

Changes to Clinical Coverage Policy 3L, Personal Care Services Benefit Program Provider Manual Updates

Liberty Healthcare Corporation of North Carolina

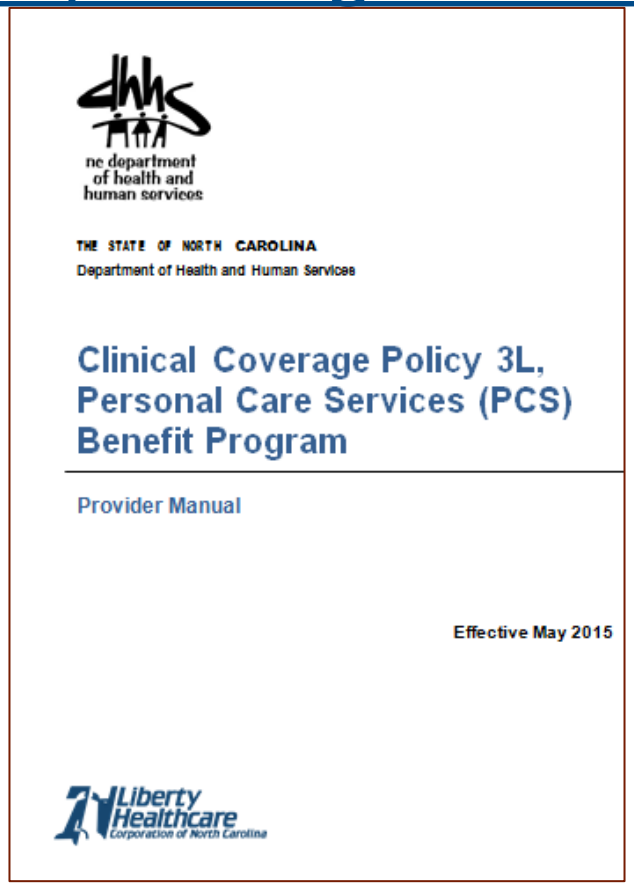
May 2015

OBJECTIVES:

- Become knowledgeable of tools and resources available to PCS Providers
- Gain an understanding of the changes made to the PCS Provider manual

Where Can I Get One?

The Provider Manual is updated and located on the website of Liberty Healthcare of NC at http://nc-pcs.com/training-announcement/



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What is New?

- Includes proposed Clinical Coverage Policy 3L changes;
- New Service Plan requirements;
- Updated PASRR requirements;

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What is New?

- Updated requirements for the new 3051 form, including Medical and Non-Medical COS requests;
- Changes to the request process for additional safeguards;
- A copy of the new 3051 form;

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What is New?

- A copy of the new PCS Provider Quality Improvement Attestation Form; and
- A new version of the PCS Beneficiary Participation Guide – updated based on PCS Provider feedback.

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What is Missing?

- A copy of the proposed Clinical Coverage Policy 3L – currently posted for public comment
- Instructions on how to complete the new service plan; and
- Instructions on how to navigate through the new provider portal.

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Proposed Clinical Coverage Policy 3L

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Let's Jump Right In

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Section 4.2.2 – Medicaid Not Covered Specific Criteria

- Medicaid shall not cover PCS when performed by the beneficiary's legally responsible person
- Spouses are expected to care for each other unless medical documentation, work verification, or other information indicates otherwise

Section 4.2.3 – Medicaid Additional Criteria Not Covered

Medicaid shall not cover PCS when rendered in conjunction with another substantially equivalent Federal or State funded service. Equivalent services are home health aide services and in-home aide services in the Community Alternatives Program (CAP/C, CAP/Choice, CAP/DA, CAP/Innovations) and any other Federal or State funded service that provides hands-on assistance with ADLs

Section 5.2.3 – EPSDT Additional Requirements for PCS

Medicaid may authorize services that exceed the PCS service limitations under EPSDT based on specific documentation being submitted prior to PCS being rendered.

Section 5.4.5 – Requirements for PCS Reassessments

PCS Providers shall report all discharges within 7 business days

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Section 5.4.6 – Requirements for PCS Change of Status Reviews

- COS can be medical or non-medical
- COS Medical must be submitted by a physician only and beneficiary must have seen their physician in the last 90 days
- COS Non-Medical may be submitted by a non-practitioner and only when a beneficiary has a change in environment or caregiver availability

Section 5.4.11 – Requirements for Selecting and Changing PCS Providers

The PCS provider will have 2 business days to accept or reject referrals.

Section 6.0 – Providers Eligible to Bill for the Service

In order to bill for services, the PCS provider shall ensure the individual delivering PCS does not have any of the following:

- Various felonies
- Misdemeanors involving abuse, cruelty, healthcare fraud
- Substantiated allegation listed with the NC Health Care Registry

Section 6.1.3 – Requirements for State Plan PCS On-line Service Plan

- PCS providers must submit through the QiReport Provider Portal
- A new service plan must be completed for each assessment completed
- The beneficiary/legally responsible person must understand/participate in the development of the service plan

Section 6.1.3 – Requirements for State Plan PCS On-line Service Plan

- The PCS Provider must complete, validate, and receive consent for the service plan within 3 business days
- The PCS service plan is not a care plan
- Reimbursement will only be approved for authorized hours and services specified in the validated service plan

Section 6.1.4 – Requirements for Aide Documentation

- PAs will not be granted until the on-line service plan is entered into the portal and validated
- Provider organization must maintain documentation that demonstrates aide tasks listed in the service plan are performed at the frequency indicated
- Task worksheets provided in the portal are optional

Section 7.7 – Internal Quality Improvement Program

- The provider organization shall conduct at minimum an annual written beneficiary satisfaction survey
- PCS Providers shall submit an attestation to DMA by December 31st of each year that they are in compliance with all requirements for an internal quality improvement program

*Attestation form and instructions can be found on DMA's website at http://www.ncdhhs.gov/dma/pcs/pas.html

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Public Comment Period

- Public comment period ends May 17, 2015!
- Find a full copy of the proposed policy and comment on the DMA webpage: http://www.ncdhhs.gov/dma/mpproposed/

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The End

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