

**THE STATE OF NORTH CAROLINA**

Department of Health and Human Services

# Clinical Coverage Policy 3L, Personal Care Services (PCS) Benefit Program

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Provider Manual

Effective August 2017



Liberty Healthcare Corporation  
of North Carolina

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# Introduction: Program Overview

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## General Information

The Personal Care Services (PCS) Program is a Medicaid State Plan benefit provided under the North Carolina Medicaid Program. Personal Care Services are provided for Medicaid beneficiaries who have a medical condition, cognitive impairment or disability and demonstrate unmet needs for hands-on assistance with qualifying activities of daily living (ADLs). Qualifying ADLs are bathing, dressing, mobility, toileting, and eating.

The PCS program is designed to provide personal care services to individuals residing in a private living arrangement or in a residential facility licensed by the State of North Carolina as an adult care home, a combination home as defined in G.S. 131E-101(1a), or a group home licensed under Chapter 122C of the General Statutes and defined under 10A NCAC 27G as a supervised living facility for two or more adults whose primary diagnosis is mental illness, a developmental disability, or substance abuse dependency. PCS is provided in the beneficiary's living environment by paraprofessional aides employed by licensed adult care homes, home care agencies or by home staff in supervised living homes.

The amount of service provided is based on an assessment conducted by an Independent Assessment Entity (IAE) to determine the individual's ability to perform ADLs. The performance is rated on a five point scale that includes totally independent, requiring cueing or supervision, requiring limited hands-on assistance, requiring extensive hands-on assistance, or totally dependent.

Beneficiaries are awarded prior approvals (PAs) for a number of service hours dependent on their assessed needs. Qualifying Medicaid beneficiaries who are 21 years or older may be authorized up to 80 hours of service per month. A Medicaid beneficiary who meets the eligibility requirements for PCS and other eligibility criteria mandated by [N.C. Session Law 2013-306](#) <http://www.ncga.state.nc.us/Sessions/2013/Bills/House/PDF/H492v7.pdf> may be authorized for up to 50 additional hours of Medicaid Personal Care Services per month for a total amount of up to 130 hours. Qualifying Medicaid beneficiaries under 21 years of age may be authorized for up to 60 hours of service per month, except if additional hours are approved under Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

## PCS Beneficiary Qualification Requirements

*The information in this section references Clinical Coverage Policy 3L, Section 3.0*

In order to qualify for PCS, Medicaid beneficiaries are required to have active Medicaid at the time of service. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for PCS. Beneficiaries who are enrolled with N.C. Health Choice (NCHC) do not qualify for Personal Care Services.

PCS is considered for beneficiaries who have a medical condition, cognitive impairment or disability and demonstrate unmet needs for, at a minimum;

- a. three of the five qualifying ADLs with limited assistance hands-on assistance;
- b. two ADLs, one of which requires extensive assistance; **or**
- c. two ADLs, one of which requires assistance at the full dependence level.

**AND**, reside 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.

Additional general program requirements include:

- The home environment is safe and free of health hazards for the beneficiary and the PCS provider(s) to receive and provide service;
- The residential setting has received inspection conducted by the Division of Health Service Regulation (DHSR);
- The place of service is safe for the beneficiary to receive PCS and for an aide to provide PCS;
- No third-party payer is responsible for covering PCS;
- No family or household member or other informal caregiver is available, willing, and able to provide the authorized services during the approved time frame;
- Be referred by their Primary Care Physician, Attending Physician, Nurse Practitioner or Physician Assistant;
- Have a documented medical condition that supports the need for hands on assistance;
- Be certified as medically stable by the referring entity;
- Under on-going care of a physician for the condition or diagnosis causing the functional limitations;
- Have been seen by the referring entity within the previous 90 days;
- Have been screened for Serious Mental Illness (SMI). All Medicaid beneficiaries referred to or seeking admission into an Adult Care Home 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. 131 D-2.4 will not receive PCS prior approval to bill PCS without verification of an ACH PASRR number.

**NOTE:** Exceptions to the above eligibility criteria may be approved for a child under the EPSDT provision.

## **EPSDT (Early and Periodic Screening, Diagnostics, and Treatment) Program**

*Information in this section references Clinical Coverage Policy 3L, section 2.2*

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 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.

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. 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.

**NOTE:** Once the beneficiary turns 21 years of age, their approved EPSDT hours will cease and PCS will end. A new 3051 form should be mailed to the Independent Assessment Entity PRIOR to the 21<sup>st</sup> birthday in order for the beneficiary to be assessed and if approved, PCS to continue after they turn 21.

## PCS Covered Tasks and Services

*The information in this section references Clinical Coverage Policy 3L, Section 3.3 and 3.4*

### Personal Care Services

PCS is a non-skilled service and should not be considered as a substitute for ongoing medical treatment; PCS includes the following tasks and services that needs to 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 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.

The following additional assistance may be approved under **EPSDT** criteria for beneficiaries under 21 year 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.

### Medication Assistance

Medicaid shall cover medication assistance when it is:

1. Delivered in a private residence and consists of medication self-administration assistance described in 10A NCAC 13J;

2. Delivered in an adult care home and includes medication administration as defined in 10A NCAC 13F and 13G; or
3. Delivered in a supervised living home and includes medication administration as defined in 10A NCAC 27G.

## PCS Non-Covered Tasks and Services

*The information in this section references Clinical Coverage Policy 3L, Section 4.2*

PCS does **NOT** include the following services:

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. Instruments of daily living (IADL's) in the absence of associated Activities of daily living (ADL);
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 Plan of Care; and
14. Room and board.

**NOTE:** A beneficiary may not receive PCS and another substantially equivalent federal or state funded in conjunction with another substantially equivalent Federal or State funded service. Examples of equivalent services include but are not limited to home health aide services and in-home aide services in the Community Alternatives Programs (CAP/Disabled Adults, CAP/Children, CAP/Choice, and CAP Innovations).

Medicaid does not cover Personal Care Services (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 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 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 residence;
9. The PCS is performed by an individual who is the beneficiary's legal responsible person, spouse, child, parent, sibling, grandparent, grandchild, or equivalent step or in-law relationship to the beneficiary;
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.

Medicaid does 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 General Statutes and licensure rules and regulations.

## **Role of the Division of Medical Assistance (DMA)**

DMA is the state agency that administers Medicaid and is responsible for overseeing the PCS Program. In adherence to the PCS Policy and its contract with Liberty Healthcare of North Carolina, DMA is responsible for:

- Establishing the scope and amount of PCS to be provided, based on information entered into the independent assessment tool and according to the criteria in the PCS Policy.
- Enacting program and procedure changes as mandated by the North Carolina General Assembly.

## **Role of the PCS Provider Stakeholder Group**

The purpose of the PCS Provider Stakeholder group is to provide the opportunity for stakeholders in North Carolina who have an interest in the development and implementation of the Personal Care Services to collaborate and share their recommendations. The NC Department of Health & Human Services (DHHS) convenes on a monthly basis with community stakeholders to engage and seek their input. The meetings are designed to share project status, gather input and identify next steps. Stakeholder meetings are held every third Thursday of the month 1:00 p.m.-2:30 p.m. Meeting agendas, handouts, and minutes are available for download on the PCS webpage at <http://www.ncdhhs.gov/dma/pcs/pas.html>. Items and concerns you would like addressed during the stakeholder meetings should be submitted at least three days in advance of the regularly scheduled meetings with a notation "FOR STAKEHOLDER MEETING." Stakeholders should submit questions through the PCS mailbox at [PCS\\_Program\\_Questions@dhhs.nc.gov](mailto:PCS_Program_Questions@dhhs.nc.gov).

To get involved call 919-855-4360 or Email [PCS\\_Program\\_Questions@dhhs.nc.gov](mailto:PCS_Program_Questions@dhhs.nc.gov)

## **Role of the Independent Assessment Entity (IAE)**

As the IAE, Liberty Healthcare of North Carolina (LHC-NC) is under contract with the North Carolina Division of Medical Assistance (DMA) to conduct independent assessments for PCS. In accordance with the PCS Policy and its contract with DMA, Liberty Healthcare of North Carolina is responsible for:

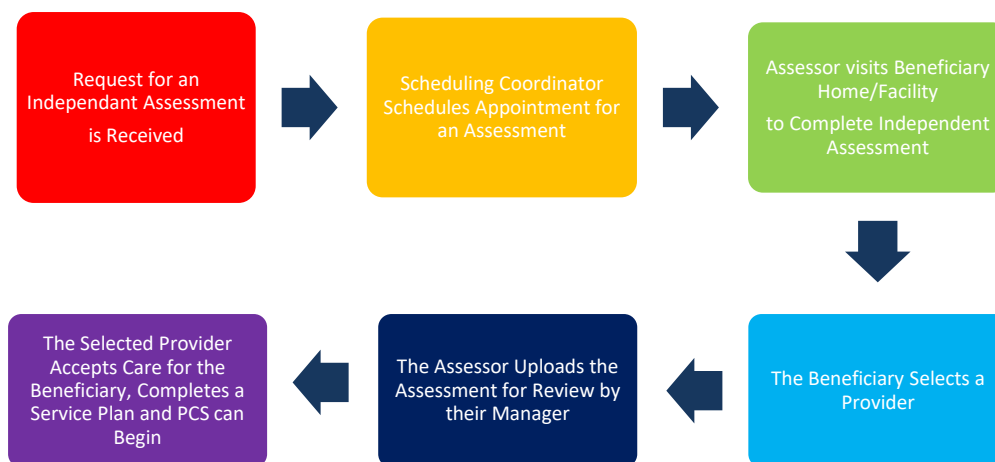
- Processing all PCS requests, including new referrals, expedited requests, change of status, and change of provider requests;
- Conducting all PCS assessments, including new admission assessments, annual reassessments, result of mediation assessments, and any other required assessments per policy or at the request of DMA;

- Determining the qualifying ADLs and the level of assistance required for each ADL task;
- Issuing notification letters to beneficiaries and PCS providers that inform them of the determination of need for PCS;
- Conducting provider training sessions and publish educational resources in order to advise providers about the PCS program and its processes;
- Providing customer assistance through our customer support center for any inquiries regarding PCS;
- Maintaining a website which beneficiaries, physicians, providers, and other referral sources can access important announcements, educational materials and PCS forms.

## PCS Independent Assessment Completion Process Overview

The PCS independent assessment completion process that is executed by the IAE is very complex and takes approximately 3-4 weeks to complete for each beneficiary who requests an independent assessment to be considered for PCS. Though complex, in summary, it can be broken down into 6 main steps from beginning to end; they are as follows:

1. **PCS Request** – The beneficiary has their primary care physician or attending physician complete the DMA Form 3051 Request for Independent Assessment for Personal Care Services and send it to LHC-NC for processing.
2. **Scheduling the Assessment** – Once a request has been processed, a Scheduling Coordinator will contact the beneficiary or facility for those residing in an ACH, and schedule a date for an Assessor to go to the beneficiary’s home or facility to complete the independent assessment.
3. **Performing the Assessment** – On the day of the scheduled appointment, the Assessor will go to the beneficiary’s home or facility and complete an assessment that will determine if the beneficiary is eligible for personal care services.
4. **Provider Selection and Acceptance** – At the conclusion of the assessment, the beneficiary is provided a randomized list of providers to select their provider of choice for services if they are approved for PCS.
5. **Assessment Review** – After provider selection, the assessment is uploaded and reviewed by the Assessor’s Manager for approval. Once approved, the Manager submits the assessment for hour calculation which is executed automatically by the current IT solution called QiRePort.
6. **Provider Acceptance and Notification** – If it is determined that the beneficiary is eligible for personal care services; the selected provider will be sent a request for service form to accept or reject the beneficiary’s request. Once the provider accepts the beneficiary for care and completes a service plan, a formal notification is sent to the beneficiary and to the provider and PCS services may begin.



# Chapter 1: Personal Care Service Provider Requirements

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## 1.1 General Requirements

*The information in this section references Clinical Coverage Policy 3L, Section 6.0 and 7.0*

In order to receive PCS referrals and to submit billing claims for services, providers shall:

1. Meet Medicaid qualifications for participation;
2. Have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
3. 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 Clinical Coverage Policy 3L:

- a. Felonies related to manufacture, distribution, prescription or dispensing of a controlled substance;
- b. Felony health care fraud;
- c. Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult;
- d. Felony or misdemeanor patient abuse;
- e. Felony or misdemeanor involving cruelty or torture;
- f. Misdemeanor healthcare fraud;
- g. Misdemeanor for abuse, neglect, or exploitation listed with the NC Health Care Registry; or
- h. 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.

To be eligible to bill for procedures, products, and services related to the Clinical Coverage Policy 3L policy, providers shall be:

- ✓ A home care agency licensed by the North Carolina Division of Health Services Regulation (DHSR) to operate in the county or counties where the PCS Services are being provided;
- ✓ A residential facility licensed by the DHSR 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
- ✓ A residential facility licensed under Chapter 122C of the General Statutes and defined under 10A NCAC 27G as a supervised living facility for two or more adults whose primary diagnosis is a developmental disability, or a developmental disability, or substance abuse dependency.

**IMPORTANT NOTE:** Please see full policy in Appendix D for complete listing of requirements.

## 1.2 Agency Staffing Requirements

In addition to the following requirements listed in section 1.1, providers are also responsible for complying with all staffing requirements outlined by their respective North Carolina licensing entity and the North Carolina Board of Nursing (available at [www.ncbon.com](http://www.ncbon.com)).

## 1.3 Registered Nurses (RNs)

PCS Home Care agencies must employ a qualified RN with a valid North Carolina license, who will be responsible for the following:

- Writing and updating the plans of care for all of the agency's PCS clients.
- Supervision of the agency's Continuous Quality Improvement (CQI) program.
- Maintaining agency complaint logs and service records.
- Supervising all in-home care aides and ensuring that the aides are delivering care consistent with the PCS plan of care, with the PCS policy, as well as federal and state practice laws.

Special PCS certification training for RNs is not required by DMA. However, providers must also maintain compliance requirements outlined in the North Carolina Home Care Licensure Rules (10A NCAC 13J.1003) and by the North Carolina Board of Nursing (available at [www.ncbon.com](http://www.ncbon.com)).

## 1.4 Supervision of PCS Aides

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

1. Supervising and ensuring that all services provided by the Aides under their 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. Supervision of the Provider Organization's CQI program;
3. Completion and approval of all service plans for assigned beneficiaries;
4. Implementing the service plan;
5. Maintaining complaint logs and service records in accordance with state requirements

## 1.5 Supervisory Visits in Beneficiary Private Residences

The In-Home PCS agency RN is responsible for conducting supervisory visits to each beneficiary's home every 90 days. Two visits per year must be completed while the PCS aide is scheduled to be in the beneficiary's home. The RN should conduct the first supervisory visit 90 days from the date of the first admission visit to the beneficiary's home, then every 90 days thereafter Clinical Coverage Policy 3L allows a 7-day grace period for these visits.

The RN Supervisor shall:

1. Confirm that the In-Home Aide is present and has been present as scheduled during the preceding 90 days.
2. Validate that the information recorded 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. Identify and document any new health or safety risks that may be present in the home.
6. Evaluate the beneficiary's satisfaction with services provided by the In-Home Aide and any services performed by the home care agency.
7. 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. Service plan deviations are documented;
  - d. Services, dates and times of services provided are documented on a daily basis;
  - e. Separate logs are maintained for all beneficiaries;
  - f. All occasions when the beneficiary was not available to receive services or refused services for any reason are documented in the service record, including the reason the beneficiary was not available or refused services; and
  - g. On a weekly basis, logs are signed by the In-Home Aide and the beneficiary
8. Document all components of the supervisory visits to include the date, arrival and departure time, purpose of visit, discoveries and supervisor's signature.

## 1.6 Supervisory Visits in Residential Settings

The Residential PCS Provider shall ensure that a qualified professional conducts a supervisor visit 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.

## 1.7 PCS Aides

Before hiring a new PCS aide, the provider agency is required to perform a criminal background check. This background check will include a review of the North Carolina Health Care Registry to determine if the potential employee has any substantiated findings for any criminal activity, including client neglect, stealing/selling drugs belonging to a provider, abusing/stealing a client's property, or fraud. The PCS Provider shall ensure that the In-Home and Residential Care Aides hired are not listed on the North Carolina Health Care Registry or as having a substantiated finding in accordance to the health care personnel registry G. S. 131E-256.

Additionally, 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 the Clinical Coverage Policy 3L:

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.

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). An individual file is maintained on all In-Home and Residential Aides that document aide training, background checks, documents 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, (Clinical Coverage Policy 3L, Section 7.10).

Additionally, the agency may not assign an aide to provide services to a beneficiary when the aide is related to the beneficiary (legally responsible person, spouse, parents, siblings, grandparents, or other “step-“ or “in-law” relationships) or in cases where the person lives with the beneficiary, regardless of relationship to the beneficiary (PCS Policy 3L, Section 4.2).

## **1.8 Non-Certified Personal Care Aides**

According to the North Carolina licensure rules, if an aide is not listed with the nurse aide registry, the agency must show that the aide is competent to assist with certain self-care tasks. Each agency must document in the aide’s personnel record that he/she is able to assist with:

1. Mobility: ambulation, bed mobility and transfers
2. Showering and bathing
3. Toileting and continence needs
4. Eating
5. Dressing

The RN for the agency must document that he/she has observed the aide assisting with these tasks. They must also document that the aide is competent to provide assistance with these ADLs. This requirement applies to all aides hired after April 1, 2009.

A PCS aide who has NA I or NA II certification may assist with Special Assistance tasks listed on the independent assessment, as long as the agency RN has endorsed/signed off on the aide’s competency with each task and as long as the aide is in compliance with the North Carolina Board of Nursing Practice Rules. A full list of NA I and NA II tasks can be found in the North Carolina Board of Nursing Practice Rules (21 NCAC 36.0403).

## **1.9 Certified Nurse’s Aide I and Certified Nurse’s Aide II (NA I, NA II)**

The provider is required to assign an aide who has completed and passed a certification program to beneficiaries who need extensive or greater assistance with more than two ADLs (i.e., an “extensive” rating is noted in the “Assessor’s Overall Self-Performance Capacity Rating” box in Sections H-L on the independent assessment). This is not applicable to a beneficiary who has “extensive assistance” marked for one or two individual ADL tasks, but has “limited” assistance marked in the “Assessor’s Overall Self- Performance Capacity Rating” box (North Carolina Home Care Licensure Rules, 10A NCAC 13J.1107).

Aides with NA I or NA II certification are considered competent to assist with Special Assistance tasks listed on the independent assessment.

## 1.10 Staff Development and Training

PCS Policy 3L requires providers to offer an orientation based upon licensure rules for all new hire staff for In-Home and Residential Aides. This orientation should include an overview of the PCS Policy and the North Carolina Home Care Licensure Rules. The agency must also offer ongoing training pertaining to the job responsibilities of each employee as well as the requirements of the Clinical Coverage (PCS) Policy 3L. This includes skill and competency training for all personal care aides. The agency must keep records of all training activities and staff orientation sessions conducted. Competency training and evaluations of the required competencies for In-Home and Residential Aides must provide competency training and evaluations as specified in 10A NCAC 13F and 13G, and, 10A NCAC 27G.

The agency administrator should be informed of regional training programs, conference calls and webinars which pertain to the PCS programs. These trainings may be offered by DMA, or its designee. Information regarding training sessions will be published on the DMA Personal Care Services webpage (<http://www.ncdhhs.gov/dma/pcs/pas.html>) and in the monthly Medicaid Bulletin. Information regarding training sessions sponsored by Liberty Healthcare of North Carolina will be available on their webpage (<http://www.nc-pcs.com>) under 'Training'. All staff members who have management responsibilities should plan to attend these regional training programs to insure the agency is compliant with all rules and procedures.

It is the responsibility of the agency administrator to be informed of staff training requirements related to the each employee's professional licensure, as well as the agency's licensure, which are separate from those outlined in the PCS Policy. Information on these requirements can be obtained from the North Carolina Board of Nursing ([www.ncbon.com](http://www.ncbon.com)) and from the DHSR Certification Section (<http://www.ncdhhs.gov/dhsr>).

### Training for Additional Safeguards

In accordance to N.C. Session Law 2013-306; Caregivers who provide services to beneficiaries receiving additional safeguards require training in caring for individuals with 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 language skills.

Providers must attest to the training of their caregiver staff to provide services by submitting the DMA 3085 – SL 2013-306 PCS Training Attestation Form to [DMA.PCSTraining@lists.ncmail.net](mailto:DMA.PCSTraining@lists.ncmail.net); please see Appendix E for a copy of this form or visit <http://info.dhhs.state.nc.us/olm/forms/dma/dma-3085-ia.pdf>

If providers do not have access to training curriculum that meets the aide training requirements of SL 2013-306, providers may use training made available through the N.C Division of Health Service Regulation licensure section or Liberty Healthcare Corporation Alzheimer's and Dementia Caregiver Center at <http://www.nc-pcs.com/Alzheimers/>. The Alzheimer's and Dementia Caregiver Center offers free individual on-line care training in dementia care through the Alzheimer's Association.

Providers must maintain record of the required training in the caregiver staff's personnel file.

## 1.11 Requirements for Aide Documentation

The provider organization accepting the referral to provide services shall:

- ✓ 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;
- ✓ Document aide services provided, to include, at minimum, the date of service, care tasks provided, and the aide providing the service; and
- ✓ Document all deviations from the service plan; this documentation shall include, at minimum, care tasks not performed and reason tasks were not performed.

**NOTE:** 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.

## 1.12 PCS Online Service Plan

All IAE referrals are transmitted to provider organizations through the Provider Interface; no mailed or faxed referrals are provided. The provider organization accepting the referral to provide services shall:

1. 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;
2. Provider organizations shall designate staff they determine appropriate to complete and submit the service plan via the Provider Interface.
3. 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.
4. 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.
5. 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.
6. 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.
7. 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.

8. The PCS service plan must be developed, and validated within seven (7) business days of the Provider accepting receiving the IAE referral.
9. 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.
10. 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.



11. 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.
12. 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.
13. 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.
14. Provider organizations shall be reimbursed only for PCS authorized hours and services specified and scheduled in the validated PCS service plan.
15. 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.  
**NOTE:** If an agency fails to complete their service plan and the beneficiary is discharged, changes providers, or becomes deceased, DMA will not authorize retro PA's for the beneficiary as PA's will not be released until the service plan has been completed and beneficiary/legal guardian consent is required for service plan approval.

There will be times when a PCS agency is unable to fulfill the requirement of the completion of a service plan within the provider interface. When the service plan hours do not match the total hours awarded in the assessment, a service plan will need to be completed outside of the system. The following scenarios would warrant the PCS Provider to complete a manual service plan outside of QiReport:

- EPSDT temporary summer hours are awarded;
- Mediation or court settlements (if different hours are awarded);
- Expedited assessments;
- Maintenance of Service (MOS) hours are not reflected in the previous year's assessment
- A Change of Provider request when the beneficiary has an active appeal; and
- A Change of Provider request and the beneficiary is currently approved for more hours than what is reflected in the provided assessment.

When creating a manual service plan, the PCS Provider shall:

- Complete their own assessment to determine task and frequency need and reflect those needs in their manual service plan;
- The service plan must reflect service for the total hours approved;
- Use a template of their choice to create a manual service plan; and
- The manual service plan must be uploaded to 'Supporting Docs' within 7 business days of acceptance.  
**NOTE:** Anytime a service plan must be completed outside of the system, a call is warranted to Liberty to process the assessment so PAs can be generated.

In addition to the exception of creating a manual service plan outside of the system, there are a few instances when the ability to create a service plan will be removed if not drafted within the 7 days allotted.

Scenarios of when a service plan will be removed if not completed in a timely manner include:

- The beneficiary requested a Change of Provider, but the old provider never completed the service plan; and
- The beneficiary is on MOS, went to mediation, reached a settlement, but the PCS Provider never completed the MOS Service Plan.

**NOTE:** For the two scenarios above, Liberty will call the PCS Provider and give them 1 day to complete the service plan before removal. Removal of the service plan will result in non-compliance to the service plan requirement and subject the PCS Provider to a Program Integrity audit.

### 1.13 Pre-Admission Screening and Annual Resident Review (PASRR)

The Preadmission Screening and Annual Resident Review (PASRR) is a review of any individual who is being considered for admission into a Medicaid Certified Adult Care Home. As required by the US Department of Justice Settlement Agreement effective January 1, 2013, individuals requesting admission to Adult Care Homes (ACH) must be pre-screened for serious mental illness (SMI). The North Carolina Department of Health and Human Services (DHHS) is the agency that provides a Level I screening, conducted by an independent screener for all applicants to Adult Care Homes licensed under G.S. 131D, Article 1 to identify beneficiaries with SMI.

Clinical Coverage Policy 3L (3.2.3b) remains in effect and requires that a Medicaid beneficiary residing in or applying for admission to an ACH be screened for serious mental illness using the PASRR prior to an assessment for PCS. Adult Care Home providers licensed under G.S. 131D-2.4 will not receive PCS prior approval to render or bill for PCS without verification of an ACH PASRR number. ACH PASRR numbers are 10 digits followed by any of the following letter codes:

Authorization Codes & Corresponding Time Frames/ Restrictions	
G	Dementia Primary (requires MD certification)
O	Level I : No evidence of SMI / SPMI
K	Level II: Evidence of SMI / SPMI
U	Level II : Medically unstable- Medical Needs cannot be met in ACH
R	Level II : Psychiatrically unstable -Behavioral Health Needs cannot be met in ACH
T	Time Limited : 6 Months (Terminal Illness Certification)

## PASRR Verification

Liberty Healthcare will verify a PASRR has been approved on every new ACH PCS request. Verification is confirmed through the NCMust system. If unable to verify a PASRR through the NCMust system, Liberty will call the facility in an attempt to obtain a PASRR. Liberty Healthcare will also send a letter to the beneficiary stating a PASRR is required for the processing of their PCS request. If a PASRR is not required, Liberty Healthcare will request the admission date (if prior to 1.1.13) through a copy of an FL2 or any other documentation that reflects the admission date or have the facility confirm they are a 5600a or 5600c.

If unable to obtain a PASRR within 30 business days of the PCS request, Liberty will send a letter of denial for PCS to the beneficiary. If the beneficiary still wishes to be considered for PCS, they may submit a new request after they have obtained a PASRR.

**NOTE:** Beneficiaries who reside in a 5600a or 5600c facility do not require a PASRR. Beneficiaries who have been admitted into an ACH prior to January 1, 2013, regardless of payer source (Private, Medicaid, or pending Medicaid) require no PASRR even if the beneficiary subsequently becomes Medicaid-eligible; however, if there is a change in status or if the beneficiary moves to another facility and requires Personal Care Services, a PASRR is required. To learn more about PASRR requirements, visit [www.ncmust.com](http://www.ncmust.com).

## Prior Approval (PA) Effective Dates and PASRR

If a PASRR is effective on the date the PCS request is received or prior, PAs will be effective the date the request is received. If the PASRR is received within 30 days from the request received date, then the PAs will become effective the date the PASRR became effective; please see the following table for further detail:

Date of Request	Completed?	Sent to Liberty Within 30 Days of Date of Request	PASRR Effective Date Prior to or Same as Date of Request?	PA Effective Date
8/1/17	✓ Yes	✓ Yes	✓ Yes	Date of the Request
Example		Sent on 8/2/17	PASRR Date 7/1/17	8/1/17
8/1/17	✓ Yes	X No	✓ Yes	Date Liberty RECEIVES the Request
Example		Sent on 9/12/17	PASRR Date 8/1/17	9/12/17
8/1/17	X No	✓ Yes	✓ Yes	Date the Corrected Request is Received
Example		Sent on 8/2/17	PASRR Date 8/1/17	See above comments
8/1/17	✓ Yes	✓ Yes	X No	Effective Date of the PASRR
Example		Sent on 8/2/17	PASRR Date 8/9/17	8/9/17

## 1.14 Change of Ownership

When an agency takes over the ownership of an existing agency, there is usually a delay between the date of receipt of an NPI and the date when the provider becomes an enrolled provider in NCTRACKS, which may prevent the processing of any new or existing PCS requests. The following steps will need to be followed each time there is a change in ownership to ensure proper processing and billing of PCS beneficiaries when their agency comes under new ownership.

### **New PCS Beneficiaries**

Liberty Healthcare of North Carolina will not issue prior approvals for new PCS beneficiaries who have selected a provider that is not enrolled in NCTracks. Although DMA Provider Enrollment will consider specific requests for retroactive effective dates of enrollment, providers are not guaranteed a retroactive effective date and are strongly encouraged to provide services only after they are enrolled as an N.C. Medicaid and/or N.C. Health Choice (NCHC) provider.

The provider should seek to enroll their NPI in NCTracks as soon as possible. DMA will not retroactively authorize PCS for new beneficiaries. PCS authorization may begin when the provider is active in NCTRACKS and a completed DMA 3051 Request for Independent Assessment has been received by Liberty Healthcare Corporation.

Providers should check their status of enrollment daily through NCTracks. As soon as the provider is active, they should contact Liberty Healthcare Corporation of N.C.

### **Current PCS Beneficiaries**

In the cases where an agency takes over ownership and there are beneficiaries who are currently receiving PCS under a previous provider, a Change of Provider Request (see Chapter 2) will need to be submitted by the new provider within 30 days of the effective date of ownership change. Once a Change of Provider Request is received, Liberty will process the request and retro the PAs to reflect the effective date of changed ownership. If a Change of Provider Request is sent in after 30 days of the new ownership, then Liberty will process the request and the PAs will be effective the date the request is received.

DMA does not guarantee that the submission of the DMA 3051 Request for Independent Assessment form guarantees a commitment to award or authorize PCS. Each issue will be reviewed case by case

For questions regarding your application to become enrolled in NCTracks or manage change requests submitted, you may contact NC Tracks at 800-688-6694 or by email at [NCTracksprovider@nctracks.com](mailto:NCTracksprovider@nctracks.com). If you are then directed to contact DMA, you should contact DMA Provider Enrollment at 919-855-4000.

## 1.15 Internal Quality Improvement Program

It is required that all agencies providing PCS have an established Internal Quality Improvement Program. The Quality Improvement Program should measure quality of care, service problems, and beneficiary satisfaction. The PCS agency is required to attest to an established Internal Quality Improvement Program annually (section 7.7). A DMA 3136 Internal Quality Improvement Program Attestation Form must be completed by December 31<sup>st</sup> of each year and sent to DMA. When completing the 3136 form, the agency must attest that they have implemented and are in compliance with the following:

- 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; and
- d. Maintain complete records of all CQI activities and results.

A copy of the DMA 3136 Internal Quality Improvement Program Attestation Form can be found in Appendix F.

## 1.16 QiReport - Provider Interface Overview

The Provider Interface is a secure, web-based information system called QiRePort that is managed by Viebridge, Inc. The Independent Assessment Entity uses this system to support the PCS Independent Assessment process. QiRePort was developed and is hosted by VieBridge, Inc. All PCS Providers are required to enroll in the Provider Interface.

The provider portal can be accessed at: [www.qireport.net](http://www.qireport.net) and allows registered agencies to:

- Access electronic copies of independent assessment documents, referrals, and notification letters;
- Receive service referrals and accept/reject them electronically;
- Create required PCS beneficiary service plans;
- Manage servicing beneficiaries' accounts, including access to historical assessments and PA's;
- Submit discharges;
- Submit Non-Medical Change of Status Requests;
- Manage servicing territories;
- Change provider billing numbers for clients who need to have their service transferred from one provider office to another within the same agency;
- Update/Correct Modifiers;
- Receive electronic notification once a current client has entered an appeal, as well as the status of the appeal once it is resolved; and
- Receive electronic notification of upcoming annual assessments for beneficiaries.

### Portal Registration

PCS providers are required to be registered with QiRePort in an effort to keep all personal health information secured through electronic exchange. In order to get registered and gain access to the provider portal through QiRePort, a PCS provider would need to follow these three steps:

1. Have a registered NCID; for more information on NCID, visit <https://www.ncid.its.state.nc.us/>
2. Complete a Provider Registration Form (see Appendix C for a copy of this form or visit <https://www.qireport.net> ) and submit to Viebridge, Inc. via the following:  
**Fax:** 919-301-0765  
**Email:** [support@qireport.net](mailto:support@qireport.net)  
**Mail To:** 8130 Boone BLVD, STE 350, Vienna, VA 22182
3. Log in!

## Usage Requirements

Internet access is required in order to use the Provider Interface of QiRePort. Users should access the site using an Internet Explorer or Firefox web browser. Adobe Acrobat reader is also required in order to read documents that are transmitted in PDF format. A free version of this software can be downloaded from the Adobe website. Finally, it is important that you set your browser to allow “pop-ups” to appear when you are accessing QiRePort. Pop-ups are boxes that appear to display information or allow entry of data.

A complete user guide to the Provider Interface is available on the Home Page of QiRePort. Click the “Getting Started” link to access the guide.

## Privacy Requirements

Provider usage of QiRePort is governed by the Health Information Portability and Accountability Act (HIPAA). Users are responsible for ensuring that this information remains secure, since the system transmits Protected Health Information (PHI) electronically. Violations of HIPAA are punishable under federal law.

In order to protect beneficiary information, you should:

- Have your own user name and password and keep your password secure.
- Lock your workstation every time you leave your desk.
- Use timeouts for screen displays and change your computer’s system settings to require a password to return to work once the screensaver appears.
- Log out of QiRePort as soon as you finish your session.
- Lock and limit access to any devices (USB drives, CDs, etc.) used to save records from QiRePort.

## Portal Navigation and Usage

For all training materials regarding navigation through the portal and execution of tasks in the provider portal, please reference the training materials listed under the ‘Training Resources’ link in the left hand tool bar of the provider portal.

## Chapter 2: Request for Independent Assessment for Personal Care Services

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Beneficiaries requesting Personal Care Services must submit a Request for Independent Assessment for PCS 3051 form to Liberty Healthcare. The 3051 form allows a beneficiary to be considered for:

- ✓ Approval for PCS
- ✓ Change of Status Medical/Non-Medical (increase or decrease of services)
- ✓ Additional Safeguards
- ✓ Change of Service Provider
- ✓ Expedited Requests for PCS

A copy of the 3051 form can be found in Appendix A of this manual or by visiting <http://www.nc-pcs.com/Medicaid-PCS-forms/>. Once completed, the 3051 form can be submitted to LHC-NC via fax at 919-307-8307 or 855-740-1600 (toll free). Forms may also be sent via mail to 5540 Centerview DR, Suite 114, Raleigh, NC 27606.

Once received, all requests are reviewed and processed within 2 business days. If a beneficiary, physician, or PCS provider wishes to inquire about the receipt and status of a PCS request, LHC-NC asks they call **AFTER** the 2 business day processing period.

### 2.1 New Request for Independent Assessment for PCS

In accordance with Clinical Policy 3L, section 5.4.2, the beneficiary shall be referred to PCS by his or her primary care or attending physician; the signing physician must be a Medical Doctor (MD), Nurse Practitioner (NP), or a Physician's Assistant (PA).

The beneficiary's Primary Care Physician (PCP) should complete the request in most cases. If the beneficiary is in a rehab facility or the hospital, the facility's attending physician may submit the request form. If the beneficiary does not have a PCP, the physician who is treating the beneficiary's health problem that is related to the need for PCS should submit the referral. If the beneficiary has not been seen by their physician during the past 90 calendar days, he or she must schedule an office visit to request a referral for a PCS eligibility assessment. The beneficiary, the beneficiary's family or legally responsible person is responsible for contacting the PCP or attending physician to request a referral for PCS.

**NOTE:** If a beneficiary is already enrolled in the PCS Program, a new referral should not be requested. A Change of Status Medical/Non-Medical request form should be submitted if a beneficiary requires another independent assessment due to a change in medical condition or functional status. The provider, physician or the beneficiary may submit a Change of Status request form (see section 2.2, "Change of Status Requests", for more details).

#### 2.1.1 Completing a New Request

In order for the 3051 Request for Independent Assessment form to be approved for eligibility and processed timely, all required sections of the form must be completed and legible. Incomplete request forms may result in a delay of processing or denial of the request. To ensure the 3051 request form is processed timely, the following sections of the referral form must be completed by a practitioner only:

- ✓ **Section A, Beneficiary Demographics** – Required fields are as follows:
  - Date of Request
  - Medicaid ID – Only those with active Medicaid are eligible for PCS; eligibility status is verified prior to the processing of any request for an independent assessment.
  - Demographic Information - Beneficiary name, date of birth, contact information
  - ACH PASRR number (beneficiaries who reside in an Adult Care Home setting only)
  - Indication if the beneficiary has an active Adult Protective Service Case
  
- ✓ **Section B, Beneficiary's Conditions that Result in Need for Assistance with ADLs** – Required fields are as follows:
  - Medical diagnosis with corresponding complete current diagnosis code
  - Indication if the diagnosis listed impacts the beneficiary's ability to perform their ADLs - Diagnoses must impact ADLs or the request for an independent assessment will not be processed (Clinical Policy 3L, section 5.4.2)
  - Date of Onset
  - Indicate expected duration of ADL limitation
  - Check if the beneficiary is medically stable
  - Check if 24-hour caregiver availability is required

**Optional Attestation** – If the criteria listed in this section is applicable to the beneficiary, the practitioner should hand initial each line item that applies for consideration in the assessment for PCS; typed initials are not accepted.

**NOTE:** Diagnosis Header Codes will not be accepted. The complete and accurate current diagnosis code, ex. XXX.X or XXX.XX, associated with the identified medical diagnosis must be present.

- ✓ **Section C, Practitioner Information** – Required fields are as follows:
  - Date of Last Visit to Referring Practitioner – The beneficiary must have seen their PCP within the last 90 days to be eligible for PCS.
  - Attesting Practitioner Name and NPI#
  - Practice Information – Practice Name, NPI#, and contact phone number
  - Practitioner Attestation for Medical Need – Signature, Credentials and Date – Must be signed by a MD, NP, or PA. If credentials are not included or cannot be verified, the request will not be processed.

**NOTE:** A PCS provider may assist a beneficiary in the completion of the 3051 form, but responsibility of submission of the form to LHC-NC rests with the beneficiary and the referring practitioner.

## 2.1.2 Expedited Request for Personal Care Services

Effective January 2014, the NC Division of Medical Assistance (DMA) approved an expedited assessment process to provisionally approve beneficiaries for Medicaid PCS. The PCS expedited process determines beneficiary provisional eligibility and the authorized service level pending the completion of the full independent assessment conducted by Independent Assessment Entity (IAE) Assessors.



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

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

**NOTE:** \*PASRR is required for beneficiaries seeking admission to an Adult Care Home licensed under G.S. 131 D-2.4.

In addition, an expedited PCS request may only be submitted by one of the following:

- A Hospital Discharge Planner;
- An Adult Protective Services (APS) Worker;
- A Nursing Home Discharge Planner; or
- An approved LME-MCO Transition Coordinator.

## **The Expedited Assessment Completion Process**

If eligibility requirements are met, a hospital discharge planner, skilled nursing facility discharge planner, Adult Protective Services (APS) worker, or LME-MCO Transition Coordinator may request an Expedited Assessment by faxing a completed Request for Independent Assessment for PCS 3051 form (see section 2.1.1 for complete criteria) to Liberty Healthcare at 919-322-5942 or 855-740-0200 (toll free) followed by a call to LHC-NC at 855-740-1400.

**NOTE:** Expedited assessments for beneficiaries seeking placement in an ACH (not 5600s) will require a PASRR number for the processing of an expedited request.

Once the fax is submitted, the requestor will contact LHC-NC Customer Services Center to follow up on expedited request that was faxed. The Customer Service Team Member will review and immediately approve or deny the expedited assessment based on eligibility requirements only. **If approved to move forward:**

1. The caller will be transferred to a Request Processor who will process the request.
2. Once processed, the Request Processor will transfer the call to a Liberty Healthcare nurse who will conduct a brief telephone assessment comprised of fifteen questions directly related to the 5 ADLs.
3. If eligible for PCS based off the telephone assessment, the beneficiary will be immediately awarded temporary hours for PCS services and a letter will be sent to the selected PCS Provider.
4. If a PCS Provider is not identified, Liberty will provide a randomized list of providers for selection by the beneficiary and then send a request for service to the selected provider.
5. Following the expedited process, LHC-NC will contact the beneficiary within 14 business days to schedule and complete an independent assessment in the beneficiary's place of residence.

## **Personal Care Services Provisional Approval**

A beneficiary approved through the expedited assessment process may receive a minimum of 35 hours and up to 60 hours of services during the provisional period, not to exceed a 60-day period.

Beneficiaries will not receive PCS authorization without active Medicaid eligibility. If a beneficiary is provisionally approved for PCS through the expedited assessment process, but is determined not to be Medicaid eligible, Liberty Healthcare will hold the authorization for up to 60 calendar days. If after 60 days Medicaid eligibility is not approved, the beneficiary will receive a technical denial for PCS.

### 2.1.3 Incomplete New Requests and Denials

If the request form is missing any of the required information listed in section 2.1.1, Liberty Healthcare will fax an “Unable to Process” notice to the referring entity to alert them that the request form is incomplete and missing required information. If a response is not received from the referring entity within two business days, Liberty will file the form as incomplete. A denial notification will be sent to the beneficiary and a copy is faxed to the practitioner.

In addition, if all information is provided, but the beneficiary does not meet the eligibility criteria in accordance with Clinical Policy 3L, then the beneficiary and physician will also receive a notice of denial; non-qualifying factors would include:

- The date of the last Physician visit is greater than 90 days
- The referring entity has indicated that the beneficiary is not medically stable
- Diagnosis does not impact the ADLs

**NOTE:** The beneficiary has the right to appeal a denial decision based on the incomplete request. The beneficiary’s copy of the denial notice contains instructions and the necessary form for submitting an appeal. In addition, communication regarding an incomplete request is limited to the referring entity and the beneficiary only; communication does not occur with any PCS provider agencies.

## 2.2 Change of Status (COS) Requests

A Change of Status request may be submitted to LHC-NC for an existing beneficiary who is currently authorized for PCS when there has been a change in medical condition, environmental condition or location, or caregiver status that causes the need for assistance to increase or decrease. For any change of status that is due to a change in medical condition, a Change of Status Medical request may be submitted by a practitioner only. For any change in status that is due to a change in the beneficiary’s environmental condition, location, or caregiver status, the beneficiary, beneficiary’s family, or legally responsible person, residential provider, home care provider; or beneficiary’s physician may submit a Change of Status Non-Medical request. A Medical and Non-Medical Change of Status request may be submitted anytime by the approved referring entity when appropriate.

**NOTE:** Beneficiary consent is required for the submission of a COS request. PCS Providers and Physicians must obtain permission from the beneficiary to submit on their behalf.

### 2.2.1 Completing a Change of Status Medical Request

A Change of Status Medical Request may only be submitted by a practitioner any time a beneficiary has a change in medical condition and their treating practitioner feels an increase or decrease in PCS should be evaluated. In order to submit a Change of Status Medical request, the practitioner must complete the Request for Independent Assessment for PCS form (3051) and fax or mail a copy to Liberty Healthcare.

The following sections are required fields that should be completed when submitting a COS Medical Request:

- ✓ **Section A, Beneficiary Demographics** – Required fields are as follows:
  - Date of Request
  - Medicaid ID – Only those with active Medicaid are eligible for PCS; eligibility status is verified prior to the processing of any request for an independent assessment
  - Demographic Information - Beneficiary name, date of birth, contact information
  - Indication if the beneficiary has an active Adult Protective Service Case
  
- ✓ **Section B, Beneficiary's Conditions that Result in Need for Assistance with ADLs** – Required fields are as follows:
  - Medical diagnosis with corresponding complete current diagnosis code
  - Indication if the diagnosis listed impacts the beneficiary's ability to perform their ADLs - Diagnoses must impact ADLs or the request for an independent assessment will not be processed (Clinical Policy 3L, section 5.4.2).
  - Date of Onset
  - Indicate expected duration of ADL limitation
  - Check if the beneficiary is medically stable
  - Check if 24-hour caregiver availability is required

**Optional Attestation** – If the criteria listed in this section is applicable to the beneficiary, the Practitioner should hand initial each line item that applies for consideration in the assessment for PCS; typed initials are not accepted.

**NOTE:** Diagnosis Header Codes will not be accepted. The complete and accurate current diagnosis code, ex. XXX.X or XXX.XX, associated with the identified medical diagnosis must be present.

- ✓ **Section C, Practitioner Information** – Required fields are as follows:
  - Date of Last Visit to Referring Practitioner– The beneficiary must have seen their PCP within the last 90 days in order to process a COS Medical Request
  - Attesting Practitioner Name and NPI#
  - Practice Information – Practice Name, NPI#, and contact phone number
  - Practitioner Attestation for Medical Need – Signature, Credentials, and Date – Must be signed by a MD, NP, or PA. If credentials are not included or cannot be verified, the request will not be processed.

**Section D, Change of Status: Medical** - The requesting practitioner must complete this section providing a detailed description of the specific change in medical condition and the impact the change has on the beneficiary's ability to perform their ADLs.

## 2.2.2 Completing a Change of Status Non-Medical Request

PCS Providers who are registered to use the Provider Interface of QiRePort may complete a Change of Status Non-Medical request and submit the form online through the portal. All other requestors may complete the Request for Independent Assessment for Personal Care Services (3051) form and fax or mail a copy to Liberty Healthcare.

When submitting the 3051 form, the requestor must complete page 3 only, filling out the top demographic section and section E with the required fields being as follows:

- ✓ **Beneficiary Demographics** – Required fields are as follows:
  - Date of Request
  - Medicaid ID – Only those with active Medicaid are eligible for PCS; eligibility status is verified prior to the processing of any PCS request form.
  - Demographic Information – Beneficiary name, date of birth, contact information
  
- ✓ **Section E, Change of Status: Non-Medical** – Required fields are as follows:
  - ‘Request By’ along with ‘Requestor Name’
  - PCS Provider NPI#, Name, and Phone
  - Reason for non-medical change requiring a reassessment checked
  - Non-medical change described in detail and how the change impacts the beneficiary’s ability to perform ADLs

**NOTE:** DMA or DHHS designated contractor retains sole discretion in approving or denying requests to conduct a change of status reassessment. It is important that the description section include documentation of the change in the beneficiary’s medical condition, informal caregiver availability, environmental condition that affects the individual’s ability to self-perform, the time required to provide the qualifying ADL assistance and the need for reassessment. Change of status assessments are face-to-face assessments that are conducted by the designated IAE.

### 2.2.3 Incomplete Change of Status Requests and Denials

Change of Status Request forms that are missing information or are completed on the wrong form will not be processed; this will result in a delay of the independent assessment scheduling.

If the beneficiary’s physician or the provider agency has submitted a Change of Status request form that is missing information required for processing, Liberty Healthcare will fax an “Unable to Process” notice to the individual who submitted the request. If requested information is not provided in two business day, LHC-NC will file the request as incomplete.

If the Change of Status request form is missing a description of the change in the client’s condition and/or proper documentation of the need for a reassessment, Liberty Healthcare will issue a notice of denial that is sent to the beneficiary. If the provider submitted the request using the Provider Interface of QiReport, a “Rejected” status will appear on the “Requests Submitted” page. If the Provider clicks the hyperlink, the PCS request rejection reason can be viewed.

**NOTE:** This is not a denial of currently authorized services; it is a denial of the Change of Status request only. The PCS provider should continue services at the currently authorized, approved level.

## 2.3 Requesting Additional Safeguards

A Medicaid beneficiary who meets the eligibility criteria in accordance with Clinical Policy 3L, Section 3.0 and Section 5.3 may be eligible for up to 50 additional safeguard hours of Medicaid Personal Care Services per month if the beneficiary:

- Requires an increased level of supervision (observation resulting in an intervention) as assessed during an independent assessment conducted by State Medicaid Agency or entity designated by State Medicaid Agency;
- 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;
- Regardless of setting, requires a physical environment that addresses safety and safeguards the beneficiary because of the recipient's gradual memory loss, impaired judgment, disorientation, personality change, difficulty learning, and loss of language skill; and
- Medical 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.

To initiate the process for consideration of additional safeguard hours in addition to the base maximum allowance of PCS (80 hours), a beneficiary must have his/her Primary Care Physician or Attending Physician complete the optional attestation portion in Section B of the 3051 form in addition to the required sections depending on type of request. Additional Safeguards may be requested with a new request or a change of status medical. It is important for the Primary Care Physician or Attending Physician completing the request to note any pertinent medical diagnoses that may have caused the need for additional safeguards.

**NOTE:** At the discretion of DMA or LHC-NC, additional medical documentation may be requested in order to validate the physician attestation. A beneficiary does **NOT** have to be a current PCS recipient in order to be considered for additional safeguards.

## 2.4 Change of Provider (COP) Requests

A PCS beneficiary has the right to change their PCS provider at any time. Only the beneficiary or a caregiver who has Power of Attorney or Legal Guardianship for the beneficiary can submit a Change of Provider request. A COP request may be submitted using the 3051 form or the beneficiary may call the Customer Support Center for Liberty Healthcare of NC at 855-740-1400.

**NOTE:** PCS providers, physicians and non-designated family members may **NOT** submit a Change of Provider request. **The only exception is a transfer or planned transfer of a beneficiary from one licensed residential facility to another licensed residential facility.**

### 2.4.1 Completing a Change of Provider Request via Phone

If the beneficiary wishes to change his/her provider, only approved persons may call the Customer Support Center with Liberty Healthcare at 919-322-5944 or 855-740-1400 (toll free) to make this request. The caller will be asked a series of questions before proceeding with processing the COP request to determine if the COP should be expedited or processed following the standard process. Once the purpose for change is understood, the Call Center Representative (CCR) will inquire about the new provider of choice. If the beneficiary does not have a provider selection, then the CCR will generate a randomized provider list and recite the provider options in the order listed to assist with the selection process.

**NOTE:** All COP phone requests are recorded. If the CCR is unable to confirm beneficiary identity or obtain the proper approval to process the COP request then the COP request may be delayed.

## 2.4.2 Completing a Change of Provider Request via the 3051 Form

Though strongly encouraged to call the Customer Support Center for all COP requests, a beneficiary may also submit their Change of Provider request by using the 3051 form.

**NOTE:** Only in cases where a beneficiary is moving from one facility to another may the facility submit a Change of Provider request on behalf of the beneficiary.

When submitting the 3051 form, the beneficiary must complete page 3 only, filling out the top demographic section and section F with the required fields being as follows:

- ✓ **Beneficiary Demographics** – Required fields are as follows:
  - Date of Request
  - Medicaid ID – Only those with active Medicaid are eligible for PCS; eligibility status is verified prior to the processing of any PCS request form.
  - Demographic Information - Beneficiary name, date of birth, contact information
  
- ✓ **Section F, Change of Provider Request** – Required fields are as follows:
  - ‘Requested by’ indicated, along with name and contact information
  - Reason for Provider Change
  - Beneficiary’s Preferred Provider Section, including:
    - Setting Type
    - Agency Name, Address, and Phone
    - PCS Provider NPI#
    - Facility License # and Date if applicable

Once completed, the beneficiary or facility may fax the completed form to 919-307-8307 or 855-740-1600 (toll free) or mail it to 5540 Centerview DR, Suite 114, Raleigh, NC 27606.

## 2.4.3 Processing the Completed Change of Provider and Provider Acceptance

All COP requests are processed within 2 business days. If a beneficiary is submitting the COP and it is not a facility change, they should expect a call from Liberty Healthcare within 2 business days to confirm the request and process the COP. Once Liberty Healthcare has processed the request, the newly requested provider will receive a Change of Provider referral that includes a copy of the most recent independent assessment. After the new provider accepts the referral, the “old provider” will receive a letter by fax notifying them that the beneficiary has submitted a change in agencies. It also states that the agency must discharge the beneficiary in 10 days. The new provider may not begin services for the beneficiary or bill for services, before the date listed on the notification letter.

A new assessment shall not be required unless a change of status has occurred. The IAE shall furnish the new provider with a copy of the assessment and the new service authorization. The new PCS Provider shall develop and implement a service plan within 7 business days of accepting the referral (Clinical Policy 3L, section 5.4.11).

## Expedited Processing vs. Standard Processing

The standard processing timeframe on a Change of Provider request is 10 business days from the date of provider acceptance. LHC-NC will send a notification letter to the 'new' PCS provider to inform them of the date they may begin services. In exception to this rule, there are a few scenarios that require a COP to be processed in an expedited manner so the PCS beneficiary does not have their services interrupted; those scenarios are as follows:

- The PCS agency is closing
- The beneficiary has relocated to a new facility
- There is Adult Protective Service involvement

Expedited Change of Provider referrals have a one-day authorization effective date. This means that the referral letter will state, *"The effective date of this beneficiary's authorization will be the first business day following Liberty Healthcare's receipt of your acceptance to provide services."* Please make every effort to accept or decline the referral within 1-2 business days to prevent a lapse in service for the beneficiary. The authorization date will be specified in the notification letter. Providers will not be compensated for services provided before the authorization date indicated in the notification letter.

**NOTE:** PCS agencies that are closing should notify DHHS, Provider Enrollment and Liberty Healthcare as far in advance of the closing date as possible. The agency should fax a list of all current beneficiaries, along with contact information for each beneficiary to Liberty Healthcare. Liberty Healthcare will then contact each beneficiary to complete a Change of Provider request for each client. The beneficiary may also call Liberty Healthcare to submit the request. It is important that the beneficiary states the reason for the request is that the current agency is closing.

## Change of Provider vs. New Requests

It is often confused as to when a provider agency should submit a new request versus a change of provider for a beneficiary who has come under their care; please see the following table that outlines the appropriate request that is required based off the particular scenario and the processing time for each:

Beneficiary moves from:	Required Request Type
ACH to ACH	COP request – Effective in 1 day
IHC to IHC	COP request – Effective in 10 days
IHC to ACH	New Request – Effective date is the date of the new request if within 10 calendar days from the date the IAE received the request form.
ACH to IHC	New Request – Effective date is the date of the new request if within 10 calendar days from the date the IAE received the request form.

## 2.5 Reconsideration Request for Initial Authorization for PCS

A beneficiary, 21 years of age or older, who receives an initial approval for more than 0, but less than 80 hours per month may submit a Reconsideration Request Form to the IAE if they do not agree with the initial level of service determined (Clinical Coverage Policy 3L, section 5.6).

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

- ✓ The beneficiary received an initial approval for PCS within the last 60 days (see date on mailed notification);
- ✓ The hour award was more than 0 but less than 80;
- ✓ The request for more hours is not based on a Change of Status (see section 2.2 of this manual);
- ✓ The request was submitted to Liberty within 31 to 60 days from the initial approval date; and
- ✓ The beneficiary is able to provide supporting documentation that explains and supports the need for additional hours.

### 2.5.1 Completing the DMA 3114 Request for Reconsideration of PCS Authorization Form

In the case where a beneficiary wishes to have their initial approval of hours reconsidered, they will need to complete the 'DMA 3114 Request for Reconsideration of PCS Authorization Form' (see Appendix G for a copy of the form and instructions). The IAE will only accept/process forms that have been completed with the following required information:

- ✓ **Section A: Beneficiary Demographics** – Required fields are as follows:
  - Beneficiary Name (first and last)
  - Date of Birth
  - Medicaid ID
  - Contact Information
- ✓ **Section B: Reconsideration** – Required fields are as follows:
  - The ADL(s) indicated that are not being supported by the current authorized hours; or
  - A brief description of why the beneficiary is requesting reconsideration.
- ✓ **Section C: Supporting Documentation** – Supporting documentation is required for processing of a reconsideration request.
- ✓ **Medicaid Beneficiary or Legal Guardian/POA signature**

Once completed, the beneficiary may fax the completed form to 919-322-5942 or 855-740-0200(toll free) or mail it to 5540 Centerview DR, Suite 114, Raleigh, NC 27606.

**NOTE:** Incomplete, illegible, or requests submitted without supporting documentation as indicated above, will not be processed. A reconsideration request is not considered complete without supporting documentation as indicated in PCS Policy 3L 5.6 (c and d).



## 2.5.2 The Reconsideration Process

- a. After receiving an initial approval for an amount of hours more than 0, but less than 80 hours per month, a beneficiary must wait 30 calendar days from the date of notification to submit a reconsideration request form.
- b. The beneficiary must submit a reconsideration request form, along with supporting documentation, 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. Upon receipt of a completed Reconsideration Request for additional hours, a nurse will review the request and determine if a reassessment is required or if the previous assessment should be modified.
- d. If a reassessment is required, the beneficiary will receive a call from the IAE within 7 business days to schedule. If the nurse determines the previous assessment needs to be modified, modification will be executed within 3 business days.
- e. 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 the beneficiary will receive this approval letter with no adverse notice or appeal rights provided.
- f. If the reconsideration determines that the PCS hours authorized during the initial assessment are sufficient to meet the beneficiary's needs, an adverse decision will be sent to the beneficiary with appeal rights.

**Note:** The above process does not apply to beneficiaries seeking the additional safeguard hours as documented in subsection 5.3.1.b of Clinical Coverage Policy, 3L (see Appendix D for a copy of the full policy).

## 2.6 Short-Term Increase Request for PCS (EPSDT)

When Medicaid beneficiaries under 21 years of age require a short-term increase in their currently authorized hours for Personal Care Services (PCS), a request may be submitted by completing the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Short-Term Increase Request Form (DMA 3116). Medicaid's EPSDT benefit may cover these short term increases when they are determined to be medically necessary.

A short-term increase in hours may be requested for the following reasons:

- Extended school holidays (may include teacher work days or early release)
- Summer and track-out sessions
- Primary caregiver temporarily unable to provide care due to extenuating circumstances (hospitalization, surgery, etc.) – Medical documentation must accompany request

Requests must be submitted **14 business days** prior to the start date of the requested increase.

A work schedule and disability verification is required for any and all legally responsible individuals (e.g. mother, father, legal guardian, etc.). Work verification must be on company letterhead and include the specific work days and hours for the parent, legal guardian, or other responsible individual. The work verification must include the supervisor's contact information and signature. The employer will be contacted and employment verified. Disability verification must be completed and signed by a physician with an explanation of the parent, legal guardian or other responsible individual's inability to perform the hands-on-care needs of the child.

**NOTE:** Medicaid does not cover PCS when other family members or other informal caregivers are willing, able, and available on a regular basis to meet the need for PCS. Requests submitted without work schedule or disability verification will be denied.

All requests are to be submitted to the Division of Medical Assistance (DMA) via fax at 919-715-0102. Requestors may contact DMA EPSDT nurse consultants with questions at 919-855-4360.

## Chapter 3: The Independent Assessment

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In accordance with Clinical Coverage Policy 3L, section 5.4.2, once ordered by the beneficiary's physician, the PCS assessment shall be performed by an IAE Assessor at the beneficiary's home or residential facility. The requirements for the PCS Eligibility Assessment are as follows (Clinical Coverage Policy 3L, section 5.4.3):

- ✓ 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.
- ✓ All PCS assessments shall be performed by Independent Assessors.
- ✓ All assessments shall be face to face and conducted in the beneficiary's home or residential facility.
- ✓ 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 shall include verification of a valid facility license.

Though an independent assessment may be conducted for various reasons, the process and assessment of the beneficiary remains the same. An assessment may be conducted at any time at the discretion of the current IAE or DMA for, but not limited to, the following reasons:

- Admission Assessment
- Annual Assessment
- Expedited Assessment
- Change of Status Medical/Non-Medical Assessment
- ROM (assessment as a result of a mediation or appeal)
- Turning 21 Assessment
- Reconsideration Reassessment

### Admission Assessment

New requests are to be submitted for beneficiaries who are currently not receiving PCS or beneficiaries who have switched their residency type (IHC to ACH or ACH to IHC). A new assessment is scheduled within 14 days from the date the request is reviewed and approved for PCS eligibility by a Request Processor.

### Annual Assessment

Annual assessments will be conducted for beneficiaries who are currently receiving PCS; these assessments must be scheduled and conducted within 365 days of their last assessment. Liberty begins outreach as early as two months prior to the beneficiary's annual due date to ensure timely scheduling and to ensure there is no lapse in service. **NOTE:** PCS Providers will receive an electronic notification posted on their portal which informs them of the beneficiary's need for a reassessment and the annual due date.

## **Expedited Assessment**

Expedited assessments may be conducted for beneficiaries who are medically stable and being discharged from a hospital, Skilled Nursing Facility, or Adult Protective Services. These assessments are conducted by a Liberty Healthcare Assessor over the telephone. The mini expedited assessment is followed with a full assessment in the beneficiary's home or residential facility that occurs within 14 business days of the completed mini expedited assessment.

## **Change of Status Medical/Non-Medical Assessment**

A Change of Status (COS) Assessment can be requested by the beneficiary, their physician, or PCS provider. A COS is submitted if the beneficiary would like to request additional PCS hours or a decrease in PCS hours as a result of a change in their medical condition, residency, or informal caregiver status. If the request is approved, the Scheduling Coordinator will schedule this assessment within 12 business days from the date the request was approved by a Request Processor.

## **ROM - Assessment as a Result of a Mediation or Appeal**

As a result of receiving a denial or reduction in services, also known as an adverse decision, the beneficiary has the right to appeal. In certain cases, another assessment will be scheduled and conducted in order to have an up to date assessment available in the mediation process; these assessments will be scheduled within 7 business days from the date of the assessment request or prior to mediation, whichever occurs first.

**NOTE:** In most instances, the ROM assessment will be scheduled with a different Assessor than who completed the appealed assessment to ensure objectivity.

## **Turning 21 Assessment**

When a PCS beneficiary is turning 21, and therefore no longer eligible for EPSDT, they must be reassessed under the provisions for an adult recipient in the PCS program. An assessment is required within 30 days of their 21<sup>st</sup> birthday.

## **Reconsideration Reassessment**

A beneficiary, 21 years of age or older, who receives an initial approval for more than 0, but less than 80 hours per month may submit a Reconsideration Request Form to the IAE if they do not agree with the initial level of service determined. If the 'Reconsideration Request Review Nurse' determines a reassessment is required to determine level of need, then a reconsideration reassessment will be scheduled.

## 3.1 The Assessment Scheduling Process

The Request Processors review and approve new or Change of Status requests for PCS before the request is sent to the scheduling department so an assessment may be scheduled.

**NOTE:** Eligibility is verified for each beneficiary prior to the scheduling of an assessment.

After receipt, the Scheduling Coordinator (SC) will attempt to reach the beneficiary or his or her authorized representative to schedule the assessment. The SC will ask whether he or she wishes to have a trusted person with knowledge of the beneficiary's condition present during the assessment. If the beneficiary or authorized representative elects to have a person there the SC will make reasonable efforts with the beneficiary/authorized representative to schedule the assessment for a date and time when the selected person may attend the assessment and provide information to the assessor. SC will make three attempts to contact the third person that has been selected by the beneficiary/authorized representative to schedule the assessment.

If the attempt to contact the beneficiary is unsuccessful on the first attempt, a total of three attempts will be made within a 10 business day period. After three contact attempts, if contact is unsuccessful, a technical denial will be issued and a denial of service letter will be sent to the beneficiary. If contact is successful, then the SC will proceed with scheduling the assessment for a day that is most convenient for the beneficiary and if at all possible prior to the indicated due date.

**NOTE:** If a beneficiary is not available for their assessment within 30 days of the indicated due date, then their request for PCS will be removed and a new request will be required when they are available to participate in the full assessment process.

Assessments are scheduled on weekdays only with appointment times between the hours of 8:30am and 4:00pm and may take up to 90 minutes to complete. When requested, exceptions to both scheduled day and time may be considered if the schedule of the Independent Assessor in that specific region permits.

### 3.1.1 Cancellations and Reschedules

When a beneficiary or facility needs to reschedule or cancel a scheduled assessment, LHC-NC requests the cancellations be made with as much advance notice as possible. When rescheduling, the SC will attempt to reschedule the assessment prior to the due date of the assessment or if not, the earliest available date following.

**NOTE:** A beneficiary may reschedule any given assessment up to three times. After the third reschedule, the beneficiary may be issued a technical denial and denied PCS. Should that occur, the beneficiary will be required to submit a new Request for PCS to restart the process..

### 3.1.2 No-Shows

If a beneficiary is unavailable for their scheduled assessment or a "no-show", then the Independent Assessor will leave a door hanger informing the beneficiary of the missed visit and directing them to call LHC-NC to reschedule. If a call is not received, LHC-NC will follow up with the beneficiary in an attempt to reschedule. If contact is not successful, a technical denial will be issued for PCS.

**NOTE:** A "no show" is defined as any appointment that is not cancelled/rescheduled prior to the Assessor showing up to the appointment location on the scheduled date and time. The Independent Assessor will remain at the home or facility for 15 minutes after the scheduled appointment time in hopes that the beneficiary will arrive and become available for their assessment before determining it is a no-show. If a beneficiary is a no-show twice, then a technical denial will be issued for PCS. If they wish to still be considered for PCS, the beneficiary will be required to submit a new Request for Services to restart the process.

## 3.2 Conducting the Independent Assessment

When an appointment has been scheduled for an independent assessment, the Assessor scheduled to conduct the assessment will call the beneficiary or facility 24 hours in advance to confirm the scheduled appointment. During the call, the assessor will also remind the beneficiary or facility administrator to have their all medications available, that they may supply any appropriate or necessary medical documentation, and that any persons they feel can assist in the completion of the independent assessment may be present.

On the day of the scheduled appointment and before conducting the assessment, the Independent Assessor will review the 'Medicaid PCS Beneficiary Participation Guide' with the beneficiary. This form outlines the rights the beneficiary has regarding the independent assessment and their responsibility to fully participate in completing the assessment (please see Appendix B for the complete form). Following the review of the participation guide, the beneficiary will be asked to sign a consent form that gives the Assessor permission to conduct the independent assessment.

Generally, the beneficiary can expect the assessment to take between 60 - 90 minutes. The Assessor will be asking questions about various daily activities and the beneficiary's ability to perform these activities. The Assessor will require the beneficiary to demonstrate these activities to determine level of ability.

**NOTE:** The beneficiary will not be required to undress, bath, or toilet. The Assessor will ask them to demonstrate or simulate these tasks fully clothed.

In detail and in accordance with Clinical Policy 3L, section 5.4.9, during the Assessment the Assessor shall evaluate and document the following factors for each qualifying ADL:

1. Beneficiary capacities to self-perform specific ADL tasks;
2. Beneficiary capacities to self-perform IADL tasks directly related to each ADL;
3. Use of adaptive and assistive devices and durable medical equipment;
4. Availability, willingness, and capacities of beneficiary's family members and other informal caregivers to provide assistance to the beneficiary to perform ADLs;
5. Availability of other home and community-based support and services;
6. Medical conditions and symptoms that affect ADL self-performance and assistance time; and
7. Environmental circumstances and conditions that affect ADL self-performance and assistance time.

The Assessor will also speak with the beneficiary, any available family members or caregivers and staff about the beneficiary's medical conditions and their need for PCS services.

## 3.3 The Independent Assessment Tool

The PCS assessment tool provided and approved by DMA is designed to accomplish the following in an accurate and consistent manner while ensuring comparability in all settings:

- Determine the beneficiary's eligibility for PCS;
- Determine and authorize hours of service and level of care;
- Provide the basis for plan of care development;
- Support PCS compliance reviews and program utilization.

The assessment tool is a standardized assessment that shall include the following components:

- a. Outlining tasks for each of the qualifying ADLs;
- b. The medical diagnosis or diagnoses causing the need for PCS;

- c. Any exacerbating medical symptoms or conditions 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:

<b>Beneficiary’s Self-Performance Rating</b>	<b>Description</b>
0 – Totally able	Beneficiary is able to self-perform 100% of activity, with or without aids or assistive devices, and without supervision or assistance setting up supplies and the environment
1 – Needs verbal cueing or supervision only	Beneficiary is able to self-perform 100% of the activity, with or without aids or assistive devices, and requires supervision, 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% of the 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% of the 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 individual to perform all of the activity

The Assessor will enter the level of assistance needed for each demonstrated task into the assessment tool. A standard amount of time is then indicated for each day that ADL assistance is needed. The authorized monthly time is calculated automatically once the completed assessment is uploaded. The total hours authorized is based on the ADLs with which the beneficiary requires assistance, the amount of assistance needed and the number of days per week PCS is needed. No time is authorized for ADL tasks that the beneficiary performs independently or for tasks for which the beneficiary requires only verbal cueing, supervision or already has assistance.

For more information on the assessment design and service level determinations, please see Appendix A in Clinical Policy 3L (see appendix D of this manual).

# Chapter 4: The PCS Provider Selection Process, Referrals, and Notifications

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Referrals to provider agencies are solely based upon the beneficiary's choice of provider at the time of the independent assessment. The Assessor will offer the options for personal care service providers in a manner that is free from personal or commercial bias through the use of a randomized provider list. The randomized provider list is generated through QiRePort and is based on information from the DHHS Provider Enrollment Division as well as on information that healthcare agencies enter into QiRePort about the counties they service. Every Medicaid enrolled provider who is located in the beneficiary's county or has reported via QiRePort that they serve the beneficiary's county, appears on that county list every time. The list is randomized, which means that no one provider appears at the top of the list every time.

## 4.1 Provider Selection

Clinical Coverage Policy 3L, section 5.4.11 dictates that beneficiaries should select three providers at the time of the assessment, although the beneficiary does have the option of specifying one provider for all three choices. DMA and Liberty Healthcare strictly enforce the following procedure for determining provider choice:

1. Present the beneficiary with a randomized list of licensed, eligible PCS providers in the beneficiary's county.
2. Inquire if the beneficiary has any preferred PCS provider(s), which may include the current provider, if they so choose.
3. If the beneficiary does not have a preferred PCS provider(s), then the Assessor would direct the beneficiary to the presented randomized provider list to make a selection.
4. If unable to select a preferred PCS provider at the time of the assessment, the Assessor will leave the randomized provider list and follow up with the beneficiary the next day for their provider selection. The Assessor will follow up a maximum of three times within 3 business days to capture the beneficiary's provider selection in order to complete the assessment process.
5. If the beneficiary remains unresponsive to the contact attempts made by the Assessor, the beneficiary will be sent a letter requesting they make a provider selection within 30 days. If unable to make a provider selection within 30 days, the PCS request will be removed and a new request would need to be resubmitted if the beneficiary still wishes to be considered for PCS.

If the beneficiary qualifies for the PCS Program and a provider choice was made, LHC-NC will send the referral to the beneficiary's first choice service provider. If the provider declines or does not respond to the referral within 2 business days, LHC-NC will make a call to the first choice provider to inform them they have been sent a referral and response is needed. If LHC-NC is not able to successfully contact the first choice PCS provider within 5 business days or they do not respond to the referral, LHC-NC will reject the referral on behalf of the provider and will send the referral to the beneficiary's second choice of provider and if necessary, to the beneficiary's third choice of provider. For cases when the beneficiary offers only



one choice of provider and this provider does not respond to the referral or declines it, LHC-NC will contact the beneficiary by telephone to request another provider choice. If unable to contact the beneficiary, LHC-NC will send a letter to the beneficiary requesting they make a new provider selection. If a new provider selection is not made within 30 days, then the request is removed and a new request would be required if the beneficiary wished to still be considered for PCS.

**NOTE:** Beneficiaries or their guardians or those designated as Power of Attorney may also choose to change providers at any time for any reason. They can accomplish this change by contacting the IAE by telephone. The IAE will take the steps necessary to ensure that the caller is in fact authorized to make the change. Providers may not request a change of provider on the beneficiary’s behalf. Notifications will be issued to the beneficiary, the old provider and the new provider in the event of an approved change in provider.

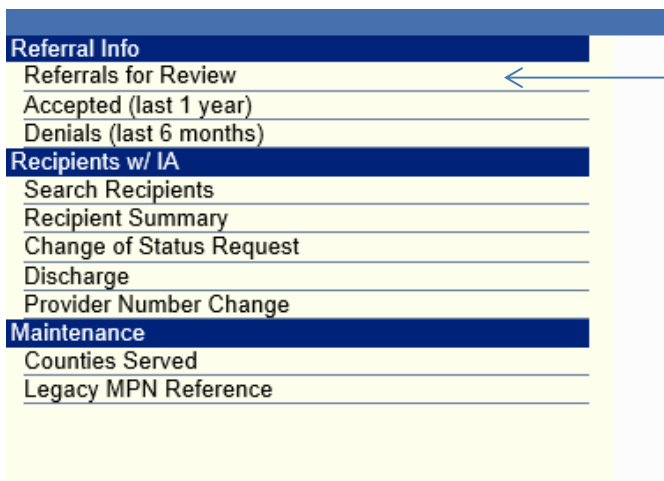
## 4.2 Responding to a Referral

A “referral notice” is a letter that notifies the provider agency that a beneficiary has selected the agency to provide his/her PCS services. The notice includes the beneficiary’s name and his/her Medicaid Identification (MID) number, as well as the service level authorized. Based on this information and the agency’s qualifications to provide the needed services, the notice requests an “accept” or “reject” response to the referral.

**NOTE:** The referral notice is not an authorization to begin services for the beneficiary. Providers should always refer to the decision notice to determine the effective date of the service authorization.

### Responding to a Referral through QiRePort

The selected agency will receive an electronic copy of the referral notice and a copy of the beneficiary’s independent assessment. To access these referrals, the provider will select the link in the left hand tool bar titled ‘Referrals for Review’ (please see figure below).



Click here for pending request for service referrals.

Once selected, a list of all referrals that have been sent to the provider will populate on the screen; select the name of the beneficiary you wish to view. When you select a beneficiary's name, a screen will display that provides the beneficiary's demographic information, their PCS request, their assessment, and a display of the total approved hours (see next figure). It is from this screen that the provider will need to respond to the referral by selecting a "Referral Decision" of "Accept" or "Reject".

The screenshot shows a web application interface for 'Referrals'. At the top, there is a blue header with the title 'Referrals' and a sub-header 'Referral for Acceptance Review'. Below the header, there is a search icon and a 'Print' button. A red asterisk indicates required fields. The main content area is divided into several sections:

- Recipient Data:** A table with fields for Recipient Name, Address 1, City, State Zip, Phone, Gender, Medicaid ID, Address 2, County, DOB, and Status. Red boxes are placed over the Recipient Name, Address 1, and Medicaid ID fields.
- Requests for Independent Assessment:** A table with columns for Recipient Name, MID, Phone Number, Request Date, and Request Type. A red box is placed over the Recipient Name and MID fields. The Request Date is 2/25/2014 and the Request Type is Change of Status.
- Independent Assessments on file for Recipient:** A table with columns for Assessment Date, Comments, Assessment Type, and Hours. Two rows are shown: one for 4/25/2014 with a 'Change of Status' assessment type and 39 hours, and another for 5/7/2013 with an 'Admission' assessment type and 39 hours. Red arrows point from the '4/25/2014' date and the '39' hours to the 'Referral Decision' dropdown and the 'Hours awarded is displayed here' text, respectively.
- Referral Decision:** A dropdown menu currently set to '-- select --'. A red arrow points from the '39' hours to this dropdown.
- Comment:** A text area with a red arrow pointing to it from the text 'Click here to access a copy of the assessment'.
- Save:** A button at the bottom of the form.

**Provider should select a response to request by selecting the appropriate response decision**

**NOTE:** Providers are expected to accept/reject referrals within 2 business days. If the PA's end for a beneficiary and the PCS Provider did not accept within 2 business days of the referral, DMA will not authorize retro pay for the lapsed time period.

### 4.3 Referral and Decision Notices

Liberty Healthcare will send a "decision notice" to the provider that accepts the referral. This notice contains information about the authorized service level and identifies the date when the agency should begin services for the beneficiary.

**NOTE:** Medicaid will not compensate providers for services provided before the effective date listed on the decision notice. In addition, Medicaid will not compensate providers for services provided at the previous authorization level after the effective date of the reduced authorization or denial in services, unless the beneficiary files a timely appeal. Finally, for any notification that does not indicate an 'end date', the servicing provider can expect the effective period to have a duration of 365 calendar days.

An "adverse decision notice" indicates a reduction in the service authorization or a denial of services. If a beneficiary chooses to contest Medicaid's decision, the adverse decision notice also contains instructions for the appeal process. The beneficiary's copy of this notice contains a Request for Hearing

Form, which the beneficiary must complete in order to begin the appeal process (see Chapter 5 for more information on the appeal process). The Request for Hearing Form is not included in the provider's copy of the notice. Liberty Healthcare sends adverse decision notices to beneficiaries by regular USPS mail that is trackable but does not require a signature. This enables DMA and Liberty Healthcare to verify that the beneficiary received the notice.

The following are types of decision notices a PCS provider may receive upon accepting a PCS beneficiary:

- **Notice of Decision on Initial Request for Medicaid Services:** This notice may indicate an approval or a denial of services and is issued to beneficiaries who received an independent assessment following a new referral for PCS services. It is also issued to beneficiaries who could not be reached to schedule an assessment or who missed two scheduled appointments following a new referral. If the notice indicates a denial in services, it will specify the reason for the denial. The beneficiary's copy will include instructions for filing an appeal and the Request for Hearing Form.
- **Notice of Change in Services:** This notice is issued to beneficiaries who were previously receiving PCS services and who are authorized for a reduced number of hours based on the most recent independent assessment. The beneficiary's copy will include instructions for filing an appeal and the Request for Hearing Form.
- **Notice of Decision on a Continuing Request for Medicaid Services:** This notice is issued to beneficiaries who are approved for continued services following a reassessment.
- **Notice of Denial in Services:** This notice is issued to beneficiaries who were previously receiving PCS services and have now been determined not to qualify for PCS based on the most recent independent assessment. It is also issued to beneficiaries for whom a continuing request for services is denied for any of the following reasons, but not limited to:
  - The beneficiary missed two scheduled independent assessment appointments;
  - The beneficiary rescheduled their appointment for an assessment more than 3 times;
  - The beneficiary was unavailable for an assessment 30+ days for the indicated due date;
  - LHC-NC was unable to contact the beneficiary for independent assessment scheduling; or
  - The Change of Status request submitted for the beneficiary was denied because it was missing a description of the change in the client's condition and/or documentation of the need for a reassessment, or because the described change in the client's condition did not warrant a reassessment. This letter serves as notice that the requested reassessment is denied; however, authorization at the current service level will continue.
  - The beneficiary account in NCTracks now reflects as PCS ineligible due to the Medicaid status or that they are receiving duplicative services making them ineligible for PCS.

## Chapter 5: The Appeal Process

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In accordance with federal law, the beneficiary has the right to appeal a decision when a beneficiary's service is denied, reduced, suspended, or terminated. Liberty Healthcare sends a notice to the beneficiary, with a copy to the provider of record that includes the following:

- An explanation of why the service was reduced, denied, suspended or terminated;
- A citation of the state law that supports the decision; and
- The effective date of the denial or reduction.

Beneficiary Only:

- A list of steps the beneficiary should follow in order to appeal the decision;
- Contact information for someone who can answer questions about the case; and
- A Request for Hearing form.

Beneficiaries who have entered a timely appeal (within 30 days of the date on the notice) are entitled to Maintenance of Service until the appeal is resolved (see "Maintenance of Service", section 5.5 of this manual).

### 5.1 Steps in the Appeal Process

As outlined in the notice sent to beneficiaries and their providers of record, the steps in the appeal process are as follows:

1. The beneficiary completes the Request for Hearing form found on the last page of the decision notice. Only the beneficiary or his/her legal guardian can make the decision to appeal. Providers may assist the beneficiary by mailing or faxing the completed form to OAH.
2. The beneficiary mails or faxes the form to "Clerk, Office of Administrative Hearings" and to the "Department of Health and Human Services: CPP Appeals Section".
  - a. The appeal must be filed within 10 calendar days of the date of the notice, to avoid a break in service payment for a continuing request for service.
  - b. If the beneficiary files an appeal on day 11 through day 30 from the date of the notice, payment for services will be reinstated the date the appeal is filed (received by the Office of Administrative Hearings (OAH)).
  - c. If the beneficiary appeals after day 30, maintenance of service will not apply.
  - d. The beneficiary may represent himself/herself in the appeal process, ask a family member or friend to speak for him/her, assign another spokesperson, or obtain an attorney to provide representation. The appeal form has a place for the beneficiary to designate a representative and provide contact information for the representative.
3. OAH forwards the appeal to DMA and the Mediation Network of North Carolina. The assigned mediation center then offers mediation to the beneficiary or his/her representative.

4. If the beneficiary accepts the offer of mediation, the session is conducted in person or over the phone and includes the mediator, the beneficiary and/or the beneficiary's designated representative(s), and a representative from Liberty Healthcare on behalf of DMA.
5. If the mediation is successful or if the beneficiary/representative(s) chooses to withdraw the appeal, the appeal is resolved without a court hearing, the results are legally binding, and the case will be closed.
6. If the beneficiary/representative(s) and the Liberty Healthcare representative are unable to reach a compromise during mediation, the case proceeds to a hearing at OAH.
7. If the case does not settle at mediation, the formal hearing is conducted before an Administrative Law Judge. The judge's decision in the case is the final agency decision.
8. OAH will notify the beneficiary and/or the representative designated on the appeal form via regular USPS mail of the date, time, and location of the hearing.
9. The beneficiary receives a copy of the Administrative Law Judge's final agency decision. If the beneficiary disagrees with the final agency decision, he/she may request a hearing in Superior Court. This hearing must be requested within 30 days of the date the final agency decision is mailed to the beneficiary.

## 5.2 Mediation

Mediation is an informal hearing process for appeals. The purpose of mediation is to attempt to reach a resolution to the appeal that is mutually acceptable to the beneficiary and to DMA, through a confidential and legally binding proceeding facilitated by a mediator. Most of the mediation discussions occur over the telephone. The beneficiary does have the option to participate in person at the local mediation center if they so choose. There is no charge to the beneficiary for mediation.

In addition to the beneficiary, the mediation session includes:

- **The Mediator** - an unbiased party who helps to guide the discussion and helps the parties to come to a resolution.
- **A Representative from DMA** - a Liberty Healthcare mediation nurse acts as the representative from DMA for PCS appeal cases. In order to avoid a conflict of interest, the nurse who completed the independent assessment that is being contested does not act as the DMA representative during mediation.
- **The Beneficiary Representative** - the beneficiary may designate anyone else to speak on his/her behalf or to assist him/ her during the mediation such as a family member, friend, provider agency staff member, or an attorney. Best practice is for someone who is familiar with the beneficiary's needs to participate in the mediation and hearing processes.

If the mediation results in a resolution that is satisfactory to both parties, the appeal will be dismissed. If the beneficiary withdraws his or her appeal, the original decision (reduction in hours or denial of services) will remain valid. If an offer of settlement hours is made and the beneficiary accepts, both the beneficiary and the beneficiary's provider of choice will receive a notification letter that lists the new number of authorized hours. This authorization will remain valid until the beneficiary's next independent assessment.

Beneficiaries are not required to participate in mediation. The beneficiary may choose instead to request that the case go straight to hearing before an Administrative Law Judge. If the beneficiary does wish to participate in mediation in an effort to resolve the appeal, the mediation session must be completed within 25 calendar days of the date that OAH received the beneficiary's Request for Hearing form. For example, if OAH received the beneficiary's Request for Hearing form on June 1, the mediation process should be completed by June 26.

If the beneficiary does not accept the outcome of mediation, the mediator will file an "impasse" decision with OAH. The case will then proceed to the next stage, which is a hearing before an Administrative Law Judge. If the beneficiary declines to participate in mediation, the mediator will report this outcome to OAH, and the case will proceed to hearing.

A successful resolution to the appeal at Mediation is legally binding, so the beneficiary does not have the option to re-open the case once it is settled through mediation.

### **5.3 Court Hearing and Final Agency Decision**

If the beneficiary declines the offer of mediation and desires his/ her case to go straight to hearing, an OAH court hearing will be scheduled in lieu of mediation. A hearing will be scheduled following mediation for beneficiaries who do not accept a settlement offer during mediation.

An administrative law judge presides over the OAH hearing. The beneficiary may participate in the hearing over the phone, by teleconference, or may come in person to Raleigh. Prior to the hearing date, the beneficiary may request the hearing to be in person at a location within or near the beneficiary's county of residence. The beneficiary may represent him/herself or appoint an attorney or someone else (friend, family member, etc.) to speak for him/her during the hearing.

DMA will be represented by an attorney from the Attorney General's Office. That attorney will send the documents related to the appeal, including the independent assessment if applicable, to the beneficiary or his/her designated representative prior to the hearing. A registered nurse from DMA will be present during the hearing. Additionally, the registered nurse who completed the assessment may participate in the hearing.

All of the information is presented anew, during the hearing. None of the discussion or interaction that occurred during mediation is entered into the court hearing. As necessary, the beneficiary may also present new information that was not shared during the mediation discussion. Following the hearing, the administrative law judge will enter his/her decision in the case which will be rendered as the final agency decision. The beneficiary will receive written notification of the judge's decision.

The OAH hearing should be completed within 55 days of the date the beneficiary's Request for Hearing Form was received by OAH. This timeline includes 25 days for completion of mediation.

### **5.4 Superior Court Judicial Review**

If the beneficiary wishes to contest the final agency decision in the case, he or she may request a hearing in North Carolina Superior Court. The beneficiary has 30 days from receipt of the notice of the final agency decision to request a hearing in Superior Court.

## 5.5 Maintenance of Service (MOS)

A beneficiary who files a timely appeal may continue to receive the same level of service as he or she was receiving when the notification letter was mailed. For example, if a client was receiving 60 hours of service per month and then submits a timely appeal of the decision that reduced the authorization for those services to 40 hours, the client is entitled to receive services at the 60-hour level, from the date the appeal request is filed until the date the appeal is resolved.

In order to qualify for Maintenance of Service, the beneficiary must:

1. Have been receiving services at the time of the adverse decision. A beneficiary who receives a denial following a new referral to the PCS Program is not eligible for MOS.
2. Be eligible for the type of Medicaid that covers PCS services. If the beneficiary has a lapse in Medicaid eligibility, he or she cannot receive MOS until Medicaid eligibility is restored.

DMA administers MOS in accordance with federal law. The effective date of MOS is determined by the date that the beneficiary's Request for Hearing Form is received by OAH. There will be no lapse in the beneficiary's services if the Request for Hearing Form is received before the reduction authorization or service denial goes into effect. However, if the beneficiary submits the Request for Hearing form after the 10-day effective date of the reduction or denial decision, and before 30 days, there will be a service lapse that extends from the effective date of the reduction or denial decision until OAH receives the form. Once the form is received, within 30 days, the authorization for the prior service level will be reinstated. If the beneficiary appeals after day 30 from the date of the notice, MOS will not be authorized.

Here are some examples of these two scenarios:

### **No Lapse in Service:**

*A beneficiary who was authorized for 50 hours of service per month from the previous independent assessment receives a Notice of Denial in services. The notice is dated February 15 (the same date it was mailed) and is effective on February 26. The beneficiary mails the Request for Hearing Form to OAH, and it is received on February 23 (within eight days). Medicaid will authorize MOS for 50 hours (the previous service level) for this beneficiary effective February 26. This authorization will remain in effect until the appeal is resolved. Since the Request for Hearing Form was received before the effective date of the denial, there is no interruption in authorized services. In this case, the MOS authorization supersedes the denial decision.*

### **Lapse in Service:**

*A beneficiary who was authorized for 70 hours of service per month from the previous independent assessment receives a Notice of Denial in services. The notice is dated February 16 (the same date it was mailed) and is effective on February 27. The beneficiary mails the Request for Hearing Form to OAH, and it is received on March 2 (more than 10 days after the notice was mailed). Medicaid will authorize MOS for 70 hours (the previous service level) for this beneficiary effective March 2. Since the Request for Hearing Form was received after the effective date of the denial, but before 30 days, the service authorization will be interrupted from February 27 – March 1. Although this beneficiary's appeal was submitted in a timely manner, the denial went into effect before the MOS authorization.*

## 5.6 Change of Provider Requests During the Appeal Process

If a beneficiary wishes to change providers while the appeal is pending, the MOS authorization will be transferred to the new provider. The new provider will not receive a copy of this assessment since the beneficiary is contesting the most recent independent assessment. In this case, the provider agency RN should write the plan of care for the authorized MOS hours based on a discussion with the beneficiary about his or her need for assistance. The provider should continue to base the client's care on this plan of care until Liberty Healthcare notifies the provider that the appeal has been resolved. At that point, the provider will need to revise the plan of care based on awarded hours or discharge the client as appropriate.



## Chapter 6: Billing

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Computer Science Corporation (CSC) is the current vendor responsible for the processing of all Medicaid claims, which includes claims for PCS. NCTracks is the Medicaid billing system used by CSC to receive and process all claims. Liberty Healthcare issues prior approval for services based on the independent assessment results and QiRePort transmits the authorization to NCTracks to authorize payment of eligible PCS provider claims.

### 6.1 Prior Approval

Once a beneficiary who has been deemed eligible is awarded hours under the PCS program following an assessment or a settlement through the appeals process, a 'Prior Approval' (PA) is issued. The PA will reflect the total hours awarded monthly for PCS. In accordance with Clinical Policy 3L, section 5.2.2, in order to be approved for PCS payment, the beneficiary shall:

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

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 the following documents submitted by the provider before PCS is rendered:

- ✓ Work and School verification 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;
- ✓ Verification from the Exceptional Children's program per county if PCS is being requested in school setting;
- ✓ Health record documentation from the beneficiary's physician, therapist, or other licensed practitioner;
- ✓ Physician documentation of primary caregiver's limitation that would prevent the caregiver from caring for the beneficiary; and/or
- ✓ 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.

### Prior Approval Effective Dates

DMA has authorized retroactive prior approval for PCS that were approved on or after August 1, 2017. Retroactive prior approval will only be applied to initial requests for PCS. The retroactive effective date for authorization will be the request date on the Request for Independent Assessment for Personal Care Services 3051 form, provided the date is not more than 30 calendar days from the date that the Independent Assessment Entity (IAE), Liberty Healthcare, received a completed request form. If the request is received by Liberty Healthcare more than 30 calendar days from the request date on the request form, the authorization will be effective the date Liberty Healthcare received the form. If the initial

request is missing information, the received date will not be effective until the correct information is provided to process the referral.

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) program, retroactive prior approval does not apply. PCS authorization will be made effective the date beneficiary receives their PASRR.

**Example 1:**

Request Date:	08/01/2017
IAE Received Date:	08/26/2017
Effective Date	08/01/2017

**Example 2:**

Request Date:	08/01/2017
IAE Received Date:	09/12/2017
Effective Date	09/12/2017

For all other request types, the effective dates are as follows:

Request Type	PA Effective Date
Change of Status – Increase in Hours	1 day from the date of provider acceptance
Change of Status – Decrease in Hours or New Provider Selection During COS Assessment	10 days from the notification date
Reassessment	10 days from the notification date
Change of Provider – In-Home	10 days from the notification date
Change of Provider – Adult Care Home	1 day from the notification date
Change of Provider – Lapse (all settings)	1 day from the notification date
Reconsideration – Increase in hours, same provider selection	1 day from the date of provider acceptance
Reconsideration – All outcomes, new provider selection	10 days from the date of provider acceptance

Providers will always receive a notification that will indicate the effective date on all prior approvals. If an end date is not indicated for the effective period, the servicing provider can expect the service period to be effective for 365 calendar days from the effective date.

**NOTE:** Providers are expected to accept/reject referrals within 2 business days. If the PA’s end for a beneficiary and the PCS Provider did not accept within 2 business days of the referral, DMA will not authorize retro pay for the lapsed time period.

**6.2 Reimbursement**

In order to receive reimbursement for PCS, the beneficiary must have Medicaid which provides reimbursement for PCS. It is the responsibility of the servicing PCS provider to verify each Medicaid beneficiary’s eligibility every time service is rendered (Clinical Policy 3L, section 2.1.1).

**NOTE:** A beneficiary may have been approved for PCS and a prior approval awarded, but if their Medicaid is not active, does not provide coverage for PCS, or they have since been enrolled in another state program that cannot be administered in conjunction with PCS, reimbursement will be denied. Providers shall verify each Medicaid beneficiary's eligibility each time a service is rendered. For those with active Medicaid, the current rates for reimbursement for personal care services are as follows:

<u>Dates of Service</u>	<u>Rate</u>	
Prior to 10/1/13	<b>\$3.88</b>	per 15 minutes (\$15.52 per hour)
10/1/2013-12/31/13	<b>\$3.58</b>	per 15 minutes (\$14.32 per hour)
01/01/2014 forward	<b>\$3.47</b>	per 15 minutes (\$13.88 per hour)

**NOTE:** When rounding billing units, the provider should follow the 7/8 rule: seven minutes of service or less should be counted as "0" units; eight minutes of service or more should be counted as one unit.

### Billing Codes and Modifiers

Providers should submit billing for PCS services, including any services delivered under the MOS provision, using the procedure code of 99509 (effective January 1, 2013) along with the appropriate modifier. The modifier is specific to setting and must match the indicated modifier on the PA or claims will be denied; please see the table below for a listing of modifier types:

Procedure Code	Modifier	Program Description
99509	HA	Personal Care Services, Private Residences, Beneficiaries Under 21 Years
99509	HB	Personal Care Services, Private Residences, Beneficiaries 21 Years and Older
99509	HC	Personal Care Services, Adult Care Homes
99509	HH	Personal Care Services, Supervised Living Facilities, Adults with MI/SA
99509	HI	Personal Care Services, Supervised Living Facilities, Adults with MR/DD
99509	HQ	Personal Care Services, Family Care Home
99509	SC	Personal Care Services, Adult Care Homes, Special Care Unit
99509	TT	Personal Care Services, Adult Care Homes, Combination Homes

It is important that provider(s) comply with the *Basic Medicaid and NCHC Billing Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC; this includes obtaining appropriate referrals for a beneficiary enrolled in the Medicaid and the following:

#### **A. Claim Type**

Professional (CMS-1500/837P transaction)

#### **B. International Classification of Diseases, Ninth Revisions, Clinical Modification (ICD-10-CM) Codes**

Provider(s) shall report the ICD-10-CM diagnosis code(s) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10-CM 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. **Before October 1, 2015**, the provider shall continue to use ICD-9 code sets to report medical diagnoses and procedural codes. **Effective October 1, 2015** the provider shall use ICD-10 code sets for reporting.

#### **C. Code(s)**

Provider(s) shall select the most specific billing code that accurately and completely describes the procedure, product, or service(s) provided. In cases where the beneficiary has multiple ICD-10 (diagnosis) codes listed on the referral and/or independent assessment, the provider should submit billing using the code that is most relevant to the beneficiary's need for ADL assistance from an in-home aide. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), ICD-10-CM diagnosis codes, 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.

### **6.3 Denied Claims**

Liberty Healthcare of North Carolina does not have access to denied claims nor do they have the authorization to deny claims. It is the responsibility of LHC-NC, in conjunction with Viebridge, Inc. to generate a prior approval with appropriate effective dates for PCS and transmit that data to NCTracks for claim processing. When claims are denied for PCS, the provider should attempt to answer the following questions before contacting NCTracks or Liberty:

1. Did I complete a service plan for the most current assessment for the beneficiary? (verify in QiReport)
2. Does the beneficiary have active Medicaid? (verify through NCTracks)
3. Does the beneficiary have an active PA? (verify through NCTracks)
4. Does the modifier on the PA match the modifier assigned in NCTracks? (verify through the QiReport Provider Portal)
5. Have I already billed for all approved hours this month? (verify in NCTracks)
6. Am I billing within the approved effective dates? (verify in NCTracks)

It is important to note that Liberty Healthcare does not have full access to NCTracks and is therefore limited to addressing billing issues. If a provider is experiencing a billing issue for other reasons that do not involve the PA for PCS, they are strongly encouraged to contact NCTracks.

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# Appendix A: Request for Independent Assessment for PCS 3051 Form

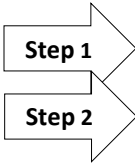
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**North Carolina Department of Health and Human Services - Division of Medical Assistance  
REQUEST FOR INDEPENDENT ASSESSMENT FOR PERSONAL CARE SERVICES (PCS)  
ATTESTATION OF MEDICAL NEED**

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

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

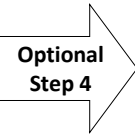
**Please select one:**    New Request    Change of Status: Medical   **Date of Request:** \_\_\_/\_\_\_/\_\_\_



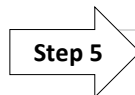
<b>SECTION A. BENEFICIARY DEMOGRAPHICS</b>			
<b>Beneficiary's Name:</b> First: _____ MI: _____ Last: _____ <b>DOB:</b> ___/___/___			
<b>Medicaid ID#:</b> _____ <b>PASRR#(For ACHs Only):</b> _____ <b>PASRR Date:</b> ___/___/___			
<b>Gender:</b> <input type="checkbox"/> M <input type="checkbox"/> F <b>Language:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			
<b>Address:</b> _____ <b>City:</b> _____			
<b>County:</b> _____ <b>Zip:</b> _____ <b>Phone:</b> _____			
Alternate Contact (Non-PCS Provider)/Parent/Guardian (required if beneficiary < 18): Name: _____			
Relationship to Beneficiary: _____		Phone: _____	
Active Adult Protective Services Case? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Beneficiary currently resides:</b> <input type="checkbox"/> At home <input type="checkbox"/> Adult Care Home <input type="checkbox"/> Hospitalized/medical facility <input type="checkbox"/> Skilled Nursing Facility			
<input type="checkbox"/> Group Home <input type="checkbox"/> Special Care Unit (SCU) <input type="checkbox"/> Other _____ D/C date (Hospital/SNF) : ___/___/___			



<b>SECTION B. BENEFICIARY'S CONDITIONS THAT RESULT IN NEED FOR ASSISTANCE WITH ADLS</b>			
Identify the current <b>medical diagnoses related to the beneficiary's need for assistance with</b> qualifying Activities of Daily Living (bathing, dressing, mobility, toileting, and eating). List <i>both</i> the diagnosis and the ICD-9 code for each.			
Medical Diagnosis	ICD-9 Code (Complete Codes Only)	Impacts ADLs	Date of Onset (mm/yyyy)
	- - - - . - - -	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	- - - - . - - -	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	- - - - . - - -	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	- - - - . - - -	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	- - - - . - - -	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>In your clinical judgment, the ADL limitations are:</b> <input type="checkbox"/> Short Term (3 Months) <input type="checkbox"/> Intermediate (6 Months)			
<input type="checkbox"/> Expected to resolve or improve (with or without treatment) <input type="checkbox"/> Chronic and stable <input type="checkbox"/> Age Appropriate			
<b>Is Beneficiary Medically Stable?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Is 24-hour caregiver availability required to ensure beneficiary's safety?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			



<b>OPTIONAL ATTESTATION: Practitioner should review the following and initial <u>only</u> if applicable:</b>
The beneficiary requires an increased level of supervision.   Initial if Yes: _____
The beneficiary requires caregivers with training or experience in caring for individuals who have a degenerative disease, characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.   Initial if Yes: _____
Regardless of setting, the beneficiary requires a physical environment that includes modifications and safety measures to safeguard the beneficiary because of the beneficiary's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.   Initial if Yes: _____
The beneficiary has a history of safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.   Initial if Yes: _____



**SECTION C. PRACTITIONER INFORMATION**

Attesting Practitioner's Name: \_\_\_\_\_ Practitioner NPI#: \_\_\_\_\_

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

Practice Name: \_\_\_\_\_

Practice Stamp:

Practice NPI#: \_\_\_\_\_

Practice Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

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

**Practitioner Signature AND Credentials:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

\*Signature stamp not allowed\*

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

Sign Here

Change of Status - Medical

**SECTION D. CHANGE OF STATUS: MEDICAL**

**Complete for medical change of status request only.**

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

**- PRACTITIONER FORM ENDS HERE -**

This Space Intentionally Left Blank



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

**Step 1** Please select one:  Change of Status: Non-Medical  Change of PCS Provider **Date of Request:** \_\_/\_\_/\_\_

**Step 2** Beneficiary's Name: First: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_

Medicaid ID#: \_\_\_\_\_ Gender:  M  F Language:  English  Spanish  Other \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Relationship to Beneficiary: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**SECTION E. CHANGE OF STATUS: NON-MEDICAL**

Requested By (select one):  PCS Provider  Beneficiary  
Responsible Party:  Guardian  Legal Power Of Attorney (POA)  Family (Relationship): \_\_\_\_\_

Requestor Name: \_\_\_\_\_

PCS Provider NPI#: \_\_\_\_\_ PCS Provider Locator Code#: \_\_\_\_\_ (three digit code)

Facility License # (if applicable): \_\_\_\_\_ License Date (if applicable): \_\_\_\_\_ (mm/dd/yyyy)

Provider Contact Name: \_\_\_\_\_ Contact's Position: \_\_\_\_\_

Provider Phone \_\_\_\_\_ Provider Fax: \_\_\_\_\_

Email: \_\_\_\_\_

**Reason for Change in Condition Requiring Reassessment:**

- Change in beneficiary's location affecting ability to perform ADLs
- Change in caregiver status
- Change in days of need
- Other: \_\_\_\_\_

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

Change of Status: Non-Medical

**SECTION F. CHANGE OF PCS PROVIDER**

Requested By (select one):  Care Facility  Beneficiary  Other (Relationship to Beneficiary): \_\_\_\_\_

Requestor Contact's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Reason for Provider Change (select one):**

- Beneficiary or legal representative's choice
- Current provider unable to continuing providing services
- Other: \_\_\_\_\_

**Status of PCS Services (select one):**

- Discharged/Transferred on \_\_\_\_\_ (mm/dd/yyyy)
- Scheduled for discharge/transfer on \_\_\_\_\_ (mm/dd/yyyy)
- Continue receiving services until beneficiary is established with a new provider agency; no discharge/transfer is planned

**Beneficiary's Preferred Provider (select one):**

<input type="checkbox"/> Home Care Agency	<input type="checkbox"/> Family Care Home	<input type="checkbox"/> Adult Care Home	<input type="checkbox"/> Adult Care Bed in Nursing Facility	<input type="checkbox"/> SLF-5600a	<input type="checkbox"/> SLF-5600c	<input type="checkbox"/> Special Care Unit
---	---	--	---	------------------------------------	------------------------------------	--

Agency Name: \_\_\_\_\_ Phone: \_\_\_\_\_

PCS Provider NPI#: \_\_\_\_\_ PCS Provider Locator Code#: \_\_\_\_\_ (3 digit code)

Facility License # (if applicable): \_\_\_\_\_ License Date (if applicable): \_\_\_\_\_ (mm/dd/yyyy)

Physical Address: \_\_\_\_\_

Change of Provider

# Appendix B: Medicaid PCS Beneficiary Participation Guide

## Medicaid Personal Care Services Beneficiary Participation Guide

You have submitted a request to receive Personal Care Services (PCS) through NC Medicaid. Before conducting an assessment to determine if you are eligible or continue to be eligible for the PCS program, you need to know:

### Beneficiary Rights

1. You have the right to have an independent assessment or observation to determine your ability to care for yourself.
2. You can have anyone you wish present at the assessment.
3. You can give the assessor any medical records or other information that you think would be helpful for them to understand your needs.
4. If your services are reduced or denied, you have the right to appeal.
5. You can decide not to have an assessment, but you cannot have Medicaid PCS without one.
6. If your living situation or your ability to take care of yourself change, or if people who were helping you can no longer do so, you may request another assessment.

### Beneficiary Responsibilities

1. You must be enrolled in the NC Medicaid Program.
2. The place you live must be safe for you and your caregivers.
3. You cannot receive Medicaid PCS if you have people who are willing and able to help you care for yourself the same days/time PCS would be provided.
4. You must be under the care of a doctor or other healthcare provider.
5. You cannot have anyone who lives with you or is related to you take care of you and be paid for it; this includes a legally responsible person, spouse, child, parent, sibling, grandparent, or grandchild (blood relatives, step, or in-laws).
6. You must keep your address and contact information current so Medicaid can reach you.
7. You must respond to calls from Liberty Healthcare to schedule your appointment and receive other important information.
8. You must participate in the assessment to the best of your ability and choose a PCS provider who accepts Medicaid.

**\* Beneficiaries residing in their primary private residence who believe that they need additional assistance with medication management or are unable to self-administer medication, should contact their primary care provider to discuss their need for additional assistance and seek referrals to be assessed for alternative services, such as home health, that may assist with medication management**

For the full Medicaid PCS Clinical Coverage Policy 3L, please visit: <http://www.ncdhhs.gov/dma/mp/3L.pdf>.  
By signing this form, you are confirming that the guide was explained to you and that you received a copy.

\_\_\_\_\_  
Beneficiary Printed Name/Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (if Beneficiary is unable to sign) Printed Name/Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Independent Assessor Printed Name/Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Medicaid #

\_\_\_\_\_  
DOB

A copy of PCS Beneficiary Participation Guide was left

Beneficiary declined to sign

# Appendix C: Provider Registration for PCS Agency or Facility Use of QiRePort Form and Instructions



## Provider Registration For PCS Agency or Facility Use of QiRePort

Complete this form and send to VieBridge, Inc. QiReport Support at fax (919)301-0765 or mail: VieBridge, Inc. QiReport Team, 8130 Boone Boulevard, Suite 350, Vienna, VA 22182. For questions, call QiReport Support Team at 888-705-0970 option 3 or email at Support@qireport.net.

### Agency/Facility Identification and Primary Contact Information

Owner/Corporate Identity (Full name)					Main Phone		Main Fax	
Agency/Facility Name If Different Than Corporate Identity (dba):			NPI number w/3 digit locator code: i.e. 1001110000-003				ACH only DHSR License #	
Agency/Facility Mailing Address								
Street Address or PO Box			City		State	NC	Zip	
Agency/Facility Staff Contact Information For QiReport Support and Communications (For the agency/facility as a whole, QiReport Administrators)								
Last Name		First Name		Position		Telephone		E-Mail
Last Name		First Name		Position		Telephone		E-Mail

### List Agency/Facility NPI Numbers with 3 digit Locator Codes Used For PCS Billing (List up to 15 NPI numbers below); i.e. 1001110000-003


### List Staff Requiring Access To Beneficiary Information For All Agency/Facility NPI Numbers Listed Above (Up to 5 agency/facility staff)

Agency/Facility Staff or Designated Representatives				
Last Name	First Name	Type of Access To QiRePort *	E-Mail Address	Telephone

\* Type of Access Select either (Add/Edit=2 Administrators) or (View Only=Users)

**List Staff Requiring Access To Beneficiary Data Associated With A Single Agency/Facility NPI Number with 3 digit locator code**

Enter NPI Number with 3 digit Locator Code Below: i.e. 1001110000-003	Enter Agency/Facility Location Associated With NPI Number (If applicable)				Telephone	Fax
	Street	City	State	Zip		
<b>List Agency/Facility staff requiring access to beneficiary information for a specific agency/facility NPI number (Maximum of five staff per office)</b>						
LastName	FirstName	Type of Access To QiRePort *	E-MailAddress		Telephone	

\* Type of Access: Select either (Add/Edit=2 Administrators) or (View Only=Users)

**List Staff Requiring Access To Beneficiary Data Associated With A Single Agency/Facility NPI Number with 3 digit locator code**

Enter NPI Number with 3 digit Locator Code Below: i.e. 1001110000-003	Enter Agency/Facility Location Associated With NPI Number (If applicable)				Telephone	Fax
	Street	City	State	Zip		
<b>List agency/facility staff requiring access to beneficiary information for a specific agency/facility NPI number (Maximum of five staff per office)</b>						
LastName	FirstName	Type of Access To QiRePort *	E-MailAddress		Telephone	

\* Type of Access: Select either (Add/Edit=2 Administrators) or (View Only=Users)

(If you have more than two agency/facility NPI numbers you want to set up separately for QiRePort access, make extra copies of page 2)

**Certification**

I certify that all the individuals listed in this form are either staff or designated agency/facility representatives of the agency and require access to beneficiary information:

Signature: \_\_\_\_\_ Print/Type Name: \_\_\_\_\_ Position: \_\_\_\_\_ Date: \_\_\_\_\_

## Instructions For Completion Of The Agency/Facility Provider Registration Form

The PCS Provider Registration Form for QiRePort is used to register PCS agency/facility staff or designated agency/facility representatives as QiRePort users. QiRePort contains beneficiary information and is a secure site. All users must be registered and log-in to QiRePort with individualized NCIID usernames and passwords obtained from NCID.nc.gov.

Provider registration is organized around the NPI numbers with 3 digit locator codes used by your agency/facility. If you have staff that require access to beneficiary information for every PCS NPI number, a separate place is provided on the form to identify those staff.

Follow these instructions for completion of the form:

### Agency/Facility Identification and Primary Contact Information

- Complete all fields.
- Make sure to provide two contact persons for your agency/facility that will be responsible for communicating to QiReport Support any changes in staff access to QiRePort. These two individuals will be the only persons able to submit the names of any new staff that require QiRePort access or the names of agency/facility staff no longer allowed QiRePort access representing your agency.

### Agency NPI Numbers with 3 digit Locator Codes Used By Agency/Facility For PCS

- Provide a list of all agency/facility NPI numbers with 3 digit locator codes used for PCS billing. If your agency/facility has more than 15 billing numbers, submit an additional copy of page 1 of this form with the additional NPI numbers.

### Agency/Facility Staff Requiring Access To Beneficiary Information For All Agency/Facility NPI Numbers with 3 Digit Locator Codes

- List up to five staff that will be able to access QiRePort for all Medicaid billing NPI numbers with 3 digit locator codes of your agency/facility. If you only have one agency/facility number, skip page 2 except for the certification and signature.
- All fields must be completed in this section of the form.
- Select only one option for primary role. Select from the following two options:
  - ✓ **Add/edit (administrator)** – Staff members assigned to this category will be able to enter and edit key information such as a referral decisions, change of status requests for reassessments, and beneficiary discharges. These users will also be to view beneficiary data associated with the NPI number that they are registered under. Generally staff members who are involved in agency/facility management or staff supervision are granted this type of access.
  - ✓ **View Only (user)** – Staff members assigned to this category will be able to view beneficiary information such as assessment requests and assessment results. However, these staff members will not be able to access any tools/functions in QiRePort where agency/facility decisions/requests for independent assessments are entered or edited.
- Every registered user must have an individual e-mail. This allows QiRePort to send e-mail to a registered user in cases where the user forgets their own password.

#### Agency/Facility Staff Requiring Access To QiRePort For Location NPI Numbers with Locator Code

- If you have multiple locations and/or multiple NPI numbers, you have the option of registering staff for individual NPI numbers.
- List up to five staff or designated representatives for each NPI number. Complete all fields.
- The same staff member or representative can be listed on more than one NPI number. Remember, any staff requiring access to all information related to all of your agency/facility's NPI numbers are included in the first list on page 1 of the form.
- If your agency/facility has more than two billing NPI numbers, make a copy of page 2 of the form and add it to the bottom of the Word document. Add as many additional pages as needed to document all your provider numbers.
- Be sure to enter the NPI number with 3 digit locator code for the Agency/Facility location.
- Enter up to five staff requiring access to the beneficiary information associated with the listed location NPI number with 3 digit locator code.

#### Certification

- Sign the form.
- Provide the related identification information for the individual signing the form.

#### **Transmittal to QiReport Support**

Once the registration form is completed, it should be sent to VieBridge, Inc. QiReport Support at fax (919)301-0765 or mail: VieBridge, Inc. QiReport Team, 8130 Boone Boulevard, Suite 350, Vienna, VA 22182.

#### **Confirmation Of Registration**

Once QiReport Support enters the registration information you provide, each registered user will receive an e-mail generated by QiRePort confirming the registration and a user name and temporary password to be entered in the log-in page of QiRePort. Some e-mail programs have junk mail and spam filters that will block or divert the registration e-mail to a junk mail folder. Be sure to check your junk mail before inquiring on the status of the confirmation of registration.

#### **Access To QiRePort**

As of September 3, 2013 all QiReport users must have an NCID userid and password to obtain access to qireport.net.

For questions, contact QiReport Support Team at 888-705-0970 option 3 or email support@qireport.net.

#### **QiReport/DMA 10/01/2013**

# Appendix D: Clinical Coverage Policy 3L

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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:

- b. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;

- c. the beneficiary does not meet the criteria listed in **Section 3.0**;
- d. the procedure, product, or service duplicates another provider's procedure, product, or service;  
or
- e. 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.

<b>Beneficiary's Self-Performance Rating</b>	<b>Description</b>
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:

- g. 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;
- h. 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;
- i. 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;
- j. The IAE shall furnish the new provider with a copy of the assessment and service authorization;
- k. The new PCS Provider shall be required to develop a new service plan;
- l. The new PCS Provider shall complete the service plan within seven (7) business days of accepting the referral;
- m. 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;
- n. Providers shall notify the IAE of any discharges as they occur via the Provider Interface; and
- o. 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 (1<sup>st</sup>, 2<sup>nd</sup> or 3<sup>rd</sup> 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:

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

- e. 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;
- f. implement an organizational CQI Program designed to identify and correct quality of care and quality of service problems;
- g. conduct at least annually a written beneficiary PCS satisfaction survey for beneficiaries and their legally responsible person;
- h. maintain complete records of all CQI activities and results;
- i. 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
- j. 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.

## **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

<b>Beneficiary's Overall Self-Performance Capacity</b>			
<b>ADL</b>	<b>Limited Assistance</b>	<b>Extensive Assistance</b>	<b>Full Dependence</b>
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
<b>Medication Assistance</b>			
<b>Reminders/ Set-Up/Supervision</b>	<b>Routine Administration, 8 or Fewer</b>	<b>Routine Administration Plus PRN</b>	<b>Poly pharmacy and/or Complex</b>
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](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/>

# Appendix E: DMA 3085 PCS Training Attestation Form and Instructions

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N.C. Department of Health and Human Services – Division of Medical Assistance  
**SESSION LAW 2013-306 PCS TRAINING ATTESTATION FORM DMA-3085**

Send completed form and supporting documentation to NC - Division of Medical Assistance at [DMA.PCSTraining@lists.ncmail.net](mailto:DMA.PCSTraining@lists.ncmail.net). For questions, contact 919-855-4337 or send an email to [PCS\\_Program\\_Questions@dhhs.nc.gov](mailto:PCS_Program_Questions@dhhs.nc.gov)

<b>PROVIDER TYPE (select one)</b>	<b>DATE OF SUBMISSION:</b> _____ (mm/dd/yyyy)
<input type="checkbox"/> Home Care Agency <input type="checkbox"/> Family Care Home <input type="checkbox"/> Adult Care Home <input type="checkbox"/> Adult Care Bed in Nursing Facility <input type="checkbox"/> SLF-5600a	
<input type="checkbox"/> SLF-5600c <input type="checkbox"/> Special Care Unit (stand-alone Special Care Unit or SCU bed) <input type="checkbox"/> Non-Provider: _____	

**PART I SUBMITTER INFORMATION**

National Provider Identifier (NPI#): \_\_\_\_\_

Provider Name: \_\_\_\_\_

Submitter Name: First: \_\_\_\_\_ Last: \_\_\_\_\_ M.I.: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ Zip: \_\_\_\_\_ (zip code + 4 digit extension) Phone: \_\_\_\_\_

Suite: \_\_\_\_\_ Email: \_\_\_\_\_ Fax (If Applicable): \_\_\_\_\_

**PART II TRAINER QUALIFICATIONS**

Check the box to the left if you have attached additional documentation for this section.

List Trainer Qualifications.

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**PART III CURRICULUM OUTLINE**

Check the box to the left if you have attached additional documentation for this section.

Outline the structure and training methodology. Include goals, core competencies, and skills validation.

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**SUBMITTER SIGNATURE**

**DATE** (mm/dd/yyyy)

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(\_\_\_\_/\_\_\_\_/\_\_\_\_)



## SESSION LAW 2013-306 PCS TRAINING ATTESTATION FORM DMA-3085

### INSTRUCTIONS

These instructions offer guidance for completing the Personal Care Services (PCS) Session Law 2013-306 PCS Training Attestation Form DMA-3085 and should be read in its entirety before completing the form. This form should ONLY be used by Providers to attest to their compliance with NC Aide Training Requirements per Session Law 2013-306.

Completed Attestation Forms should be submitted electronically to NC- Division of Medical Assistance (DMA) via [DMA.PCSTraining@lists.ncmail.net](mailto:DMA.PCSTraining@lists.ncmail.net)

In accordance to Session Law 2013-306; Providers serving beneficiaries seeking additional hours of PCS due to Alzheimer's or other Memory Care complications are required to have 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.

The NC DMA PCS program requires that providers intending to claim services rendered to beneficiaries receiving additional hours of PCS under Session Law 2013-306 attest to their aide training curriculum and submit the form to DMA.

Indicate the date of the submission in the outlined format. When selecting the Provider Type indicate the type of provider employing the caregiver who has completed Alzheimer's and Memory care training.

#### **PART I – SUBMITTER INFORMATION:**

1. Attestation forms cannot be processed if they are missing any of the information listed below:
  - National Provider Identifier #
  - Provider Name
  - Submitter Name (i.e., First, Last)
  - Provider/Submitter Address (including city, state, and zip)
  - County
  - Contact Phone Number
  - Contact Email

#### **PART II – TRAINER QUALIFICATIONS:**

1. If the provider's chosen training curriculum has a written component outlining the Trainer qualifications it can be supplied along with the form to provide additional information for this section. If additional materials related to this section are included, the check box at the top of Part II should be checked.
2. The qualifications required for a Trainer to teach using the named training curriculum should be listed in the supplied area in Part II. For example, if the chosen training course can only be taught by a Registered Nurse, the qualification in this section would be RN. If the form provides insufficient space for the information, additional documents may be attached as per #1 above. List the trainer qualifications as accurately as possible.
3. If the provider's chosen training curriculum includes online or pre-developed modules that do not require active teachers the organization that developed the module should be listed under training qualifications.

### **PART III – CURRICULUM OUTLINE:**

1. If the training curriculum has a written outline describing the structure and training methodology it can be supplied along with the form to provide additional information for this section. If additional materials related to this section are included, the check box at the top of Part III should be checked.
2. The curriculum must include description of training goals, core competencies, and skills validation in addition to general training methodology. Online or pre-developed modules used as components of the selected training curriculum should also be listed under this section. If possible, information concerning these modules, such as descriptions or summaries, should be included in this section as well. Online modules provided by Liberty Healthcare need only be referenced. If the form provides insufficient space for the information, additional documents may be attached as per #1 above.

Complete the DMA-3085 and submit by email, or U.S. mail as noted below along with any required materials as noted on the form.

**Email:** [DMA.PCSTraining@lists.ncmail.net](mailto:DMA.PCSTraining@lists.ncmail.net)

**Fax to:** PCS Program Committee 919-715-0102

**Mail to:** NC DMA Home & Community Care

2501 Mail Service Center

Raleigh, NC 27699-2501

**Do not submit materials directly to DMA Staff.**

### **REVIEW AND ACKNOWLEDGEMENT**

The DMA PCS program committee will review submitted attestations.

- Submissions received by 5pm Wednesday will be reviewed the following Monday.
- Auto-reply feature is provided to inform Providers of successful submission.
- Incomplete submissions will not be processed.

# Appendix F: DMA 3136 Internal Quality Improvement Program Attestation Form and Instructions

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N.C. Department of Health and Human Services – Division of Medical Assistance  
**INTERNAL QUALITY IMPROVEMENT PROGRAM ATTESTATION FORM**

Completed form should be submitted via email to NC - Division of Medical Assistance  
[DMA.PCSQualityImprovement@lists.ncmail.net](mailto:DMA.PCSQualityImprovement@lists.ncmail.net) For questions, contact 919-855-4360 or send an email to  
[PCS\\_Program\\_Questions@dhhs.nc.gov](mailto:PCS_Program_Questions@dhhs.nc.gov)

**SUBMISSION REQUIREMENTS**

PCS Providers shall submit this Attestation to DMA by December 31st of each year certifying compliance with “a” through “d” of Clinical Coverage Policy 3L Section 7.7 by initialing each of the items described below.

**PROVIDER TYPE (select one)**

- Home Care Agency    
  Family Care Home    
  Adult Care Home    
  Adult Care Bed in Nursing Facility    
  SLF-5600a  
 SLF-5600c    
  Special Care Unit (stand-alone Special Care Unit or SCU bed)    
  Non-Provider: \_\_\_\_\_

**SUBMITTER INFORMATION**

**NPI:** \_\_\_\_\_  
**Provider Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_  
**County:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ (zip code + 4 digit extension) **Phone:** \_\_\_\_\_  
**Suite:** \_\_\_\_\_ **Email:** \_\_\_\_\_ **Fax (If Applicable):** \_\_\_\_\_

**INTERNAL QUALITY IMPROVEMENT REQUIREMENTS - CLINICAL COVERAGE POLICY 3L SECTION 7.7**

**INITIAL**

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	_____

Person Completing this Form:

\_\_\_\_\_  
 Name (Printed)

\_\_\_\_\_  
 Title

SIGNATURE

DATE (mm/dd/yyyy)

( \_\_\_\_ / \_\_\_\_ / \_\_\_\_ )

(LEGIBLY SIGN YOUR NAME (STAMPS and ELECTRONIC SIGNATURES ARE NOT ACCEPTABLE FOR THIS FORM.)

I hereby attest that I am in compliance with the items described in Clinical Coverage Policy 3L Section 7.7. I also agree to provide any of the referenced documents to DMA or a DHHS designated contractor upon request in conjunction with any on-site or desktop quality improvement review.

**NC-DIVISION OF MEDICAL ASSISTANCE  
DMA 3136  
INTERNAL QUALITY IMPROVEMENT PROGRAM ATTESTATION FORM**

**INSTRUCTIONS**

These instructions offer guidance for completing the Internal Quality Improvement Program Attestation Form and should be read in its entirety before completing the form. This form should ONLY be used by Providers to attest to their compliance with Clinical Coverage Policy 3L Section 7.7 Internal Quality Improvement Program. Completed Attestation Forms should be **submitted electronically to NC- Division of Medical Assistance (DMA) via [DMA.PCSQualityImprovement@lists.ncmail.net](mailto:DMA.PCSQualityImprovement@lists.ncmail.net)**.

In accordance to Clinical Coverage Policy 3L Section 7.7 Internal Quality Improvement Program, Providers serving beneficiaries receiving PCS are required to complete and adhere to an organizational Quality Improvement Plan or set of quality improvement policies and procedures.

The NC DMA PCS program committee requires that Providers attest to items a. through d. of the Internal Quality Improvement Section of PCs Policy 3L and submit the form to DMA for recordkeeping.

**PROVIDER TYPE**

Attesting Providers must indicate on the form which of the general Provider cohort designations fit their organization.

**SUBMITTER INFORMATION**

Attestation forms cannot be processed if they are missing any of the information listed below:

- National Provider Identifier #
- Provider Name
- Provider/Requestor Address (including city, state, and zip)
- County
- Contact Phone Number
- Contact Fax Number (if applicable)
- Contact Email

**INTERNAL QUALITY IMPROVEMENT REQUIREMENTS**

Attesting Providers must review each requirement before initialing each item individually in the area provided.

**SUBMISSION REQUIREMENTS**

The DMA 3136 Internal Quality Improvement Program Attestation form must be completed, signed, and dated on or before December 31<sup>st</sup> for each calendar year.

Example: Attestation forms for 2015 are due to DMA on or before December 31<sup>st</sup> 2015.

Attestation forms should not be submitted prior to the completion of requirements which include continuous quality improvement programs and activities conducted at least quarterly.

Complete the DMA 3136 and submit by email, or U.S. mail as noted below.

**Email:** [DMA.PCSQualityImprovement@lists.ncmail.net](mailto:DMA.PCSQualityImprovement@lists.ncmail.net)

**Mail to:** NC DMA Home & Community Care  
2501 Mail Service Center  
Raleigh, NC 27699-2501

Do not submit materials directly to DMA Staff.

# Appendix G: DMA 3114 Request for Reconsideration of PCS Authorization and Instructions

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# Request for Reconsideration of PCS Authorization

North Carolina Department of Health and Human Services – Division of Medical Assistance

*Following an initial PCS Service Authorization for less than 80 hours per month, beneficiaries 21 years of age or older, may submit a Request for Reconsideration of PCS Authorization form to request additional hours. Reconsideration request must be received no earlier than 31 calendar days and no later than 60 calendar days from the date of the initial approval notification.*

Completed form should be submitted to Liberty Healthcare Corporation-NC via fax to 919-322-5942 or 855-740-0200. For questions, call 855-740-1400 or 919-322-5944. Incomplete or illegible forms will not be processed.

## **Section A: Beneficiary Information**

### Beneficiary Demographics

Name: First: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_ DOB: \_\_\_\_\_

Medicaid ID: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Address (if Different from Initial Request): \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ Zip: \_\_\_\_\_

### Alternate Contact (optional)

Name: First: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Relationship to Beneficiary: \_\_\_\_\_ Phone: \_\_\_\_\_

## **Section B: Reconsideration**

Please specify which ADL(s) and Task(s) are not being supported by the current authorized hours of PCS.

- Bathing
- Dressing
- Mobility
- Toileting
- Eating
- Other – If other, describe

\_\_\_\_\_  
\_\_\_\_\_

## **Section C: Supporting Documentation**

Supporting documentation must be submitted that specifies, explains, and supports why more authorized hours of PCS are needed and which ADL(s) and Task(s) are not being met by the current hours. The 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.

\_\_\_\_\_  
\_\_\_\_\_  
**Signature of Medicaid Beneficiary or Legal Guardian/POA**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name (Print)**  
DMA 3114  
[7/1/2016]

\_\_\_\_\_  
**Relationship to Beneficiary**

These instructions offer guidance for completing the Request for Reconsideration of PCS Authorization Form DMA-3114 and should be read in its entirety before completing the form. This form should ONLY be used by beneficiaries, 21 years of age or older, following an initial PCS Service Authorization for less than 80 hours per month. Completed Reconsideration of PCS Authorization Forms should be submitted no earlier than 31 calendar days and no later than 60 calendar days from the date of the initial approval notification to Liberty Healthcare Corporation-NC via fax to 919-322-5942 or 855-740-0200.

In accordance with *Pettigrew v. Brajer*; A Reconsideration may be requested by a beneficiary that is 21 years and older who receives an **initial approval** for less than 80 PCS hours per month. The Reconsideration request is a request to increase hours above the initial approval and may be submitted if the beneficiary does not agree with the initial level of service as determined. *The Reconsideration process does not apply to beneficiaries seeking hours in accordance with Subsection 5.3.1b of the PCS Policy 3L.*

Requests for reconsideration will not be processed if they are missing any of the information listed below:

**Section A: Beneficiary Information**

- Beneficiary Name (i.e., First, Last)
- Date of Birth (DOB)
- Medicaid ID
- Contact Telephone Number
- Address
- Alternate Contact Information (Optional)

**Section B: Reconsideration**

- Place a check mark (✓) in each box (□) that represents the ADL(s) or Task(s) that are not being supported by the current authorized hours of PCS.
- If ADL(s) or Task(s) listed do not represent your need for reconsideration, write a short description of why you are requesting this reconsideration.

**Section C: Supporting Documentation**

- When submitting the Request for Reconsideration of PCS Authorization Form DMA-3114, supporting documentation must also be faxed.
- Supporting documentation must specify, explain, and support why additional hours of PCS are needed and which ADL(s) and Task(s) are not being met with the current hours.
- 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.

Complete the Request for Reconsideration of PCS Authorization Form DMA-3114 and submit via fax along with any required materials as noted on the form.

Liberty Healthcare Corporation  
919-322-5942 or 855-740-0200

**Review and Acknowledgment**

Nurse reviewers from Liberty Healthcare Corporation-NC will evaluate submitted Request for Reconsideration of PCS Authorization Forms and supporting documentation.

Incomplete, Illegible, or requests submitted without supporting documentation as indicated above, will not be processed. A reconsideration request is not considered complete without supporting documentation as indicated in PCS Policy 3L 5.6(c and d).



## Appendix H: Provider Resources and Contact Information

Department Name	Contact Information	Resource Information
Division of Medical Assistance (DMA),	<a href="http://www.ncdhhs.gov/dma/medicaid">http://www.ncdhhs.gov/dma/medicaid</a> 800-662-7030	DHHS Customer Service
DMA Personal Care Services (PCS)	<a href="http://www.ncdhhs.gov/dma/pcs/pas.html">http://www.ncdhhs.gov/dma/pcs/pas.html</a> 919-855-4360	For questions or concerns regarding PCS clinical policy
DMA, Program Integrity Section	<a href="http://www.ncdhhs.gov/dma/pi.htm">http://www.ncdhhs.gov/dma/pi.htm</a> 800-662-7030	For questions or concerns regarding provider agency fraud and abuse
DMA Finance	919-814-0060	For questions about recoup and repay
Liberty Healthcare of North Carolina	<a href="http://www.nc-pcs.com">http://www.nc-pcs.com</a> 919-322-5944 855-740-1400	For questions regarding PCS procedures such as submitting referrals and requests, the independent assessment process, or beneficiary status questions
Computer Science Corporation (CSC)	800-688-6696	For questions regarding submitting PCS billing claims, billing errors or issues with the electronic claims submission tool.
Computer Science Corporation (CSC), Provider Enrollment	<a href="http://www.ncdhhs.gov/dma/provenroll/index.htm">http://www.ncdhhs.gov/dma/provenroll/index.htm</a> 866-844-1113 OMMISS.ProviderRelations@dhhs.nc.gov	For questions regarding Medicaid provider enrollment and agency records

<p>Division of Health Service Regulations</p>	<p><a href="http://www.ncdhhs.gov/dhsr">www.ncdhhs.gov/dhsr</a></p> <p>Acute and Home Care Licensure  <a href="http://www.ncdhhs.gov/dhsr/ahc/index.html">http://www.ncdhhs.gov/dhsr/ahc/index.html</a>  919-855-4620</p> <p>Adult Care Licensure:  <a href="http://www.ncdhhs.gov/dhsr/acls/index.html">http://www.ncdhhs.gov/dhsr/acls/index.html</a>  919-855-3765</p>	<p>For questions or concerns regarding licensure requirements.</p>
<p>Division of Social Services</p>	<p><a href="http://www.ncdhhs.gov/dss/local">www.ncdhhs.gov/dss/local</a>  919-733-3055</p>	<p>For questions about how to reach your local county Social Services Agency</p>
<p>Division of Aging and Adult Services</p>	<p><a href="http://www.ncdhhs.gov/aging/">http://www.ncdhhs.gov/aging/</a>  919) 733-3983</p>	<p>For questions regarding social services and some benefits programs for older and persons with disabilities and their families as provided by the state's 100 county departments of social services.</p>
<p>North Carolina Board of Nursing</p>	<p><a href="http://www.ncbod.com">www.ncbod.com</a>  919-782-3211</p>	<p>For questions regarding RN, CNA, or PCA licensure requirements.</p>
<p>Division of Mental Health, Developmental Disabilities, and Substance Abuse Services</p>	<p>Barbara Flood – EAST – 919-218-3872,  <a href="mailto:barbara.flood@dhhs.nc.gov">barbara.flood@dhhs.nc.gov</a>  Patricia McNear – CENTRAL – 919-218-3272,  <a href="mailto:patricia.mcnear@dhhs.nc.gov">patricia.mcnear@dhhs.nc.gov</a>  Bill Joyce – WEST – 336-312-0212,  <a href="mailto:bill.joyce@dhhs.nc.gov">bill.joyce@dhhs.nc.gov</a></p>	<p>For questions regarding PASRR requirements.</p>

## Manual Implementation and History

**Original Effective Date:** October 2014

### History:

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
May 2015	Provider Manual – Cover Page	“May 2015”
May 2015	Contents Page 2; Chapter 2:	“Request for Independent Assessment for PCS”
May 2015	Contents Page 2; Chapter 2.1	“New Request for Independent Assessment for PCS...”
May 2015	Contents Page 3; Appendix A:	“Request for Independent Assessment for PCS”
May 2015	Contents Page 3; Appendix B:	“Medicaid PCS Beneficiary Participation Guide”
May 2015	Contents Page 3; Appendix F added:	“DMA 3136 Internal Quality Improvement Program Attestation Form”
May 2015	Contents Page 3; Appendix G	“Appendix G: Provider Resources and Contact Information”
May 2015	Page 6; Heading, “Additional general program requirements include:” (last bullet)	“...will not receive PCS without verification of an ACH PASRR number.”
May 2015	Page 7; Personal Care Services; first sentence; add'l information at the end	“...tasks and services that needs to occur at minimum, once per week:”
May 2015	Page 7; Personal Care Services; #4; deleted information	“4...causing the functional limitations requiring the PCS”
May 2015	Page 7; Personal Care Services; under EPSDT criteria; #1; add'l information	“1 ...and monitoring (precautionary observation) related to qualifying ADLs;”
May 2015	Page 7; Personal Care Services; under EPSDT criteria; #2; add'l information	“2...and coaching related to qualifying ADL's:
May	Page 7; Medication Assistance;	“Medicaid shall cover medication assistance when it is:”

2015	first sentence revised	
May 2015	Page 7; Medication Assistance; #1 deleted	“1. Directly linked to a documented medical condition or physical or cognitive impairment causing the functional limitations requiring the PCS;”
May 2015	Page 8; “NOTE” revised to read	“A beneficiary may not receive PCS and another substantially equivalent federal or state funded in conjunction with another substantially equivalent Federal or State funded service. Examples of equivalent services include home health aide services and in-home aide services in the Community Alternatives Programs (CAP/Disabled Adults, CAP/Children, CAP/Choice, and CAP Innovations. This restriction also includes any other federal or state funded service that provides hands-on assistance with ADLs.”
May 2015	Page 8; under the heading: Medicaid does not cover Personal Care Services (PCS) when; #8 revised to read	“8. The PCS is provided by an individual whose primary private residence is the same as the beneficiary’s primary residence;”
May 2015	Page 10; under the heading PCS Independent Assessment Completion Process Overview; first para	“...for each beneficiary who requests an independent assessment to be considered for PCS.”
May 2015	Page 10; under the heading PCS Independent Assessment Completion Process Overview; #1 revised to read	1. “1. PCS Request – The beneficiary has their primary care physician or attending physician complete the DMA Form 3051 Request for Independent Assessment for Personal Care Services and send it to LHC-NC for processing.
May 2015	Page 10; under the heading PCS Independent Assessment Completion Process Overview; #6 revised to read	6. Provider Acceptance and Notification – If it is determined that the beneficiary is eligible for personal care services; the selected provider will be sent a request for service form to accept or reject the beneficiary’s request. Once the provider accepts the beneficiary for care and completes a service plan, a formal notification is sent to the beneficiary and to the provider and PCS services may begin.
May 2015	Page 11; 1.1 General Requirements; #2, #3 and #4 revised to read	<ol style="list-style-type: none"> <li>1. Have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement;</li> <li>2. Bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity; and</li> <li>3. Ensure any individual delivering Medicaid PCS does not have any of the following findings on their background check: <ol style="list-style-type: none"> <li>a. 1. felonies related to manufacture, distribution,</li> </ol> </li> </ol>

		<p>prescription or dispensing of a controlled substance;</p> <ol style="list-style-type: none"> <li>b. 2. felony health care fraud;</li> <li>c. 3. more than one felony conviction;</li> <li>d. 4. felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult;</li> <li>e. 5. felony or misdemeanor patient abuse;</li> <li>f. 6. felony or misdemeanor involving cruelty or torture;</li> <li>g. 7. misdemeanor healthcare fraud;</li> <li>h. 8. misdemeanor for abuse, neglect, or exploitation listed with the NC Health Care Registry; or</li> <li>i. 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.</li> </ol>
May 2015	Page 12; 1.4 Supervision of PCS Aides; #3 and #4 revised to read	<p>3. Completion and approval of all service plans for assigned beneficiaries;</p> <p>4. Implementing the service plan;</p>
May 2015	Page 13; 1.5 Supervisory Visits in Beneficiary Private Residences; The RN Supervisor shall; #5 revised to read	5..."beneficiary's service plan exceeds and/or no longer meets the beneficiary's needs for ADL assistance."
May 2015	Page 13; 1.5 Supervisory Visits in Beneficiary Private Residences; The RN Supervisor shall; #8b and #8c revised to read	<p>8a. Services listed in the service plan have been implemented;</p> <p>8b. Service plan deviations are documented;</p>
May 2015	Page 14; 1.7 PCS Aides; 2 <sup>nd</sup> para added to sentence	..."(legally responsible person, spouse, parents, siblings, grandparents,..."
May 2015	Page 15; 1.11 Requirements for Aide Documentation; section revised to read	<p>The provider organization accepting the referral to provide services shall:</p> <ul style="list-style-type: none"> <li>✓ 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;</li> <li>✓ Document aide services provided, to include, at minimum, the date of service, care tasks provided, and the aide providing the service; and</li> <li>✓ Document all deviations from the service plan; this documentation shall include, at minimum, care tasks not performed and reason tasks were not performed. <ul style="list-style-type: none"> <li>✓ The Provider Interface provides an option for documenting aide services and task sheets. If a provider organization elects to use their own aide task</li> </ul> </li> </ul>

		worksheets, the worksheets must accurately reflect all aide tasks and schedule documented in the online PCS service plan, task by task.
May 2015	Page 16 and Page 17; 1.12 PCS; title and section revised to read	<p>1.12 PCS On-line Service Plan</p> <ol style="list-style-type: none"> <li>1. All IAE referrals are transmitted to provider organizations through the Provider Interface. No mailed or faxed referrals are provided;</li> <li>2. 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;</li> <li>3. c. Provider organizations shall designate staff they determine appropriate to complete and submit the service plan via the Provider Interface.</li> <li>4. 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;</li> <li>5. 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;</li> <li>6. 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;</li> <li>7. 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;</li> <li>8. h. The provider organization shall obtain the written consent of the beneficiary or their legally responsible person to the proposed PCS service plan. The written consent must be reported in the PCS service plan documentation included in the Provider Interface;</li> <li>9. i. 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;</li> <li>10. j. The PCS service plan must be developed, validated and agreed to by the beneficiary or their legally responsible person within three (3) business days of receiving the IAE referral or notice of service authorization via the Provider Interface, or by the date requested by the beneficiary, whichever is later; the provider shall make a copy of the</li> </ol>

		<p>validated service plan available to the beneficiary or their legally responsible person within 2 business days of a verbal request;</p> <ol style="list-style-type: none"> <li>11. k. 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.</li> <li>12. . 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;</li> <li>13. m. 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;</li> <li>14. n. Provider organizations shall be reimbursed only for PCS authorized hours and services specified and scheduled in the validated PCS service plan; and,</li> <li>15. o. 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.</li> </ol>
May 2015	Page 17; 1.13 Section; 2 <sup>nd</sup> para, 2 <sup>nd</sup> sentence; revised to read	Adult Care Home providers licensed under G.S. 131D-2.4 will not receive PCS prior approval to render or bill for PCS without verification of an ACH PASRR number. ACH PASRR numbers are 10 digits followed by any of the following letter codes:
May 2015	Page 18; <i>added a formatted table</i> for the Authorization Codes & Corresponding Time Frames/Restrictions	See table.
May 2015	Page 18; PASRR Verification; NOTE revised to read	NOTE: Beneficiaries who reside in a 5600a or 5600c facility do not require a PASRR. Beneficiaries who have been admitted into an ACH prior to January 1, 2013, regardless of payer source (Private, Medicaid, or pending Medicaid) require no PASRR even if the beneficiary subsequently becomes Medicaid-eligible; however, if there is a change in status or if the beneficiary moves to another facility and requires Personal Care Services, a PASRR is required.
May	Page 19; Section number only	1.14 QiReport, Provider Interface Overview

2015	changed to read	
May 2015	Page 19; Section 1.14; changes in bulleted items to read	<ul style="list-style-type: none"> <li>▪ Access electronic copies of independent assessment documents, referrals, and notification letters;</li> <li>▪ Receive service referrals and accept/reject them electronically;</li> <li>▪ Create required PCS beneficiary service plans;</li> <li>▪ Manage servicing beneficiaries' accounts, including access to historical assessments and PA's;</li> <li>▪ Submit discharges;</li> <li>▪ Submit Non-Medical Change of Status Requests;</li> <li>▪ Manage servicing territories;</li> <li>▪ Change provider billing numbers for clients who need to have their service transferred from one provider office to another within the same agency;</li> <li>▪ Update/Correct Modifiers;</li> <li>▪ Receive electronic notification once a current client has entered an appeal, as well as the status of the appeal once it is resolved.</li> </ul>
May 2015	Page 21; Chapter 2; Title change to read	Chapter 2: Request for Independent Assessment for Personal Care Services
May 2015	Page 21; Chapter 2; first para; revised to read	Beneficiaries requesting Personal Care Services must submit a Request for an Independent Assessment for PCS 3051 form to Liberty Healthcare. The 3051 form allows a beneficiary to be considered for:
May 2015	Page 21; Chapter 2; v2 revised and v3 deleted	✓ Change of Status Medical/Non-Medical (increase or decrease of services)
May 2015	Page 21; Chapter 2; third para revised to read	Once received, all requests for an independent assessment are reviewed and processed within 2 business days. If a beneficiary, physician, or PCS provider wishes to inquire about the receipt and status of a PCS request, LHC-NC asks they call AFTER the 2 business day processing period.
May 2015	Page 21; 2.1 title changed	2.1 New Request for an Independent Assessment for PCS
May 2015	Page 21; 2.1 Section; NOTE;; Sentence two revised to read	NOTE: If a beneficiary is already enrolled in the PCS Program, a new referral should not be requested. A Change of Status Medical/Non-Medical request form should be submitted if a beneficiary requires another independent assessment due to a change in medical condition or functional status.
May	Page 21 and Page 22; Section	In order for the 3051 request for an independent assessment form



2015	2.1 Completing a New Request; first para revised to read	to be approved for eligibility and processed timely, all required sections of the form must be completed and legible. Incomplete request forms may result in a delay of processing or denial of the request for an independent assessment. To ensure the 3051 PCS request form is processed timely, the following sections of the referral form must be completed by a physician only:
May 2015	Page 22; Section 2.1.1; Section A and Section B revised to read	<p>√ Section A, Beneficiary Demographics – Required fields are as follows:</p> <ul style="list-style-type: none"> <li>✓ Date of Request</li> <li>✓ Medicaid ID – Only those with active Medicaid are eligible for PCS. Eligibility status is verified prior to the processing of any request for an independent assessment</li> <li>✓ Demographic Information - Beneficiary name, date of birth, contact information</li> <li>✓ ACH PASRR number (beneficiaries who reside in an Adult Care Home setting only)</li> <li>✓ Indication if the beneficiary has an active Adult Protective Service Case</li> </ul> <p>√ Section B, Beneficiary’s Conditions that Result in Need for Assistance with ADLs– Required fields are as follows:</p> <ul style="list-style-type: none"> <li>✓ Medical diagnosis with corresponding complete current diagnosis code</li> <li>✓ Indication if the diagnosis listed impacts the beneficiary’s ability to perform their ADLs - Diagnoses must impact ADLs or the request for an independent assessment will not be processed(Clinical Policy 3L, section 5.4.2)</li> <li>✓ Date of Onset</li> <li>✓ Indicate expected duration of ADL limitation</li> <li>✓ Check if the beneficiary is medically stable</li> <li>✓ Check if 24-hour caregiver availability is required</li> </ul> <p>Optional Attestation – If the criteria listed in this section is applicable to the beneficiary, the Practitioner should hand initial each line item that applies for consideration in the assessment for PCS; typed initials are not accepted.</p>
May 2015	Page 22 and Page 23; Section 2.1.1; NOTE (s) and Section C revised to read	<p>Note: Diagnosis Header Codes will not be accepted. The complete current diagnosis code ex. XXX.X or XXX.XX associated with the identified medical diagnosis must be present.</p> <p>√ Section C, Practitioner Information– Required fields are as follows:</p> <ul style="list-style-type: none"> <li>• Date of Last Visit to Referring Practitioner– The beneficiary must have seen their PCP within the last 90 days to be eligible for PCS</li> <li>• Attesting Practitioner Name and NPI#</li> </ul>

		<ul style="list-style-type: none"> <li>Practice Information – Name, NPI#, and contact phone number</li> <li>Practitioner Attestation for Medical Need – Signature, Credentials, and Date – Must be signed by a MD, NP, or PA. If credentials are not included or cannot be verified, the request will not be processed.</li> </ul> <p>NOTE: A PCS provider may assist a beneficiary in the completion of the 3051 form, but responsibility of submission of the form to LHC-NC rests with the beneficiary and the referring practitioner.</p>
May 2015	Page 23; 2.1.2 Expedited Request for Personal Care Services; √ 3 revised to read	Have an ACH Preadmission Screening and Resident Review (PASRR) number on file*
May 2015	Page 23; 2.1.2 Expedited Request for Personal Care Services; NOTE revised	NOTE: *PASRR is required for beneficiaries seeking admission to an Adult Care Home licensed under G.S. 131 D-2.4.
May 2015	Page 23; 2.1.2 Expedited Request for Personal Care Services; NOTE revised; second bullet	An Adult Protective Services (APS) Worker; or
May 2015	Page 23; “The Expedited Assessment Completion Process” Heading; first para revised	“If eligibility requirements are met, a hospital discharge planner, skilled nursing facility discharge planner or Adult Protective Services (APS) worker may request an Expedited Assessment by faxing a completed Request for an Independent Assessment for PCS 3051 form (see section 2.1.1 for complete criteria) to Liberty Healthcare at 919-322-5942 or 855-740-0200 (toll free) followed by a call to LHC-NC at 855-740-1400.”
May 2015	Page 24; Personal Care Services Provisional Approval; first para; third sentence to word addition	“If a beneficiary is provisionally approved for PCS through the expedited assessment process, but is determined not to be Medicaid eligible, Liberty Healthcare will hold the authorization for up to 60 calendar days.”
May 2015	Page 24; 2.1.3 Incomplete New Requests and Denials; first para revised and bullets eliminated; revised to read	...” A denial notification will be sent to the beneficiary and a copy is faxed to the practitioner.
May 2015	Page 24; 2.1.3 Incomplete New Requests and Denials; second para; bulleted item	Diagnosis does not impact the ADLs

	added	
May 2015	Page 25; first para revised to read	...”or caregiver status that causes the need for assistance to increase or decrease. For any change of status that is due to a change in medical condition, a Change of Status Medical request may be submitted by a practitioner only. For any change in status that is due to a change in the beneficiary’s environmental condition, location, or caregiver status, the beneficiary, beneficiary’s family, or legally responsible person; residential provider, home care provider; or beneficiary’s physician may submit a Change of Status Non-Medical request A Medical and Non-Medical Change of Status request may be submitted anytime by the approved referring entity when appropriate.”
May 2015	Page 25; 2.2.1 Completing a Change of Status Request; title change	2.2.1 Completing a Change of Status Medical Request
May 2015	Page 25; 2.2.1 Completing a Change of Status Medical Request; revised	<p>“A Change of Status Medical Request may only be submitted by a practitioner any time a beneficiary has a change in medical condition and their treating practitioner feels an increase or decrease in PCS should be evaluated. In order to submit a Change of Status Medical request, the practitioner must complete the Request for Independent Assessment for PCS form (3051) and fax or mail a copy to Liberty Healthcare.</p> <p>The following sections are required fields that should be completed when submitting a COS Medical Request:</p> <ul style="list-style-type: none"> <li>✓ Section A, Beneficiary Demographics – Required fields are as follows: <ul style="list-style-type: none"> <li>• Date of Request</li> <li>• Medicaid ID – Only those with active Medicaid are eligible for PCS. Eligibility status is verified prior to the processing of any request for an independent assessment</li> <li>• Demographic Information - Beneficiary name, date of birth, contact information</li> <li>• Indication if the beneficiary has an active Adult Protective Service Case</li> </ul> </li> <li>✓ Section B, Beneficiary’s Conditions that Result in Need for Assistance with ADLs – Required fields are as follows: <ul style="list-style-type: none"> <li>• Medical diagnosis with corresponding complete current diagnosis code</li> <li>• Indication if the diagnosis listed impacts the</li> </ul> </li> </ul>

		<p>beneficiary’s ability to perform their ADLs - Diagnoses must impact ADLs or the request for an independent assessment will not be processed(Clinical Policy 3L, section 5.4.2)</p> <ul style="list-style-type: none"> <li>• Date of Onset</li> <li>• Indicate expected duration of ADL limitation</li> <li>• Check if the beneficiary is medically stable</li> <li>• Check if 24-hour caregiver availability is required</li> </ul> <p>Optional Attestation – If the criteria listed in this section is applicable to the beneficiary, the Practitioner should hand initial each line item that applies for consideration in the assessment for PCS; typed initials are not accepted.</p> <p>Note: Diagnosis Header Codes will not be accepted. The complete current diagnosis code ex. XXX.X or XXX.XX associated with the identified medical diagnosis must be present.</p> <p>✓ Section C, Practitioner Information – Required fields are as follows:</p> <ul style="list-style-type: none"> <li>• Date of Last Visit to Referring Practitioner– The beneficiary must have seen their PCP within the last 90 days in order to process a COS Medical Request</li> <li>• Attesting Practitioner Name and NPI#</li> <li>• Practice Information – Name, NPI#, and contact phone number</li> <li>• Practitioner Attestation for Medical Need – Signature, Credentials, and Date – Must be signed by a MD, NP, or PA. If credentials are not included or cannot be verified, the request will not be processed.</li> </ul> <p>Section D, Change of Status: Medical–The requesting practitioner must complete this section providing a detailed description of the specific change in medical condition and the impact the change has on the beneficiary’s ability to perform their ADLs.</p>
May 2015	Page 26 and Page 27; 2.2.2 Completing a Change of Status Non-Medical Request; section revised to read	<p>2.2.2 Completing a Change of Status Non-Medical Request</p> <p>Providers who are registered to use the Provider Interface of QiRePort may complete a Change of Status Non-Medical request and submit the form online through the portal. All other requestors may complete the Request for an Independent Assessment for Personal Care Services (3051) form and fax or mail a copy to Liberty Healthcare.</p>

		<p>When submitting the 3051 form, the requestor must complete page 3 only, filling out the top demographic section and section E with the required fields being as follows:</p> <ul style="list-style-type: none"> <li>✓ Beneficiary Demographics – Required fields are as follows: <ul style="list-style-type: none"> <li>• Date of Request</li> <li>• Medicaid ID – Only those with active Medicaid are eligible for PCS. Eligibility status is verified prior to the processing of any PCS request form.</li> <li>• Demographic Information - Beneficiary name, date of birth, contact information</li> </ul> </li> <li>✓ Section E, Change of Status: Non-Medical – Required fields are as follows: <ul style="list-style-type: none"> <li>• Request By along with Requestor Name</li> <li>• PCS Provider NPI#, Name, and Phone</li> <li>• Reason for non-medical change requiring a reassessment checked</li> <li>• Non-medical change described in detail and how the change impacts the beneficiary’s ability to perform ADLs</li> </ul> </li> </ul> <p>Note: DMA or its designee retains sole discretion in approving or denying requests to conduct a change of status reassessment. It is important that the description section include documentation of the change in the beneficiary’s medical condition, informal caregiver availability, environmental condition that affects the individual’s ability to self-perform, the time required to provide the qualifying ADL assistance and the need for reassessment. Change of status assessments are face-to-face assessments that are conducted by the designated IAE.</p>
May 2015	Page 27; 2.2.2; revised #	2.2.3 Incomplete Change of Status Requests and Denials
May 2015	2.3 Change of Provider (COP) Requests; first para revised to read	A PCS beneficiary has the right to change their PCS provider at any time. Only the beneficiary or a caregiver who has Power of Attorney or Legal Guardianship for the beneficiary can submit a Change of Provider request. A COP request may be submitted using the 3051 form or the beneficiary may call the Customer Support Center for Liberty Healthcare of NC at 855-740-1400.
May 2015	Page 28; 2.3.1 Completing a Change of Provider Request via Phone; first sentence, word change	If the beneficiary wishes to change his/her provider, only approved persons may call the Customer Support Center with Liberty Healthcare at 919-322-5944 or 855-740-1400 (toll free) to make this request.

<p>May 2015</p>	<p>Page 28; 2.3.2 Completing a Change of Provider Request via the 3051 Form; revised to read</p>	<p>Though strongly encouraged to call the Customer Support Center for all COP requests, a beneficiary may also submit their Change of Provider request by using the 3051 form.</p> <p>NOTE: Only in cases where a beneficiary is moving from one facility to another may the facility submit a Change of Provider request on behalf of the beneficiary.</p> <p>When submitting the 3051 form, the beneficiary must complete page 3 only, filling out the top demographic section and section F with the required fields being as follows:</p> <ul style="list-style-type: none"> <li>✓ Beneficiary Demographics – Required fields are as follows: <ul style="list-style-type: none"> <li>• Date of Request</li> <li>• Medicaid ID – Only those with active Medicaid are eligible for PCS. Eligibility status is verified prior to the processing of any PCS request form.</li> <li>• Demographic Information - Beneficiary name, date of birth, contact information</li> </ul> </li> <li>✓ Section F, Change of Provider Request – Required fields are as follows: <ul style="list-style-type: none"> <li>• ‘Requested by’ indicated, along with name and contact information</li> <li>• Reason for Provider Change</li> <li>• Beneficiary’s Preferred Provider Section, including: <ul style="list-style-type: none"> <li>▪ Setting Type</li> <li>▪ Agency Name, Address, and Phone</li> <li>▪ PCS Provider NPI#</li> <li>▪ Facility License # and Date if applicable</li> </ul> </li> </ul> </li> </ul>
<p>May 2015</p>	<p>Page 29; 2.3.3 Processing the Completed Change of Provider and Provider Acceptance; second para revised to read</p>	<p>A new assessment shall not be required unless a change of status has occurred. The IAE shall furnish the new provider with a copy of the assessment and the new service authorization. The new PCS Provider shall develop and implement a service plan within 3 business days of receiving notice of service authorization or by the date requested by the beneficiary, whichever is later (Clinical Policy 3L, section 5.4.11).</p>
<p>May 2015</p>	<p>Page 30; 2.4 Requesting Additional Safeguards; second para revised and V’s eliminated</p>	<p>To initiate the process for consideration of additional safeguard hours in addition to the base maximum allowance of PCS (80 hours), a beneficiary must have his/her Primary Care Physician or Attending Physician complete the optional attestation portion in Section B of the 3051 form in addition to the required sections depending on type of request. Additional Safeguards may be requested with a new</p>

		request or a change of status medical.
May 2015	Page 30; bottom of page, last para revised to read	“It is important for the Primary Care Physician or Attending Physician completing the request to note any pertinent medical diagnoses that may have caused the need for additional safeguards.”
May 2015	Page 30 and Page 31; NOTE revised to read	“NOTE: At the discretion of DMA or LHC-NC, additional medical documentation may be requested in order to validate the physician attestation. A beneficiary does NOT have to be a current PCS recipient in order to be considered for additional safeguards.”
May 2015	Page 31; Chapter 3 The Independent Assessment; 4 <sup>th</sup> bullet revised to read	Change of Status Medical/Non-Medical Assessment
May 2015	Page 32; Change of Status title revised to read	Change of Status Medical/Non-Medical Assessment
May 2015	Page 34; 3.2 Conducting the Independent Assessment; second para revised to read	On the day of the scheduled appointment and before conducting the assessment, the Independent Assessor will review the Medicaid PCS Beneficiary Participation Guide with the beneficiary. This form outlines the rights the beneficiary has regarding the independent assessment and their responsibility to fully participate in completing the assessment (please see Appendix B for the complete form). Following the review of the Participation Guide, the beneficiary will be asked to sign a consent form that gives the Assessor permission to conduct the independent assessment.
May 2015	Page 45; Chapter 6; 6.1 Prior Approval; revised to read	<p>Once a beneficiary who has been deemed eligible is awarded hours under the PCS program following an assessment or a settlement through the appeals process, a ‘Prior Approval’ (PA) is issued. The PA will reflect the total hours awarded monthly for PCS. In accordance with Clinical Policy 3L, section 5.2.2, in order to be approved for PCS payment, the beneficiary shall:</p> <ul style="list-style-type: none"> <li>✓ Obtain a Physician Referral; and attestation, when applicable;</li> <li>✓ Obtain an ACH PASRR screen if seeking admission to, or residing in, an adult care home licensed under G.S. 131D-2.4;</li> <li>✓ Receive an independent assessment from the IAE;</li> <li>✓ Meet minimum program admission requirements;</li> <li>✓ Obtain a service authorization for a specified number of PCS hours per month; and</li> <li>✓ Obtain an approved service plan from the provider.</li> </ul>

		<p>EPSDT Additional Requirements for PCS:</p> <p>Medicaid may authorize services that exceed the PCS service limitations if determined to be medically necessary under EPSDT based on the following documents submitted by the provider before PCS is rendered:</p> <ul style="list-style-type: none"> <li>✓ Work and School verification 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.</li> <li>✓ Verification from the Exceptional Children’s program per county if PCS is being requested in school setting.</li> <li>✓ Health record documentation from the beneficiary’s physician, therapist, or other licensed practitioner; and</li> <li>✓ Physician documentation of primary caregiver’s limitation that would prevent the caregiver from caring for the beneficiary.</li> </ul>
May 2015	Page 46; Prior Approval Effective Dates; first para revised to read	DMA has authorized retroactive prior approval for PCS that were approved on or after January 1, 2013. Retroactive prior approval will only be applied to initial requests for PCS. The retroactive effective date for authorization will be the request date on the Request for Independent Assessment for Personal Care Services 3051 form, provided the date is not more than 10 calendar days from the date that the Independent Assessment Entity (IAE), Liberty Healthcare, received a completed request form. If the request is received by Liberty Healthcare more than 10 calendar days from the request date on the request form, the authorization will be effective the date Liberty Healthcare received the form. If the initial request is missing information, the received date will not be effective until the correct information is provided to process the referral.
May 2015	Page 47; 6.2 Reimbursement; NOTE; added statement of policy	NOTE: A beneficiary may have been approved for PCS and a prior approval awarded, but if their Medicaid is not active, or does not provide coverage for PCS, or they have since been enrolled in another state program that cannot be administered in conjunction with PCS, reimbursement will be denied. Providers shall verify each Medicaid beneficiary’s eligibility each time a service is rendered.
May 2015	Page 49; 6.3 Denied Claims; numbers 3 and 5 grammar revised to read	<p>3. Does the modifier on the PA match the modifier assigned in NCTracks? (verify through the QiReport Provider Portal)</p> <p>5. Am I billing within the approved effective dates? (verify in NCTracks)</p>
May 2015	Page 51 and 52 revised form and Appendix B	Replacement of NEW FORM – EFFECTIVE 2/1/2015 (“ <i>Request for Independent Assessment for Personal Care Services (PCS) Attestation of Medical Need</i> ”)



May 2015	Page 66; Appendix D: Clinical Coverage Policy 3L; important notice added	Important: This provider manual will be updated with the finalized 3L policy June 1, 2015
May 2015	Page 105; Appendix F; title addition	“Appendix F: Provider Resources and Contact <i>Information:</i> ”
July 2015	Cover	Effective date changed from May 2015 to July 2015
July 2015	Table of Contents 1.12	Plan of Care (POC) changed to Online Service Plan
July 2015	Table of Contents 1.14 added	[Title] “Change of Ownership”
July 2015	Table of Contents 1.15	Section 1.15 added
July 2015	Table of Contents; Appendices	Appendix F changed to read: “Provider Resources and Contact Information”
July 2015	Page 6; Additional general program requirements include	Second and Third bullet changed to read: “The residential setting has received inspection conducted by the Division of Health Service Regulation (DHSR):” and third bullet reads: “The place of service is safe for the beneficiary to receive PCS and for an aide to provide PCS;”
July 2015	Page 8; #13	The word “authorized” changed to read: “identified”
July 2015	Page 9; #11	The words “or mental health disorders” inserted
July 2015	Page 11; Chapter 1; #4	Changed to read: “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 Clinical Coverage Policy 3L:
July 2015	Page 11; Chapter 1: 4c	4c is removed from policy
July 2015	Page 13; The RN Supervisor Shall; #5	#5 is removed from policy
July	Page 15; 1.10 Staff Development and Training; 1 <sup>st</sup>	Revised last sentence to read: “Competency training and evaluations of the required competencies for In-Home and

2015	paragraph	Residential Aides must provide competency training and evaluations as specified in 10A NCAC 13F and 13G, and, 10A NCAC 27G”
July 2015	Page 16; 1.12 PCS On-line Service Plan	<p>Revised to change:</p> <p>7. 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.</p> <p>8. 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.</p> <p>9. i. The PCS service plan must be developed, and validated within seven (7) business days of the Provider accepting receiving the IAE referral.</p> <p>10. 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;</p> <p>11. 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.</p> <p>12. 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.</p> <p>13. 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;</p> <p>n. Provider organizations may continue to request a Change of Status Review, as described in Subsection 5.4.6b, by the IAE if there</p>

		<p>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;</p> <p>o. Provider organizations shall be reimbursed only for PCS authorized hours and services specified and scheduled in the validated PCS service plan; and,</p> <p>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.</p>
July 2015	Page 18; 1.14	New section added, “Change of Ownership”
July 2015	Page 19	Heading revised to read: “1.15 QiReport – Provider Interface Overview”
July 2015	Page 28; second paragraph; last sentence	Revised to read: “The new PCS Provider shall develop and implement a service plan within 7 business days of accepting the referral (Clinical Policy 3L, section 5.4.11).”
July 2015	Page 38; bullet “Notice of Denial in Services”, last reason	Revised reason reads: “The beneficiary account in NCTracks now reflects as PCS ineligible due to the Medicaid status or that they are receiving duplicate services making them ineligible for PCS.”
July 2015	Page 47; 6.3 Denied Claims; #1	Revised to read: “ Did I complete a service plan for the most current assessment for the beneficiary? (verify in QiReport)”
July 2015	Page 55; Medicaid Personal Care Services Beneficiary Participation Guide	Updated form replaced prior version
July 2015	Page 91-111; Table of Contents	Prior policy replaced with updated policy amended June 10, 2015
July 2015	Page 117; Appendix	Appendix change from ‘G’ to ‘F’
Sept. 2015	Page 1; Date	Month changed to September for version control
Sept. 2015	Page 16; Section 1.12	Details were added for exceptions to drafting a Service Plan within QiReport
Sept. 2015	Page 19; Section 1.14 “Change of Ownership”	New Section Added

Sept. 2015	Page 20; Section 1.15 "Internal Quality Improvement Program"	New Section Added
Sept. 2015	Page 20; Section 1.16 "Provider Interface Overview"	Section number changed from 1.15 to 1.16
Sept. 2015	Page 104; Appendix F	New Appendix, Inserted the 'DMA 3136 Internal Quality Improvement Program Attestation Form and Instructions'
Sept. 2015	Page 107: Appendix G	Appendix letter changed from F to G
Aug. 2016	Page 9, Intro. – 'PCS Non-Covered Tasks and Services'	Add #13. "Independent medical information does not validate the assessment, PCS hours may be reduced, denied, or terminated based on the additional information".
Aug. 2016	Page 13, Section 1.7 PCS Aides	Additional criteria added, bullet points 1 - 8
Aug. 2016	Page 17, Section 1.12 PCS Online Service Plan	Note: If an agency fails to complete their service plan and the beneficiary is discharged, changes providers, or becomes deceased, DMA will not authorize retro PA's for the beneficiary as PA's will not be released until the service plan has been completed and beneficiary/legal guardian consent is required for service plan approval.
Aug. 2016	Page 21, Section 1.16 QiReport – Provider Interface Overview	Bullet add – "Receive electronic notification of upcoming annual assessments for beneficiaries".
Aug. 2016	Page 25, Section 2.1.2 Expedited Request for PCS	Criteria Add – "Be an individual served through the transition to community living initiative", being submitted by "An approved LME-MCO Transition Coordinator".
Aug. 2016	Page 32, Section 2.5 – Reconsideration Request for Initial Authorization for PCS	New section added.
Aug. 2016	Page 33, Section 2.5.2 – The Reconsideration Process	New section added.
Aug. 2016	Page 35, Chapter 3 – The Independent Assessment	Added section titled 'Reconsideration Assessment'
Aug. 2016	Page 36, Section 3.1 The Assessment Scheduling Process	Language add – "After receipt, the Scheduling Coordinator (SC) will attempt to reach the beneficiary and/or an identified third party, or if in a facility, the facility director or persons responsible for scheduling such assessments and schedule the assessment."
Aug. 2016	Page 41, Section 4.2 Responding to a Referral	NOTE: Providers are expected to accept/reject referrals within 2 business days. If the PA's end for a beneficiary and the PCS Provider did not accept within 2 business days of the referral, DMA will not authorize retro pay for the lapsed time period.

Aug. 2016	Page 48, Section 6.1 Prior Approval	EPSDT Additional Requirements for PCS, bullet add and note - 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.
Aug. 2016	Page 49, Section 6.1 Prior Approval	PA Effective Dates, adds for Reconsideration and note add - NOTE: Providers are expected to accept/reject referrals within 2 business days. If the PA's end for a beneficiary and the PCS Provider did not accept within 2 business days of the referral, DMA will not authorize retro pay for the lapsed time period.
Aug. 2016	Appendix G	Changed to 'DMA 3114 Request for Reconsideration of PCS Authorization Form and Instructions'
Aug. 2016	Appendix H	Changed from G to H
Aug. 2017	Page 7, note added	Once the beneficiary turns 21 years of age, their approved EPSDT hours will cease and PCS will end. A new 3051 form should be mailed to the Independent Assessment Entity PRIOR to the 21 <sup>st</sup> birthday in order for the beneficiary to be assessed and if approved, PCS to continue after they turn 21.
Aug. 2017	Page 19, Section 1.13	Prior Approval (PA) Effective Dates and PASRR, table updated
Aug. 2017	Page 25, Section 2.1.2	If eligibility requirements are met, a hospital discharge planner, skilled nursing facility discharge planner, Adult Protective Services (APS) worker, or LME-MCO Transition Coordinator...
Aug. 2017	Page 33, Section 2.6	New section added
Aug. 2017	Page 50, Section 6.1	Prior Approval Effective Dates; changed from 10 days to 30 days. Updated examples.
Aug. 2017	Appendix B	Medicaid PCS Beneficiary Participation Guide; form updated
Aug. 2017	Appendix D	Clinical Coverage Policy 3L; updated