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1.0 Description of the Procedure, Product, or Service

State Plan Personal Care Services (PCS) provide Personal Care Services in the Medicaid beneficiary's living arrangement by paraprofessional aides employed by licensed home care agencies, licensed adult care homes, or home staff in licensed supervised living homes.

For the remainder of this policy, State Plan PCS is referenced as PCS.

The amount of prior approved service is based on an assessment conducted by an independent entity 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.

Beneficiary performance is rated as:

- a. totally independent;
- b. requiring cueing or supervision;
- c. requiring limited hands-on assistance;
- d. requiring extensive hands-on assistance; or
- e. totally dependent.

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

The term "General" found throughout this policy applies to all Medicaid and NCHC policies)

- a. An eligible beneficiary shall be enrolled in either:
 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.1 Specific

(The term “Specific” found throughout this policy only applies to this policy)

Medicaid

None Apply.

NCHC

NCHC beneficiaries are not eligible for State Plan Personal Care Services (PCS).

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary’s physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary’s right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider’s documentation shows that the requested service is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition” [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://dma.ncdhhs.gov/>

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover procedures, products, and services related to this policy when they are medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

No specific criteria apply to both Medicaid and NCHC, as PCS applies only to Medicaid and does not apply to NCHC.

3.2.2 Medicaid Specific Criteria:

Medicaid shall cover PCS only for a beneficiary who:

- a. has a medical condition, disability, or cognitive impairment and demonstrates unmet needs for, at a minimum:
 1. three of the five qualifying activities of daily living (ADLs) with limited hands-on assistance. Refer to **Subsection 5.4.3**;
 2. two ADLs, one of which requires extensive assistance; **or**
 3. two ADLs, one of which requires assistance at the full dependence level.

and

- b. resides in:
 1. a private living arrangement (primary private residence);
 2. a residential facility licensed by the State of North Carolina as an adult care home (ACH) as defined in G.S. 131D-2.1, a combination home as defined in G.S. 131E-101(1a); **or**
 3. a group home licensed under Chapter 122C of the General Statutes and under 10A NCAC 27G .5601 as a supervised living facility for two or more adults whose primary diagnosis is mental illness, a developmental disability, or substance abuse dependency and is eligible to receive personal care services under the Medicaid State Plan.

3.2.3 Medicaid Additional Criteria Covered

- a. In addition to the specific criteria in **Subsection 3.2.2** of this policy, the following criteria must be met:
 1. The home environment is safe and free of health hazards for the beneficiary and PCS provider(s), as determined by an in-home environmental assessment conducted by DMA or a DHHS designated contractor;
 2. The residential setting has received inspection conducted by the Division of Health Service Regulation (DHSR)
 3. The place of service is safe for the beneficiary to receive PCS and for an aide to provide PCS;
 4. No other third-party payer is responsible for covering PCS;
 5. No family or household member or other informal caregiver is available, willing, and able to provide the authorized services during those periods of time when the services are provided;
 6. The required PCS are directly linked to a documented medical condition or physical or cognitive impairment causing the functional limitations requiring the PCS;
 7. The beneficiary is under the ongoing direct care of a physician for the medical condition or diagnosis causing the functional limitations; and
 8. The beneficiary is medically stable and does not require continuous care, monitoring (precautionary observation), or supervision (observation resulting in an intervention) by a licensed nurse or other licensed health care professional.
- b. Screening for Serious Mental Illness (SMI) in Adult Care Homes licensed under G.S. 131D-2.4 **Effective January 1, 2013, all Medicaid beneficiaries referred to or seeking admission to Adult Care Homes licensed under**

G.S. 131D-2.4 must be screened through the Pre-admission Screening and Resident Review (PASRR). Adult Care Home providers licensed under G.S. 131D-2.4 shall not receive PCS prior approval without verification of an ACH PASRR number.

3.2.4 NCHC Additional Criteria Covered

None Apply.

3.3 Personal Care Services

- a. Medicaid shall cover any of the following Personal Care Services needs that occur at minimum, once per week:
 1. Hands-on assistance to address unmet needs with qualifying ADLs;
 2. Set-up, supervision, cueing, prompting, and guiding, when provided as part of the hands-on assistance with qualifying ADLs;
 3. Assistance with home management Instrumentals of Daily Living (IADLs) that are directly related to the beneficiary's qualifying ADLs and essential to the beneficiary's care at home;
 4. Assistance with medication when directly linked to a documented medical condition or physical or cognitive impairment as specified in **Subsection 3.2**;
 5. Assistance with adaptive or assistive devices when directly linked to the qualifying ADLs;
 6. Assistance with the use of durable medical equipment when directly linked to the qualifying ADLs; or
 7. Assistance with special assistance (assistance with ADLs that requires a Nurse aide II) and delegated medical monitoring tasks.
- b. Medicaid may approve any of the following additional assistance if EPSDT criteria met for a Medicaid beneficiary under 21 years of age:
 1. Supervision (observation resulting in an intervention) and monitoring (precautionary observation) related to qualifying ADLs;
 2. Cueing, prompting, guiding, and coaching related to qualifying ADLs;
 3. After school care if PCS tasks are required during that time and no other individuals or programs are available to provide this service; and
 4. Additional hours of service authorization.

3.4 Medication Assistance

Medicaid shall cover medication assistance when it is:

- a. delivered in a private residence and consists of medication self-administration assistance described in 10A NCAC 13J;
- b. delivered in an adult care homes, and includes medication administration as defined in 10A NCAC 13F and 13G; or
- c. delivered in supervised living homes, and includes medication administration as defined in 10A NCAC 27G.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover procedures, products, and services related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

No specific criteria apply to both Medicaid and NCHC, as PCS applies only to Medicaid and does not apply to NCHC.

4.2.2 Medicaid not covered specific criteria

- a. Medicaid shall not cover PCS when:
 1. the initial independent assessment has not been completed;
 2. the PCS is not documented as completed in accordance with this clinical coverage policy;
 3. a reassessment has not been completed within 30 calendar days of the end date of the previous prior authorization period because the beneficiary refused assessment, could not be reached to schedule the assessment, or did not attend the scheduled assessment;
 4. the PCS is provided at a location other than the beneficiary's primary private residence or residential setting, except when EPSDT requirements are met as listed in **Subsection 2.2**;
 5. the PCS exceeds the amount approved by the Independent Assessment Entity (IAE);
 6. the PCS is not completed on the date the service is billed;
 7. the PCS is provided prior to the effective date or after the end date of the prior authorized service period;
 8. the PCS is provided by an individual whose primary private residence is the same as the beneficiary's primary private residence;
 9. the PCS is performed by an individual who is the beneficiary's legally responsible person, spouse, child, parent, sibling, grandparent, grandchild, or equivalent step or in-law relationship to the beneficiary;
Note: Spouses are expected to provide care for each other unless medical documentation, work verification, or other information indicates otherwise.
 10. family members or other informal caregivers are willing, able, and available on a regular basis adequate to meet the beneficiary's need for personal care;

11. the requested services consist of treatment or training related to behavioral problems or mental health disorders such as attention deficit disorder or oppositional defiant behavior;
12. the requested ADL assistance consists of activities that a typical child of the same chronological age could not safely and independently perform without adult supervision; or
13. independent medical information does not validate the assessment, PCS hours may be reduced, denied, or terminated based on the additional information.

Note: PCS is not intended as a substitute for childcare, daycare, or afterschool care. PCS is not covered for infants or children when the personal care needs do not meet the medical necessity criteria, or the needs are a parental responsibility or are age-appropriate needs.

- b. Medicaid shall not cover PCS in licensed residential facilities when:
 1. the beneficiary is ventilator dependent;
 2. the beneficiary requires continuous licensed nursing care;
 3. the beneficiary's physician certifies that placement is no longer appropriate;
 4. the beneficiary's health needs cannot be met in the specific licensed care home, as determined by the residence; or
 5. the beneficiary has other medical and functional care needs that cannot be properly met in a licensed care home, as determined by NC General Statutes and licensure rules and regulations.

Note: DMA will allow time for the development and execution of a safe and orderly discharge prior to PCS termination.

- c. Medicaid shall not cover **any** of the following services under PCS:
 1. Skilled nursing services provided by a LPN or RN;
 2. Services provided by other licensed health care professionals;
 3. Respite care;
 4. Care of non-service-related pets and animals;
 5. Yard or home maintenance work;
 6. IADLs in the absence of associated ADLs;
 7. Transportation;
 8. Financial management;
 9. Errands;
 10. Companion sitting or leisure activities;
 11. Ongoing supervision (observation resulting in an intervention) and monitoring (precautionary observation), except when approved under EPSDT as specified in **Subsection 2.2**;
 12. Personal care or home management tasks for other residents of the household;
 13. Other tasks and services not identified in the beneficiary's Independent Assessment and noted in their Service Plan; and
 14. Room and board.

4.2.3 Medicaid Additional Criteria Not Covered

Medicaid shall not cover PCS when rendered concurrently with another substantially equivalent Federal or State funded service. Services equivalent to PCS include:

- a. home health aide services and in-home aide services in the Community Alternatives Programs (CAP/Children, CAP/Choice, CAP/Disabled Adults, CAP Innovations) and;
- b. Private Duty Nursing (PDN).

4.2.4 NCHC Additional Criteria Not Covered

- a. None Apply.
- b. NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
 1. No services for long-term care.
 2. No nonemergency medical transportation.
 3. No EPSDT.
 4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Medicaid shall require prior approval for PCS.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2.2** of this policy.

5.2.2 Specific

To be prior approved for PCS, the beneficiary shall:

- a. Obtain a Physician Referral; and attestation, when applicable;
- b. Obtain an ACH PASRR screen if seeking admission to, or residing in, an adult care home licensed under G.S. 131D-2.4
- c. Receive an independent assessment from the IAE;
- d. Meet minimum PCS eligibility requirements;
- e. Obtain a service authorization for a specified number of PCS hours per month; and

- f. Obtain an approved service plan from the provider.

5.2.3 EPSDT Additional Requirements for PCS

Medicaid may authorize services that exceed the PCS service limitations if determined to be medically necessary under EPSDT based on some or all of the following documents submitted by the provider before PCS is rendered:

- a. Work and School verification, where applicable, for the beneficiary's caregiver, legal guardian, or power of attorney. PCS may not cover all time requested by caregiver for work and school that exceed full-time hours;
- b. Verification from the Exceptional Children's program per county if PCS is being requested in school setting;
- c. Health record documentation from the beneficiary's physician, therapist, or other licensed practitioner;
- d. Physician documentation of primary caregiver's limitation that would prevent the caregiver from caring for the beneficiary, if applicable; or
- e. Any other independent records that address ADL abilities and need for PCS.

Note: If additional information does not validate the assessment, PCS hours may be reduced, denied, or terminated based on additional records.

5.3 Additional Limitations or Requirements

5.3.1 Monthly Service Hour Limits

- a. The following hour limits apply to a beneficiary who meets PCS eligibility requirements and coverage criteria in this policy:
 - 1. A beneficiary under 21 years of age may be authorized to receive up to 60 hours of service per month; and
 - 2. A beneficiary age 21 years and older may be authorized to receive up to 80 hours of service per month.
- b. A Medicaid beneficiary who meets the eligibility criteria in **Section 3.0** of this policy and **all** of the criteria provided below is eligible for up to 50 additional hours of PCS per month for a total amount of the maximum hours approved by the State Plan in accordance with an independent assessment and a service plan.
 - 1. Requires an increased level of supervision (observation resulting in an intervention) as assessed during an independent assessment conducted by DMA or a DHHS designated contractor;
 - 2. 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 learning, and the loss of language skills;
 - 3. Regardless of setting, requires a physical environment that addresses safety and safeguards the beneficiary because of the beneficiary's

- gradual memory loss, impaired judgment, disorientation, personality change, difficulty learning, and loss of language skill; and
4. Health record documentation or verifiable information provided by a caregiver obtained during the independent assessment reflects a history of escalating safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.

5.4 Authority to Conduct PCS Assessments, Expedited Assessments, Reassessments, Change of Status Reviews, Service Authorizations, and Related Administrative Tasks

- a. PCS assessments, expedited assessments, reassessments, and change of status reviews for the purpose of determining eligibility and authorizing services must be conducted by the IAE designated by DMA.
- b. In-home care and residential care provider organizations are not authorized to perform PCS assessments for the purpose of authorizing Medicaid services. Such assessments are initial assessments of a beneficiary referred to PCS, continuing need reviews or reassessments for PCS and change of status reviews for PCS. All beneficiaries requiring PCS assessments for the purpose of authorizing services shall be referred to the designated IAE.
- c. DMA's designated IAE shall determine the effective date and issue prior authorization for a beneficiary approved for services.
- d. The designated IAE shall determine the qualifying ADLs, the level of assistance required for each, and the amount and scope of PCS to be provided, according to the criteria provided in **Appendix A** of this clinical coverage policy.
- e. The designated IAE shall determine the end date for approval of services and the date of the next reassessment that shall be no later than 365 calendar days from the approval date, or a shorter period of time based on the beneficiary's chronic or continuing acute condition and expectation for improvement in the beneficiary's medical condition causing the need for PCS.
- f. DMA, at its sole discretion, shall conduct a review of a beneficiary's PCS or order a re-assessment of the unmet need for PCS at any time.
- g. When a beneficiary is contacted by the designated IAE to schedule an assessment, the beneficiary shall respond as soon as possible. If the IAE is unable to schedule an assessment services will be denied.

5.4.1 Requirement for Qualifying Activities of Daily Living (ADLs)

PCS are provided to a Medicaid beneficiary who qualify for coverage and have documented unmet needs for hands-on assistance with:

- a. Bathing;
- b. Dressing;
- c. Mobility;
- d. Toileting; or
- e. Eating.

5.4.2 Requirement for Physician Referral

The beneficiary shall be referred to PCS by his or her primary care practitioner or attending physician utilizing the Physician Referral approved by DMA.

- a. The Physician Referral approved by DMA is the DMA-3051 *PCS Request for Independent Assessment for Personal Care Services Attestation for Medical Need*.
- b. Medicaid shall accept the signature of a physician, nurse practitioner or physician assistant on the referral in accordance with G.S. §90-18.3 of the Physician Practice Act.
- c. The beneficiary or the beneficiary's family or legally responsible person is responsible for contacting his or her primary care or attending physician and requesting a referral for Medicaid PCS.
- d. If the beneficiary has not been seen by his or her practitioner during the preceding 90 calendar days the referral is not processed. He or she shall schedule an office visit to request a referral for a Medicaid PCS eligibility assessment.
- e. If the practitioner indicates that the medical diagnosis or diagnoses listed on the PCS referral does not impact the beneficiaries activities of daily living (ADLs) the request is not processed.
- f. A beneficiary participating in Community Care of North Carolina (CCNC) shall be referred for PCS by his or her designated primary care physician, except as described in **Subsection 5.4.3.f**.
- g. If a beneficiary does not have a primary care physician, he or she shall obtain a referral from the practitioner who is providing the care and treatment for the medical, physical, or cognitive condition causing the functional limitations requiring PCS.
- h. Once a referral is made by the beneficiary's practitioner, the PCS assessment shall be performed by an IAE Assessor at the beneficiary's primary private residence or residential facility.

5.4.3 Requirements for PCS Eligibility Assessments

- a. All PCS assessments to determine beneficiary eligibility and authorized service level shall be conducted by IAE Assessors using a standardized process and assessment tool provided or approved by DMA.
- b. All PCS assessments shall be performed by Independent Assessors.
- c. All assessments for new admissions to PCS shall be face to face and conducted in the beneficiary's primary private residence, or residential facility.
- d. In-home assessments shall include an assessment of the beneficiary's home environment to identify any health or safety risks to the beneficiary or to the PCS aides who will provide the services. Assessments in residential facilities must report verification of a valid facility license.
- e. Physician attestation that PCS is medically necessary is required.
- f. If the beneficiary is an inpatient in a medical facility such as a hospital, rehabilitation center, nursing facility, or in the care of Adult Protective Services (APS), his or her physician may order the PCS assessment through the facility's discharge planning office as described in **Subsection 5.4.4, Requirements for PCS Expedited Assessment Process**. A written copy of the order shall be placed in the beneficiary's medical record and, if requested, shall be provided to DMA or the IAE.
- g. Physician, nurse practitioner or physician assistant referring a beneficiary for PCS shall complete the *PCS Request for Independent Assessment for*

Personal Care Services Attestation for Medical Need form, which documents medical necessity attestation, and submit the form to the IAE via secure facsimile or mail. The form shall be complete and provide:

1. physician authorization for the IAE to perform a PCS assessment;
2. the medical diagnosis or diagnoses and related medical information that result in the unmet need for PCS assistance.
3. the current diagnosis code associated with the identified medical diagnosis; and
4. a signed and dated PCS referral Request for Independent Assessment for Personal Care Services Attestation for Medical Need form which contains a physician signed attestation to the medical necessity of the service.

Home care agencies, and residential providers may access the independent assessment electronically by registering with the Provider Interface.

A beneficiary may receive a new assessment to determine if there is a need for a change in PCS.

5.4.4 Requirements for PCS Expedited Assessment Process

To qualify for the expedited process the beneficiary shall:

- a. be medically stable;
- b. eligible for Medicaid or pending Medicaid eligibility;
- c. have a Pre-Admission Screening and Resident Review (PASRR) if seeking admission to an Adult Care Home licensed under G.S. 131 D-2.4;
- d. in process of being discharged from the hospital following a qualifying stay;
- e. in process of being discharged from a skilled nursing facility;
- f. be under adult protective services; or
- g. be an individual served through the transition to community living initiative.

PCS approval through the expedited process is provisional and subject to the standard PCS assessment process within 14 business days. The provisional prior approval must not exceed a 60 calendar day period without DMA approval. The process requirements are:

- a. The PCS expedited assessment process to determine beneficiary eligibility and authorized service level shall be conducted by IAE Assessors using a standardized process and assessment tool provided or approved by DMA.
- b. The expedited process must be requested by a hospital discharge planner, skilled nursing facility discharge planner or Adult Protective Services (APS) Worker, LME-MCO Transition Coordinators.
- c. If the beneficiary qualifies for the expedited assessment process, an expedited assessment is conducted over the phone to determine eligibility.

- d. If it is determined the beneficiary provisionally qualifies for PCS, a provider shall be identified and the hospital discharge planner, skilled nursing facility discharge planner, or APS worker must communicate the beneficiary's choice of provider and intended admission date to the selected provider and the IAE.
- e. A beneficiary approved through the expedited process may receive up to 60 hours of services during the provisional period. The qualifying ADLs and the amount of service approved is indicated by the results of the expedited assessment conducted.
- f. A beneficiary receiving approval through the expedited assessment process is authorized for services within two business days of completed request.
- g. If the beneficiary's Medicaid eligibility is pending, provisional authorization remains pending until Medicaid eligibility is effective. If the beneficiary is not Medicaid eligible within the 60 calendar day provisional period, the beneficiary shall request PCS through the standard PCS assessment process.
- h. PCS Provider shall inform the IAE when a beneficiary, who is pending Medicaid eligibility, becomes Medicaid eligible before receiving prior approval for PCS.

5.4.5 Requirements for PCS Reassessments

- a. All reassessments for continuing authorization of PCS must be conducted by the designated IAE.
- b. The IAE schedules annual reassessments to occur on or before the end of the current services authorization date.
- c. PCS providers shall report discharges to the IAE within seven (7) business days of the beneficiary discharge via the Provider Interface.
- d. Reassessments may vary in type and frequency depending on the beneficiary's level of functional disability and his or her prognosis for improvement or rehabilitation, as determined by the IAE, but not less frequently than once every 365 calendar days.
- e. Reassessment frequency must be determined by the IAE as part of the new referral admission and assessment process.
- f. Reassessments must be conducted face-to-face.

5.4.6 Requirements for PCS Change of Status Reviews

- a. All Change of Status Reviews to determine changes to authorized service levels must be conducted by the designated IAE.
- b. A beneficiary may receive a Change of Status: Medical or a Change of Status: Non-Medical
 - 1. Change of Status: Medical Review may be requested at any time, by the beneficiary's practitioner or attending physician only. The date of the last visit to the physician must be less than 90 days from the request of the Change of Status: Medical. Change of Status: Medical Review must be submitted by physician when the beneficiary has experienced a change in their medical condition affecting their activities of daily living (ADL's)
 - 2. Change of Status: Non-Medical Review may be requested at any time by the beneficiary, beneficiary's family, or legally responsible

person; home care provider; or residential provider. Change of Status: Non-Medical Review must be submitted when the beneficiary has experienced a change in their informal caregiver availability or environmental condition that affects the beneficiary's ability to self-perform.

- c. Requests for Change of Status Reviews shall include documentation of the change in the beneficiary's medical condition, informal caregiver availability, or environmental condition that affects the individual's ability to self-perform or the time required to provide the qualifying ADL assistance, and the need for reassessment.
- c. DMA or its DHHS designated contractor retains sole discretion in approving or denying requests to conduct Change of Status reassessments.
- d. Change of Status Reviews must be conducted by face-to face by the designated IAE assessors.

5.4.7 Requirements for PCS Assessment and Reassessment Tools

PCS assessment and reassessment tools must be provided or approved by DMA and designed to accomplish the following in a valid and consistent manner:

- a. Determine the beneficiary's eligibility for PCS;
- b. Determine and authorize hours of service and level of care for new PCS referrals;
- c. Determine and authorize hours of service and level of care for continuation of PCS for each subsequent authorization period;
- d. Determine and authorize hours of services and level of care resulting from significant changes in the beneficiary's ability to perform their ADLs;
- e. Provide the basis for service plan development;
- f. Support PCS utilization and compliance reviews; and
- g. Support PCS quality assessment and Continuous Quality Improvement (CQI) activities.

5.4.8 Timelines for Assessment and Beneficiary Notification

The IAE shall notify the beneficiary of assessment and reassessment results:

- a. within 14 business days of a completed initial assessment for PCS;
- b. within 14 business days of a completed change of status assessment;
- c. on or before the end date of the completed authorization period; and
- d. within two business days of an expedited assessment request for a beneficiary with a planned discharge from a hospital or inpatient facility; skilled nursing facility; or under adult protective services.

5.4.9 Determination of the Beneficiary's ADL Self-Performance Capacities

The assessment tool must be a standardized functional assessment with **all** of the following components:

- a. Defining tasks for each of the qualifying ADLs;
- b. The medical diagnosis or diagnoses causing the need for the PCS;
- c. Any exacerbating medical conditions or symptoms that may affect the ability of the beneficiary to perform the ADLs; and
- d. A rating of the beneficiary's overall self-performance capacity for each ADL, as summarized in the following table.

Beneficiary's Self-Performance Rating	Description
0 – Totally able	Beneficiary is able to self-perform 100 percent of activity, with or without aids or assistive devices, and without monitoring or assistance setting up supplies and environment
1 – Needs verbal cueing or monitoring only	Beneficiary is able to self-perform 100 percent of activity, with or without aids or assistive devices, and requires, monitoring, or assistance retrieving or setting up supplies or equipment
2 – Can do with limited hands-on assistance	Beneficiary is able to self-perform more than 50 percent of activity and requires hands-on assistance to complete remainder of activity
3 – Can do with extensive hands-on assistance	Beneficiary is able to self-perform less than 50 percent of activity and requires hands-on assistance to complete remainder of activity
4 – Cannot do at all (full dependence)	Beneficiary is unable to perform any of the activity and is totally dependent on another to perform all of the activity

The PCS assessment must include a review with family members or other caregivers present at the time of assessment of the beneficiary's ability to perform qualifying ADLs, the amount of assistance required, and any physical or cognitive limitations or symptoms that may affect his or her ability to complete each ADL. The IAE assessor shall receive verbal consent from the beneficiary before family members or other caregivers present participate in the assessment review.

The IAE assessor shall evaluate and document the following factors for each qualifying ADL:

- a. Beneficiary capacities to self-perform specific ADL tasks;
- b. Beneficiary capacities to self-perform IADL tasks directly related to each ADL;
- c. Use of assistive and adaptive devices and durable medical equipment;
- d. Availability, willingness, and capacities of family members and other informal caregivers to provide assistance to the beneficiary to perform ADLs;
- e. Availability of other home and community-based services and supports;
- f. Medical conditions and symptoms that affect ADL self-performance and assistance time; and
- g. Environmental conditions and circumstances that affect ADL self-performance and assistance time.

5.4.10 Minimum Requirement for Admission to and Continuation of PCS

To qualify for admission to PCS and continuation of PCS, the beneficiary shall meet **all** the requirements of this clinical coverage policy in addition to the functional eligibility criteria specified in **Subsection 3.2**.

5.4.11 Requirements for Selecting and Changing PCS Providers

IAE assessors shall provide options to the beneficiary to select a provider organization to provide PCS. This process must contain the following steps:

- a. Each beneficiary may select at least three providers from a randomized list of available providers that are licensed to provide home care or residential care services in the county where he or she resides, which may include the county in which he or she chooses to live;
- b. The IAE shall make a referral to the beneficiary's first choice of PCS Provider; the provider will have 2 business days to accept or reject the referral. If the provider does not accept the referral, the IAE shall make a referral to the second provider on the beneficiary's list and, if necessary the third provider on the list;
- c. The beneficiary may change his or her PCS Provider during the course of the authorized service period by notifying the IAE of the desired change. A new assessment shall not be required unless a change of status review is required;
- d. The IAE shall furnish the new provider with a copy of the assessment and service authorization;
- e. The new PCS Provider shall be required to develop a new service plan;
- f. The new PCS Provider shall complete the service plan within seven (7) business days of accepting the referral;
- g. The beneficiary may request another aide to perform the PCS. The PCS Provider shall make a reasonable attempt to accommodate the request and shall document the outcome. If the request cannot be accommodated, the Provider shall document the reasons the request cannot be accommodated;
- h. Providers shall notify the IAE of any discharges as they occur via the Provider Interface; and
- i. Beneficiaries or their representatives shall certify, in a manner prescribed by DMA, that they have exercised their right to choose a provider of choice and have not been offered any gifts or service-related inducements to choose any specific provider organization.

5.5 Retroactive Prior Approval for PCS

Retroactive prior approval applies to initial requests for services. The retroactive effective date for authorization is the request date on the *Request for Independent Assessment for Personal Care Services Attestation for Medical Need* form submitted to the IAE, providing the date is not more than 30 calendar days from the date the IAE received the request form. If the *Request for Independent Assessment for Personal Care Services Attestation for Medical Need* form is received by IAE more than 30 calendar days from the request date on the form, the authorization is effective the date the IAE received the form.

Retroactive prior approval does not apply, if a beneficiary requesting admission to an Adult Care Home, licensed under G.S. 131D-2.4, has not received a screening through the Preadmission Screening and Resident Review (PASRR). PCS authorization may not

precede the effective date of the beneficiary's PASRR. If the effective PASRR date is not within 30 calendar days of the submission of the Physician Referral, the Referral is invalid and a new Referral is required.

5.6 Reconsideration Request for initial authorization for PCS

A beneficiary, 21 years of age or older, who receives an initial approval for less than 80 hours per month may submit a Reconsideration Request Form (DMA 3114) to the IAE if they do not agree with the initial level of service determined, through the following process:

- a. After receiving an initial approval for an amount of hours less than 80 hours per month, a beneficiary must wait 30 calendar days from the date of notification to submit a reconsideration request form. This 30-calendar-day requirement does not apply to the beneficiary's submission of a Change of Status request, which may be submitted at any time if the change of status criteria are met.
- b. The beneficiary must submit a reconsideration request form to increase hours above the initial approval no earlier than 31 calendar days and no later than 60 calendar days from the date of the initial approval notification.
- c. The request for hours in excess of the initial approval that are not based on a Change of Status must be submitted with supporting documentation that specifies, explains, and supports why additional authorized hours of PCS are needed and which ADLs and tasks are not being met with the current hours.
- d. The Reconsideration Request form and supporting documentation should also provide information indicating why the beneficiary believes that the prior assessment did not accurately reflect the beneficiary's functional capacity or why the prior determination is otherwise insufficient.
- e. Upon receipt of a completed Reconsideration Request for additional hours a reassessment may be scheduled or the previous assessment modified. A reconsideration request is not considered complete without supporting documentation as indicated in **Subsection 5.6(c and d)**.
- f. If the reconsideration determines a need for additional PCS hours, additional hours are authorized under clinical coverage policy 3L, *State Plan Personal Care Services (PCS)*. This constitutes an approval and no adverse notice or appeal rights are provided.
- g. If the reconsideration determines that the PCS hours authorized during the initial assessment are sufficient to meet the beneficiary's needs, an adverse decision is issued with appeal rights.

Note: The above process does not apply to beneficiaries seeking hours as documented in Subsection 5.3.1.b of this policy.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Providers shall not bill for Medicaid PCS services provided by an individual with any of the following convictions on the criminal background check conducted in accordance with 7.10(d.1) of this policy:

1. felonies related to manufacture, distribution, prescription or dispensing of a controlled substance;
2. felony health care fraud;
3. felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult;
4. felony or misdemeanor patient abuse;
5. felony or misdemeanor involving cruelty or torture;
6. misdemeanor healthcare fraud;
7. misdemeanor for abuse, neglect, or exploitation listed with the NC Health Care Registry; or
8. any substantiated allegation listed with the NC Health Care Registry that would prohibit an individual from working in the healthcare field in the state of NC.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

To be eligible to bill for procedures, products, and services related to this policy, providers shall be:

- a. a home care agency licensed by the DHSR to operate in the county or counties where the PCS Services are being provided;
- b. a residential facility licensed by the State of North Carolina as an adult care home as defined in G.S. 131D-2, or a combination home as defined in G.S. 131E-101(1a); or
- c. a residential facility licensed under Chapter 122C of the General Statutes and defined under 10A NCAC 27G.5601 as a supervised living facility for two or more adults whose primary diagnosis is mental illness, a developmental disability, or substance use disorder.

6.1.1 PCS Paraprofessional Aide Minimum Qualifications

PCS Aides shall be:

- a. High school graduates or equivalent; or
- b. Eighteen (18) years of age or older.

6.1.2 PCS Paraprofessional Aide Minimal Training Requirements

Personnel records of aides providing PCS must provide documentation of training in, at minimum, each of the following content areas:

- a. Beneficiary rights;
- b. Confidentiality and privacy practices;
- c. Personal care skills, such as assistance with the following ADLs:
 1. Bathing;
 2. Dressing;
 3. Mobility;
 4. Toileting; and
 5. Eating.
- d. In-home and Residential Care Aides providing services to beneficiaries receiving hours in accordance with Session Law 2013-306, have 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. Providers shall submit an attestation to DMA that they are in compliance with this requirement. The attestation form (DMA-3085) and instructions are located on the DMA PCS webpage.
- e. Documentation and reporting of beneficiary accidents and incidents;
- f. Recognizing and reporting signs of abuse and neglect; and
- g. Infection control.

6.1.3 Provider Interface: Web-Based Beneficiary and Provider Records Management

The Provider Interface is a secure, web-based information system that the IAE uses to support the PCS independent assessment process. All PCS Providers shall enroll in the Provider Interface. The Provider Interface allows the provider organization to:

- a. Receive and respond to PCS referrals online;
- b. Access electronic copies of independent assessments documents, referrals, and notification letters;
- c. Develop and submit the PCS on-line service plan;
- d. Submit Non-Medical Change of Status requests and discharge beneficiaries online;
- e. Change provider National Provider Identification (NPI) numbers for beneficiaries who need to have their service transferred from one provider office to another within the same agency;
- f. Enter information about counties served by the provider, if applicable;
- g. Update billing modifiers online, if applicable;
- h. Receive electronic notification for beneficiary once an appeal has been entered, and the status of the appeal once it is resolved.
- i. Receive electronic notification of upcoming annual assessments for beneficiaries.

6.1.4 Requirements for State Plan PCS On-line Service Plan

Providers shall develop an on-line PCS service plan through the Provider Interface. The following requirements for the on-line PCS service plan must apply.

- a. All IAE referrals are transmitted to provider organizations through the Provider Interface. No mailed or faxed referrals are provided;
- b. The provider organization accepting the IAE referral to provide PCS services shall review the IAE independent assessment results for the beneficiary being referred, and develop a PCS service plan responsive to the beneficiary's specific needs documented in the IAE assessment;
- c. Provider organizations shall designate staff they determine appropriate to complete and submit the service plan via the Provider Interface.
- d. Each IAE referral and assessment shall require a new PCS service plan developed by the provider organization that is based on the IAE assessment results associated with the referral;
- e. The service plan must address each unmet ADL, IADL, special assistance or delegated medical monitoring task need identified in the independent assessment, taking into account other pertinent information available to the provider;
- f. The provider organization shall ensure the PCS service need frequencies documented in the independent assessment are accurately reflected in the PCS service plan schedule as well as any special scheduling provisions such as weekend days documented in the assessment.
- g. The provider organization shall ensure that the beneficiary or their legally responsible person understands and, to the fullest extent possible participates in the development of the PCS service plan.
- h. Once the provider organization completes the service plan, the service plan must be validated by the Provider Interface for consistency with the IAE assessment, and related requirements for the service plan content.
Note: For EPSDT beneficiaries, the provider organization must complete the service plan based on the DMA nurse review of the assessment and documents provided in accordance with **Subsection 5.2.3**. DMA nurse guidance will be provided to the provider organization prior to acceptance of the referral and in the service plan.
- i. The PCS service plan must be developed, and validated within seven (7) business days of the Provider accepting receiving the IAE referral.
- j. The provider organization shall obtain the written consent in the form of the signature of the beneficiary or their legally responsible person within 14 business days of the validated service plan. The written consent of the service plan must be printed out and uploaded into the Provider Interface;
- k. The provider shall make a copy of the validated service plan available to the beneficiary or their legally responsible person within three (3) business of a verbal request.
- l. **The PCS service plan is not a plan of care** as defined by the applicable state licensure requirements that govern the operation of the provider organizations. Provider organizations are expected to complete a separate plan of care in accordance to licensure requirements as specified in 10ANCAC 13J, 10A NCAC 13F and 13G, and 10A NCAC 27G.

- m. Provider organizations may enter PCS service plan revisions in the Provider Interface at any time as long as the changes do not alter the aide tasks or need frequencies identified in the corresponding IAE assessment;
- n. Provider organizations may continue to request a Change of Status Review, as described in Subsection 5.4.6b, by the IAE if there has been a significant change that affects the beneficiary's need for PCS since the last assessment and service plan. Any Change of Status reassessment requires a new PCS service plan documented in QiRePort;
- o. Provider organizations shall be reimbursed only for PCS authorized hours and services specified and scheduled in the validated PCS service plan; and,
- p. Prior approval for PCS hours or units is not granted until the on-line PCS service plan is entered into and validated by the Provider Interface.

6.1.5 Requirements for Aide Documentation

The provider organization accepting the referral to provide services shall:

- a. Maintain documentation that demonstrates all aide tasks listed in the PCS service plan are performed at the frequency indicated on the service plan and on the days of the week documented in the service plan;
- b. Document aide services provided, to include, at minimum, the date of service, aide tasks provided, and the aide providing the service; and;
- c. Document all deviations from the service plan; this documentation shall include, at minimum, the date care tasks not performed and reason(s) tasks(s) were not performed. A deviation is a scheduled task that is not performed for any reason.
- d. The Provider Interface provides an option for documenting aide services and task sheets. If a provider organization elects to use their own aide task worksheets, the worksheets must accurately reflect all aide tasks and schedule documented in the online PCS service plan, task by task.

Nurse Aide Tasks

- a. In-home aides may provide Nurse Aide I and Nurse Aide II tasks under this clinical coverage policy when they meet the training, competency evaluation, and other professional qualifications specified in 21 NCAC 36.0403 (a) and 21 NCACE 36.0403 (b) respectively, and such tasks are specified on the beneficiary's service plan.
- b. If a beneficiary approved for services in a primary private residence requires Nurse Aide II tasks, the home care agency selected to provide the services shall have this level of expertise available;
- c. Residential nurse aides may provide tasks under this clinical coverage policy when they meet the training, competency evaluation, and other professional qualifications specified in 10A NCAC 13F and 13G and 10A NCAC 27G.

6.2 Provider Certifications

None apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

- Provider(s) shall comply with the following in effect at the time the service is rendered:
- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
 - b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Note: Providers also shall maintain all home and residential care service records as specified in 10A NCAC 13J, 10A NCAC 13F and 13G, and 10A NCAC 27G.

7.2 Assessment Tools, Service Plans, and Forms

Providers shall utilize those assessment tools, report formats, surveys, and related documents required by DMA.

7.3 Automated Reporting

Providers shall utilize all available Internet-based assessments, forms, reports, surveys, and other documents required by DMA to submit information to DMA, the IAE, the beneficiary's physician, and other individuals or organizations designated by DMA.

7.4 Telephony

Providers may utilize telephony and other automated systems to document the provision of PCS.

7.4.1 Provider Requirements

Provider agencies furnishing PCS services using telephony system shall:

- a. inform the beneficiary that a telephony system is used to document the time the PCS aide spends in the primary private residence, and the approved personal care services provided;
- b. explain to the beneficiary how the system works;
- c. inform the beneficiary that calls made are not charged to his or her telephone, and there is no cost to the beneficiary for use of this system;
- d. ensure that the beneficiary agrees to participate in the telephony system prior to implementation;
- e. ensure that the beneficiary understands that he or she shall be present in the primary private residence and receiving approved PCS in accordance with his or her service plan between the arrival and departure times documented by the telephony system; and
- f. provide evidence that these requirements have been met by having the beneficiary sign and date a letter or form acknowledging that he or she:
 1. understands the telephony system and its purpose;

2. understands how it works, and;
3. agrees to the use of this system to document that authorized services were provided between the time-in and time-out calls.

Providers furnishing PCS aide services under the above-referenced programs are required to orient all PCS aides to program requirements for service documentation under the telephony system and the implications of submitting inaccurate or falsified records. Upon request from DMA, provider agencies shall provide evidence that such an orientation has been completed for each aide.

The provider agencies shall use the beneficiary's telephone landline to record the exact arrival and departure time of the PCS aide. The system must be capable of verifying that this is the beneficiary's telephone number. When the beneficiary does not have a telephone landline, the PCS provider may use an authorized personal or agency cell phone. When a cell phone is used the beneficiary shall verbally verify over the same cell phone that approved PCS were received between the reported arrival and departure times.

These requirements must be addressed in the provider agency's written policies and procedures and available for review upon request by DMA.

7.4.2 Minimum Telephony System Requirements

DMA does not approve or endorse specific types or brands of telephony systems. The telephony system employed must provide, at a minimum, the following functionality:

- a. identifies calls made from unauthorized numbers;
- b. identifies each aide through a unique and secure identification number;
- c. records essential beneficiary identification data, services provided, and medical monitoring tasks;
- d. records date of service, day of week, time in, and time out;
- e. automatically alerts the agency when an aide fails to clock in for a scheduled visit;
- f. tracks aide actions and compliance with beneficiary's service plan;
- g. records deviations from approved schedule and service plan;
- h. maintains service schedules that can be cross-referenced by aide and beneficiary;
- i. employs appropriate security to prevent unauthorized manipulation of recorded data;
- j. stores the data in an easily retrievable format;
- k. prints hard copies of reports; and
- l. meets HIPAA standards for privacy and electronic security.

The beneficiary shall not be required to sign a service log or otherwise verify that he or she received services during the scheduled visit when a telephony system is used. If the telephony system meets the requirements of an aide signature on the service log, a printed hard copy with the aide signature on the log is not necessary.

Provider agencies employing telephony systems shall take adequate precautions to prevent loss of data, such as off-site storage of backup disks or tapes, or, if necessary, backup hard copies of critical service and billing records to include service logs.

The provider agencies employing telephony shall continue to comply with all applicable federal and state statutes, rules, regulations, policies, standards, and guidelines for recordkeeping under the PCS program. The provider agency shall maintain a hard-copy recordkeeping system for those beneficiaries who do not agree to participate in the telephony system, or when other circumstances prevent its use.

7.5 Marketing Prohibition

Agencies providing PCS under this Medicaid Program are prohibited from offering gifts or service related inducements of any kind to entice beneficiaries to choose it as their PCS Provider or to entice beneficiaries to change from their current provider.

7.6 DMA Compliance Reviews

The PCS Provider Organization shall:

- a. Cooperate with and participate fully in all desktop and on-site quality, compliance, prepayment, and post-payment audits that may be conducted by DMA or a DHHS designated contractor;
- b. Meet DMA requirements for addressing identified program deficiencies, discrepancies, and quality issues through the DMA corrective action process and any overpayment recovery or sanctioning process imposed by DMA's Program Integrity Section; and
- c. Maintain all clinical records and billing documentation in an accessible location in a manner that will facilitate regulatory reviews and post payment audits.

7.7 Internal Quality Improvement Program

The PCS Provider Organization shall:

- a. develop, and update at least quarterly, an organizational Quality Improvement Plan or set of quality improvement policies and procedures that describe the PCS CQI program and activities;
- b. implement an organizational CQI Program designed to identify and correct quality of care and quality of service problems;
- c. conduct at least annually a written beneficiary PCS satisfaction survey for beneficiaries and their legally responsible person;
- d. maintain complete records of all CQI activities and results;
- e. PCS Providers shall submit by December 31 of each year an attestation to DMA that they are in compliance with "a" through "d" of this Subsection. The attestation form and instructions are posted on the DMA PCS website; and
- f. provide these documents to DMA or a DHHS designated contractor upon request in conjunction with any on-site or desktop quality improvement review.

7.8 Quality Improvement, Utilization Review, Pre- and Post-Payment Audits

The PCS Provider Organization shall cooperate with and participate fully with the following DMA quality improvements, utilization reviews, and pre- and post-payment audits:

- a. Provider on-site reviews, evaluations, and audits;
- b. Desktop reviews;
- c. Targeted record reviews;
- d. Beneficiary in-home and residential reviews;
- e. Beneficiary PCS satisfaction surveys;
- f. Reviews of attestation forms and supporting documentation;
- g. Retroactive utilization and medical necessity reviews;
- h. Quality of care and quality of service reviews and evaluations;
- i. Program Integrity prepayment and post-payment reviews;
- j. Reviews of beneficiary complaints; and
- k. Reviews of critical incident reports.

7.9 Beneficiary Health, Welfare, and Safety

The PCS Provider Organization shall:

- a. implement and demonstrate compliance with all beneficiary rights and responsibilities, as specified in 10A NCAC 13J, 10A NCAC 13F and 13G, and GS 122C; 131D;
- b. maintain a comprehensive record of beneficiary complaints about the PCS; and
- c. ensure that all incidents involving alleged, suspected, or observed beneficiary abuse, neglect, or exploitation are documented and reported immediately to the county Department of Social Services and the DHSR in accordance to N.C. G.S. 108A-102.

7.10 Provider Supervision and Staffing Requirements

a. PCS Paraprofessional Aide Supervision

The PCS provider shall provide a qualified and experienced professional, as specified in the applicable licensure rules, to supervise PCS, and who shall be responsible for:

1. Supervising and ensuring that all services provided by the aides under his or her supervision are conducted in accordance with this clinical coverage policy, other applicable federal and state statutes, rules, regulations, policies and guidelines and the provider agency's policies and procedures;
2. Supervising the Provider Organization's CQI program;
3. Completing or approving all service plans for assigned beneficiaries;
4. Implementing the service plan; and
5. Maintaining service records and complaint logs in accordance with state requirements.

b. Supervisory Visits In Beneficiary Primary Private Residences

The in-home PCS provider shall ensure that a qualified RN Nurse Supervisor conducts a RN Supervisor visit to each beneficiary's primary private residence location every 90 calendar days (**Note:** a seven calendar day grace period is allowed). Two visits within 365 calendar days must be conducted when the in-home aide is scheduled to be in the primary private residence. The RN Supervisor shall:

1. Confirm that the in-home aide is present or has been present as scheduled during the preceding 90 calendar days;

2. Validate that the information documented on the aide's service log accurately reflects his or her attendance and the services provided;
3. Evaluate the in-home aide's performance;
4. Identify any changes in the beneficiary's condition and need for PCS that may require a change of status review;
5. Request a change of status review if the beneficiary's service plan exceeds or no longer meets the beneficiary's needs for ADL assistance;
6. Identify any new health or safety risks that may be present in the primary private residence;
7. Evaluate the beneficiary's satisfaction with services provided by the in-home aide and the services performed by the home care agency;
8. Review and validate the in-home aide's service records to ensure that:
 - A. Documentation of services provided is accurate and complete;
 - B. Services listed in the service plan have been implemented;
 - C. Deviations from the service plan are documented;
 - D. Dates, times of service, and services provided are documented on a daily basis;
 - E. Separate logs are maintained for each beneficiary;
 - F. All occasions when the beneficiary is not available to receive services or refused services for any reason are documented in the service record along with the reason the beneficiary was not available or refused services; and
 - G. Logs are signed by the in-home aide and the beneficiary after services are provided on a weekly basis.
9. Document all components of the supervisory visits: the date, arrival and departure time, purpose of visit, findings and supervisor's signature.

c. Supervision in Residential Settings

The residential PCS provider shall ensure that a qualified professional conducts Supervision to each beneficiary in accordance to 10 A NCAC 13 F and 13G and 10A NCAC 27G.

The residential PCS provider shall assure appropriate aide supervision by a qualified professional in accordance to 10A NCAC 13F and 13G, and. 10A NCAC 27G.

d. PCS Paraprofessional Aide Training Licensure Requirements

The PCS provider shall ensure that:

1. criminal background checks are conducted on all in-home and residential care aides before they are hired as specified in licensure requirements;
2. in-Home and Residential Care Aides hired are not listed on the North Carolina Health Care Registry as having a substantiated finding in accordance to the health care personnel registry G.S. 131E-256;
3. all in-home and residential aides shall meet the qualifications contained in the applicable North Carolina Home Care, Adult Care Home, Family Care Home and Mental Health Supervised Living Licensure Rules (10A NCAC 13J, 10A NCAC 13F and 13G, and 10A NCAC 27G); and
4. An individual file is maintained on all in-home and residential aides that documents aide training, background checks, and competency evaluations and provides evidence that the aide is supervised in accordance with the requirements specified in 10A NCAC 13J, 10A NCAC 13F and 13G, and 10A NCAC 27G.

e. Staff Development and Training

The PCS Provider Organization based on licensure rules shall:

1. provide a new employee orientation for all new in-home and residential aides and other agency employees that includes information on state rules pertaining to home care agencies and residential providers and the requirements of this clinical coverage policy;
2. develop, implement, and manage an ongoing staff development and training program appropriate to the job responsibilities of agency and facility staff;
3. provide competency training and evaluate the required competencies for in-home aides;
4. provide competency training and evaluation for residential aides as specified in 10A NCAC 13F and 13G, and. 10A NCAC 27G;
5. maintain comprehensive records of all staff orientation and training activities;
and
6. ensure that agency directors, administrative personnel, RN nurse supervisors, and other agency and facility personnel with management responsibilities attend regional and on-line training programs conducted by DMA or its designee.

8.0 Policy Implementation and History

Original Effective Date: January 1, 2013

History:

Date	Section Revised	Change
01/01/2013	All sections and attachment(s)	Initial Promulgation of new program
01/02/2013	Subsection 4.2.a.12	"...same chronological age could safely and independently perform without adult supervision." corrected to read "...same chronological age could not safely and independently perform without adult supervision.
12/01/2013	Section 1.0	Content of section 1.0 has been moved to Section 3.2.1 "Specific Criteria Covered" and Section 3.3 "Personal Care Services."
12/01/2013	Subsection 2.4	Section 2.4 "Functional Eligibility Criteria" has been changed to "Medicaid Specific Criteria" and content is now located in Section 3.2.1
12/01/2013	Subsection 3.2	Subsection 3.2 "Specific Criteria" is now Subsection 3.2.2 "Medicaid Additional Criteria Covered"
12/01/2013	Subsection 3.2.2	Subsection 3.2.2.b includes Screening for Serious Mental Illness (SMI) in Adult Care Homes licensed under G.S. 131D-2.4
12/01/2013	Subsection 3.3	Section 3.3 "Covered Tasks Under PCS" now titled "Personal Care Services" content remains the same
12/01/2013	Subsection 4.2.1	Subsection 4.2.1c.10 – "monitoring" defined as precautionary observation and "supervision" defined as observation resulting in an intervention
12/01/2013	Subsection 5.3.1.b	Criteria for additional hours updated. The criteria reflect updates made to the State Plan Amendment.
12/01/2013	Subsection 5.4.2	Subsection 5.4.2 "Monthly Service Hour Limits" has been moved to Subsection 5.3.1. This section has been updated to include the criteria mandated by Session Law 2013-306 to include additional 50 hours of PCS
12/01/2013	Subsection 5.4.3	Subsection 5.4.3 "Authority to Conduct PCS Assessments, Reassessments, Change of Status Reviews, Service Authorizations, and Related Administrative tasks" is now Section 5.4 and has been reworded to include "Acknowledgment of new Expedited Process."

Date	Section Revised	Change
12/01/2013	Subsection 5.4.5	Subsection 5.4.5 “Requirement for Physician Referral” is now Subsection 5.4.2. This section updated to include the following statement, “The Physician Referral approved by DMA is the DMA-3051 PCS Request for Services Form. ”
12/01/2013	Subsection 5.4.6.g	Subsection 5.4.6g is now Subsection 5.4.3g. Section reads “the beneficiary may receive a PCS assessment in the inpatient medical facility” ... updated to read, the beneficiary may receive a preliminary PCS assessment in the inpatient medical facility ... statement also update to state “A standard PCS assessment will be conducted once the beneficiary resides in the setting where PCS services will be provided within 60 calendar days”
12/01/2013	Subsection 5.4.6.h	Subsection 5.4.6h is now Subsection 5.4.3h. wording updated to remove referral and reference the Request for Services Form
12/01/2013	Subsection 5.4.4	Section 5.4.4 “Requirement for PCS Expedited Process” added to policy. The Expedited Process will allow beneficiaries who meet the identified criteria to receive PCS services within 2 business days.
12/01/2013	Subsection 5.4.10.d	Subsection 5.4.10d moved to subsection 5.4.8d“Within five business days of an assessment request for a beneficiary with a planned discharge from a hospital or inpatient facility”, statement updated to read “within two business days of a PCS expedited process request for a beneficiary who with a planned discharge from a hospital or inpatient facility; or under protective services.
12/01/2013	Subsection 5.4.10.e	Subsection 5.4.10e “Within five business days of the referral of a beneficiary who is under a Department of Social Services protective order” is deleted and included in 5.4.8d
12/01/2013	Subsection 5.4.12	Subsection 5.4.12 a and b. Revised to read “conduct an internal assessment, review the independent assessment conducted by the IAE for beneficiaries.....
12/01/2013	Subsection 5.4.13	Subsection 5.4.13 Requirements for Selecting and Changing PCS Providers is now Subsection 5.4.11. Subsection 5.4.11f deletes “home visit” and replaces with “ The new PCS Provider shall be required to develop a new plan of care.” Subsection 5.4.11g deletes “within 30 days of effective date of this clinical coverage”

Date	Section Revised	Change
12/01/2013	Subsection 5.4.14	Subsection 5.4.14 Requirements for PCS Plan of Care moved to Subsection 5.4.12. Subsection 5.4.12a deletes “home visit” and replaces with “internal assessment”. 5.4.12b deletes “visit” and replaces with “internal assessment. 5.4.12g deletes “within 30 days of the effective date of this clinical coverage policy.”
12/01/2013	Section 5.0	Retroactive Prior Approval added to Section 5.0 as subsection 5.5
12/01/2013	Section 6.3	Section 6.3 is now Subsection 6.1.2. Subsection 6.1.2 now includes additional requirement “Training and providing care to individuals with impaired judgment, disorientation, loss of language skills, inappropriate behaviors, like wandering that are resulting from the exacerbation of dementia;
12/01/2013	Section 7.4	Section 7.4 “Telephony” updated to include Provider Requirements for use of “Telephony”.
12/01/2013	Section 7.10	Section 7.10 Provider Supervision and Staffing Requirements. Section updated to include “calendar days” in subsections 7.10b and 7.10b.1.
12/01/2013	Subsection 7.10.d.2	Subsection 7.10.d.2 language updated to read “In-Home and Residential Care Aides hired are not listed on the North Carolina health Care Registry as being under investigation or as having a substantiated finding in accordance to the health care personnel registry G.S. 131E-256.
12/01/2013	Service Level Determinations	#3. Updated to read “For all conditions affecting the beneficiary’s ability to perform ADLs no more than 25% of additional time shall be provided.”
12/01/2013	Service Level Determinations	#4. Updated to read “For all conditions affecting the beneficiary’s ability to perform ADLs no more than 25% of additional time shall be provided.”
12/01/2013	Service Level Determinations	#5. Removed following text from statement “The total authorized service hours per month may not exceed 80 for adults 21 years and older.”
12/01/2013	Service Level Determinations	#6. Updated to include criteria mandated by Session Law 2013-306 and service levels approved by SPA 13-009. Now reads as follows: “Total authorized PCS hours may exceed 80 hours per month for adults, if there is present: a) a physician attestation of need for expanded hours; and b) qualifying criteria as established in Session Law 2013-306 . In no case will expanded PCS hours exceed the maximum hours approved by State Plan Amendment . The number of expanded PCS hours to be authorized for individuals qualifying for expanded hours will be based on the PCS hours determination methodology described in Steps 1-4 above.”

Date	Section Revised	Change
12/01/2013	Attachment A	Attachment A – modifiers – HA modifier updated to read “Any beneficiary Under 21 Years regardless of setting”
12/01/2013	Appendix A	Service Level Determinations: #6 updated to include the determination criteria for beneficiaries who may receive PCS hours that exceed 80 hours per month for adults or 60 hours for children, under 21 years of age and not approved under EPSDT. “if there is present: a) a physician attestation of need for expanded hours; b) qualifying criteria as established in Session Law 2013-306. In no case will expanded PCS hours exceed the maximum hours approved by State Plan Amendment 13-009. The number of expanded PCS hours to be authorized for individuals qualifying for expanded hours will be based on the PCS hours determination methodology described in steps 1-4”
01/15/2014	Section 8.0	Minor revisions to table, clarifying changes made in the 12/01/2013 Amended version
10/01/2013	Section 1.0	Section 1.0 Updated to read that PCS services must be performed by home staff “licensed” in the supervised living home.
10/01/2013	Subsection 3.3.a	Subsection 3.3 a 7 updated to stated definition of “special assistance”.
10/01/2013	Subsection 4.2.1.a	Subsection 4.2.1a. added #2.to read as follows “The PCS is not documented as completed in accordance with this clinical coverage policy”
10/01/2013	Subsection 4.2.1.c	Subsection 4.2.1c added #6 to read as follows “Instruments of daily living (IADL’s) in the absence of associated Activities of daily living (ADL)”.
10/01/2013	Subsection 4.2.1 c 7	Subsection 4.2.1 c 7. Removed wording “non medical” so statement only reads “transportation”.
10/01/2013	Subsection 5.4.2.b	Removed “physician” from physician referral. Text identifies physician referral as “referral”
10/01/2013	Subsection 5.4.3.f	5.4.3 f – removes “attending” from physician.
10/01/2013	Subsection 5.4.3.g	5.4.3g – removed from policy
10/01/2013	Subsection 5.4.3.h	5.4.3h – removed wording “primary care or attending and replaced with Physician, Nurse practitioner, and Physician assistant

Date	Section Revised	Change
10/01/2013	Subsection 5.4.3	Last paragraph wording updated to read as follows “Beneficiaries who do not agree with the results of the independent assessment that grant fewer hours than previously approved may appeal the results and provide additional documentation to support the need for additional amounts of PCS. Beneficiaries may request referring physicians, home care agencies, and residential providers to assist them with the appeal process
10/01/2013	Subsection 5.4.5.d	Subsection 5.4.5d wording updated to add the following at the end of statement “but not less frequently than once every 365 calendar days.”
10/01/2013	Subsection 5.4.4	Subsection 5.4.4” Requirements for PCS Expedited Assessment Process” revised to say “PCS approval through the expedited process is provisional and subject to the standard PCS assessment process within 14 business days.”
10/01/2013	Subsection 5.4.4.d	Subsection 5.4.4.d revised to read “If it is determined the beneficiary qualifies for PCS, a provider must be identified and the hospital discharge planner, skilled nursing facility discharge planner, or APS must communicate beneficiary's choice of provider and intended admission date to the selected provider and the IAE.”
10/01/2013	Subsection 5.4.4	Paragraph updated to read The provisional prior approval shall not exceed a 60 day period “without DMA approval”.
10/01/2013	Subsection 5.4.4	Subsection 5.4.4 updated to read “Beneficiaries receiving approval through the expedited assessment process will be authorized for services within two business days of completed request. “
10/01/2013	Subsection 5.4.9	Subsection 5.4.9 paragraph under Beneficiaries self-performance table is updated with a final sentence that reads as follows “The IAE assessor must receive verbal consent from beneficiary before including family members or other caregivers present in the assessment review”.
10/01/2013	Subsection 5.4.11.c	Section c removed from subsection and placed in Section 6.1.5 b
10/01/2013	Subsection 5.4.12	Subsection 5.4.12 “Requirements for PCS Plan of Care moved to Subsection 6.1.3
10/01/2013	Subsection 5.4.13	Subsection 5.4.13 “Requirements for Aide Documentation moved to Subsection 6.1.4
10/01/2013	Subsection 5.4.14	Subsection 5.4.14 “Requirements for Aide Documentation moved to Subsection 6.1.5

Date	Section Revised	Change
10/01/2013	Subsection 5.5	Subsection 5.5 Retroactive Prior Approval – updated to also state “If a beneficiary requesting admission to an Adult Care Home Licensed under G.S. 131D-2.4 has not received a screening through the Pre-admission Screening and Resident Review (PASRR) retroactive prior approval does not apply. PCS authorization will be made effective the date beneficiary receives their PASRR”
10/01/2013	Subsection 6.1.3	Subsection 6.1.3 added to include Provider Interface: Web-based Beneficiary and Provider Records Management
10/01/2013	Subsection 6.1.5	Subsection updated with b. from former section 5.4.11 c. to read “If a beneficiary approved for services in a private residence requires Nurse Aide II tasks , the home care agency selected to provide the services shall have this level of expertise immediately available”.
10/01/2013	Subsection 7.9	Subsection 7.9 “Beneficiary Health, Wealth, and Safety” a. updated to include “131D”.
10/01/2013	Subsection 7.10.d	Subsection 7.10.d title changed from PCS Paraprofessional Aide Training Requirements to “PCS Paraprofessional Aide Training “Licensure” Requirements”.
10/01/2013	Service Level Determinations	Service Level Determination notes # 3. Changed to read as follows: Additional time up to 25% may be authorized for exacerbating conditions and symptoms that affect the beneficiary’s ability to perform and/or the time required to assist with the beneficiary’s qualifying ADLs as identified by the independent assessment. For all conditions affecting the beneficiary’s ability to perform ADLs, no more than 25% of additional time shall be provided.
10/01/2013	Service Level Determinations	#5. Changed to include the up to 50 additional hours of PCS criteria in accordance with Session Law 2013-306.
10/01/2013	Service Level Determinations	#6. Now reads as follows “The total authorized service hours per month may not exceed 60 for children under 21 years of age, unless the requested services are approved under EPSDT.
10/01/2013	Service Level Determinations	# 7 added to read “The total authorized PCS hours may only exceed 80 hours per month for adults, if there is a present: a) a physician attestation of need for expanded hours; and b) qualifying criteria as established above. In no case will PCS hours exceed the maximum of 130 hours per month.

Date	Section Revised	Change
06/13/2014	Section 5.4.3	Removed strikethroughs which were left in during the revision process. f. removed “attending” from “ ... his or her attending physician shall order the PCS ...” And in g., removed the strikethrough “the Internet or by,” from “ ... submit the form to the IAE via secure facsimile or mail ...”
06/10/2015	All Sections and Attachments	Title of policy revised to reflect “State Plan Personal Care Services”
06/10/2015	Section 1.0	Personal Care Services changed to “State Plan Personal Care Services
06/10/2015	Section 3.2.3 (1)	3.2.3 (1) the follow sentence removed from (1) and made into separate sentence (2). The residential setting has received inspection conducted by the Division of Health Service Regulation (DHSR)
06/10/2015	Section 3.3	“instruments” corrected to read “instrumentals”
06/10/2015	Subsection 3.4	3.4.a. statement “a” removed. Requirement is identified in Section 3.3.
06/10/2015	Subsection 4.2.2	A(11) updated to include mental health disorders and now read as follows “the requested services consist of treatment or training related to behavioral problems or mental health disorders such as attention deficit disorder or oppositional defiant behavior; or
06/10/2015	Subsection 4.2.2	Added: Note: PCS is not intended as a substitute for childcare, daycare, or afterschool care. PCS is not covered for infants or children when the personal care needs do not meet the medical necessity criteria, or the needs are a parental responsibility or are age-appropriate needs
06/10/2015	Subsection 4.2.2	Subsection 4.2.2 #8 wording changed to read as follows: “PCS is provided by an individual whose primary residence is the same as the beneficiary’s primary residence.”
06/10/2015	Subsection 4.2.2	Subsection 4.2.2 #9 enhanced to also states “Spouses are presumptively able to provide care for each other unless medical documentation, work verification, or other information indicates otherwise.”
06/10/2015	Subsection 4.2.2	Subsection 4.2.2 b. note added to read “DMA will allow time for the development and execution of a safe and orderly discharge prior to PCS termination.
06/10/2015	Subsection 4.2.2	4.2.2 c. 13 term “authorized” removed replaced with “identified”

Date	Section Revised	Change
06/10/2015	Subsection 4.2.3	Now reads “Medicaid shall not cover PCS when rendered concurrently with another substantially equivalent Federal or State funded service. Services equivalent to PCS include but are not limited to home health aide services and in-home aide services in the Community Alternatives Programs (CAP/Children, CAP/Choice, CAP/Disabled Adults, and CAP Innovations) and Private Duty Nursing (PDN).” Previously read “None Apply”
06/10/2015	Subsection 5.2.2/Multiple Sections	All references to PCS “plan of care” have been changed to PCS “service plan or on-line service plan”
06/10/2015	Subsection 5.2.2	Subsection 5.2.2 revised to read “Meet minimum PCS eligibility requirements;
06/10/2015	Subsection 5.2.3	Subsection added to include State Plan PCS EPSDT Additional Requirements
06/10/2015	Subsection 5.4	Subsection 5.4 enhanced to include 5.4 g which reads “When a beneficiary is contacted by the designated IAE to schedule an assessment, the beneficiary shall respond as soon as possible. If the IAE is unable to schedule an assessment services will be denied.”
06/10/2015	Subsection 5.4.2	Subsection 5.4.2 has been revised to change reference of the PCS “Request for Services form” to the “Request for Independent Assessment for Personal Care Services Attestation for Medical Need.”
06/10/2015	Subsection 5.4.2	Subsection 5.4.2 d updated to read as follows “If the beneficiary has not been seen by his or her physician during the preceding 90 calendar days the referral will not be processed, he or she shall schedule an office visit to request a referral for a Medicaid PCS eligibility assessment.”
06/10/2015	Subsection 5.4.2	Subsection 5.4.2 e added to read “If the physician indicates that the medical diagnosis or diagnoses listed on the PCS referral does not impact the beneficiaries activities of daily living (ADLs) the request will not be processed.”
06/10/2015	Subsection 5.4.3	Subsection 5.4.3 c. Sentenced changed to read as follows: All assessments for new admissions to the PCS program shall be face to face and conducted in the beneficiary’s home or residential facility.
06/10/2015	Subsection 5.4.3	Subsection 5.4.3 e. removed from sentence “the approved”.
06/10/2015	Subsection 5.4.3	Subsection 5.4.3 f. sentence revised to include “as described in subsection 5.4.4 Requirements for PCS Expedited Assessment Process

Date	Section Revised	Change
06/10/2015	Subsection 5.4.3	Subsection 5.4.3 g2 sentence revised to read “The medical diagnosis or diagnoses and related medical information that result in the unmet need for PCS assistance.
06/10/2015	Subsection 5.4.3	Subsection 5.4.3 g3 sentence removed “ICD-9” and now states “current International Classification of Diseases”
06/10/2015	Subsection 5.4.3	Subsection 5.4.3 g4. Sentence revised to read “A signed and dated PCS referral.”
06/10/2015	Subsection 5.4.3	Paragraph following 5.4.3 g4 removes “referring physician” from statement.
06/10/2015	Subsection 5.4.4	Paragraph updated to specify that a PASRR is needed for a beneficiary seeking an expedited assessment if they are seeking admission in to an ACH licensed under G.S. 131 D-2.4.
06/10/2015	Subsection 5.4.5	Subsection 5.4.5 f now reads “reassessments shall be conducted face to face”.
06/10/2015	Subsection 5.4.5	5.4.5 c. now reads “PCS providers shall report discharges to the IAE within seven (7) business days of the beneficiary discharge via the Provider Interface.
06/10/2015	Subsection 5.4.6	Subsection 5.4.6 Requirements for PCS Change of Status Reviews. Entire section updated with new requirements.
06/10/2015	Subsection 5.4.7	5.4.7 e. “plan of care” replaced with “ service plan ” in this section and throughout policy.
06/10/2015	Subsection 5.4.8	Subsection 5.4.8 updated with new timelines.
06/10/2015	Subsection 5.4.10	5.4.10 – reference subsection 2.4 has been changed to 3.2.
06/10/2015	Subsection 5.4.11	5.4.11 b. updated to establish business days to accept or reject referral.
06/10/2015	Subsection 5.4.11	5.4.11.f. 72 hours changed to 7 business days. The new provider shall implement the service plan within 7 business days of accepting the referral, or by the date requested by the beneficiary, whichever is later.
06/10/2015	Subsection 5.5	Subsection header changed to read “Retroactive” Prior Approval for PCS.
06/10/2015	Subsection 5.5	Reference to “request for services form” removed and replaced with the name of the new DMA 3051 referral “Request for Independent Assessment for Personal Care Services Attestation for Medical Need.”

Date	Section Revised	Change
06/10/2015	Subsection 5.5	Second paragraph re-worded to clarify PASRR and retroactive PCS requirements. Second paragraph now reads “If a beneficiary requesting admission to an Adult Care Home, Licensed under G.S. 131D-2.4, has not received a screening through the Pre-admission Screening and Resident Review (PASRR), retroactive prior approval does not apply. PCS authorization will be made effective the date beneficiary receives their PASRR, as long as the effective PASRR date is within 30 days of the submission of the Physician Referral. If the effective PASRR date is not within 30 days of the submission of the Physician Referral, the Referral is invalid and a new Referral will be required.”
06/10/2015	Subsection 6.0	Providers shall not bill for Medicaid PCS services provided by an individual with any of the following convictions on the criminal criminal background check: <ol style="list-style-type: none"> 1. felonies related to manufacture, distribution, prescription or dispensing of a controlled substance; 2. felony health care fraud; 4. felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult; 5. felony or misdemeanor patient abuse; 6. felony or misdemeanor involving cruelty or torture; 7. misdemeanor healthcare fraud; 8. misdemeanor for abuse, neglect, or exploitation listed with the NC Health Care Registry; or 9. any substantiated allegation listed with the NC Health Care Registry that would prohibit an individual from working in the healthcare field in the state of NC.

Date	Section Revised	Change
06/10/2015	Subsection 6.1.1	Item “d” Deleted, “Training about providing care to individuals with impaired judgment, disorientation, loss of language skills, inappropriate behaviors, such as wandering, that are resulting from the exacerbation of dementia;” Added, “In-home and Residential Care Aides providing services to beneficiaries receiving hours in accordance with Session Law 2013-306, have 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. Providers shall submit an attestation to DMA that they are in compliance with this requirement. The attestation form (DMA-3085) and instructions are located on the DMA PCS webpage”
06/10/2015	Subsection 6.1.2	6.1.3 c. added Reads “Develop and submit the PCS On-line Service Plan”.
06/10/2015	Subsection 6.1.3	6.1.3 Header changed to read as follows “Requirement for State Plan PCS online Service Plan.”
06/10/2015	Subsection 6.1.3	Subsection 6.1.3 includes an introduction paragraph section that reads as follows, “Providers shall develop an on-line PCS service plan through the Provider Interface. The following requirements for the on-line PCS Service plan must apply:”
06/10/2015	Subsection 6.1.3	Entire section updated to detail the service plan requirements.
06/10/2015	Subsection 6.1. 4	Subsection 6.1.5 updated to include Aide services provided may be documented utilizing the Provider Interface generated task sheets. Provider Interface generated task sheets are not required as the only form of PCS documentation. Documentation must reflect all services provided as scheduled in the online service plan task by task. Also includes further clarification of a “deviation”
06/10/2015	Subsection 7.7	7.7 Internal Quality Improvement Program requirements updated.
06/10/2015	Subsection 7.8	7.8 e. updated to include PCS satisfactory surveys; and “f” Reviews of attestation forms and supporting documentation.
06/10/2015	Section 7.10	7.10d. 2 – sentenced updated to remove “being under investigation

Date	Section Revised	Change
06/10/2015	Section 7.10	7.10 d. section updated to remove previous statement “in home and residential aides under investigation for those reasons listed in Subsection 7.10.d.2 above do not work with beneficiaries until the investigation is completed and the individual is cleared of any crime or misconduct.” Providers should adhere to their DHSR licensure rules for additional guidance.
06/10/2015	Section 7.10	Section 7.10 e updated to reference DHSR licensure requirement.
06/10/2015	Appendix A.	Assessment Tool Design – #4. And # 17.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
11/01/2015	Subsection 6.1.1	This subsection returned to the policy, after being inadvertently left out during an earlier revision. 6.1.1 PCS Paraprofessional Aide Minimum Qualifications PCS Aides shall be: a. High school graduates or equivalent; or b. Eighteen (18) years of age or older.
07/01/2016	Subsection 4.2.2	4.2.2 (a)(13) added to this subsection to read Independent medical information does not validate the assessment, PCS hours may be reduced, denied, or terminated based on the additional information.
07/01/2016	Subsection 5.2.3	5.2.3 Updated to include “e” Any other Independent Records that address ADL abilities and need for PCS services. Note added “If additional information does not validate the assessment, PCS hours may be reduced, denied, or terminated based on additional records.
07/01/2016	Subsection 5.4.4	Subsection 5.4.4 updated to include additional qualifying individuals for the expedited PCS process and who may request the expedited process on their behalf.
07/01/2016	Subsection 5.6	Subsection 5.6 added to include the “Reconsideration Request for initial authorization of PCS” process. 5.6 Reconsideration Request for initial authorization for PCS A beneficiary, 21 years of age or older, who receives an initial approval for less than 80 hours per month may submit a Reconsideration Request Form (DMA 3114) to the IAE if they do not agree with the initial level of service determined, through the following process
07/01/2016	Subsection 6.1.3	Subsection 6.1.3 (i) added to include “receive electronic notification of upcoming annual assessments for beneficiaries.

Date	Section Revised	Change
07/01/2016	Service Level Determination	Note updated to read “When basic meal preparation is covered under services paid for by State/County Special Assistance then assistance with clean-up and basic meal preparation services that duplicate State and County Special Assistance (Section M – Eating and Meal Preparation tasks 6-9 of the PCS independent assessment tool) will be scored as needs met.
08/01/2017	Subsection 5.5	Subsection 5.5 Retroactive Prior Approval for PCS amended to include language that extends the allowable retroactive period for prior approvals for PCS from 10 days to 30 days.
08/04/2017	All Sections and Attachments	Amended policy posted on this date, with an EFFECTIVE Date of 08/01/2017.

Appendix A: Assessment Design and Service Level Determinations

Assessment Tool Design

All PCS assessments must be conducted using a standardized functional assessment tool provided or approved by DMA. The assessment must include documentation and evaluation of the following:

1. Assessment identification information, including date, completion time, and names and relationships of others attending;
2. Beneficiary identification information, including name and Medicaid ID, gender, date of birth, primary language, contact information, and alternate contacts;
3. Referral summary, including date and practitioner name and contact information;
4. Diagnoses and diagnosis code related to the need for services;
5. Medications and the IAE assessor's evaluation of the beneficiary's ability to self-manage medication;
6. Special diet types;
7. Availability of other supports, including names and relationships of informal caregivers and their capacity and availability to provide ADL assistance, and provider names and types of other formal supports and services;
8. Assistive devices the beneficiary uses to perform each ADL;
9. Task needs for each ADL, including required assistance level and number of days per week of unmet need for assistance;
10. IAE assessor's overall rating of the beneficiary's capacity to self-perform each ADL;
11. The beneficiary's needs for assistance with special assistance and delegated medical monitoring tasks;
12. Conditions and symptoms that affect the time for the beneficiary to perform and an aide to assist with the completion of the beneficiary's qualifying ADLs;
13. Facility license date or the designated IAE assessor's evaluation of the functional status of primary private residence structures and utilities, safety and adequacy of the beneficiary's primary private residence for providing PCS, and environmental conditions and circumstances that affect the time for the beneficiary to perform and an aide to assist with completion of the beneficiary's qualifying ADLs;
14. For a Medicaid beneficiary under 21 years of age, requested PCS service hours and caregiver or facility staff report of how PCS services maintain or improve the beneficiary's condition or prevent it from worsening;
15. IAE assessor comments about essential information not captured elsewhere on the assessment; and
16. The beneficiary's preferred PCS provider.
17. The next reassessment date identified by number of weeks.

Service Level Determinations

1. Time is authorized for each day of unmet need for assistance with qualifying ADLs from the Daily Minutes table as follows:

Daily Minutes for Qualifying ADLs and Medication Assistance

Beneficiary's Overall Self-Performance Capacity			
ADL	Limited Assistance	Extensive Assistance	Full Dependence
Bathing	35 minutes per day	50 minutes per day	60 minutes per day
Dressing	20 minutes per day	35 minutes per day	40 minutes per day
Mobility	10 minutes per day	20 minutes per day	20 minutes per day
Toileting	25 minutes per day	30 minutes per day	35 minutes per day
Eating	30 minutes per day	45 minutes per day	50 minutes per day
Medication Assistance			
Reminders/ Set-Up/Supervision	Routine Administration, 8 or Fewer	Routine Administration Plus PRN	Poly pharmacy and/or Complex
10 minutes per day	20 minutes per day	40 minutes per day	60 minutes per day

Notes: Eating ADL includes meal preparation and preparation of textured-modified diets. When basic meal preparation is covered under services paid for by State/County Special Assistance then assistance with clean-up and basic meal preparation services that duplicate State/County Special Assistance (Section M – Eating and Meal Preparation tasks 6-9 of the PCS independent assessment tool) will be scored as needs met. Time may be authorized for Medication Assistance services that are allowed by state law.

2. If the total time assigned for all qualifying ADLs and IADLs is less than 60 minutes per day, total time is increased to 60 minutes per day of unmet need for assistance.
3. Additional time, up to 25%, may be authorized for exacerbating conditions and symptoms that affect the beneficiary's ability to perform and/or the time required to assist with the beneficiary's qualifying ADLs as identified by the independent assessment. For **all** conditions affecting the beneficiary's ability to perform ADLs, no more than 25% of additional time is provided.
4. Additional time, up to 25%, percent may be authorized for environmental conditions and circumstances that affect the beneficiary's qualifying ADLs as identified by the independent assessment. For **all** conditions affecting the beneficiary's ability to perform ADLs, no more than 25% of additional time is be provided.
5. In accordance with Session Law 2013-306, up to 50 additional hours of PCS services may be authorized to a beneficiary if: 1) The beneficiary requires an increased level of supervision. 2) 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. 3) Regardless of setting, the beneficiary requires a physical environment that includes modifications and safety measures to safeguard the recipient because of the beneficiary's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills. 4) The beneficiary has a history of safety concerns related to inappropriate wandering, ingestion,

aggressive behavior, and an increased incidence of falls. Once all of these conditions are met, as shown by the Physician's Attestation and as verified by the independent assessment, additional hours may be approved for any of the exacerbating conditions outlined in Session Law 2013-306 as assessed in Sections D and O of the independent assessment.

- a. If one exacerbating condition is present, up to 10 hours additional per month will be approved.
 - b. If two exacerbating conditions are present up to 20 hours additional per month will be approved.
 - c. If three exacerbating conditions are present, up to 30 hours additional per month will be approved.
 - d. If four exacerbating conditions are present, up to 40 hours additional per month will be approved.
 - e. If five or more exacerbating conditions are present, up to 50 hours additional per month will be approved
6. The total authorized service hours per month may not exceed 60 for children under 21 years of age, unless the requested services are approved under EPSDT.
 7. Total authorized PCS hours may only exceed 80 hours per month for adults, if there is present: a) a physician attestation of need for expanded hours; and b) qualifying criteria as established above. In no case will PCS hours exceed the maximum of 130 hours per month.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

CPT Code(s)
99509

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

Providers	Modifier(s)
Any beneficiary Under 21 Years regardless of setting	HA
In-Home Care Agencies, Beneficiary 21 Years and Older	HB
Adult Care Homes	HC
Combination Homes	TT
Special Care Units	SC
Family Care Homes	HQ
Supervised Living Facilities for adults with MI/SA	HH
Supervised Living Facilities for adults with I/DD	HI

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

1 unit of service = 15 minutes

PCS follows wage and hour requirements for rounding billing units (7/8 rule).

F. Place of Service

PCS is provided in the beneficiary’s primary private residence or a residential facility licensed by the State of North Carolina as an adult care home, a family care home, a combination home, or a supervised living facility for adults with intellectual disabilities, developmental disabilities or mental illness.

Beneficiaries under 21 years of age approved for PCS under EPSDT may receive services in the home, school, or other approved community settings. Refer to **Subsection 5.2.3**.

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at <http://dma.ncdhhs.gov/>.

For NCHC refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html

H. Reimbursement

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <http://dma.ncdhhs.gov/>