North Carolina
Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance

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Attention:

Personal Care Services Providers

Personal Care Services-Plus Program

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TABLE OF CONTENTS

INTRODUCTION

On November 1, 2003, the N.C. Medicaid program implemented the new Personal Care Services-Plus (PCS-Plus) program. The program is designed to enhance the current Personal Care Services (PCS) program by providing up to 20 additional hours of PCS each month to eligible recipients.

Providers attending the PCS-Plus seminar will learn about:

- the criteria used to qualify for PCS-Plus
- the steps in the PCS-Plus prior approval process
- how to initiate the required documentation for PCS-Plus
- how PCS differs from PCS-Plus
- how to bill for PCS-Plus

PCS-Plus Background

Program History

Over the past several years, there has been enormous growth in PCS. Due to this rapid program growth, in January 2002, the N.C. General Assembly implemented a 3.5-hour daily limit on PCS. In December 2002, the N.C. General Assembly reduced the monthly limit on PCS hours from 80 hours to 60 hours. However, since those reductions were implemented, it has become clear that there are many PCS clients that need more than 60 hours of PCS a month in order to remain at home.

How PCS-Plus Funding Became Available

Earlier this year, the Legislature eliminated the Home Health Purchase of Care Program within the Division of Public Health and transferred over $3 million to Medicaid. The purpose of this transfer was to maximize federal Medicaid matching funds for Home Care Personal Care Services. This transfer will generate additional federal funds of $6 million, which will increase funds for personal care services by a total of $9 million. The Division of Medical Assistance (DMA) will use this funding opportunity to implement PCS-Plus and provide additional PCS hours to clients who need the extra help to remain at home.

How PCS Differs From PCS-Plus

PCS	PCS-Plus
• 60 hour monthly limit	• 80 hour monthly limit
• 3.5 hour daily limit	• No daily limit on hours
• No prior approval required	• Prior approval required
• Basic eligibility criteria	• More stringent eligibility criteria

QUALIFYING FOR PCS-PLUS

To qualify for PCS-Plus, a client must be eligible for PCS and meet one of the following three criteria:

1. At a minimum require extensive assistance in four or more activities of daily living (ADLs).
2. At a minimum require extensive assistance in three or more ADLs **and** need the in-home aide to perform at least one task at the NA II level.
3. At a minimum require extensive assistance in three or more ADLs **and** have a medical or cognitive impairment that requires extended time to perform needed in-home aide tasks.

Criterion 1

Recipient meets PCS criteria AND requires at a minimum extensive assistance in four or more ADLs.

- ADLs include: bed mobility, transfer, ambulation, eating, toilet use, bathing, dressing, personal hygiene, and self-monitoring of medications.
- **Extensive assistance** is when a recipient requires weight-bearing support while performing part of an activity such as the guiding or maneuvering of limbs. **Extensive assistance also** refers to needing substantial or consistent "hands-on" assistance with eating, toileting, bathing, dressing, personal hygiene, and self-monitoring of medications.
- **Full dependence** is when a recipient cannot perform the activity and requires another individual to perform the entire activity.
- The definitions of extensive assistance and full dependence are based on the federally approved Minimum Data Set (MDS), 2.0 version.

Criterion 2

Recipient meets PCS criteria AND requires at a minimum extensive assistance in three or more ADLs AND requires at least one Nurse Aide II (NA II) task.

Nurse Aide II Tasks

- The N.C. Board of Nursing has determined that NA II tasks are within the scope of practice for a Nurse Aide I (NA I).
- The N.C. Board of Nursing requires the NA I to have completed additional training in the NA II task.
- A registered nurse (RN) must validate the NA I's competency to perform the NA II task.
- Agencies must notify the N.C. Board of Nursing of the NA II tasks performed by their NA I staff.
- For more information, visit http://www.ncbon.com/prac-naiibyi.asp.

The N.C. Board of Nursing defines NA II tasks as any of the following:

- Oxygen Therapy: room set-up, monitoring flow-rate
- Suctioning: oropharyngeal, nasopharyngeal
- Elimination Procedures: ostomy care, irrigation
- Nutrition Activities: oral/nasogastric infusions after placement verified by RN, gastrostomy feedings, clamping tubes, removing oral/nasogastric feeding tubes
- Sterile Dressing Change: wound over 48 hours old
- Break-up and Removal of Fecal Impaction
- Wound Irrigation
- Tracheostomy Care

- I.V. – Assistive Activities: assemble/flush tubing during set-up, monitoring flow-rate, site care/dressing change, discontinuing peripheral I.V. infusions
- Urinary Catheters: catherizations, irrigation of tubing

Note: DMA will evaluate the frequency of the NA II tasks and expects that most recipients qualifying for PCS-Plus under Criterion 2 will require at least one NA II task on a daily basis.

Criterion 3

Recipient meets PCS criteria AND requires, at a minimum, extensive assistance in three or more ADLs AND has a medical or cognitive impairment requiring extended time to perform needed in-home aide tasks.

- Diagnosis should include a medical or cognitive impairment that supports the in-home aide needing extended time.
- In addition, the assessment must document at least one of the following:
    1. Presence of continuous and/or substantial pain interfering with individual's activity or movement.
    2. Dyspneic or noticeably short of breath with minimal exertion during the performance of ADLs and requires continuous use of oxygen.
    3. Due to cognitive functioning, individual requires extensive assistance with performing ADLs. Individual is not alert and oriented or is unable to shift attention and recall directions more than half the time.
    4. Bowel incontinence more often than once daily.
    5. Urinary incontinence during the day and night.

Summary of Criteria for PCS-Plus

North Carolina Division of Medical Assistance (DMA)
PERSONAL CARE SERVICES-PLUS (PCS-PLUS) CRITERIA

Medicaid recipients who require additional time for the in-home aide to perform delegated tasks are eligible for PCS-Plus if they qualify for PCS *and* meet one of the following three criteria:

1. At a minimum require extensive assistance in four or more activities of daily living (ADLs). **OR**
2. At a minimum require extensive assistance in three or more ADLs *and* need the in-home aide to perform at least one task at the nurse aide II level. **OR**
3. At a minimum require extensive assistance in three or more ADLs *and* have a medical or cognitive impairment that requires extended time to perform needed in-home aide tasks.

The recipient's assessment must contain documentation that supports the PCS-Plus criteria.

The North Carolina Division of Medical Assistance (DMA) will interpret the PCS-Plus criteria as follows:

***Criterion 1*: Recipient meets PCS criteria AND requires at a minimum extensive assistance in four or more activities of daily living (ADLs).** (Note: Recipient could also be fully dependent in four or more ADLs or require a combination of extensive and fully dependent assistance needs in four or more ADLs.)

Activities of Daily Living include:
Bed mobility, transfer, ambulation, eating, toilet use, bathing, dressing, personal hygiene, and self-monitoring of medications.

- *Extensive assistance* is when a recipient requires weight-bearing support while performing part of an activity such as the guiding or maneuvering of limbs. *Extensive assistance also* refers to needing substantial or consistent "hands-on" assistance with eating, toileting, bathing, dressing, personal hygiene, and self-monitoring of medications.
- *Full dependence* is when a recipient cannot perform the activity and requires another individual to perform the entire activity.
- The definitions of extensive assistance and full dependence are based on the federally approved Minimum Data Set (MDS), 2.0 version.

***Criterion 2:* Recipient meets PCS criteria AND requires at a minimum extensive assistance in 3 or more ADLs (as defined above) AND requires at least one Nurse Aide II task.** (Note: DMA will evaluate the frequency of the Nurse Aide II tasks and expects that most recipients qualifying for PCS-Plus under Criterion 2 will require at least one Nurse Aide II task on a daily basis.

Nurse Aide II tasks are defined as any of the following:		
1. Oxygen Therapy	**4. Nutrition Activities**	**9. I.V. – Assistive Activities**
• Room set-up	• Oral/nasogastric infusions *(after placement verified by RN)*	• Assemble/flush tubing during set-up
• Monitoring flow-rate	• Gastrostomy feedings	• Monitoring flow-rate
2. Suctioning	• Clamping tubes	• Site care/dressing change
• Oropharyngeal	• Removing oral/nasogastric feeding tubes	• Discontinuing peripheral I.V. infusions
• Nasopharyngeal	**5. Sterile Dressing Change** *(Wound over 48 hours old)*	**10. Urinary Catheters**
3. Elimination Procedures	**6. Break-up & Removal of Fecal Impaction**	• Catherizations
• Ostomy Care	**7. Wound Irrigation**	• Irrigation of tubing
• Irrigation	**8. Tracheostomy Care**	

***Criterion 3:* Recipient meets PCS criteria AND requires at a minimum extensive assistance in 3 or more ADLs (as defined above) AND has a medical or cognitive impairment requiring extended time to perform needed in-home aide tasks.**

In this case, the **diagnosis** should include a medical or cognitive impairment that supports the in-home aide needing extended time. In addition, the assessment must document at least one of the following:

- Presence of continuous and/or substantial pain interfering with individual's activity or movement
- Dyspneic or noticeably short of breath with minimal exertion during the performance of ADLs and requires continuous use of oxygen
- Due to cognitive functioning, individual requires extensive assistance with performing ADLs. Individual is not alert and oriented or is unable to shift attention and recall directions more than half the time
- Bowel incontinence more often than once daily
- Urinary incontinence during the day and night

PCS-PLUS PRIOR APPROVAL

- All PCS-Plus Request forms must be faxed to DMA for prior approval. The fax number for PCS-Plus is 919-715-2628.
- The PCS-Plus Request forms are reviewed by the DMA Nurse Consultant.
- If additional information is needed to approve PCS-Plus, the DMA Nurse Consultant will contact the PCS provider by fax or phone.
- The DMA Nurse Consultant completes the prior approval within seven working days after receiving the PCS-Plus Request form.
- Due to the heavy volume of PCS-Plus Requests expected during the first quarter of implementation, there may be a delay in processing requests. If you have not received a response from DMA within 12 working days, please notify the DMA Nurse Consultant.
- Do not re-fax the PCS-Plus Request forms unless instructed to by DMA staff. This slows down the prior approval process.
- PCS-Plus prior approval is a Medicaid payment authorization and the agency's RN must determine if additional physician orders are needed to implement a pharmaceutical or medical regimen.
- For questions, call the DMA Nurse Consultant for PCS-Plus at 919-857-4021.

INITIATING PCS-PLUS SERVICES

PCS agencies must obtain prior approval from DMA before initiating PCS-Plus services. PCS agencies may request prior approval for up to a 180-day period. To obtain prior approval for PCS-Plus, the agency must take the following steps:

1. When a referral is made to the PCS agency for PCS-Plus or when the PCS agency identifies a recipient in need of PCS-Plus, the PCS agency's RN evaluates the recipient's medical and functional need for PCS-Plus and documents the findings on the PCS-Plus Request form (DMA-3000-A). A copy of this form is available online at http://www.dhhs.state.nc.us/dma/forms.htm.

2. If the recipient is not currently receiving PCS, the PCS agency's RN must follow DMA's procedure for completing the DMA-3000 and obtaining the physician's authorization for PCS. Once the physician's authorization has been obtained, the PCS agency's RN can proceed with the request for PCS-Plus.

   Note: PCS-Plus prior approval is a Medicaid payment authorization and the agency's RN must determine if additional physician orders are needed to implement a pharmaceutical or medical regimen.

3. Completed PCS-Plus Request forms must be faxed to the DMA PCS-Plus Nurse Consultant at 919-715-2628.

4. The DMA Nurse Consultant reviews the PCS-Plus Request form (DMA-3000-A) to determine if the recipient qualifies for PCS-Plus. DMA will contact the PCS agency by fax or phone if additional information is needed to make a determination.

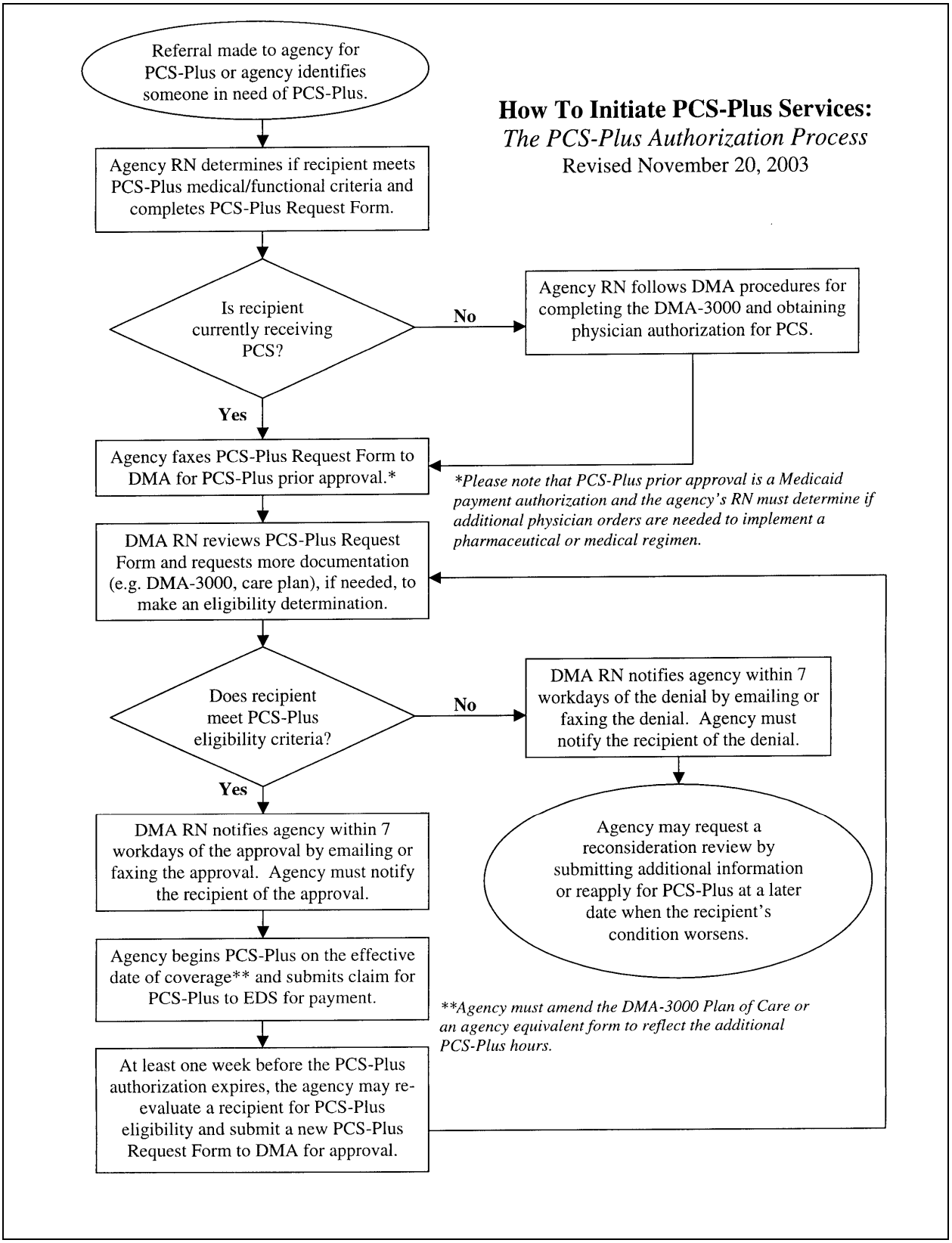
5. If the DMA Nurse Consultant determines that the recipient does not meet the criteria for PCS-Plus, the PCS agency is notified of the denial by e-mail or fax within seven workdays. The PCS agency must notify the recipient of the denial. The PCS agency may request a reconsideration review if additional information to support the recipient's need for PCS-Plus can be provided to DMA.

6. If the DMA Nurse Consultant determines that the recipient does meet the criteria for PCS-Plus, the PCS agency is notified of the prior approval by e-mail or fax within seven workdays. The prior approval specifies the number of approved PCS hours per month and the effective dates of PCS-Plus coverage (PCS-Plus authorization period). The agency must notify the recipient of the prior approval.

7. The agency must amend the recipient's DMA-3000 Plan of Care or an agency equivalent form to reflect the additional PCS-Plus hours.

8. At least one week before the PCS-Plus authorization expires, the agency must re-evaluate a recipient for PCS-Plus eligibility and submit a new PCS-Plus Request form (DMA-3000-A) to DMA for approval. PCS-Plus cannot be authorized for more than 180 days for each request.

PCS-Plus Authorization Process Flow Chart



INSTRUCTIONS FOR COMPLETING THE PCS-PLUS REQUEST FORM

Note: Please print clearly on the form and sign the Nurse Assessor Certification in Section 8.

Section 1: PCS-Plus Request

- Indicate whether you are making a PCS-Plus Initial Request or PCS-Plus Reauthorization Request by checking the appropriate box.
- Enter the date.
- Enter your name (the name of the RN submitting the request).
- Enter the total number of PCS hours/month you are requesting for the recipient. For example, if the recipient is currently receiving 60 hours of PCS/month and you are requesting an additional 20 hours of PCS/month, enter 80.
- Enter the number of days that the recipient will require PCS-Plus.
- Specify the start date you are requesting for PCS-Plus and the appropriate end date. For example, if you are requesting 120 days of PCS-Plus and you intend to start services on 11/10/03, you would enter the following: From: **11/10/03** To: **3/8/04**
- Please note that PCS-Plus authorizations cannot exceed 180 days. To request an extension, you must submit a new PCS-Plus Request form at least one week before the PCS-Plus authorization expires.

Section 2: Provider Agency Information

- Enter the name of the PCS provider agency.
- Enter the agency's seven-digit Medicaid PCS provider number. This number begins with "66."
- Enter the agency's phone number, including area code.
- Enter the agency's fax number, including area code.
- Enter the agency's street address, including street, city, and zip code.
- Enter the e-mail address for the person (at the agency) who needs to be notified of the PCS-Plus approval or denial.

Section 3: Medicaid Recipient Information

- Enter the Medicaid recipient's last name as it appears on the Medicaid identification (MID) card.
- Enter the Medicaid recipient's first name as it appears on the MID card.
- Enter the Medicaid recipient's middle name as it appears on the MID card.
- Enter the Medicaid recipient's street address, including street, city, and zip code.
- Enter the name of the county in which the Medicaid recipient resides in.
- Enter the Medicaid recipient's phone number or a number through which the recipient can be contacted. Be sure to include the area code.
- Enter the recipient's identification number (nine-digits + one alpha character) from the MID card.
- Enter the month/day/year for the recipient's date of birth.
- Indicate whether the recipient is currently receiving PCS by checking the Yes or No box. If the client is not currently on PCS, you must follow DMA procedures for completing the DMA-3000 and obtaining physician authorization for PCS before submitting the PCS-Plus Request form.
- Enter the name of the recipient's attending physician.
- Enter the phone number of the recipient's attending physician.
- Enter the date that the recipient's DMA-3000 was signed by the attending physician.

Section 4: Primary and Secondary Diagnosis

- Enter the recipient's primary and secondary diagnosis.
- If a medical or cognitive condition is being used to qualify the recipient for PCS-Plus, the assessment must document at least one of the conditions listed in Section 4. Check all the conditions that apply to the recipient.
- If a medical or cognitive condition is not being used to qualify the recipient for PCS-Plus, check the box labeled "Not Applicable."

Section 5: Current Medications

- List the name, dose, frequency, and route of administration for all prescription medications currently taken by the recipient.
- List over-the-counter medications if there is space available. Any over-the-counter medication that supports the recipient's medical diagnosis must be also listed.

Section 6: Limitations in Activities of Daily Living

- Rate the recipient's ADL Self-Performance using the ADL Self-Performance Scores listed in Section 6.A. The scores range from 0-4. Enter the score for each ADL under the column labeled "ADL Self-Performance." This column is the second column from the right under Section 6. For example, if a recipient is independent and does not require any help or oversight in Bed Mobility, you would enter 0 under the ADL Self-Performance column that corresponds to line 6a. Bed Mobility.
- Rate the recipient's ADL Support Provided using the ADL Support Scores listed in Section 6.B. The scores range from 0-3. Enter the ADL Support Provided score under the column labeled "ADL Support-Provided". This column is the first column from the right under Section 6. For example, if a recipient requires a one person physical assist in toilet use, you would enter 2 under the ADL Support Provided column that corresponds to line 6e., Toilet Use.
- In Section 6c., Ambulation, be sure to enter the type of assistive equipment used, if applicable. Examples of assistive equipment include walkers, wheelchairs or hoyer lifts.
- In Section 6d., Eating, be sure to enter the type of therapeutic diet, if applicable.

Section 7: Nurse Aide II Tasks

- In the space provided, specify any Nurse Aide II tasks that the recipient requires. Be sure to identify the frequency of the task (daily, weekly, etc.).
- If Nurse Aide II tasks are not being used to qualify the recipient for PCS-Plus, enter "Not Applicable" in this section.
- Nurse Aide II tasks are physician ordered and must be included on your DMA-3000 or physician order.

Section 8: Nurse Assessor Certification

- The nurse assessor completing the PCS-Plus Request Form must complete this section.
- In the certification statement, enter the date that the recipient's DMA-3000 was signed by the attending physician.
- The nurse assessor must print his/her name and sign and date the certification.

DMA Prior Approval (Box located in the upper right hand corner of the form)

- **Do not complete this section.**
- The DMA Prior Approval Section will be completed by the DMA Nurse Consultant after the agency has faxed the form to DMA for review.

North Carolina Division of Medical Assistance (DMA)
PERSONAL CARE SERVICES-PLUS (PCS-PLUS) REQUEST FORM

1. ☐ **PCS-Plus Initial Request** ☐ **PCS-Plus Reauthorization Request**

Date of Request: _____ Request Submitted by: _____
Total Number of PCS Hours/Month Requested: _____ **hours/month**
Duration of PCS-Plus Request*: _____ **days** From: _____ To: _____
**PCS-Plus authorizations cannot exceed 180 days. To request an extension, submit a new PCS-Plus Request Form at least one week before the PCS-Plus authorization expires.*

DMA Prior Approval
Authorization for _____ hours/month*
**Cannot exceed a total of 80 hours/month.*
Effective from: _____ to: _____
Date Request Reviewed: _____
RN Signature: _____

2. **Provider Agency Information**

Agency Name: _____ PCS Provider #: _____ Phone: _____ Fax: _____
Address: _____ Email: _____

3. **Medicaid Recipient Information**

Last Name: _____ First Name: _____ Middle Name: _____
Address: _____ County: _____
Phone Number: _____ Medicaid ID # (MID): _____ Date of Birth: _____
Currently on PCS? ☐ Yes ☐ No**If no, agency RN must follow DMA procedures for PCS assessment and obtaining MD approval.*
Physician Name: _____ Phone Number: _____ Date DMA-3000 Signed: _____

4. **Specify Primary and Secondary Diagnosis:** _____

If a medical or cognitive condition is being used to qualify for PCS-Plus, the assessment must document at least one of the following (check all that apply):

- ☐ Presence of continuous and/or substantial pain interfering with individual's activity or movement
- ☐ Dyspneic or noticeably short of breath with minimal exertion during ADL performance and requires continuous use of oxygen
- ☐ Due to cognitive functioning, individual requires extensive assistance with performing ADLs. Individual is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ Bowel incontinence more often than once daily ☐ Urinary incontinence during the day and night ☐ Not Applicable

5. **List Current Medications (include medication name, dose, frequency, and route of administration)**

6. **Limitations in Activities of Daily Living (ADLs)**

Rate the individual's ADL Self-Performance and ADL Support Provided using the scores below

A. ADL Self-Performance Scores

0. INDEPENDENT: No help or oversight needed.
1. SUPERVISION: Oversight, encouragement or cueing needed.
2. LIMITED ASSISTANCE: Individual highly involved in activity; receives help in guided maneuvering of limbs or other non-weight bearing assistance.
3. EXTENSIVE ASSISTANCE: While individual performs part of activity, help of the following is needed: *weight-bearing support OR substantial or consistent hands-on assistance with eating, toileting, bathing, dressing, personal hygiene, or self-monitoring of meds.*
4. FULL DEPENDENCE: Full performance of activity by another.

B. ADL Support Provided Scores

0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+persons physical assist

			ADL Self-Performance	ADL Support Provided
a	**Bed Mobility**	Moving to and from lying position, turning side-to-side and position body while in bed.		
b	**Transfer**	Moving to and between surfaces: bed, chair, wheelchair, standing position. (Exclude to/from bath/toilet)		
c	**Ambulation**	Note assistive equip. (walker, wheelchair, hoyer lift); self-sufficiency once in chair. **Assistive Equip:** _____		
d	**Eating**	Taking in food by any method, including tube feedings. **Therapeutic Diet:** _____		
e	**Toilet Use**	Using the toilet (commode, bedpan, urinal); transferring on/off toilet, cleaning self after toilet use, changing pads/diapers, managing any special devise required (ostomy or catheter), and adjusting clothes.		
f	**Bathing**	Taking full-body bath/shower, sponge bath, transferring in/out of tub/shower. (Exclude washing back/hair)		
g	**Dressing**	Laying out clothes, retrieving clothes from closet, putting clothes on and taking clothes off.		
h	**Personal Hygiene**	Combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands, and perineum. (Exclude baths and showers)		
i	**Self-Monitoring**	Self-monitoring of pre-poured medications, glucometers, etc.		

7. **Nurse Aide II Tasks (specify task and frequency below)**

8. **Nurse Assessor Certification**

I certify that the above information reflects this Medicaid recipient's condition and that the recipient's DMA-3000 was signed by the attending physician on (specify date) _____ to obtain authorization for PCS.
Print Name: _____ Signature: _____ Date: _____

Form DMA 3000-A 12/01/03

North Carolina Division of Medical Assistance
Optional Nursing Assessment Worksheet for PCS-Plus

Medicaid Recipient Name:	**Date of Assessment:**
Assessment Completed by:	**Agency Name:**

The DMA-3000 provides a general evaluation of the client's medical and functional health (ADL/IADL) needs. This Optional Nursing Assessment Worksheet documents medical/nursing needs that may qualify the client for PCS-Plus services. Please note observations that document the client's condition specific to the criteria. A provider agency may choose to use its own forms in lieu of the Optional Nursing Assessment Worksheet to document the client's qualification for PCS-Plus. Forms used in lieu of the Optional Nursing Assessment Worksheet must clearly document assessment observations that specify individual client needs in identified PCS-Plus criteria.

Category	Description (Observation: specify)	Diagnosis (medical & nursing indicators)
Cognitive/Perceptual Orientation, memory, judgment, sensory deficits, developmental, emotional status, behavioral, seizures, pain, vision, hearing		
Nutrition/Metabolic Diet, type and method (oral, enteral, parenteral), appetite, eating problems, swallowing, weight changes, skin integrity **NA II Task:_____**		**NA II Task:_____**
Elimination (Bowel/bladder) Digestive problems, constipation, use of laxatives/enemas, continence (frequency) and continence management, catheter (type and frequency), ostomy (type/care) **NA II Task:_____**		**NA II Task:_____**
Activity/Exercise Activity, ambulary status/assistance, assistive devices, bed mobility, paralysis, weakness, history of falls, pain, musculoskeletal		
Respiratory COPD, respiratory status, use of O_2 (type/method/frequency), dyspnea, SOB, history of asthma, TB,		**NA II Task:_____**
Cardiovascular Heart disease, pacemaker, blood pressure, pain		
Medications/Medical Treatment/ Monitoring		

FORM DMA 3000-B 11/01/03

PCS-PLUS CASE STUDIES

Case 1: Anna Jones

Ms. Jones is an 85-year old widowed schoolteacher. She lives with her working niece who is a mother of three school age children. Ms. Jones was recently discharged from the hospital with an episode of CHF. She is diabetic and insulin dependent, and has congestive heart failure with occasional shortness of breath upon exertion. She also has hypertension. When the nurse assesses her, she finds Ms. Jones sitting up in a chair. She needs help with her bath, getting in and out of the tub, and washing her extremities. She also needs help with dressing and getting on and off of her elevated toilet. She has a little trouble getting up and started. However, once she is up, she can walk using her walker and requires only some transfer assistance and gait guarding. She does get tired after she has walked a distance. Three years ago, she fell and fractured her hip. Following her hip replacement, she went to a skilled nursing facility for rehabilitation but did well and returned to her niece's home. Her niece checks her FCBS and she has a range of 100-330. The niece reports that Ms. Jones does pretty well with her diet, except that she loves cashew nuts. Ms. Jones is alert, enjoys doing crossword puzzles, and watching Wheel of Fortune on TV.

Is Ms. Jones Eligible for PCS-Plus?
No. Ms. Jones is only eligible for PCS, not PCS-Plus. She has ADL impairments in bathing, transferring, and toileting. She would be scored as needing limited assistance since she only needs help getting in and out of the tub, washing her extremities, and toileting. She does not require a total bath.

Case 2: Stella Smith

Stella Smith is a 76-year old widow with three children. She lives with her eldest son and his wife. Six years ago she had her first stroke, which left her with right-sided weakness. Last year she had a second stroke, which left her with a swallowing deficit. Through rehab, they used a combination of soft diet and thickeners with no success. She lost weight and had an episode of skin breakdown. To meet her nutritional needs, a PEG tube was inserted. Currently she receives six cans of Ensure Plus a day and a 30 cc water flush following each feeding. Stella also has a history of hypertension. When the nurse assesses Stella, she finds that she must be bathed on the BSC or requires a full bed bath. She requires maximum assistance with dressing and grooming. She can be transferred with a one-person pivot. Stella also has occasional toileting accidents, which are attributed to her immobility.

Is Stella Smith eligible for PCS-Plus?
Yes. Stella has extensive ADL impairments in bathing, grooming, and transfer. She also has the NA II task of tube feedings.

Case 3: Frances Feltbetter

Frances Feltbetter is an 80-year old retired NA who lives with her husband of 54 years. At assessment, the nurse finds that Frances has significant arthritis and rates her pain at a 7 on a scale of 1 to 10. She gets some relief from Celebrex, but she also uses Darvocett almost daily for more severe pain. She goes to the MD frequently for pain management but has experienced a lot of side effects from the medications. She has had nausea and vomiting that is attributed to the medications. She has difficulty transferring due to joint stiffness and pain. Several years ago she fell and fractured her wrist while going to the bathroom. It took months for her wrist to heal and at that time they told her she also had osteoporosis. She experiences a lot of anxiety and has difficult sleeping. Other medical problems she experiences include: hypertension, glaucoma, and stress incontinence. The nurse observes that she has difficulty transferring due to pain. She is usually bathed in the bed and her hands are soaked in warm water. She benefits from a warm shower in the shower chair, but it is described as an "ordeal". Her husband helps her by preparing her medications, managing the shopping, and completing most of the housework. Her daughter takes her to the MD and provides assistance on the weekends.

Is Frances Feltbetter eligible for PCS-Plus?
Yes. Frances is fully dependent in three ADLs: bathing, grooming, and transfer. There are also some issues with toileting. She experiences substantial pain that directly interferes with her ADLs.

Example of PCS-Plus Request Form for Case 2

North Carolina Division of Medical Assistance (DMA)
PERSONAL CARE SERVICES-PLUS (PCS-PLUS) REQUEST FORM

1. ☑ **PCS-Plus Initial Request** ☐ **PCS-Plus Reauthorization Request**
Date of Request: 11/10/03 Request Submitted by: René Realnurse, RN
Total Number of PCS Hours/Month Requested: 80 **hours/month**
Duration of PCS-Plus Request*: 120 **days** From: 11/10/03 To: 3/8/04
**PCS-Plus authorizations cannot exceed 180 days. To request an extension, submit a new PCS-Plus Request Form at least one week before the PCS-Plus authorization expires.*

DMA Prior Approval
Authorization for 80 ***hours/month****
**Cannot exceed a total of 80 hours/month.*
Effective from: 11/10/03 to: 3/8/04
Date Request Reviewed: 11/12/03
RN Signature: Donna DMA, RN

2. **Provider Agency Information**
Agency Name: Best Care, Inc. PCS Provider #: XXXXXXX Phone: XXX-XXX-XXXX Fax: XXX-XXX-XXXX
Address: 101 Street Near You, Anytown, NC XXXXX Email: rene_realnurse@hotmail.com

3. **Medicaid Recipient Information**
Last Name: Smith First Name: Stella Middle Name: S.
Address: 101 Drug Lane, Anytown, NC XXXXX County: Any County
Phone Number: XXX-XXX-XXXX Medicaid ID # (MID): XXXXXXXXX-X Date of Birth: 10/21/27
Currently on PCS? ☑ Yes ☐ No**If no, agency RN must follow DMA procedures for PCS assessment and obtaining MD approval.*
Physician Name: Dr. Dan Jones Phone Number: XXX-XXX-XXXX Date DMA-3000 Signed: 11/10/03

4. **Specify Primary and Secondary Diagnosis:** CVA 2002; swallowing deficit; PEG 03

If a medical or cognitive condition is being used to qualify for PCS-Plus, the assessment must document at least one of the following (check all that apply):
- ☐ Presence of continuous and/or substantial pain interfering with individual's activity or movement
- ☐ Dyspneic or noticeably short of breath with minimal exertion during ADL performance and requires continuous use of oxygen
- ☐ Due to cognitive functioning, individual requires extensive assistance with performing ADLs. Individual is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ Bowel incontinence more often than once daily ☐ Urinary incontinence during the day and night ☑ Not Applicable

5. **List Current Medications (include medication name, dose, frequency, and route of administration)**
HCTZ 25 mg poq am; multivitamin + poq am; coumadin 2.5 mg poq d; lanoxin 0.125 mg poq am
* meds crushed and added per PEG

6. **Limitations in Activities of Daily Living (ADLs)**
Rate the individual's ADL Self-Performance and ADL Support Provided using the scores below

A. ADL Self-Performance Scores
0. INDEPENDENT: No help or oversight needed.
1. SUPERVISION: Oversight, encouragement or cueing needed.
2. LIMITED ASSISTANCE: Individual highly involved in activity; receives help in guided maneuvering of limbs or other non-weight bearing assistance.
3. EXTENSIVE ASSISTANCE: While individual performs part of activity, help of the following is needed: *weight-bearing support OR substantial or consistent hands-on assistance with eating, toileting, bathing, dressing, personal hygiene, or self-monitoring of meds.*
4. FULL DEPENDENCE: Full performance of activity by another.

B. ADL Support Provided Scores
0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+persons physical assist

			ADL Self-Performance	ADL Support Provided
a	**Bed Mobility**	Moving to and from lying position, turning side-to-side and position body while in bed.	3	2
b	**Transfer**	Moving to and between surfaces: bed, chair, wheelchair, standing position. (Exclude to/from bath/toilet)	3	2
c	**Ambulation**	Note assistive equip. (walker, wheelchair, hoyer lift); self-sufficiency once in chair. **Assistive Equip:**	3	2
d	**Eating**	Taking in food by any method, including tube feedings. **Therapeutic Diet:** tube fed / Ensure	4	2
e	**Toilet Use**	Using the toilet (commode, bedpan, urinal); transferring on/off toilet, cleaning self after toilet use, changing pads/diapers, managing any special devise required (ostomy or catheter), and adjusting clothes.	3	2
f	**Bathing**	Taking full-body bath/shower, sponge bath, transferring in/out of tub/shower. (Exclude washing back/hair)	3	2
g	**Dressing**	Laying out clothes, retrieving clothes from closet, putting clothes on and taking clothes off.	3	2
h	**Personal Hygiene**	Combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands, and perineum. (Exclude baths and showers)	3	2
i	**Self-Monitoring**	Self-monitoring of pre-poured medications, glucometers, etc.	0	0

7. **Nurse Aide II Tasks (specify task and frequency below)**
Tube feeding: Ensure Plus 8 oz via PEG 6 can/day + 30cc H_2O flush.

8. **Nurse Assessor Certification**
I certify that the above information reflects this Medicaid recipient's condition and that the recipient's DMA-3000 was signed by the attending physician on (specify date) 11/10/03 **to obtain authorization for PCS.**
Print Name: René Realnurse, RN Signature: René Realnurse, RN Date: 11/10/03

Form DMA 3000-A 12/01/03

Example of Optional Nursing Assessment Worksheet for PCS-Plus for Case 2

Case 2

North Carolina Division of Medical Assistance (DMA)
Optional Nursing Assessment Worksheet for PCS-Plus

Medicaid Recipient Name: Stella Smith	Date of Assessment: 11/7/03
Assessment Completed by: Rene' Realnurse, RN	Agency Name: Bestcare, Inc

The DMA-3000 provides a general evaluation of the client's medical and functional health (ADL/IADL) needs. This Optional Nursing Assessment Worksheet documents medical/nursing needs that may qualify the client for PCS-Plus services. Please note observations that document the client's condition specific to the criteria. A provider agency may choose to use its own forms in lieu of the Optional Nursing Assessment Worksheet to document the client's qualification for PCS-Plus. Forms used in lieu of the Optional Nursing Assessment Worksheet must clearly document assessment observations that specify individual client needs in identified PCS-Plus criteria.

Category	Description (Observation: specify)	Diagnosis (medical & nursing indicators)
Cognitive/Perceptual Orientation, memory, judgment, sensory deficits, developmental, emotional status, behavioral, seizures, pain, vision, hearing	alert, oriented to person, place. Forgetful @ times. Had CVA x 2, 1st 97 c ®sided weakness, 2nd 2002 c swallow deficit. C/o headaches @ times. relieved c tylenol	① CVA c ®sided weakness ② CVA c swallow deficit.
Nutrition/Metabolic Diet, type and method (oral, enteral, parenteral), appetite, eating problems, swallowing, weight changes, skin integrity NA II Task: Tube fed	Tube fed. Peg placed in 10/03 due to wgt loss, problems c fatigue & not able to take in enough fluids. no skin breakdown @ present. Peg site - no s/s infection/irritation	wgt loss swallowing deficit Nsg: potential complications of immobility, potential aspiration Ensure Plus NA II Task: Tube feeding
Elimination (Bowel/bladder) Digestive problems, constipation, use of laxatives/enemas, continence (frequency) and continence management, catheter (type and frequency), ostomy (type/care) NA II Task: ~~Ø~~	Regular soft BM, occasional incontinence. Urine uses BSC c help, incontinence @ times due to urgency/problems c transfer	incontinence potential skin breakdown NA II Task: ~~Ø~~
Activity/Exercise Activity, ambulary status/assistance, assistive devices, bed mobility, paralysis, weakness, history of falls, pain, musculoskeletal	®sided weakness, transfers to chair, BSC c max assistance. uses wheelchair.	®sided weakness needs assist c bath, dress, and ADLs. immobility, at risk falls
Respiratory COPD, respiratory status, use of O_2 (type/method/frequency), dyspnea, SOB, history of asthma, TB,	Lungs clear, skin wnl, color - good. ex smoker. Denies SOB	NA II Task: ~~Ø~~
Cardiovascular Heart disease, pacemaker, blood pressure, pain	HTN - tx c medications. CVA x 2 - 1997, 2003	Hypertension Nsg. immobility
Medications/Medical Treatment/ Monitoring	① 4 medications - family manages ② BP monitoring - due to HTN stable in last 10 year.	

FORM DMA 3000-B 11/01/03

Example of Plan of Care for Case 2

(ANNUAL CERTIFICATION DUE) PCS - 11/1/04

DMA-3000
(REV 2/93)

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
PERSONAL CARE SERVICES (PCS) PHYSICIAN AUTHORIZATION AND PLAN OF CARE Case 2

CC-010-89

✓ INITIAL ASSESSMENT (REFERRAL DATE 11-4-03) ____ REASSESSMENT

Best Care, Inc (PROVIDER AGENCY) | Anytown, NC (CITY/TOWN) | (XXX) XXX-XXXX (PHONE)

PATIENT INFORMATION

1. NAME Stella Smith 2. MEDICAID NO. XXX - client #
3. ADDRESS 101 Dairy Lane, Anytown, NC
4. PHONE (XXX) XXX-XXXX 5. SEX: ____ MALE ✓ FEMALE 6. DOB 10/21/27
7. LIVES: ____ ALONE ____ W / SPOUSE ✓ W / ADULT CHILD(REN) ____ W / PARENT(S) ____ W / OTHERS
8. CONTACT PERSON: NAME Stan Smith RELATIONSHIP son.
ADDRESS 101 Dairy Lane, Anytown, NC. PHONE (H) XXX-XXX-XXXX (W) XXX XXXX
9. ATTENDING PHYSICIAN: NAME Dr Daniel Jones PHONE XXX-XXX-XXXX
ADDRESS 222 Near Hospital St. Anytown, NC
DATE OF MOST RECENT EXAMINATION 10/16/03
10. REASON FOR REFERRAL needs help c personal care - long term, peg
11. DIAGNOSIS (DATE OF ONSET) CVA c swallowing deficit - 2002; insertion peg for feeding 10/03;
CVA c (R) sided weakness - 97, HTN - 10 yrs
12. CURRENT CARE TYPE AND SOURCE
Home Health - RN and aide servics

EVALUATION

13. MEDICATIONS - NAME/DOSE/FREQUENCY/ROUTE
HCTZ 25mg po/per peg q am
Lanoxin 0.125 mg po/per peg q am.
Coumadin 2.5 mg po/per peg at supper - 6 pm.
Multivitamin 1 po/per peg - crushed /q am.
Tylenol 325mg 1 or 2 po/per peg prn pain

SELF-ADMINISTERED? (Y / N) N IF "N", WHO ASSISTS (NAME / RELATIONSHIP) daughter in law
14. AMBULATION: ____ NO PROBLEMS ____ LIMITED ABILITY ____ AMBULATORY W/ AID OR DEVICES ✓ NON-AMBULATORY
DEVICES/ASSISTANCE NEEDED transfer to chair, BSC.
15. NUTRITION: ____ ORAL ____ PARENTERAL ✓ TUBE (TYPE PEG; Ensure plus @ can/day.
DIETARY RESTRICTIONS: NPO
16. RESPIRATION: ✓ NORMAL ____ TRACHEOSTOMY ____ MECHANICAL ____ OXYGEN ____ DYSPNEA
17. SKIN: ✓ NORMAL ____ PRESSURE AREAS ____ DECUBITI ____ OTHER peg site - wash daily.
SKIN CARE NEEDS at risk - skin breakdown due to immobility
18. BOWEL: ____ NORMAL ✓ OCCASIONAL INCONTINENCE (LESS THAN DAILY) ____ DAILY INCONTINENCE
____ OSTOMY: TYPE ____ SELF-CARE? (Y / N) N
19. BLADDER: ____ NORMAL ✓ OCCASIONAL INCONTINENCE (LESS THAN DAILY) ____ DAILY INCONTINENCE
____ CATHETER: TYPE ____ SELF-CARE (Y / N) N
20. ALLERGIES: PCN
21. ORIENTATION: ✓ ORIENTATED ____ SOMETIMES DISORIENTED ____ ALWAYS DISORIENTED
22. MEMORY: ____ ADEQUATE ✓ FORGETFUL-NEEDS REMINDERS ____ SIGNIFICANT LOSS-MUST BE DIRECTED
23. BEHAVIOR: ✓ COOPERATIVE ____ PASSIVE ____ PHYSICALLY ABUSIVE ____ VERBALLY ABUSIVE
____ WANDERS ____ INJURES SELF / OTHERS / PROPERTY ____ NON-RESPONSIVE
____ OTHER
24. VISION: ✓ ADEQUATE FOR DAILY ACTIVITIES ____ LIMITED (SEE LARGE OBJECTS) ____ VERY LIMITED (BLIND)
USES: ✓ GLASSES ____ CONTACT LENS
25. HEARING: ✓ ADEQUATE FOR DAILY ACTIVITIES ____ HEAR LOUD SOUNDS / VOICES ____ VERY LIMITED (DEAF)
____ USES HEARING AID
26. SPEECH: ____ NORMAL ✓ SLURRED ____ WEAK ____ OTHER IMPEDIMENT ____ NONE
27. COMMUNICATION METHOD: ✓ SPEECH ____ GESTURES ____ WRITING ____ NONE
____ ASSISTIVE DEVICE (TYPE ____)
28. OVERALL MEDICAL CONDITION: IS PATIENT MEDICALLY STABLE ? (Y / N) Y
29. SPECIAL CARE NEEDS/COMMENTS
NA-2 Task: Tube feeding.

Example of Plan of Care for Case 2, continued

Smith, Stella Case 2

30. UNMET NEEDS: CHECK THE TASKS FOR WHICH THE PATIENT NEEDS ASSISTANCE DUE TO HIS/HER MEDICAL CONDITION AND THE NEED IS EITHER NOT MET OR INADEQUATELY MET. SHOW THE TYPE OF HELP NEEDED AND HOW OFTEN IT IS NEEDED.

TYPE HELP NEEDED / HOW OFTEN

PERSONAL CARE
- ✓ EATING PEG / Ensure plus, NPO dve to swallowing problems
- ✓ GROOMING assist to dress, at each visit - hair, mouth care
- ✓ DRESSING assist to dress
- ✓ BATHING total bath - bed or ↑ to BSC.
- ✓ USE OF TOILET total transfer to BSC; assist to clean
- ✓ TRANSFER total transfer to BSC, chair, WC.
- ___ AMBULATION
- ___ MEAL PREPARATION 0 - tube fed
- ✓ MEDICATION INTAKE assist & pre-pared meds.

INCIDENTAL HOME MANAGEMENT
- ✓ CLEANING tidy bedroom, bathroom, wash BSC,
- ✓ LAUNDERING when wet clothes / linen change
- ___ ESSENTIAL SHOPPING 0
- ✓ MAKE BED daily,

31. ARE THERE SOURCES (FAMILY, FRIENDS, PROGRAMS, & AGENCIES) TO MEET ABOVE NEEDS? (Y / N) Y
IF "Y", IDENTIFY SOURCES AND WHICH NEEDS CAN BE MET
son / shopping ; Diet - pre-pars meds

PLAN OF CARE

32 IF THE EVALUATION INDICATES THE PATIENT HAS MEDICALLY-RELATED PERSONAL CARE NEEDS REQUIRING PCS, SHOW THE PLAN FOR PROVIDING CARE. LIST THE DAY(S) SERVICES ARE NEEDED; THE TASKS TO BE PERFORMED ON THOSE DAYS; AND THE TOTAL TIME NEEDED EACH DAY.

DAY OF WEEK	TASKS TO BE ACCOMPLISHED	TIME
M	Total bath, groom, dress, ↑ to BSC, tube feed, linen change, tidy BR / bathroom.	4
T	Total bath, groom, dress, ↑ to BSC, tube feed, laundry	4
W	Total bath, groom, dress, ↑ to BSC, tube feed, vaccum.	4
Th	Total bath, groom, dress, ↑ to BSC, tube feed, linen change	4
Fr	Total bath, groom, dress, ↑ to BSC, tube fed, laundry	4

33. GOALS: NEED FOR PCS IS EXPECTED TO CHANGE / END (CIRCLE ONE) ON ___/___/___. IF NO CHANGE EXPECTED, STATE WHY: chronic illness with no improvement expected

NURSE ASSESSOR CERTIFICATION

I CERTIFY THAT I HAVE COMPLETED THE ABOVE EVALUATION OF THE PATIENT'S CONDITION.
- ✓ I FOUND THE PATIENT NEEDS PERSONAL CARE SERVICES DUE TO THE PATIENT'S MEDICAL CONDITION. I HAVE DEVELOPED THE PLAN OF CARE TO MEET THOSE NEEDS.
- ___ I FOUND THE PATIENT DOES NOT MEET THE CRITERIA FOR PERSONAL CARE SERVICES.

René Realnurse, RN (NAME) René Realnurse RN (SIGNATURE) 11-7-03 (DATE)

PHYSICIAN CERTIFICATION

I CERTIFY THAT THE PATIENT IS UNDER MY CARE AND HAS A MEDICAL DIAGNOSIS WITH ASSOCIATED PHYSICAL / MENTAL LIMITATIONS WARRANTING THE PROVISION OF THE PERSONAL CARE SERVICES IN THE ABOVE PLAN OF CARE.

MD (SIGNATURE) 11-10-03 (DATE)

Example of PCS-Plus Request Form For Case 3

North Carolina Division of Medical Assistance (DMA)
PERSONAL CARE SERVICES-PLUS (PCS-PLUS) REQUEST FORM

1. ☑ **PCS-Plus Initial Request** ☐ **PCS-Plus Reauthorization Request**

Date of Request: 11/5/03 Request Submitted by: René Realnurse, RN
Total Number of PCS Hours/Month Requested: 80 **hours/month**
Duration of PCS-Plus Request*: 120 **days** From: 11/5/03 To: 3/6/04
**PCS-Plus authorizations cannot exceed 180 days. To request an extension, submit a new PCS-Plus Request Form at least one week before the PCS-Plus authorization expires.*

DMA Prior Approval
Authorization for 80 ***hours/month****
**Cannot exceed a total of 80 hours/month.*
Effective from: 11/5/03 to: 3/6/04
Date Request Reviewed: 11/12/03
RN Signature: Donna DMA, RN

2. **Provider Agency Information**

Agency Name: Best Care, Inc. PCS Provider #: XXXXXXX Phone: XXX-XXX-XXXX Fax: XXX-XXX-XXXX
Address: 101 Street Near You, Anytown, NC XXXXX Email: goodrn@hotmail.com

3. **Medicaid Recipient Information**

Last Name: Feltbetter First Name: Frances Middle Name: B.
Address: 2626 Country Lane, Mayberry, NC XXXXX County: Anycounty
Phone Number: XXX-XXX-XXXX Medicaid ID # (MID): XXXXXXXX X-X Date of Birth: 8-21-23
Currently on PCS? ☑ Yes ☐ No* *If no, agency RN must follow DMA procedures for PCS assessment and obtaining MD approval.*
Physician Name: Dr. Arthur Ritis Phone Number: XXX-XXX-XXXX Date DMA-3000 Signed: 9-29-03

4. **Specify Primary and Secondary Diagnosis:** Severe arthritis/pain; HTN; glaucoma

If a medical or cognitive condition is being used to qualify for PCS-Plus, the assessment must document at least one of the following (check all that apply):
- ☑ Presence of continuous and/or substantial pain interfering with individual's activity or movement
- ☐ Dyspneic or noticeably short of breath with minimal exertion during ADL performance and requires continuous use of oxygen
- ☐ Due to cognitive functioning, individual requires extensive assistance with performing ADLs. Individual is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ Bowel incontinence more often than once daily ☐ Urinary incontinence during the day and night ☐ Not Applicable

5. **List Current Medications (include medication name, dose, frequency, and route of administration)**

celebrex 100mg po in am and hs
Darvocett N-100mg poq 4° prn severe pain
Diroopan 5mg po QID
HCTZ 25mg poq am
xylatan drops 4 i@ hs
Ambien 20mg poq hs
Ativan 1mg po in am & pm anxiety

6. **Limitations in Activities of Daily Living (ADLs)**

Rate the individual's ADL Self-Performance and ADL Support Provided using the scores below

A. ADL Self-Performance Scores
0. INDEPENDENT: No help or oversight needed.
1. SUPERVISION: Oversight, encouragement or cueing needed.
2. LIMITED ASSISTANCE: Individual highly involved in activity; receives help in guided maneuvering of limbs or other non-weight bearing assistance.
3. EXTENSIVE ASSISTANCE: While individual performs part of activity, help of the following is needed: *weight-bearing support OR substantial or consistent hands-on assistance with eating, toileting, bathing, dressing, personal hygiene, or self-monitoring of meds.*
4. FULL DEPENDENCE: Full performance of activity by another.

B. ADL Support Provided Scores
0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+persons physical assist

			ADL Self-Performance	ADL Support Provided
a	**Bed Mobility**	Moving to and from lying position, turning side-to-side and position body while in bed.	3	2
b	**Transfer**	Moving to and between surfaces: bed, chair, wheelchair, standing position. (Exclude to/from bath/toilet)	3	2
c	**Ambulation**	Note assistive equip. (walker, wheelchair, hoyer lift); self-sufficiency once in chair. **Assistive Equip:** walker	3	2
d	**Eating**	Taking in food by any method, including tube feedings. **Therapeutic Diet:**	0	0
e	**Toilet Use**	Using the toilet (commode, bedpan, urinal); transferring on/off toilet, cleaning self after toilet use, changing pads/diapers, managing any special devise required (ostomy or catheter), and adjusting clothes.	3	2
f	**Bathing**	Taking full-body bath/shower, sponge bath, transferring in/out of tub/shower. (Exclude washing back/hair)	3	2
g	**Dressing**	Laying out clothes, retrieving clothes from closet, putting clothes on and taking clothes off.	3	2
h	**Personal Hygiene**	Combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands, and perineum. (Exclude baths and showers)	3	2
i	**Self-Monitoring**	Self-monitoring of pre-poured medications, glucometers, etc.	1	1

7. **Nurse Aide II Tasks (specify task and frequency below)**

Not Applicable

8. **Nurse Assessor Certification**

I certify that the above information reflects this Medicaid recipient's condition and that the recipient's DMA-3000 was signed by the attending physician on (specify date) 9/29/03 **to obtain authorization for PCS.**
Print Name: René Realnurse, RN Signature: René Realnurse, RN Date: 11/5/03

Form DMA 3000-A 12/01/03

Example of Optional Nursing Assessment Worksheet for PCS-Plus for Case 3

North Carolina Division of Medical Assistance (DMA)
Optional Nursing Assessment Worksheet for PCS-Plus Case 3

Medicaid Recipient Name: Frances Fehtbeiter	Date of Assessment: 11-1-03
Assessment Completed by: Rene' Realnurse, RN	Agency Name: Best Care, Inc.

The DMA-3000 provides a general evaluation of the client's medical and functional health (ADL/IADL) needs. This Optional Nursing Assessment Worksheet documents medical/nursing needs that may qualify the client for PCS-Plus services. Please note observations that document the client's condition specific to the criteria. A provider agency may choose to use its own forms in lieu of the Optional Nursing Assessment Worksheet to document the client's qualification for PCS-Plus. Forms used in lieu of the Optional Nursing Assessment Worksheet must clearly document assessment observations that specify individual client needs in identified PCS-Plus criteria.

Category	Description (Observation: specify)	Diagnosis (medical & nursing indicators)
Cognitive/Perceptual Orientation, memory, judgment, sensory deficits, developmental, emotional status, behavioral, seizures, pain, vision, hearing	alert + oriented x 3. Has anxiety during transfers & reports some problems sleeping d/t arthritic pain (severe) - rates 7 on scale 1-10, moderate relief c meds. Problems c mobility 2° pain	arthritis (severe) mild insomnia glaucoma alteration in comfort. PAIN
Nutrition/Metabolic Diet, type and method (oral, enteral, parenteral), appetite, eating problems, swallowing, weight changes, skin integrity NA II Task: ϕ	no weight loss reported. Eats low salt diet and understands. Apetite good per patient. No skin breakdown/irritation.	low salt diet - NA II Task: ϕ
Elimination (Bowel/bladder) Digestive problems, constipation, use of laxatives/enemas, continence (frequency) and continence management, catheter (type and frequency), ostomy (type/care) NA II Task: ϕ	BM regular. Hx. constipation, uses OTC laxc relief, incontinent of urine @ times due to stress and problems c transfer.	mild, intermittant constipation. incontinence potential skin breakdown. NA II Task: ϕ
Activity/Exercise Activity, ambulary status/assistance, assistive devices, bed mobility, paralysis, weakness, history of falls, pain, musculoskeletal	Up c max assistance/walker. Can transfer to BSC/WC c pain. Hx-falls/fx wrist @ yr ago. Can move/turn in bed c pain c/o stiffness.	immobility/pain 2° to arthritis.
Respiratory COPD, respiratory status, use of O_2 (type/method/frequency), dyspnea, SOB, history of asthma, TB,	Lungs clear, resp 18 + reg. Smoked 2p/day until 1995. Denies SOB. Skin-W+d. NA II Task: ϕ	
Cardiovascular Heart disease, pacemaker, blood pressure, pain	pulse 88 + reg, BP 150/90. Mild edema ankles, PPP.	Hypertension
Medications/Medical Treatment/ Monitoring	multiple arthritic meds c untoward effects/problems c pain management, anti-anxiety, sleep meds, xylatan g Hs - glaucoma, HTN.	arthritis c severe pain anxiety hypertension

FORM DMA 3000-B 11/01/03

Example of Plan of Care for Case 3

ANNUAL CERTIFICATION DUE _____

DMA-3000
(REV. 2/93)

CC-010-89

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
PERSONAL CARE SERVICES (PCS) PHYSICIAN AUTHORIZATION AND PLAN OF CARE

9/29/03 INITIAL ASSESSMENT (REFERRAL DATE 9/28/03) 11-1-03 REASSESSMENT

Best Care, Inc (PROVIDER AGENCY) | Mayberry, NC (CITY/TOWN) | XXX-XXX-XXXX (PHONE)

PATIENT INFORMATION

1. NAME Frances Feltbetter 2. MEDICAID NO. XXX-client specific
3. ADDRESS 2626 Country Lane, Mayberry, NC
4. PHONE (XXX) XXX-XXXX 5. SEX: ____ MALE ✓ FEMALE 6. DOB 8/20/1923
7. LIVES: ____ ALONE ✓ W/ SPOUSE ____ W/ ADULT CHILD(REN) ____ W/ PARENT(S) ____ W/ OTHERS
8. CONTACT PERSON: NAME Floyd Feltbetter RELATIONSHIP husb
ADDRESS 2626 Country Lane PHONE (H) XXX-XXXX (W) XXX-XXXX
9. ATTENDING PHYSICIAN: NAME Arthur Ritis, MD PHONE XXX XXX XXXX
ADDRESS 101 Main Street, Mayberry, NC
DATE OF MOST RECENT EXAMINATION 8/20/03
10. REASON FOR REFERRAL pain; immobility - needs help c bath.
11. DIAGNOSIS (DATE OF ONSET)
Arthritis ~ 20 years; HTN - 10 yrs; glaucoma - 8 yrs / cataract c lens implant 1995
12. CURRENT CARE-TYPE AND SOURCE
PCS - 30/d/5 d week

EVALUATION

13. MEDICATIONS - NAME/DOSE/FREQUENCY/ROUTE
Celebrex 100mg po in am and hs.
Darvocet N 100mg po q 4h prn severe pain
Ditropan 5mg po BID
HCTZ 25mg po q am
Xylocaine drops 2 gtt OU @ hs.
Ambien 20 mg po @ hs
Ativan 1mg po in am - prn anxiety
SELF-ADMINISTERED? (Y/N) Y IF "N", WHO ASSISTS (NAME / RELATIONSHIP) _____
14. AMBULATION: ____ NO PROBLEMS ____ LIMITED ABILITY ✓ AMBULATORY W/ AID OR DEVICES ____ NON-AMBULATORY
DEVICES/ASSISTANCE NEEDED walker, gait guard - hx of falls
15. NUTRITION: ✓ ORAL ____ PARENTERAL ____ TUBE (TYPE _____)
DIETARY RESTRICTIONS: Low salt
16. RESPIRATION: ✓ NORMAL ____ TRACHEOSTOMY ____ MECHANICAL ____ OXYGEN ____ DYSPNEA
17. SKIN: ✓ NORMAL ____ PRESSURE AREAS ____ DECUBITI ____ OTHER _____
SKIN CARE NEEDS _____
18. BOWEL: ____ NORMAL ____ OCCASIONAL INCONTINENCE (LESS THAN DAILY) ✓ DAILY INCONTINENCE
____ OSTOMY: TYPE _____ SELF-CARE? (Y/N) ____
19. BLADDER: ____ NORMAL ____ OCCASIONAL INCONTINENCE (LESS THAN DAILY) ✓ DAILY INCONTINENCE
____ CATHETER: TYPE _____ SELF-CARE (Y/N) ____
20. ALLERGIES: none
21. ORIENTATION: ____ ORIENTATED ____ SOMETIMES DISORIENTED ____ ALWAYS DISORIENTED
22. MEMORY: ✓ ADEQUATE ____ FORGETFUL-NEEDS REMINDERS ____ SIGNIFICANT LOSS-MUST BE DIRECTED
23. BEHAVIOR: ✓ COOPERATIVE ____ PASSIVE ____ PHYSICALLY ABUSIVE ____ VERBALLY ABUSIVE
____ WANDERS ____ INJURES SELF / OTHERS / PROPERTY ____ NON-RESPONSIVE
____ OTHER anxiety - fearful of falls
24. VISION: ✓ ADEQUATE FOR DAILY ACTIVITIES ____ LIMITED (SEE LARGE OBJECTS) ____ VERY LIMITED (BLIND)
USES: ✓ GLASSES ____ CONTACT LENS
25. HEARING: ✓ ADEQUATE FOR DAILY ACTIVITIES ____ HEAR LOUD SOUNDS / VOICES ____ VERY LIMITED (DEAF)
✓ USES HEARING AID
26. SPEECH: ✓ NORMAL ____ SLURRED ____ WEAK ____ OTHER IMPEDIMENT _____ ____ NONE
27. COMMUNICATION METHOD: ✓ SPEECH ____ GESTURES ____ WRITING ____ NONE
____ ASSISTIVE DEVICE (TYPE _____)
28. OVERALL MEDICAL CONDITION: IS PATIENT MEDICALLY STABLE? (Y/N) Y
29. SPECIAL CARE NEEDS/COMMENTS
client has chronic pain; history of falls

Example of Plan of Care for Case 3, continued

30. UNMET NEEDS: CHECK THE TASKS FOR WHICH THE PATIENT NEEDS ASSISTANCE DUE TO HIS/HER MEDICAL CONDITION AND THE NEED IS EITHER NOT MET OR INADEQUATELY MET. SHOW THE TYPE OF HELP NEEDED AND HOW OFTEN IT IS NEEDED.

Case 3

TYPE HELP NEEDED / HOW OFTEN

PERSONAL CARE

- ✓ EATING pre-cut/serve · daily
- ✓ GROOMING hair daily
- ✓ DRESSING assist daily
- ✓ BATHING total bath / transfer to shower chair daily
- ✓ USE OF TOILET transfer/assist daily 2/3 x
- ✓ TRANSFER assist (max); uses walker daily
- ✓ AMBULATION walker, hx of falls- gait guard daily
- ✓ MEAL PREPARATION serve, low salt daily
- ___ MEDICATION INTAKE hand/retrieve - husband daily

INCIDENTAL HOME MANAGEMENT

- ✓ CLEANING
- ✓ LAUNDERING
- ✓ ESSENTIAL SHOPPING
- ✓ MAKE BED

31. ARE THERE SOURCES (FAMILY, FRIENDS, PROGRAMS, & AGENCIES) TO MEET ABOVE NEEDS? (Y / N) ___

IF "Y", IDENTIFY SOURCES AND WHICH NEEDS CAN BE MET

husband does shopping, children visit help on Sa/Su

PLAN OF CARE

32 IF THE EVALUATION INDICATES THE PATIENT HAS MEDICALLY-RELATED PERSONAL CARE NEEDS REQUIRING PCS, SHOW THE PLAN FOR PROVIDING CARE. LIST THE DAY(S) SERVICES ARE NEEDED; THE TASKS TO BE PERFORMED ON THOSE DAYS; AND THE TOTAL TIME NEEDED EACH DAY.

DAY OF WEEK	TASKS TO BE ACCOMPLISHED	TIME
M	bath in shower chair, wash hair, dress, assist ĉ toilet, transfer, meal	4.5
T	bath in shower chair, Δ linen, dress, assist ĉ toilet, transfer, meal	4.0
W	bath in shower chair, laundry, dress, assist ĉ toilet, transfer, meal.	4.0
Th	bath in shower chair, dress, assist ĉ toilet, transfer, meal, clean kitchen	4.0
Fr	bed bath, comb hair, transfer, prepare meal, assist to dress assist ĉ toilet	3.0
	each day: make bed, tidy living areas	

33. GOALS: NEED FOR PCS IS EXPECTED TO CHANGE / END (CIRCLE ONE) ON ___/___/___. IF NO CHANGE EXPECTED, STATE WHY: chronic pain / immobility ĉ arthritis

NURSE ASSESSOR CERTIFICATION

I CERTIFY THAT I HAVE COMPLETED THE ABOVE EVALUATION OF THE PATIENT'S CONDITION.

- ✓ I FOUND THE PATIENT NEEDS PERSONAL CARE SERVICES DUE TO THE PATIENT'S MEDICAL CONDITION. I HAVE DEVELOPED THE PLAN OF CARE TO MEET THOSE NEEDS.
- ___ I FOUND THE PATIENT DOES NOT MEET THE CRITERIA FOR PERSONAL CARE SERVICES.

Irene Realnurse, RN (NAME) — Irene Realnurse, RN (SIGNATURE) — 11-5-03 (DATE)

PHYSICIAN CERTIFICATION

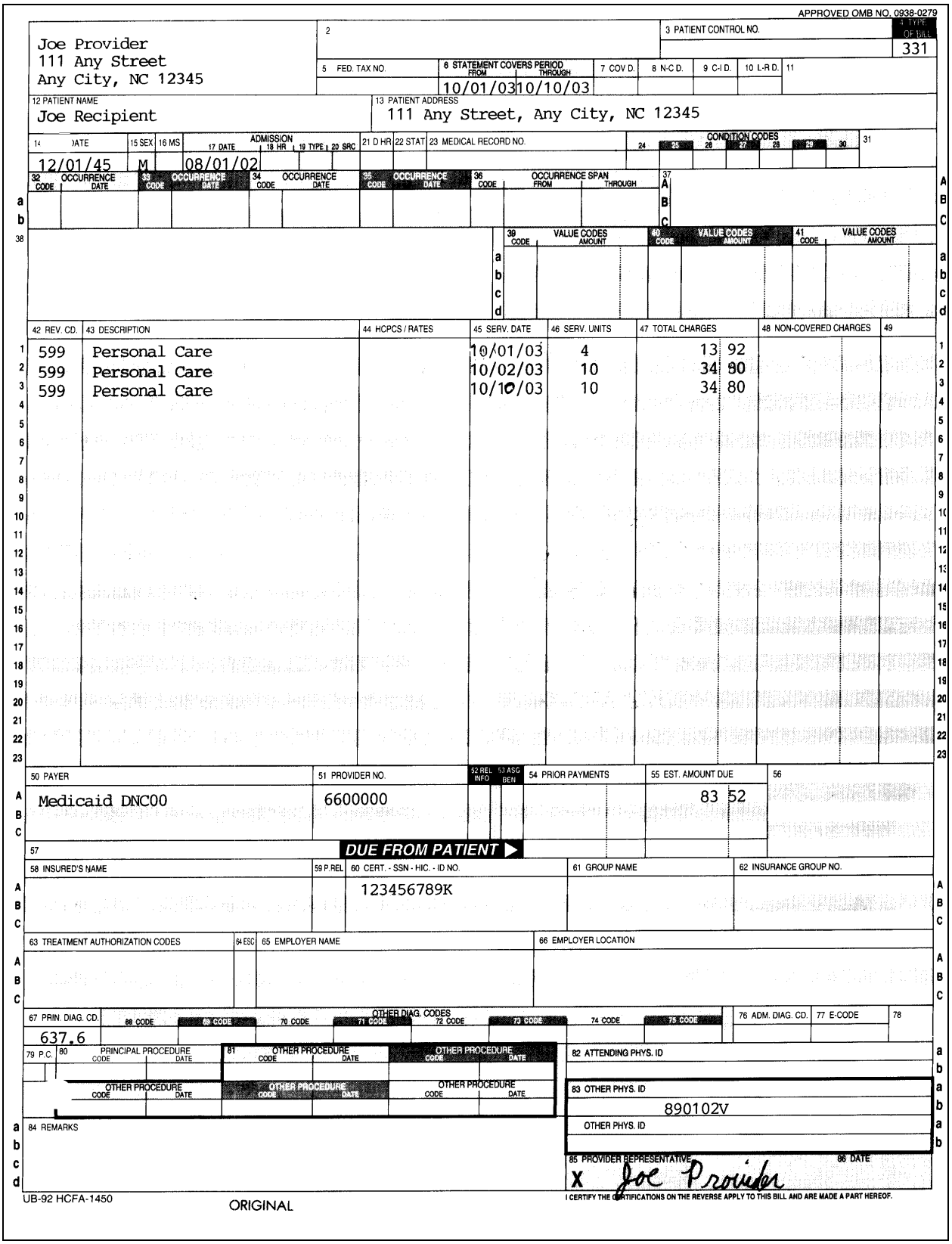
I CERTIFY THAT THE PATIENT IS UNDER MY CARE AND HAS A MEDICAL DIAGNOSIS WITH ASSOCIATED PHYSICAL / MENTAL LIMITATIONS WARRANTING THE PROVISION OF THE PERSONAL CARE SERVICES IN THE ABOVE PLAN OF CARE.

SIGNATURE — 11-15-03 (DATE)

PCS-PLUS BILLING INSTRUCTIONS

PCS agencies must bill for approved PCS-Plus services using the same procedure that is used to bill for regular PCS (Refer to Section 14 of the *N.C. Medicaid Community Care Manual*). Claims must be submitted to EDS on a UB-92 claim form or 837 Institutional format using revenue code RC599. Claims submitted for PCS-Plus services that have not been prior approved will not be paid.

Example of UB-92 Claim For Personal Care Services-Plus



APPROVED OMB NO. 0938-0279

Joe Provider
111 Any Street
Any City, NC 12345

3 PATIENT CONTROL NO. | 4 TYPE OF BILL: 331

6 STATEMENT COVERS PERIOD FROM: 10/01/03 THROUGH: 10/10/03

12 PATIENT NAME: Joe Recipient

13 PATIENT ADDRESS: 111 Any Street, Any City, NC 12345

14 DATE: 12/01/45 | 15 SEX: M | 17 ADMISSION DATE: 08/01/02

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
599	Personal Care		10/01/03	4	13 92	
599	Personal Care		10/02/03	10	34 80	
599	Personal Care		10/10/03	10	34 80	

50 PAYER: Medicaid DNC00 | 51 PROVIDER NO.: 6600000 | 55 EST. AMOUNT DUE: 83 52

DUE FROM PATIENT ▶

60 CERT. - SSN - HIC. - ID NO.: 123456789K

67 PRIN. DIAG. CD.: 637.6

83 OTHER PHYS. ID: 890102V

85 PROVIDER REPRESENTATIVE: X Joe Provider

UB-92 HCFA-1450 ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

AUTOMATED ATTENDANT TELEPHONE LINE

The **Automated Attendant Telephone line** (1-800-688-6696 or 919-851-8888) can be used to access the EDS Provider Services unit, Prior Approval unit or the Electronic Commerce Services (ECS) unit.

For Electronic Commerce Services "Press 1"	**For Prior Approval "Press 2"**	**For Provider Services Press 3"**
If you select Electronic Claims Submission from the main menu, you will be prompted to: **"Press 1 to reach an ECS Analyst"**	If you select Prior Approval from the main menu, you will be prompted to: **"Press 2 for Optical or Hearing Aid"** **"Press 3 for Long-Term Care, Surgery or Out-of-State"** (This includes Psychiatric and Ambulance services) **"Press 4 for Dental"** **"Press 5 for DME"** **"Press 9 for Enhanced Care, Therapeutic Leave or Hospice"** (Includes High Risk Intervention providers)	If you select Provider Services from the main menu, you will be prompted to: **"Press 6 if you are calling from a Physician's office or a County Health Department"** (This includes Health Check, Eye Care, Chiropractor, Ambulatory Surgery, Independent Practitioners, Nurse Midwife, Nurse Practitioner, Radiologist, Podiatrist, Health-Related Services in Public Schools Providers, Certified Registered Nurse Anesthetists, Independent Diagnostic Testing Facilities, Independent Mental Health providers, and Anesthesiology providers) **"Press 7 if you are calling from a Hospital or a Long-Term Care Facility"** (This includes Mental Health, Psychiatric Residential Treatment Facilities (Level II – IV), Hearing Aid, and Dialysis providers) **"Press 8 if you are a Pharmacy, Dental, Home Health Care, Personal Care, Durable Medical Equipment or Domiciliary Care Facility"** (This includes Ambulance, Community Alternatives Program, DSS/DHS, Hospice, Home Infusion Therapy, Private Duty Nursing, Rural Health, FQHC, Adult Care Homes, At-Risk Case Management, and HIV Case Management providers)
"For operator-assisted calls - stay on the line" Once you select the appropriate unit, your call will be transferred to an individual or placed in a queue for the first available agent. All calls placed in a queue are handled in the order in which they are received.		

AUTOMATED VOICE RESPONSE SYSTEM

The **Automated Voice Response (AVR) system** allows enrolled providers to readily access detailed information pertaining to the North Carolina Medicaid program. AVR is available 24 hours per day (except 1:00 a.m. to 5:00 a.m. on the 1st, 2nd, 4th, & 5th Sunday, and 1:00 a.m. to 7:00 a.m. on the 3rd Sunday) by calling 1-800-723-4337. Using a touch-tone telephone, providers may inquire about the following:

- ☎ Current Claim Status
- ☎ Procedure Code Pricing
- ☎ Hospice Participation
- ☎ Managed Care Enrollment
  (Carolina ACCESS, ACCESS II or HMO)
- ☎ Checkwrite Information
- ☎ Prior Approval Information
- ☎ Refraction Benefit Limitation
- ☎ Drug Coverage Information
- ☎ Recipient Eligibility Verification
- ☎ Dental Benefit Limitations

Refer to the following transaction codes and information before placing your call. (**Note:** Providers will be allowed up to 15 transactions per call.)

Transaction	Description	Required Information
1	Verify Claim Status	Provider Number, MID, "FROM DOS", Total Billed Amount
2	Checkwrite Information	Provider Number
3	Drug Coverage	Provider Number, Drug Code, and DOS
4	Procedure Code Pricing and Modifier Information	Provider Number, Procedure Code, Type of Treatment Code or Modifier Code
5	Prior Approval	Provider Number, Procedure Code, Type of Treatment Code or Modifier Code and MID
6	Recipient Eligibility and Coordination of Benefits and Managed Care Status	Provider Number, MID or SSN#, DOS, and "FROM DOS" **Note**: Response includes: HMO or Carolina ACCESS PCP Name, Phone Number; Transfer of Assets Information
7	Sterilization Consent or Hysterectomy Statement	Provider Number, MID, and DOS
9	To Repeat Options 1-7	

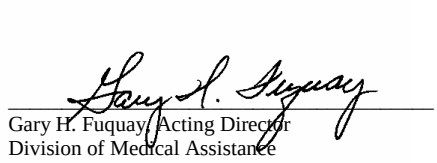
Alphabetic Data Table

The following table is a reference for using alphabetic data. Use the numeric codes to identify the letters necessary. Be sure to press the asterisk (*) key before entering the numeric codes.

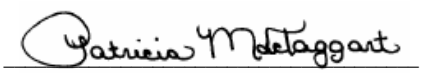
A – *21	E – *32	I – *43	M – *61	Q – *11	U – *82	Y – *93
B – *22	F – *33	J – *51	N – *62	R – *72	V – *83	Z – *12
C – *23	G – *41	K – *52	O – *63	S – *73	W – *91	
D – *31	H – *42	L – *53	P – *71	T – *81	X – 92	

The alphabetic code is represented by two digits. The first digit is the sequential number of the telephone key pad where the alphabetic character is located. The second digit is the position of the alphabetic character on the key. For example, "V" is on key #8 in the third position, thus 83.

Note: Refer to the **July 2001 Special Bulletin, *Automated Voice Response System Provider Inquiry Instructions*** for detailed instructions on using the AVR system. This special bulletin is available on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm.



Gary H. Fuquay, Acting Director
Division of Medical Assistance
Department of Health and Human Services



Patricia MacTaggart
Executive Director
EDS

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Raleigh, North Carolina 27622

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