**DRAFT**

**To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.**

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**DRAFT**

**Related Clinical Coverage Policies**
Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:
3L, State Plan Personal Care Services in In-Home Settings

# 1.0 Description of the Procedure, Product, or Service

State Plan Personal Care Services (PCS) are provided in congregate settings for a Medicaid beneficiary 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

### 2.1.1 General

**(*The term "General" found throughout this policy applies to all Medicaid policies*)**

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*).
b. Provider(s) shall verify each Medicaid 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.

### 2.1.2 Specific

(*The term "Specific" found throughout this policy only applies to this policy*)

**a. Medicaid**

None Apply

## 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.

b. **EPSDT and Prior Approval Requirements**

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: https://medicaid.ncdhhs.gov/

# 3.0 When the Procedure, Product, or Service Is Covered

## 3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when 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 Medicaid

Medicaid shall cover State Plan Personal Care Services (PCS) Provided in Congregate Settings when the beneficiary meets the following specific criteria:

Medicaid shall cover PCS when a beneficiary meets ONE of the criteria in both a and b:

a. has a medical or mental 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.
b. resides in:
   1. a congregate facility licensed by the State of North Carolina as an Adult Care Home (ACH) as defined in NC G.S. §131D-2.1, a combination home as defined in NC G.S. § 131E-101; **or**

2. a group home licensed under Chapter 122C of the General Statutes and under 10A NCAC 27G .5601 (b)(2) 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.

c. In addition to the specific criteria in **Subsection 3.2.1 a and b** of this policy, the following criteria must be met:
   1. The congregate setting is safe and free of health hazards for the beneficiary and PCS provider(s), as determined by a facility environmental assessment conducted by NC Medicaid or a DHHS designated contractor;
   2. The congregate 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 or mental 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; and

d. Screening for Serious Mental Illness (SMI) in Adult Care Homes licensed under G.S. §131D-2.4 **Effective November 1, 2018 any Medicaid beneficiary referred to or seeking admission to Adult Care Homes licensed under G.S. 131D-2.4 must be referred to a Tailored Plan Transition Coordinator for the Referral Screening Verification Process. Adult Care Home providers licensed under G.S. § 131D-2.4 shall not receive a PCS assessment or prior approval without verification of a Referral Screening ID.**

### 3.2.2 Medicaid 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 their private residence;
   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.

### 3.4 Medication Assistance

Medicaid shall cover medication assistance when it is:
a. Delivered in an Adult Care Homes, and provides medication administration as under 10A NCAC 13F and 13G; or
b. Delivered in supervised living homes and provides medication administration under 10A NCAC 27G.

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

### 4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:
a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

### 4.2 Specific Criteria Not Covered

#### 4.2.1 Medicaid Additional Criteria Not Covered

Medicaid shall not cover PCS when:

1. the initial independent assessment has not been completed;
2. the PCS is not documented as completed according to 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 the assessment, could not be reached to schedule the assessment, or did not attend the scheduled assessment;

**Note:** A delayed scheduling of a reassessment due to the vendor's timeline does not impact the continuous coverage of PCS while the reassessment is being arranged.

4. the PCS is provided at a location other than the beneficiary's primary congregate living setting;
5. the PCS exceeds the amount approved by the Comprehensive Independent Assessment Entity (CIAE);
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 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;
9. 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;
10. independent medical information does not validate the assessment, PCS hours may be reduced, denied, or terminated based on the additional information.

**Note**: Adult Care Home Providers are not subject to the EVV requirement.

b. Medicaid shall not cover PCS in a licensed congregate facility 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:** NC Medicaid shall 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 Licensed Practical Nurse (LPN) or Registered Nurse (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. Instrumental activities of daily living (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),
12. Other tasks and services not identified in the beneficiary's Independent Assessment and noted in their Service Plan; and
13. Room and Board.

#### 4.2.2 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 are:

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

## 5.0 Requirements for and Limitations on Coverage

### 5.1 Prior Approval

Medicaid shall require prior approval for State Plan Personal Care Services (PCS) Provided in Congregate Settings. The provider shall obtain prior approval before rendering State Plan Personal Care Services (PCS) Provided in Congregate Settings.

### 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** of this policy.

#### 5.2.2 Specific

To obtain prior approval for PCS, the beneficiary shall:

a. Obtain a Physician Referral; and attestation, when applicable;
b. Obtain a Referral Screening ID 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 CIAE;
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.

## 5.3 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 18 years of age and older may be authorized to receive up to 80 hours of service per month.

b. A Medicaid beneficiary 18 years of age who meets the eligibility criteria in **Section 3.0** of this policy and ALL 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 according to 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 NC Medicaid 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 determining eligibility and authorizing services must be conducted by the CIAE designated by NC Medicaid.
b. Congregate care provider organizations are not authorized to perform PCS assessments for 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 authorizing services shall be referred to the designated CIAE.
c. NC Medicaid's designated CIAE shall determine the effective date and issue prior authorization for a beneficiary approved for services.
d. The designated CIAE 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 CIAE 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. NC Medicaid, 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 or congregate facility is contacted by the designated CIAE to schedule an assessment, the beneficiary or congregate facility shall respond as soon as possible. If the CIAE is unable to schedule an assessment, services can be denied.

### 5.4.1 Requirement for Qualifying Activities of Daily Living (ADLs)

PCS are provided to a qualified Medicaid beneficiary and who has 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 their primary care practitioner or attending physician utilizing the Physician Referral approved by NC Medicaid.

a. The Physician Referral approved by NC Medicaid is the NC Medicaid-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 according to G.S. §90-18.3
c. The beneficiary or the beneficiary's family or legally responsible person is responsible for contacting their primary care or attending physician and requesting a referral for Medicaid PCS.
d. If the beneficiary has not been seen by their practitioner during the preceding 90 calendar days, the referral is not processed. The beneficiary 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 beneficiary's 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 their designated primary care physician, except as described in **Subsection 5.4.3.f.**
g. If a beneficiary does not have a primary care physician, they 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 must be performed by a CIAE Assessor at the beneficiary's congregate facility.

### 5.4.3 Requirements for PCS Eligibility Assessments

a. All PCS assessments to determine beneficiary eligibility and authorized service level must be conducted by CIAE Assessors using a standardized process and assessment tool provided or approved by NC Medicaid.

b. All PCS assessments must be performed by Independent Assessors.

c. All assessments for new admissions to PCS must be face to face and conducted in the beneficiary's congregate facility.

**Note:** Notwithstanding the foregoing, an initial assessment may be conducted by telephone to ensure the health, safety, and well-being of the Medicaid beneficiary. Health, safety, and well-being includes the need for timely access to care to prevent institutionalization, injury, or loss of function. The reason for the telephonic assessment must be documented in the assessment record. The Medicaid beneficiary must agree to the telephonic assessment. When the telephonic assessment results in a potential denial, reduction, or termination, a face-to-face assessment must be conducted within 5 business days to evaluate the Medicaid beneficiary's ADL needs in person. An initial telephonic assessment that does not result in a denial, reduction, or termination must be followed by a face-to-face assessment within two to three months from the completed telephonic assessment.

d. Assessments in congregate 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), their 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 must be placed in the beneficiary's health record and, if requested, must be provided to NC Medicaid or the CIAE.

g. A 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 CIAE via secure facsimile, mail electronic submission. The form must be complete and provide all of the following:

1. physician authorization for the CIAE 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.

**Note:** Home care agencies and congregate providers can 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. be eligible for Medicaid or pending Medicaid eligibility;
c. have a Referral Screening ID if seeking admission to an Adult Care Home licensed under G.S. §131 D-2.4;
d. be in process of a planned discharged from the hospital following a qualifying stay;
e. be in process of a planned discharged from a skilled nursing facility;
f. be under adult protective services;
g. be served through the transition to community living initiative; or
h. be approved for a fast-track assessment to assist in mitigating beneficiary harm, prevent institutionalization, injury, or loss of function while the assessment is being scheduled.

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 NC Medicaid approval. The process requirements are:

a. The PCS expedited assessment process determines beneficiary eligibility and authorized service level. The assessment must be conducted by CIAE Assessors using a standardized process and assessment tool provided or approved by NC Medicaid.

b. The expedited process must be requested by a hospital discharge planner, skilled nursing facility discharge planner or Adult Protective Services (APS) Worker, or 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. The PCS fast-track assessment process pre-authorizes up to 80 billable PCS hours for a Medicaid beneficiary to reduce revenue gaps experienced by the facility from admission to the date of the completed assessment. All qualifying conditions for a new referral or a change in status shall be met before the fast-track hours are awarded. The PCS hours are adjusted to the assessed needs upon the completion of the face-to-face assessment. The face-to-face assessment must be completed within three to five months of the pre-authorized hours.

e. If it is determined the beneficiary provisionally qualifies for PCS through the expedited process, a provider shall be identified and the hospital discharge

planner, skilled nursing facility discharge planner, or APS worker shall communicate the beneficiary's choice of provider and intended admission date to the selected provider and the CIAE.

f. 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.

g. A beneficiary receiving approval through the expedited assessment process is authorized for services within two (2) business days of completed request.

h. A beneficiary receiving approval through the fast-track assessment process is granted a service authorization, and the facility is provided a prior approval (PA) shortly after submitting a PCS referral that aligns with the requirement outlined in this policy for placement in a facility. The PA permits the facility to submit PCS claims in the interim of the face-to-face assessment scheduling and completion.

i. 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.

j. PCS Provider shall inform the CIAE 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 CIAE.

b. The CIAE schedules annual reassessments to occur on or before the end of the current services authorization date.

c. PCS providers shall report discharges to the CIAE 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 their prognosis for improvement or rehabilitation, as determined by the CIAE, but not less frequently than once every 365 calendar days.

e. Reassessment frequency must be determined by the CIAE as part of the new referral admission and assessment process.

f. Reassessments must be conducted face-to-face.

**Note:** Notwithstanding the foregoing, an annual assessment may be conducted by telephone to ensure the health, safety, and well-being of the Medicaid beneficiary. Health, safety, and well-being includes the need for timely access to care to prevent institutionalization, injury, or loss of function. The reason for the telephonic assessment must be documented in the assessment record. The Medicaid beneficiary must agree to the telephonic assessment. When the telephonic assessment results in a potential denial, reduction, or termination, a

face-to-face assessment must be conducted within 5 business days to evaluate the Medicaid beneficiary's ADL needs in person. An annual telephonic assessment that does not result in a denial, reduction, or termination must be followed by a face-to-face assessment within six to eight months from the completed telephonic assessment.

### 5.4.6 Requirements for PCS Change of Status Reviews

a. All Change of Status Reviews determine changes to authorized service levels must be conducted by the designated CIAE.

b. A beneficiary may receive a Change of Status, Medical review or a Change of Status, Non-Medical review as follows:

   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 calendar 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 congregate 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 must include documentation of the change in the beneficiary's medical condition, informal caregiver availability, or environmental condition affecting their ability to self-perform or the time required to provide the qualifying ADL assistance, and the need for reassessment.

d. NC Medicaid or its DHHS designated contractor retains sole discretion in approving or denying requests to conduct Change of Status reassessments.

e. Change of Status Reviews must be conducted by face-to face by the designated CIAE assessors.

   **Note:** Notwithstanding the foregoing, a change of status assessment may be conducted by telephone to ensure the health, safety, and well-being of the Medicaid beneficiary. Health, safety, and well-being includes the need for timely access to care to prevent institutionalization, injury, or loss of function. The reason for the telephonic assessment must be documented in the assessment record. The Medicaid beneficiary must agree to the telephonic assessment. When the telephonic assessment results in a potential denial, reduction, or termination, a face-to-face assessment must be conducted within five (5) business days to evaluate the Medicaid beneficiary's ADL needs in person. A change in status telephonic assessment that does not result in a denial, reduction, or termination must be followed by a face-to-face assessment within two to three months from the completed telephonic assessment.

### 5.4.7 Requirements for PCS Assessment and Reassessment Tools

PCS assessment and reassessment tools must be provided or approved by NC Medicaid 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 fourteen (14) business days of a completed initial assessment for PCS;
b. within fourteen (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 (2) business days of an expedited assessment request for a beneficiary with a planned discharge from a hospital or inpatient facility; skilled nursing facility; rehabilitation center; 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** 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 affect the ability of the beneficiary to perform the ADLs; and
d. A rating of the beneficiary's overall self-performance capacity for each ADL, as summarized in the following table.

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

The PCS assessment must contain 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 CIAE assessor shall receive verbal consent from the beneficiary before family members or other caregivers present participate in the assessment review.

The CIAE 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 Requirements for Selecting and Changing PCS Providers

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

a. The beneficiary can change their PCS Provider during the course of the authorized service period by notifying the CIAE of the desired change. A new assessment is not required unless a change of status review is required;
b. The CIAE shall furnish the new provider with a copy of the assessment and service authorization;
c. The new PCS Provider shall develop a new service plan;
d. The new PCS Provider shall complete the service plan within seven (7) business days of accepting the referral;
e. The beneficiary can 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;
f. Providers shall notify the CIAE of any discharges as they occur via the Provider Interface; and
g. Beneficiaries or their legally responsible person shall certify, in a manner prescribed by NC Medicaid, 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 CIAE, providing the date is not more than 30 calendar days from the date the CIAE received the request form. If the *Request for Independent Assessment for Personal Care Services Attestation for Medical Need* form is received by CIAE more than 30 calendar days from the request date on the form, the authorization is effective the date the CIAE 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 initiated the Referral Screening Verification Process and received a Referral Screening ID. PCS authorization can not precede the effective date of the beneficiary's Referral Screening ID. If the effective Referral Screening ID date is not within 30 calendar days of the submission of the Physician Referral, the Physician Referral is invalid, and a new Physician Referral is required.

## 5.6 Reconsideration Request for initial authorization for PCS

A beneficiary, 18 years of age or older, who receives an initial approval for less than 80 hours per month may submit a Reconsideration Request Form (NC Medicaid-3114) to the CIAE 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 is 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 must 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 a beneficiary 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 the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid 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 per 7.10(d.1) of this policy:

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 prohibits 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, provider shall be:

a. a congregate facility licensed by the State of North Carolina as an Adult Care Home per G.S. 131D-2, or a combination home per G.S. 131E-101(1a); or
b. a congregate facility 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 use disorder.

### 6.1.1 PCS Paraprofessional Aide Minimum Qualifications

PCS Aide shall be:

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

### 6.1.2 PCS Paraprofessional Aide Minimal Training Requirements

Personnel records of an aide providing PCS must contain 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. Congregate Care Aide providing services to a beneficiary receiving hours per Session Law 2013-306, must have training or experience in caring for a beneficiary who has 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 NC Medicaid that they are in compliance with this requirement. The attestation form (NC Medicaid-3085) and instructions are located on the NC Medicaid 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 CIAE 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 a request for Non-Medical Change of Status requests and discharge a beneficiary online;
e. Change provider National Provider Identification (NPI) number for beneficiary who needs 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; and
i. Receive electronic notification of upcoming annual assessments for a beneficiary.

### 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 provider shall comply with all of the following requirements for the on-line PCS service plan:

a. All CIAE referrals are transmitted to provider organizations through the Provider Interface. No mailed or faxed referrals are provided;
b. The provider organization accepting the CIAE referral to provide PCS services shall review the CIAE independent assessment results for the beneficiary being referred, and develop a PCS service plan responsive to the beneficiary's specific needs documented in the CIAE assessment;
c. Provider organizations shall designate staff they determine appropriate to complete and submit the service plan via the Provider Interface.
d. Each CIAE referral and assessment shall require a new PCS service plan developed by the provider organization that is based on the CIAE assessment results associated with the referral;
e. The service plan must address, the shift, task, individual completing the task and dates of service, each unmet ADL and 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, 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 CIAE assessment, and related requirements for the service plan content.
i. The PCS service plan must be developed and validated within seven (7) business days of the Provider accepting receiving the CIAE 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 fourteen (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, within fourteen (14) business days of the validated service plan;
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 days 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 per 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 CIAE assessment. When changes are needed, a change in status review must be requested to verify changing needs;
n. Provider organizations may continue to request a Change of Status Review, as described in Subsection 5.4.6b, by the CIAE 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 a daily rate for PCS specified and scheduled in the validated PCS service plan according to the documentation maintained on-site at the congregate facilities which must be made available by request; and
p. Prior approval for PCS daily rate 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 and times of the week documented in the service plan;
b. Document aide services provided, to contain, at minimum, the date, the shift, aide tasks provided, and the name of the aide providing the service;
c. Document all deviations from the service plan; this documentation must contain, at minimum, the tasks and 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; and

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 and dates of service.

**Nurse Aide Tasks**

Congregate 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

### 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 NC Medicaid'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 congregate 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 NC Medicaid.

### 7.3 Automated Reporting

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

### 7.4 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 them as their PCS Provider or to entice beneficiaries to change from their current provider.

## 7.5 NC Medicaid 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 conducted by NC Medicaid or a DHHS designated contractor;
b. Meet NC Medicaid requirements for addressing identified program deficiencies, discrepancies, and quality issues through the NC Medicaid corrective action process and any overpayment recovery or sanctioning process imposed by NC Medicaid's Program Integrity Section; and
c. Maintain all health records and billing documentation in an accessible location in a manner that facilitates regulatory reviews and post payment audits.

## 7.6 Internal Quality Improvement Program

The PCS Provider Organization shall:

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

## 7.7 Quality Improvement, Utilization Review, Pre- and Post-Payment Audits

The PCS Provider Organization shall cooperate with and participate fully with the following NC Medicaid 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 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.

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## 7.8 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 per N.C. G.S. §108A-102.

## 7.9 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 their supervision are conducted per 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. **Supervision in Congregate Settings**

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

The congregate PCS provider shall assure appropriate aide supervision by a qualified professional per 10A NCAC 13F and 13G, and. 10A NCAC 27G.

c. **PCS Paraprofessional Aide Training Licensure Requirements**
**The PCS provider shall ensure that:**

1. criminal background checks are conducted on all congregate care aides before they are hired as specified in licensure requirements;
2. Congregate Care Aides hired are not listed on the North Carolina Health Care Registry as having a substantiated finding according to the health care personnel registry G.S. 131E-256;
3. all congregate 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 congregate 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.

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d. **Staff Development and Training**

The PCS Provider Organization based on licensure rules shall:

1. provide a new employee orientation for all new congregate aides and other agency employees that contains information on state rules pertaining to home care agencies and congregate 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 congregate 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 NC Medicaid or its designee.

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# 8.0 Policy Implementation and History

**Original Effective Date:** January 1, 2024

**History:**

| Date | Section or Subsection Amended | Change |
|---|---|---|
| 00/00/0000 | All Sections and Attachment(s) | Initial promulgation of new policy For Individual Receiving PCS and Congregate settings due to a rate-change methodology |
| | | |

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# Attachment A: Claims-Related Information

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

## A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

## B. International Classification of Diseases and Related Health Problems, 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.

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.

| CPT Code(s) |
|---|
| 99509 |

**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.

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## D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

| Providers | Modifier(s) |
|---|---|
| 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

Daily Rate

## F. Place of Service

PCS is provided in the beneficiary's congregate 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.

## G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

## H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/

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# 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 NC Medicaid. The assessment must include documentation and evaluation of the following:

1. Assessment identification information, reporting date, completion time, and names and relationships of others attending;
2. Beneficiary identification information, reporting name and Medicaid ID, gender, date of birth, primary language, contact information, and alternate contacts;
3. Referral summary, reporting date and practitioner name and contact information;
4. Diagnoses and diagnosis code related to the need for services;
5. Medications and the CIAE assessor's evaluation of the beneficiary's ability to self-manage medication;
6. Special diet types;
7. Availability of other supports, documenting 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, documenting required assistance level and number of days per week of unmet need for assistance;
10. CIAE 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 CIAE assessor's evaluation of the functional status of congregate facility structures and utilities, safety and adequacy of the beneficiary's primary congregate facility 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. CIAE 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.

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## Service Level Determinations

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

**Daily Minutes for Qualifying ADLs and Medication Assistance**

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

**Notes:** Eating ADL consists of meal preparation and preparation of textured-modified diets. When basic meal preparation is covered under services paid for by State or 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) are 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 percent, may be authorized for exacerbating conditions and symptoms that affect the beneficiary's ability to perform and 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 percent of additional time is provided.
4. Additional time, up to 25 percent, 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 provided.
5. According to 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 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 18 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 must PCS hours exceed the maximum of 130 hours per month.