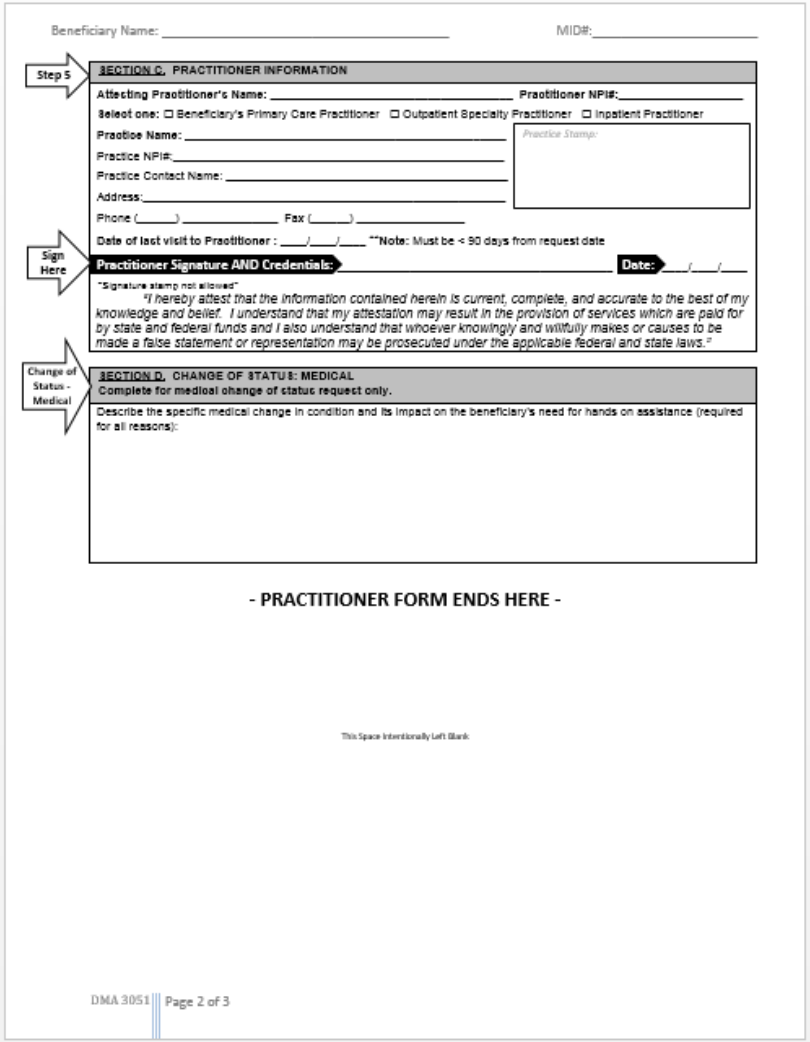
The **beneficiary requires an increased level of supervision.** Initial if Yes: _____

The **beneficiary requires caregivers with training or experience** in caring for individuals who have a degenerative disease, characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills. Initial if Yes: _____

Regardless of setting, the **beneficiary requires a physical environment that includes modifications and safety measures** to safeguard the beneficiary because of the beneficiary's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills. Initial if Yes: _____

The **beneficiary has a history of safety concerns** related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls. Initial if Yes: _____

DMA 3051 Page 1 of 3



Beneficiary Name: _____ MID#: _____

Step 5 **SECTION C. PRACTITIONER INFORMATION**

Attesting Practitioner's Name: _____ Practitioner NPI#: _____
Select one: ☐ Beneficiary's Primary Care Practitioner ☐ Outpatient Specialty Practitioner ☐ Inpatient Practitioner
Practice Name: _____
Practice NPI#: _____
Practice Contact Name: _____
Address: _____
Phone (_____) _____ Fax (_____) _____
Practice Stamp:
Date of last visit to Practitioner : ___/___/___ **Note: Must be < 90 days from request date

Sign Here **Practitioner Signature AND Credentials:** _____ **Date:** ___/___/___

"Signature stamp not allowed"

"I hereby attest that the information contained herein is current, complete, and accurate to the best of my knowledge and belief. I understand that my attestation may result in the provision of services which are paid for by state and federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement or representation may be prosecuted under the applicable federal and state laws."

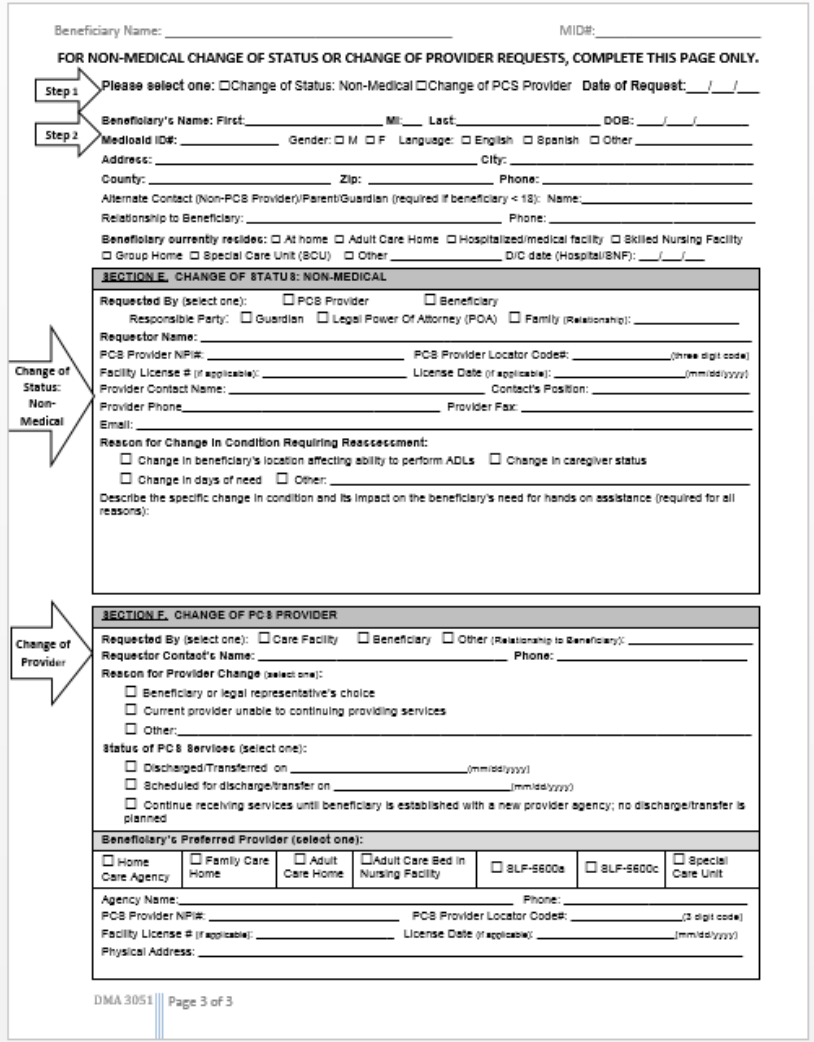
Change of Status - Medical **SECTION D. CHANGE OF STATUS: MEDICAL**
Complete for medical change of status request only.

Describe the specific medical change in condition and its impact on the beneficiary's need for hands on assistance (required for all reasons):

- PRACTITIONER FORM ENDS HERE -

This Space Intentionally Left Blank

DMA 3051 Page 2 of 3



Beneficiary Name: _____ MID#: _____

FOR NON-MEDICAL CHANGE OF STATUS OR CHANGE OF PROVIDER REQUESTS, COMPLETE THIS PAGE ONLY.

Step 1 Please select one: ☐Change of Status: Non-Medical ☐Change of PCS Provider Date of Request: ___/___/___

Step 2 Beneficiary's Name: First:_____ MI:___ Last:_____ DOB: ___/___/_____
Medicaid ID#: _____ Gender: ☐ M ☐ F Language: ☐ English ☐ Spanish ☐ Other _____
Address: _____ City: _____
County: _____ Zip: _____ Phone: _____
Alternate Contact (Non-PCS Provider)/Parent/Guardian (required if beneficiary < 18): Name: _____
Relationship to Beneficiary: _____ Phone: _____
Beneficiary currently resides: ☐ At home ☐ Adult Care Home ☐ Hospitalized/medical facility ☐ Skilled Nursing Facility ☐ Group Home ☐ Special Care Unit (SCU) ☐ Other _____ D/C date (Hospital/SNF): ___/___/___

Change of Status: Non-Medical **SECTION E. CHANGE OF STATUS: NON-MEDICAL**

Requested By (select one): ☐ PCS Provider ☐ Beneficiary
Responsible Party: ☐ Guardian ☐ Legal Power Of Attorney (POA) ☐ Family (Relationship): _____
Requestor Name: _____
PCS Provider NPI#: _____ PCS Provider Locator Code#: _____ (three digit code)
Facility License # (if applicable): _____ License Date (if applicable): _____ (mm/dd/yyyy)
Provider Contact Name: _____ Contact's Position: _____
Provider Phone _____ Provider Fax: _____
Email: _____
Reason for Change in Condition Requiring Reassessment:
☐ Change in beneficiary's location affecting ability to perform ADLs ☐ Change in caregiver status
☐ Change in days of need ☐ Other: _____
Describe the specific change in condition and its impact on the beneficiary's need for hands on assistance (required for all reasons):

Change of Provider **SECTION F. CHANGE OF PCS PROVIDER**

Requested By (select one): ☐ Care Facility ☐ Beneficiary ☐ Other (Relationship to Beneficiary): _____
Requestor Contact's Name: _____ Phone: _____
Reason for Provider Change (select one):
☐ Beneficiary or legal representative's choice
☐ Current provider unable to continuing providing services
☐ Other: _____
Status of PCS Services (select one):
☐ Discharged/Transferred on _____ (mm/dd/yyyy)
☐ Scheduled for discharge/transfer on _____ (mm/dd/yyyy)
☐ Continue receiving services until beneficiary is established with a new provider agency; no discharge/transfer is planned

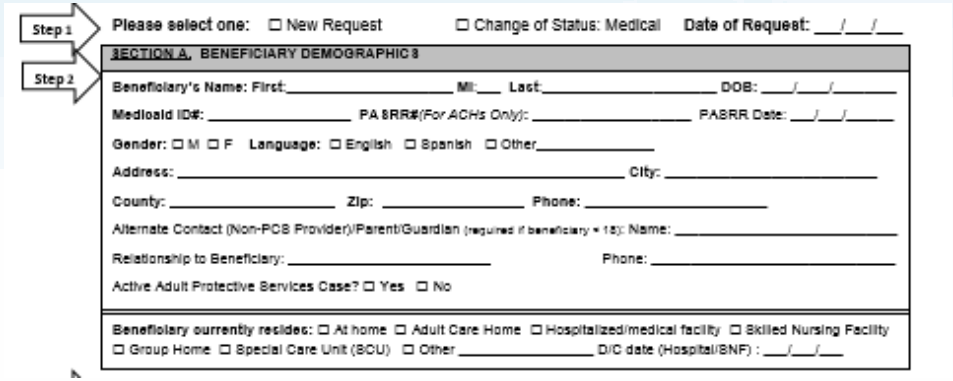
Beneficiary's Preferred Provider (select one):

☐ Home Care Agency	☐ Family Care Home	☐ Adult Care Home	☐Adult Care Bed in Nursing Facility	☐ SLF-S600a	☐ SLF-S600c	☐ Special Care Unit

Agency Name: _____ Phone: _____
PCS Provider NPI#: _____ PCS Provider Locator Code#: _____ (3 digit code)
Facility License # (if applicable): _____ License Date (if applicable): _____ (mm/dd/yyyy)
Physical Address: _____

DMA 3051 Page 3 of 3

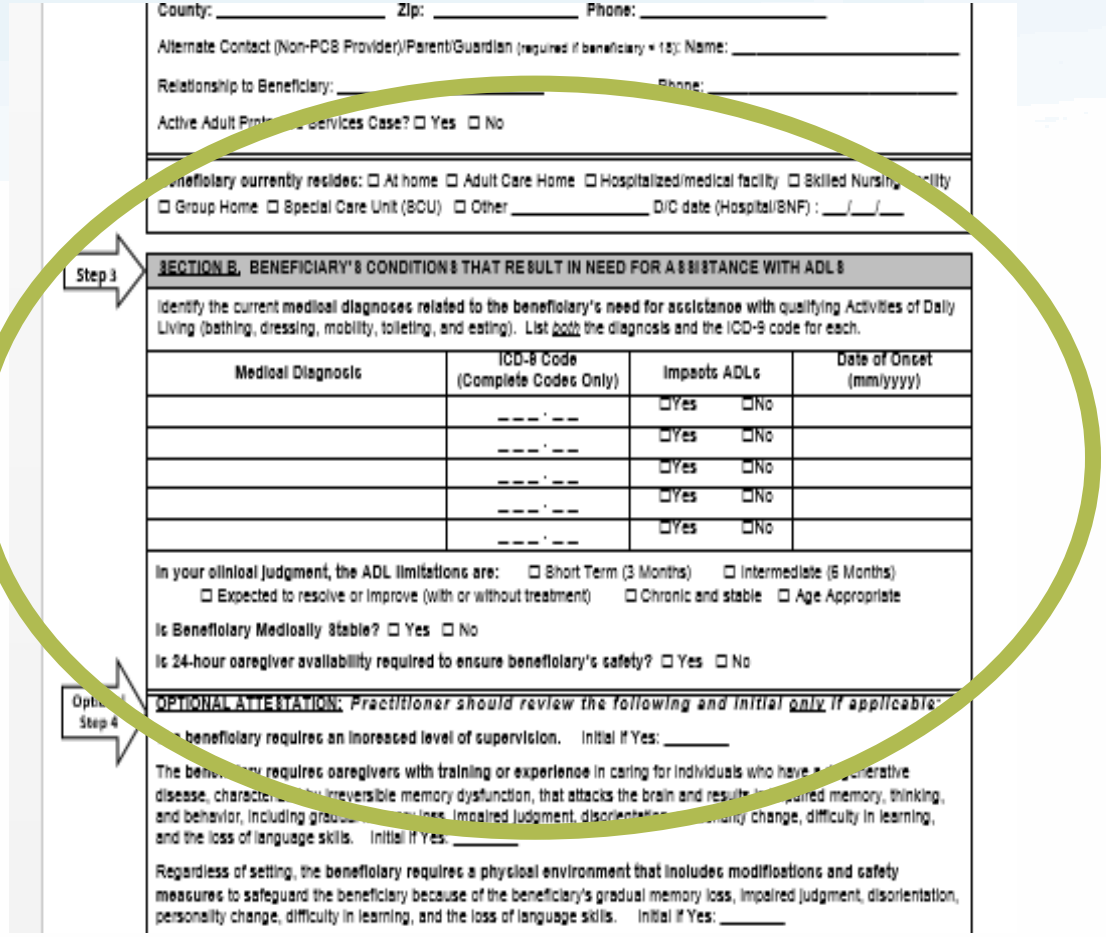
PCS Request Form: Section A


Step 1
Step 2
Please select one: ☐ New Request ☐ Change of Status: Medical Date of Request: ___/___/___
SECTION A. BENEFICIARY DEMOGRAPHICS
Beneficiary's Name: First:_____ MI:___ Last:_____ DOB: ___/___/_____
Medicaid ID#: _____ PASRR#(For ACHs Only): _____ PASRR Date: ___/___/_____
Gender: ☐ M ☐ F Language: ☐ English ☐ Spanish ☐ Other_____
Address: _____ City: _____
County: _____ Zip: _____ Phone: _____
Alternate Contact (Non-PCS Provider)/Parent/Guardian (required if beneficiary < 18): Name: _____
Relationship to Beneficiary: _____ Phone: _____
Active Adult Protective Services Case? ☐ Yes ☐ No
Beneficiary currently resides: ☐ At home ☐ Adult Care Home ☐ Hospitalized/medical facility ☐ Skilled Nursing Facility
☐ Group Home ☐ Special Care Unit (SCU) ☐ Other _____ D/C date (Hospital/SNF) : ___/___/___

- **New: means the patient is not currently receiving PCS**
- **Change of status: means the patient is receiving PCS, but a change in patient's medical or functional status has changed the intensity of patient's personal care needs (increased OR decreased)**
- **PASRR#: complete if PASRR number is known (adult care home only)**
- **Alternate contact: someone legally authorized to speak for patient**
- **Active Adult Protective Services case: complete if status is known**

PCS Request Form: Section B

- **List current medical diagnoses *related to* the need for hands-on assistance with ADL (i.e., arthritis, CHF, COPD, stroke, etc.)**
- **Must include complete ICD-9 code**
- **Indicate if diagnosis impacts ADLs – *if left blank, form will not be processed***
- **Selection regarding duration of ADL limitation will trigger a reassessment of function**
- **Use best judgment for all questions**



County: _____ Zip: _____ Phone: _____

Alternate Contact (Non-PCS Provider)/Parent/Guardian (required if beneficiary < 18): Name: _____

Relationship to Beneficiary: _____ Phone: _____

Active Adult Protective Services Case? ☐ Yes ☐ No

Beneficiary currently resides: ☐ At home ☐ Adult Care Home ☐ Hospitalized/medical facility ☐ Skilled Nursing Facility
☐ Group Home ☐ Special Care Unit (SCU) ☐ Other _____ D/C date (Hospital/SNF) : __/__/__

Step 3

SECTION B. BENEFICIARY'S CONDITIONS THAT RESULT IN NEED FOR ASSISTANCE WITH ADLS

Identify the current **medical diagnoses related to the beneficiary's need for assistance** with qualifying Activities of Daily Living (bathing, dressing, mobility, toileting, and eating). List both the diagnosis and the ICD-9 code for each.

Medical Diagnosis	ICD-9 Code (Complete Codes Only)	Impacts ADLs	Date of Onset (mm/yyyy)
	___.__	☐Yes ☐No	
	___.__	☐Yes ☐No	
	___.__	☐Yes ☐No	
	___.__	☐Yes ☐No	
	___.__	☐Yes ☐No	

In your clinical judgment, the ADL limitations are: ☐ Short Term (3 Months) ☐ Intermediate (6 Months)
☐ Expected to resolve or improve (with or without treatment) ☐ Chronic and stable ☐ Age Appropriate

Is Beneficiary Medically Stable? ☐ Yes ☐ No

Is 24-hour caregiver availability required to ensure beneficiary's safety? ☐ Yes ☐ No

Optional Step 4

OPTIONAL ATTESTATION: *Practitioner should review the following and initial only if applicable:*

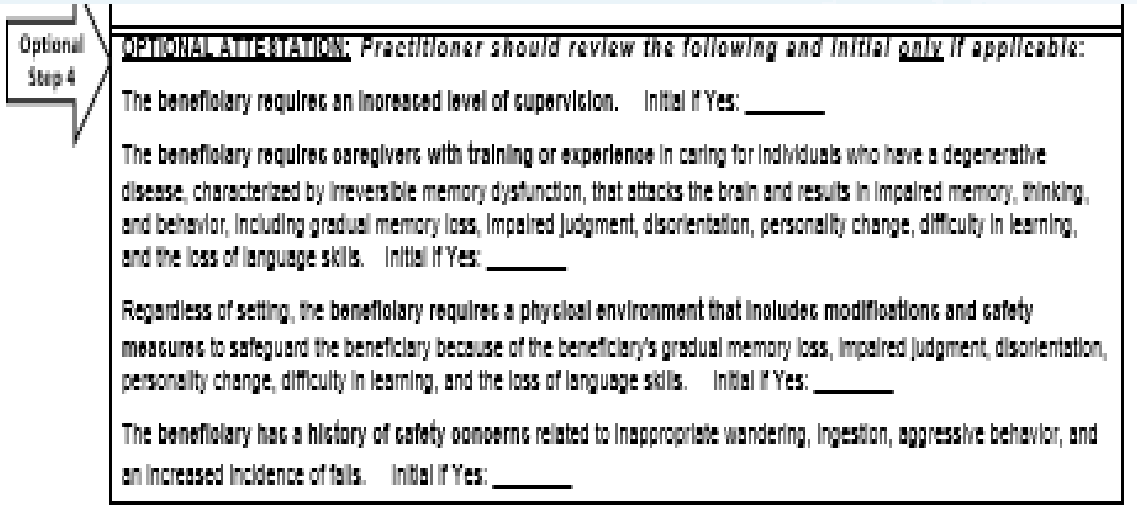
beneficiary requires an increased level of supervision. Initial if Yes: _____

The **beneficiary requires caregivers with training or experience** in caring for individuals who have a degenerative disease, characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills. Initial if Yes: _____

Regardless of setting, the **beneficiary requires a physical environment that includes modifications and safety measures to safeguard the beneficiary** because of the beneficiary's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills. Initial if Yes: _____

PCS Request Form: Optional Attestation

- **These criteria are related to eligibility for "additional safeguards"**
- **Initial statement *only if* it accurately describes beneficiary's status/condition**



Optional Step 4

OPTIONAL ATTESTATION: *Practitioner should review the following and initial only if applicable:*

The beneficiary requires an increased level of supervision. Initial if Yes: _____

The beneficiary requires caregivers with training or experience in caring for individuals who have a degenerative disease, characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills. Initial if Yes: _____

Regardless of setting, the beneficiary requires a physical environment that includes modifications and safety measures to safeguard the beneficiary because of the beneficiary's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills. Initial if Yes: _____

The beneficiary has a history of safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls. Initial if Yes: _____

PCS Request Form: Section C

- **Both practitioner and practice NPIs are required**
- **Can use a practice stamp for ease of completion**
- **Must include the date of last visit to the practitioner (patient must have been seen by the attesting practitioner in the 90 days prior to date of request or request will not be processed and denial will be issued.)**
- **Practitioner signature must be *inked* (no signature stamp)**
- **Now includes legal disclaimer statement below signature**

Beneficiary Name: _____ MID#: _____

Step 5 — SECTION C. PRACTITIONER INFORMATION

Attesting Practitioner's Name: _____ Practitioner NPI#: _____

Select one: ☐ Beneficiary's Primary Care Practitioner ☐ Outpatient Specialty Practitioner ☐ Inpatient Practitioner

Practice Name: _____

Practice NPI#: _____

Practice Contact Name: _____

Address: _____

Practice Stamp:

Phone (____) _____ Fax (____) _____

Date of last visit to Practitioner: ___/___/___ **Note: Must be < 90 days from request date

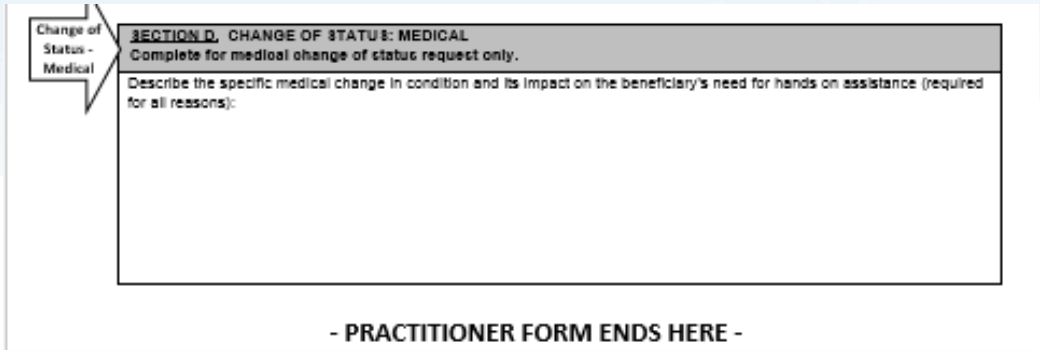
Sign Here — Practitioner Signature AND Credentials: _____ Date: ___/___/___

"Signature stamp not allowed"

"I hereby attest that the information contained herein is current, complete, and accurate to the best of my knowledge and belief. I understand that my attestation may result in the provision of services which are paid for by state and federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement or representation may be prosecuted under the applicable federal and state laws."

PCS Request Form: Section D

- **For change of status request *only***
- **Policy change: practitioner must complete this section now (when appropriate)**


Change of Status - Medical

SECTION D. CHANGE OF STATUS: MEDICAL
Complete for medical change of status request only.

Describe the specific medical change in condition and its impact on the beneficiary's need for hands on assistance (required for all reasons):

- PRACTITIONER FORM ENDS HERE -

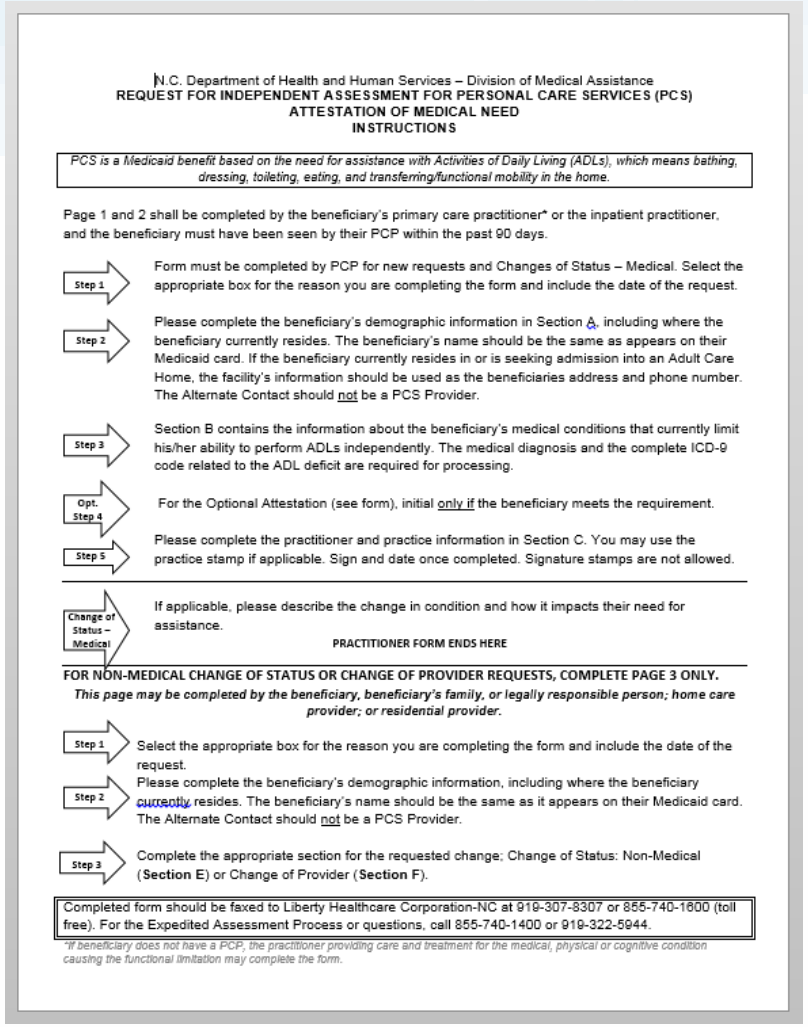
- **Describe the change in beneficiary's medical/functional status that indicates a change is needed in intensity of PCS**
- **May be a change indicating more assistance is needed OR a change indicating less or no assistance is needed**

Once form is completed

- **It should be sent directly to Liberty Healthcare of NC**
- **Liberty fax number is on page 1 of form above section A**
- **Completed form should *not* be given to beneficiary or to anyone else**

PCS Request Form Instructions

- **One-pager with instructions for completing form**
- **Includes instructions for non-PCPs at the bottom**



N.C. Department of Health and Human Services – Division of Medical Assistance
REQUEST FOR INDEPENDENT ASSESSMENT FOR PERSONAL CARE SERVICES (PCS)
ATTESTATION OF MEDICAL NEED
INSTRUCTIONS

PCS is a Medicaid benefit based on the need for assistance with Activities of Daily Living (ADLs), which means bathing, dressing, toileting, eating, and transferring/functional mobility in the home.

Page 1 and 2 shall be completed by the beneficiary's primary care practitioner* or the inpatient practitioner, and the beneficiary must have been seen by their PCP within the past 90 days.

Step 1 — Form must be completed by PCP for new requests and Changes of Status – Medical. Select the appropriate box for the reason you are completing the form and include the date of the request.

Step 2 — Please complete the beneficiary's demographic information in Section A, including where the beneficiary currently resides. The beneficiary's name should be the same as appears on their Medicaid card. If the beneficiary currently resides in or is seeking admission into an Adult Care Home, the facility's information should be used as the beneficiaries address and phone number. The Alternate Contact should not be a PCS Provider.

Step 3 — Section B contains the information about the beneficiary's medical conditions that currently limit his/her ability to perform ADLs independently. The medical diagnosis and the complete ICD-9 code related to the ADL deficit are required for processing.

Opt. Step 4 — For the Optional Attestation (see form), initial only if the beneficiary meets the requirement.

Step 5 — Please complete the practitioner and practice information in Section C. You may use the practice stamp if applicable. Sign and date once completed. Signature stamps are not allowed.

Change of Status – Medical — If applicable, please describe the change in condition and how it impacts their need for assistance.

PRACTITIONER FORM ENDS HERE

FOR NON-MEDICAL CHANGE OF STATUS OR CHANGE OF PROVIDER REQUESTS, COMPLETE PAGE 3 ONLY.
This page may be completed by the beneficiary, beneficiary's family, or legally responsible person; home care provider; or residential provider.

Step 1 — Select the appropriate box for the reason you are completing the form and include the date of the request.

Step 2 — Please complete the beneficiary's demographic information, including where the beneficiary currently resides. The beneficiary's name should be the same as it appears on their Medicaid card. The Alternate Contact should not be a PCS Provider.

Step 3 — Complete the appropriate section for the requested change; Change of Status: Non-Medical (**Section E**) or Change of Provider (**Section F**).

Completed form should be faxed to Liberty Healthcare Corporation-NC at 919-307-8307 or 855-740-1600 (toll free). For the Expedited Assessment Process or questions, call 855-740-1400 or 919-322-5944.

**If beneficiary does not have a PCP, the practitioner providing care and treatment for the medical, physical or cognitive condition causing the functional limitation may complete the form.*

Where to get new forms?

- **The new form and the instruction page are available for download from**

http://nc-pcs.com/Medicaid-PCS-forms/

In Summary: Important Information

- **Signing the form is legally an attestation of medical necessity.**
- **PCS is not a nursing service. Provided by paraprofessionals.**
- **PCS is for hands-on help with basic ADLs. Not for companionship, housekeeping, administering/managing medications, or transportation (expressly not allowed).**
- **Process should be initiated from interaction between PCP and patient about patient's needs.**
- **PCPs have no obligation to deal with forms initiated by PCS providers, including forms faxed or dropped off to the practice.**

Common concerns:

- **Forms submitted to office or brought to appointments**
  - Treat no differently from forms received by other kinds of providers who have solicited patients to receive services or supplies
  - HIPAA issues related to communications without a HIPAA compliant release
- **Patients (and families) continue to press for PCS**
  - PCS is a benefit based on medical necessity
  - System relies on medical provider to determine what is medically appropriate
  - Handle in ways similar to other seeking behavior
- **Optional attestations**
  - Each statement, in its entirety, must be applicable to the patient
  - “Increased supervision” in comparison to other individuals needing PCS

Signing this form means…

- **Important message for practitioners who are signing PCS medical attestation forms**
  - Signing medical attestation forms affirms that the patient does meet the medical need for personal care services
  - If unsure of the Medicaid criteria for medical necessity, do not sign the form; request assistance from the CCNC network's care manager
  - By attesting to medical necessity, practitioners will be held accountable to contents of form

Questions?

Please contact your local CCNC network.