



North Carolina Department of Health and Human Services

2001 Mail Service Center • Raleigh, North Carolina 27699-2001

Tel 919-733-4534 • Fax 919-715-4645

Beverly Eaves Perdue, Governor

Lanier M. Cansler, Secretary

July 10, 2009

The Honorable Beverly M. Earle, Chairman
Appropriations Subcommittee on Health and Human Services
North Carolina General Assembly
Room 634, Legislative Office Building
Raleigh, NC 27603

Dear Representative Earle:

Section 10.36(d)(21) of S.L. 2007-323 (House Bill 1473), "Personal Care Services," required DHHS to impose prior authorization on all personal care services (PCS) and to report on the status of this implementation. It is my pleasure to submit the report at this time.

Please direct all questions concerning this report to Patti Forest, M.D., Assistant Director for Clinical Policy and Programs. She can be reached at (919) 855-4260 or via e-mail at Patti.Forest@ncmail.net.

Sincerely,

A handwritten signature in cursive script that reads "Lanier".

Lanier M. Cansler

LMC:pf

Attachment

cc: Allen Feezor
Dan Stewart
Tara R. Larson.
Sharnese Ransome
Jennifer Hoffmann
Legislative Library (2)





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Lanier M. Cansler, Secretary

July 10, 2009

The Honorable Bob England, M.D., Chairman
Appropriations Subcommittee on Health and Human Services
North Carolina General Assembly
Room 303, Legislative Office Building
Raleigh, NC 27601

Dear Representative England:

Section 10.36(d)(21) of S.L. 2007-323 (House Bill 1473), "Personal Care Services," required DHHS to impose prior authorization on all personal care services (PCS) and to report on the status of this implementation. It is my pleasure to submit the report at this time.

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Beverly Eaves Perdue, Governor

Lanier M. Cansler, Secretary

July 10, 2009

The Honorable Verla Insko, Chairman
Appropriations Subcommittee on Health and Human Services
North Carolina General Assembly
Room 307-B1, Legislative Office Building
Raleigh, NC 27603

Dear Representative Insko:

Section 10.36(d)(21) of S.L. 2007-323 (House Bill 1473), "Personal Care Services," required DHHS to impose prior authorization on all personal care services (PCS) and to report on the status of this implementation. It is my pleasure to submit the report at this time.

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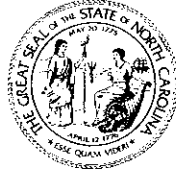
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Beverly Eaves Perdue, Governor

Lanier M. Cansler, Secretary

July 10, 2009

The Honorable William Purcell, Co-Chair
Appropriations on Health and Human Services
North Carolina General Assembly
Room 625, Legislative Office Building
Raleigh, NC 27603

Dear Senator Purcell:

Section 10.36(d)(21) of S.L. 2007-323 (House Bill 1473), "Personal Care Services," required DHHS to impose prior authorization on all personal care services (PCS) and to report on the status of this implementation. It is my pleasure to submit the report at this time.

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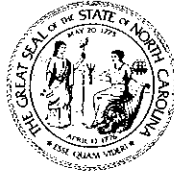
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Beverly Eaves Perdue, Governor

Lanier M. Cansler, Secretary

July 10, 2009

The Honorable Doug Berger, Co-Chair
Appropriations on Health and Human Services
North Carolina General Assembly
Room 526, Legislative Office Building
Raleigh, NC 27603

Dear Senator Berger:

Section 10.36(d)(21) of S.L. 2007-323 (House Bill 1473), "Personal Care Services," required DHHS to impose prior authorization on all personal care services (PCS) and to report on the status of this implementation. It is my pleasure to submit the report at this time.

Please direct all questions concerning this report to Patti Forest, M.D., Assistant Director for Clinical Policy and Programs. She can be reached at (919) 855-4260 or via e-mail at Patti.Forest@ncmail.net.

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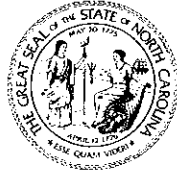
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Beverly Eaves Perdue, Governor

Lanier M. Cansler, Secretary

July 10, 2009

Marilyn Chism, Director
Fiscal Research Division
Room 619, Legislative Office Building
Raleigh, NC 27601

Dear Ms. Chism:

Section 10.36(d)(21) of S.L. 2007-323 (House Bill 1473), "Personal Care Services," required DHHS to impose prior authorization on all personal care services (PCS) and to report on the status of this implementation. It is my pleasure to submit the report at this time.

Please direct all questions concerning this report to Patti Forest, M.D., Assistant Director for Clinical Policy and Programs. She can be reached at (919) 855-4260 or via e-mail at Patti.Forest@ncmail.net.

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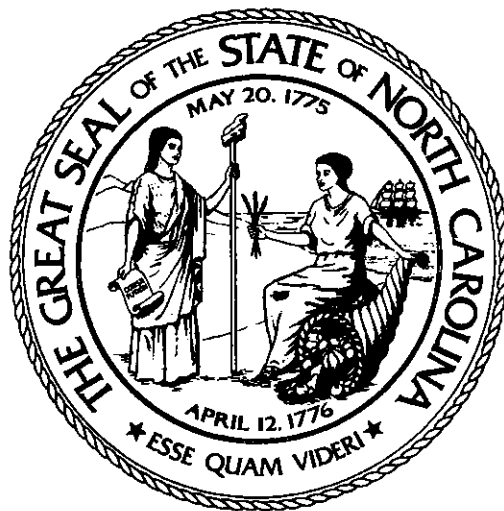
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Bcc: Patti Forest, M.D.
Pat Jeter
Will Lindsay
Kari Barsness
Gary Kugler

Implementation of Prior Authorization for all Medicaid In-Home Personal Care Services

Section 10.36(d)(21) of S.L. 2007-323



**State of North Carolina
Department of Health and Human Services
Division of Medical Assistance**



June 1, 2008

Implementation of Prior Authorization for all Medicaid In-Home Personal Care Services

A. Introduction

Section 10.36(d) of S.L. 2007-323 requires the Department of Health and Human Services, Division of Medical Assistance (DMA) to impose prior authorization on all personal care services (PCS) and to report on the status of this implementation by May 1, 2008. This report is submitted to fulfill this requirement.

In-home PCS is an optional service under the State Medical Assistance Plan and is also provided under the Community Alternatives Programs for Disabled Adults (CAP/DA) and Children (CAP/C). In-home PCS covers the services of an aide in the recipient's private residence to assist the recipient in performing activities of daily living and specified in-home tasks. The required assistance must be related to a medical condition. Personal care services are provided by a paraprofessional, who must be supervised by a registered nurse (RN), and do not include skilled medical or nursing care. Regular PCS can provide up to 60 hours of aide service per month, while PCS-Plus can provide up to 80 hours of aide service per month. Medicaid in-home PCS does not include personal care services provided to residents of adult care homes. Additional information on PCS and PCS-Plus requirements is provided in Attachments A through F of this report.

B. Scope of the Report

As specified in Section 10.36(d)(21), this report addresses the following:

- Criteria for prior authorization developed in consultation with the North Carolina Physician Advisory Group;
- Policies and procedures for the prior authorization program;
- Use of the Uniform Screening Tool and the Integrated Assessment Tool for Medicaid Long-Term Care Services for personal care services;
- Cost of implementing a prior authorization system; and
- Estimated cost savings from the implementation of a prior authorization system for personal care services.

In addition, the report concludes with a recommendation to repeal the requirement to implement prior authorization on all in-home PCS.

C. Implementation Status

1. Criteria for PCS Prior Authorization & Revised Clinical Coverage Policy

The requirements for obtaining PCS and PCS-Plus services are established in clinical coverage policy. The updated policy is currently in draft form and has not been approved by the Physician Advisory Group (NCPAG). The draft policy addresses:

- When services are covered;
- Descriptions of the in-home tasks allowed to assist recipients in activities of daily living;
- A description of the home management tasks the aide may perform;
- Required assessments and reassessments;
- Physician orders;
- Requirements for the PCS plan of care;
- Documentation and record keeping; and
- Time guidance for PCS and home management tasks.

The clinical policy for in-home personal care services and PCS Plus is being updated to reflect planned changes in program requirements and new language required by the federal Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program for children. If funds for the PCS pre-authorization program are made available, the clinical policy will be revised to reflect this requirement prior to implementation.

2. Policies and Procedures for Prior Authorization

Prior authorization policies and procedures have been developed for the PCS-Plus Program. These procedures are used in conjunction with the criteria listed above to determine the need for and number of additional hours of PCS hours required, up to 80 hours per month. These procedures are provided in Attachments D and E of this report. Attachment F contains the forms used to collect the information required for PCS approvals. This system is not automated.

3. Use of Uniform Screening and Integrated Assessment Tools

Facility and Community Care, in an effort to automate its basic program management functions planned to develop and integrate two Internet-based automated tools: (a) a uniform screening tool to identify LTC programs and services appropriate for each applicant, and (b) an assessment tool to be used by medical professionals in conducting a more comprehensive face-to-face evaluation. The screening tool would pre-populate the assessment tool and together these tools would provide the information necessary to complete the individual plan of care for each recipient.

The Uniform Screening Tool has been developed and will be implemented statewide in two phases. This September, the mental health/developmental disabilities screening tool that is part of the MUST will be implemented. This screening tool is required to meet federal regulations to screen all applicants for admission to nursing facilities for mental health and development disabilities prior to admission and replaces the current paper-based system. The full MUST will be piloted this fall and be implemented statewide in 2009.

4. Anticipated Fiscal Impact

The following assumptions were used in developing the fiscal impact analysis:

- Prior authorization will decrease the number of recipients receiving PCS, but will minimally affect the average units per recipient. The variation in units/recipient is captured in the average annual cost/recipient.
- The actual decrease in recipients receiving PCS due to prior approval is projected to be low. History from the PCS Plus prior approval process indicates that the initial information submitted for prior approval does not necessarily match the actual recipient condition. Initial information submitted often justifies prior approval. Inconsistencies are discovered only through the CCME audit process during a face-to-face assessment by a contract nurse.
- PCS recipient growth will increase by 2% per year based on the most recent three-year historical average.
- Annual cost per recipient will increase by 1.4% per year based on the most recent three-year historical average.

	(a) SFY 2008	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
Estimated Recipient Growth (b)		2%	2%	2%	2%	2%
Estimated Recipients	33,528	34,199	34,883	35,580	36,292	37,018
Estimated Annual Cost per Recipient (c)	\$8,719.00	\$8,841.07	\$8,964.84	\$9,090.35	\$9,217.61	\$9,346.66
Estimated Total Requirements for Program Services	\$292,330,632	\$302,351,726	\$312,716,343	\$323,436,259	\$334,523,654	\$345,991,125

(a) SFY 2008 is based on 9 months of data to account for claims lag

(b) Estimated Recipient Growth = 2% is the non-PCS Plus three-year average

(c) Estimated Annual Cost per Recipient = non-PCS Plus three-year average

Table 2: Estimated Requirements with Prior Authorization of PCS

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
Estimated Impact on Recipient Growth	-0.8%	-1%	-1%	-1%	-1%
Estimated Recipients	33,925	34,534	35,224	35,929	36,647
Estimated Annual Cost per Recipient	\$8,841.07	\$8,964.84	\$9,090.35	\$9,217.61	\$9,346.66
Estimated Total Requirements for Program Services	\$299,932,912	\$309,589,180	\$320,201,897	\$331,178,418	\$42,531,214

Table 3: Cost of Implementing Prior Authorization of PCS

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
Estimated Contractual Costs	\$1,929,192	\$1,967,784	\$2,026,776	\$2,107,872	\$2,213,280
Estimated IT Management Costs	\$250,000	\$100,000	\$75,000	\$50,000	\$25,000
Total Costs of PA	\$2,179,192	\$2,067,784	\$2,101,776	\$2,157,872	\$2,238,280

Table 4: Summary of Total Requirements and Projected Savings

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
Program Services Expenditures without PA	\$302,351,726	\$312,716,343	\$323,436,259	\$334,523,654	\$345,991,125
Program Services Expenditures with PA	\$299,932,912	\$309,589,180	\$320,201,897	\$331,178,418	\$342,531,214
Subtotal Projected Savings with PA	(\$2,418,814)	(\$3,127,163)	(\$3,234,363)	(\$3,345,237)	(\$3,459,911)
Less Estimated Implementation Costs of PA	\$2,179,192	\$2,067,784	\$2,101,776	\$2,157,872	\$2,238,280
Total Net Savings from PA	(\$239,622)	(\$1,059,379)	(\$1,132,587)	(\$1,187,365)	(\$1,221,631)

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
Estimated Federal Share of Savings	(\$154,460)	(\$684,359)	(\$731,651)	(\$767,037)	(\$789,174)
Estimated Local Share of Savings	(\$6,398)	N/a	N/a	N/a	N/a
Estimated State Share of Savings	(\$78,764)	(\$375,020)	(\$400,936)	(\$420,327)	(\$432,457)
Totals	(\$239,622)	(\$1,059,379)	(\$1,132,587)	(\$1,187,364)	(\$1,221,631)

D. Recommendation to Repeal Section 10.36(d)(21) – Prior Authorization of Personal Care Services

Although the General Assembly mandated prior approval (PA) of all personal care services (PCS) in 2007 and reduced DMA's General Fund appropriation for SFY 08-09 by \$3,387,384 to reflect anticipated savings associated with the PA requirement, funds were not appropriated to implement the requirement. The Department does not believe PA of all PCS is a cost effective approach to utilization management and requested the Governor recommend repeal of the requirement in the 2008 Regular Session. Should this section not be repealed, DMA will need expansion funding to cover contractual and IT costs necessary to implement this requirement.

The justification for this request is based on the five points summarized below.

1. Other Cost Containment Initiatives. In 2005, DMA revised its clinical coverage policy for personal care services. The change dramatically reduced growth in the number of recipients served. For SFY 03-04 and SFY 04-05, the average number of recipients served increased 21% and 25% respectively over the prior year. For SFY 05-06, recipient growth was less than 10% for the year. The growth in annual expenditures also slowed as a result of the change in coverage policy. For SFY 03-04 and SFY 04-05, expenditures increased 17% and 25% respectively over the prior year. For SFY 05-06, expenditures growth was 13% for the year.

In addition, the Division implemented a PCS Compliance Audit Review Program to conduct ongoing audits of PCS providers and recipients in March of 2006, just before the end of SFY 05-06. The purpose of the program is to identify non-compliant providers and recipients who do not meet the criteria for PCS. This effort has been effective in initiating and maintaining provider accountability and recipient eligibility for PCS and is believed to be a more cost effective alternative to requiring PA on all PCS. The benefits had yet to be seen when the General Assembly considered the PA requirement in the 2007 Session, but after implementing this program, the state experienced declines in total expenditures of 4.3% and average recipients of 3.4% in SFY 06-07.

The Division is currently pursuing additional updates and revisions to its clinical coverage policy for PCS to further ensure appropriate, medically necessary utilization. Given the significant impact of previous policy changes and the compliance program on recipients and expenditures, additional planned policy changes; it is unlikely that implementing PA for all PCS will yield additional savings.

2. Cost Effectiveness of PA for PCS. In addition to the previous point about other cost containment efforts, professionals in DMA's Clinical Policies and Programs staffing long-term care programs believe that PA for all PCS is not an effective cost-containment tool. Not only is such a program expensive, labor intensive, and time consuming, but determining the medical necessity for assistance with activities of daily living (ADLs) is not precise. Rather the determination is open to different, legitimate interpretations. Likewise it is difficult to objectively determine the number of hours of PCS that will be required to assist individuals with their functional disabilities.

Prior authorization is already required for recipients seeking more than 60 hours of aide service per month under the PCS-plus program. This program specifically focuses on the most costly recipients and is an appropriate targeted approach for addressing PCS costs and utilization. Expanding the effort to the entire PCS population will not generate \$3.3 million in General Fund savings during SFY 08-09. In fact, the Division will have difficulty breaking even after accounting for implementation costs, assuming the program can be up and running on July 1, 2008 (see Section C.4 for details on the fiscal analysis).

3. Insufficient Funding. The General Assembly reduced DMA's General Fund appropriation for SFY 08-09 by \$3,387,384 to reflect anticipated savings associated with the PA mandate; however they did not provide funding to implement the new requirement. DMA estimates that PA of all PCS will cost \$2.0 to \$2.2 million dollars annually to contract with an organization to provide prior authorization services and meet applicable IT requirements under SB 991. The Division has been unable to identify available funds to support these requirements in SFY 07-08.
4. Insufficient Staffing. It is projected that PA of all PCS will initially generate 80,300 contacts per year and over 92,200 by year 5 for prior authorizations, change of status requests, and annual authorization renewals. The Division does not have sufficient current staffing to take on this level of activity internally and strongly recommends these activities be covered via a contract with a qualified organization.
5. Delays in Implementation. Implicit in the need for the Division to adhere to regulations relating to contracting and implementation of projects that include information technology components (under SB 991) and based on previous experience, such a project could take several years to obtain approval, funding, RFP approval, vendor selection, and program design, development, implementation, and state-wide rollout. Contracting with an outside vendor to perform PA services does not necessarily alleviate this requirement. DMA expects adhering to SB 991 requirements will increase the cost of and delay implementation of this program. (Note any delays in implementation will impact the cost analysis).

E. Summary and Conclusion

Section 10.36(3)(21) of Session Law 2007-323 requires the Department of Health and Human Services to submit a report on the status of implementation of a Personal Care Services Prior Authorization Program by March 1, 2008. This report is submitted to fulfill this requirement.

This report documents that the required components of a preauthorization program for PCS are in place and are being utilized for prior authorization of PCS-Plus services. PCS-Plus currently serves approximately 2,000 unduplicated recipients per year.

Implementation of this prior authorization program for all Medicaid in-home personal care services would increase the number of recipients requiring initial reviews, change of status reviews, and annual reviews to over 37,000 per year without generating significant savings in program services expenditures.

While prior authorization has potential to decrease the number of PCS recipients and PCS hours provided, the funds to implement such a program have not been appropriated. In addition, if funded, implementation of the program would be substantially delayed (by as much as two years) as a result of state procedures that require:

- A competitive vendor procurement through the state RFP and contracting process; and
- Multiple types and levels of review, approval, and documentation for the information technology component of this project to comply with requirements specified in SB 991 (An Act to Improve State Government Information Technology Planning, Adopt Standards, Make Project Development more Efficient, Reduce Cost Overruns, Provide Assistance to State Agencies, and Increase Accountability).

The costs associated with IT reviews, meeting SB 991 requirements, and implementing the North Carolina IT identification system (NCID) are expected to add \$400,000 to \$500,000 to the cost of implementing this program.

As provided for in the Governor's recommended adjustments to the State's FY 2008-09 budget, it is recommended that the mandate to implement this program be repealed.

Attachment A: Criteria for Coverage of PCS

1. **Unmet ADLs** – PCS covers aide services in private residences for recipients requiring assistance with a minimum of two unmet ADLs. The unmet ADLs must be identified on the PCS Physician Authorization for Certification of Treatment (PACT) Form and be addressed in the recipient's plan of care. An unmet need exists when:
 - The recipient cannot independently perform at least two personal care tasks because of a physical or cognitive impairment and there is no household member, relative, caregiver, or volunteer to meet the need on a regular basis or third party payer responsible for covering the service; and
 - PCS is the most cost-effective and appropriate form of care for the recipient. PCS is provided to assist, not replace, the help available from family members and community resources.
2. **Medical Condition** – The recipient must have a medical condition that requires the direct and ongoing care of the attending physician prescribing PCS and be medically stable.
3. **Medically Stable** – Medically stable means that the recipient does not have a medical need for continuous monitoring and evaluation by a licensed professional.
3. **Medical Necessity** – PCS aide services are covered only when the primary purpose of the visit is to provide personal care. Each of the personal care tasks provided must be directly related to the medical condition, medically necessary, and authorized on the PCS on the PACT Form in accordance with program requirements. If the recipient does not receive this service, the recipient is at risk for placement in a skilled nursing facility, adult care home, or other similar facility. For the purpose of this policy, the term medical necessity means that if the care plan is not implemented, the recipient's medical condition will deteriorate.
4. **Billed Services** – Services provided prior to admission, on the date of admission, and services provided after the recipient returns home on the date of discharge can be billed to Medicaid.
5. **Primary Care Physician Authorization** – PCS must be authorized by the recipient's primary physician. A Nurse Practitioner (NP) or Physician Assistant (PA) working under the supervision of the recipient's primary physician may also authorize PCS (as set forth in MD/NP/PA licensing regulations).

Attachment B: Criteria for Assistance with Activities of Daily Living

1. Bathing

- Taking a full-body bath: Tub, shower or sponge/bed bath. Transferring in and out of tub and shower. A full-body bath is not defined as only washing hair, back and/or performing foot care.
- Partial Bath: A sponge bath which would include, at minimum, bathing of the face, hands, and perineum. Bathing of the feet may be done on limited days recognizing a full daily shower is not needed for an aging and non-ambulatory recipient.
- Foot care/washing back, hands or face alone does not meet the bathing description/criteria. Foot care is defined as soaking feet, applying lotion to the feet, and toenail care. Foot care alone does not qualify the client for PCS services.

2. Dressing

- Laying out clothing, handing and retrieving clothing, putting clothes on, and taking them off, including handling fasteners, zippers, and buttons.
- Application of prosthetic devices or application of therapeutic stockings.

3. Grooming/Skin Care

- Brushing teeth, denture care, shaving, washing and drying face and hands, applying lotion to non-broken skin.
- Shampoo and comb hair, basic hair care, basic nail care.

4. Bed Mobility – Moving recipient to and from a lying position, turning side-to-side, and positioning recipient in bed.

5. Transfer – Moving recipient to and between surfaces: Bed, chair, wheelchair, and standing position. Transfer may include the use of assistive devices such as Hoyer lift, transfer or slide board, gait belt, or trapeze.

6. Ambulation – Moving in the recipient's environment: To and from bathroom, bedroom, kitchen and dining area, living/sitting area, outside (porch, deck, yard). Ambulation may include the use of assistive devices including cane, walker, and wheelchair. If wheelchair bound, requires assessment of self-sufficiency once in wheelchair as it relates to ADL self performance.

7. Toileting – Using the toilet: using the toilet including transfer on and off the toilet, bedside commode, urinal and/or bedpan. Toileting includes cleaning the perineum, cleaning after incontinent episodes, and changing incontinent devices such as diapers, disposable underwear, and pads and managing special devices such as ostomy care and catheter care (including emptying the catheter bag). The frequency and severity of incontinent episodes is documented.

8. **Eating** to include:

- Taking in food by any method; and
- Oral intake of food: May include supplements, special diets, and tube feedings. Patient may require set up, hands-on assist with feeding, supervision with eating, complete feeding, and tube feeding (bolus). Meal prep is a companion Instrumental ADL. Extra time may be allowed for preparing a special diet including chopped, ground, or pureed supplements.

9. **Delegated Medical Monitoring** – Non-skilled medical tasks which are delegated to the in-home aide by the RN clinical Supervisor, in accordance with laws, practice acts, and standards of care. The tasks include: reminding and/or assisting recipient with pre-poured medications, assisting with Finger Capillary Blood Sugar (FCBS), monitoring vital signs (temperature, blood pressure, respirations and pulse), and measurement of intake and output. Agency approved NA II tasks (per Board of Nursing guidelines).

10. **Treatment** to include

- Range of Motion exercises;
- NA I approved tasks as per NC Board of Nursing guidelines; and
- NA II approved tasks as per the NC Board of Nursing guidelines.

11. **Other Medical Considerations**

- Physical conditions that may affect the amount of time allocated to a personal care task include the following: dyspnea, shortness of breath with minimal exertion, continuous use of oxygen, medication assistance, respiration, incontinence needs, and endurance or pain issues.
- Cognitive impairment causing the recipient to require extensive hands-on assistance with a personal care task may also affect the amount of time allocated to a personal care task. This is shown by lack of alertness, orientation, or by the inability to shift attention and recall directions more than half of the time.

Attachment C:

Criteria for Home Management Tasks

1. The PCS in-home aide may also complete the following home management tasks which are secondary to the personal care task. Secondary tasks are provided only when necessary for maintaining the recipient's health and directly related to his/her medical condition and identified personal care needs. The tasks are directly related to the primary needs. The tasks must be completed for the recipient only, not others living within the household.
 - The PCS in-home aide is expected, when possible, to complete multiple tasks simultaneously. For example, while the laundry is in the washer, the in-home aide would be preparing a meal or completing other home management tasks.
 - Linen change, mopping, laundry, etc. are not to be performed daily. Thus, the time allotted in the plan of care should reflect daily needs. Specific documentation may be provided to identify need and support that the tasks should be provided more frequently. For example, more frequent linen changes for an incontinent recipient.
 - Home management time should not exceed the time budgeted for personal care time. Over the course of a week, personal care activities must be the primary activity during the visit.
 - In homes where more than one recipient is receiving Medicaid PCS, home management tasks should not be duplicated. For example, the bathroom, bedroom, and living areas, etc. should not be cleaned twice per visit.
2. **Meal Preparation** for meals and/or snacks: Simple diet, therapeutic modifications (low sodium, heart healthy, diabetic). Plan menus using food guide. Clean kitchen after meal, sweep and mop, take out trash.
3. **Modified diet** for meals and/or snacks: Chop, puree, grind, cut, serve, wash dishes, food handling and storage. Clean kitchen after meal, sweep and mop, take out trash.
4. **Other Personal care tasks:**
 - Recipient Laundry: Wash, dry, fold, simple mending, press.
 - Recipient Bedroom: Make bed, change linen, vacuum, dust, tidy living areas.
 - Recipient Bathroom: Clean sink, toilet, and tub/shower.
 - Recipient living areas: Tidy, keep free of clutter, dust, sweep/vacuum, sweep pathways.
 - Run essential errands for the recipient: Pharmacy, medical supplies, groceries, pay utility bills, and other items essential for medical care.
 - Basic reading and writing tasks for recipients with an identified and documented need. For example, if the recipient is blind.
 - Observe and report symptoms of abuse, neglect, and illness to proper agency professional (reporting requirements identified in GS108-A, article 6).

5. **Nurse Aide II Tasks**

- In addition to the personal care tasks, Nurse Aide II tasks may be provided as part of PCS when the tasks are performed according to the NC Board of Nursing rules.
- Registration with the NC Board of Nursing Nurse Aide, Nurse Aide II, or special training of Nurse Aide I personnel with NC Board of Nursing approval is required.
- The PCS provider should contact the NC Board of Nursing for guidance if it is considering providing any NA II tasks or has any questions related to this.

6. **PCS coverage criteria for pregnant women (DMA prior approval required) include:**

- Complication of pregnancy confining a client to bed and requiring assistance with personal care. The patient must be confined to bed by the obstetrician. The confinement is usually to prevent premature birth. The patient must have premature labor pains threatening miscarriage or premature birth or be pregnant with twins or multiples. This may include pre-eclampsia with hypertension and edema, hyper-emesis gravidarium with dehydration.
- A pre-existing medical condition exacerbated by pregnancy and requires hands-on assistance with personal care tasks.

Attachment D

Summary of Criteria for PCS-Plus

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

Medicaid recipients who require additional time for the in-home aide to perform delegated tasks are eligible for PCS-Plus. To qualify for PCS-Plus, the applicant must meet all the requirements for PCS and, at a minimum, require extensive assistance in:

1. Four or more activities of daily living (ADLs) and identified needs must be addressed on the plan of care. **OR**
2. Three or more ADLs *and* need the in-home aide to perform at least one task at the Nurse Aide II level and identified needs must be addressed on the plan of care. **OR**
3. Three or more ADLs *and* have a medical or cognitive impairment that requires extended time to perform needed in-home aide tasks and identified needs must be addressed on the plan of care.

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

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

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

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

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

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

Nurse Aide II tasks are defined as any of the following:		
1. Oxygen Therapy <ul style="list-style-type: none"> • Room set-up • Monitoring flow-rate 	4. Nutrition Activities <ul style="list-style-type: none"> • Oral/nasogastric infusions <i>(after placement verified by RN)</i> • Gastrostomy feedings • Clamping tubes • Removing oral/nasogastric feeding tubes 	9. I.V. Assistive Activities <ul style="list-style-type: none"> • Assemble/flush tubing during set-up • Monitoring flow-rate • Site care/dressing change • Discontinuing peripheral I.V. infusions
2. Suctioning <ul style="list-style-type: none"> • Oropharyngeal • Nasopharyngeal 	5. Sterile Dressing Change <i>(Wound over 48 hours old)</i>	10. Urinary Catheters <ul style="list-style-type: none"> • Catherizations • Irrigation of tubing
3. Elimination Procedures <ul style="list-style-type: none"> • Ostomy Care • Irrigation 	6. Break-up & Removal of Fecal Impaction	
	7. Wound Irrigation	
	8. Tracheostomy Care	

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

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

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

Attachment E

Procedures for PCS-Plus Approval by Nurse Consultant

Request for Prior Approval

The provider faxes or mails a completed Request for PCS-Plus form (DMA3000B) and a copy of the last approved PACT to the PCS-Plus office for review by the PCS Nurse Consultant. DMA has seven working days to complete the review and return the Request to the provider as either approved, denied, or suspended because more information is required.

Review Procedures:

When documentation is complete, the PCS Nurse Consultant evaluates the request according to the following criteria and guidelines:

1. The PCS Request Form (DMA3000B) is complete according policy guidelines.
2. The PACT Form (DMA3000) is complete per policy guidelines and signed by the recipient's primary care physician.
3. If either of these forms is incomplete, the Request Form is faxed back to the provider with a note to provide the missing information.
4. The Nurse Consultant ensures that a medical diagnosis is provided by the recipient's physician and that this diagnosis is the cause of the functional limitations in ADLs that require hands-on assistance by a PCS aide. For example, if the recipient has had a stroke he/she might require assistance with certain specified ADLs. However, if a recipient has hypertension or diabetes he/she would generally not require assistance with ADLs based on diagnosis alone.
5. If the diagnosis alone does not provide evidence of the need for PCS, the Nurse Consultant will check for other physical or mental conditions that would cause them to have problems with ADLs.
6. The Nurse Consultant relates diagnosis to age. For example, if a recipient is 70 years old he/she might require assistance with ADLs that a 35 year old individual with the same diagnosis would not. The older individual may not be able to see well, or may have age-related mobility problems.
7. The PCS Nurse Consultant looks at the PACT Form to ensure that the scores assigned to each ADL are in accordance with the PCS Clinical Policy.
8. The PCS Nurse Consultant checks to make sure the recipient's Primary Care Physician has signed the PACT Form, as required by the PCS Clinical Policy.
9. The PCS Nurse Consultant looks at page 4 of the PACT Form to see if the agency nurse has assigned the appropriate amount of time for the PCS aide to complete each ADL and the time is within the limits specified in the PCS Clinical Policy.
10. If the time required for each ADL exceeds the guidelines, the agency must provide justification based on the recipient's medical condition.
11. If the recipient meets the scoring criteria and the forms are complete and correct, the PCS Nurse Consultant approves the requested number of hours, or adjusts the number of approved hours based on the information provided.
12. The approval is good for 180 days.
13. The Administrative assistant enters the time and approval dates into the EDS system for claims payment and faxes the approval back to the provider agency.
14. The Nurse Consultant maintains hard copy documentation of all approvals and denials.

Attachment F
Forms Used in PCS Prior Approval Program

**PERSONAL CARE SERVICES (PCS)
PHYSICIAN AUTHORIZATION FOR CERTIFICATION AND TREATMENT (PACT) FORM**

Referral Date: _____ Date Initial Assessment Completed: _____ Date Last Reassessment Completed: _____
 Provider Name: _____ PCS Provider #: _____ Provider Phone #: _____
 Provider Address: _____

PATIENT INFORMATION

1. PATIENT FIRST & LAST NAME: _____
2. MEDICAID ID # (MID): _____
3. PATIENT ADDRESS: _____
4. PATIENT PHONE: _____ 5. SEX: Male Female 6. DATE OF BIRTH (mm/dd/yy): _____
7. PATIENT LIVES: *Check all that apply* Alone w/Spouse w/Adult Child(ren) w/Parent(s) w/others
8. CONTACT PERSON'S NAME: _____ RELATIONSHIP TO PATIENT: _____
 ADDRESS: _____ PHONE: (H) _____ (W) _____
9. PRIMARY PHYSICIAN'S NAME: _____ PA/NP FOR PCP (If applicable): _____
10. ADDRESS: _____ PHONE: () _____
11. DATE OF MOST RECENT EXAM (mm/dd/yy): _____ 12. Vital Signs @ Assessment: B/P _____ T _____ P _____ R _____ Wt _____ Ht _____
13. REASON FOR REFERRAL: _____
 Referral Source: _____
14. DIAGNOSIS (Specify date of onset and ICD-9 code): _____

15. CURRENT CARE (Type and Source): _____

ASSESSMENT

16. LIST ALL MEDICATIONS BELOW: (Name/Dose/Frequency/Route)

17. Self-Administered? Yes No If no, who assists/what needed? _____

18. Does the individual have any allergies?: No Known Allergies Yes If yes, LIST ALL KNOWN ALLERGIES BELOW:

PATIENT FIRST & LAST NAME:		MEDICAID ID#:		ASSESSMENT DATE:	
Limitations in Activities of Daily Living (ADLs)					
Rate the individual's ADL Self-Performance and ADL Support Provided using the scores below. Check the applicable boxes. Indicate the days when assistance is needed in the blank beside a task. M=Mon T=Tues W=Wed Th=Thurs F=Fri S=Sat Sun=Sunday					
A. ADL Self-Performance Scores 0. INDEPENDENT: No help needed or oversight needed. 1. SUPERVISION: Oversight, encouragement, or cueing needed. 2. LIMITED ASSISTANCE: Individual highly involved in activity; receives hands-on assistance <i>guided maneuvering of limbs with eating, toileting, bathing, dressing, personal hygiene self monitoring of meds and / or other non-weight bearing assistance.</i> 3. EXTENSIVE ASSISTANCE: While individual performs part of activity, substantial or consistent hands-on assistance <i>with eating, toileting, bathing, dressing, personal hygiene, self-monitoring of meds and / or weight bearing assistance is needed.</i> 4. FULL DEPENDENCE: Full performance of activity by another.					A. ADL Self-Performance
B. ADL Support Provided Scores 0. No set-up or physical help needed 1. Set-up help only 2. One person physical assist 3. Two+ persons assist and/or one person assist w/assistive equipment					B. ADL Support Provided
Place a check in the box if agency assistance is needed (summet needs)					
19. ADL Mobility	Ambulation:	Note assistive equipment patient is to use while ambulating: <input type="checkbox"/> Cane <input type="checkbox"/> Quad cane <input type="checkbox"/> Walker <input type="checkbox"/> other _____			
	Non-ambulatory/Transfer	Moving to and between surfaces (circle): bed, chair, wheelchair, toilet, tub, shower, and standing. <input type="checkbox"/> Bed/chair bound Assistive equipment needed during transfer: <input type="checkbox"/> Hoyer lift <input type="checkbox"/> Transfer board <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Hospital bed <input type="checkbox"/> other _____ Note self sufficiency once transferred _____ <input type="checkbox"/> Pressure relief device <input type="checkbox"/> Turn & position _____ Wheelchair: <input type="checkbox"/> Manual <input type="checkbox"/> Electric			
20. ADL Eating		<input type="checkbox"/> Oral <input type="checkbox"/> Parenteral <input type="checkbox"/> Tube _____ <input type="checkbox"/> Feed patient Dietary Restrictions _____ Supplements _____ Diet Ordered _____ <input type="checkbox"/> Chop <input type="checkbox"/> Grind <input type="checkbox"/> Puree <input type="checkbox"/> Thicken			
21. ADL Bathing		<input type="checkbox"/> Full body bath _____ <input type="checkbox"/> Partial bath _____ <input type="checkbox"/> Shower _____ <input type="checkbox"/> Sponge bath _____ <input type="checkbox"/> Shampoo hair _____ <input type="checkbox"/> Foot care _____ <input type="checkbox"/> Special skin care _____ <i>Devices used:</i> <input type="checkbox"/> Shower bench/chair <input type="checkbox"/> Bath safety bars <input type="checkbox"/> Detachable shower head			
22. ADL Dressing		<input type="checkbox"/> Retrieve clothes <input type="checkbox"/> Put clothes on and take clothes off <input type="checkbox"/> Don/remove therapeutic stockings <input type="checkbox"/> Don/remove prosthesis <input type="checkbox"/> Assists with buttons, fasteners, & zippers <input type="checkbox"/> Put stockings/socks & shoes on/off			
23. ADL Toileting	Toileting Bladder	Rate assistance and frequency needed : <input type="checkbox"/> Normal <input type="checkbox"/> Ostomy <input type="checkbox"/> Indwelling catheter <input type="checkbox"/> Condom catheter <input type="checkbox"/> I/O cath <input type="checkbox"/> Occasional incontinence (less than daily) <input type="checkbox"/> Clean perineum <input type="checkbox"/> Changing _____ <i>Devices/supplies used:</i> <input type="checkbox"/> Bedside commode <input type="checkbox"/> Elevated toilet seat <input type="checkbox"/> Bedpan <input type="checkbox"/> Urinal <input type="checkbox"/> Pads <input type="checkbox"/> Cath care _____ <input type="checkbox"/> Ostomy Care _____			
	Toileting Bowel	Rate assistance and frequency needed : <input type="checkbox"/> Normal <input type="checkbox"/> Occasional incontinence (less than daily) <input type="checkbox"/> Ostomy <input type="checkbox"/> Ostomy Care _____ <i>Devices/supplies used:</i> <input type="checkbox"/> Bedside commode <input type="checkbox"/> Elevated toilet seat <input type="checkbox"/> Bedpan <input type="checkbox"/> Pads <input type="checkbox"/> Constipation <input type="checkbox"/> Use of laxatives <input type="checkbox"/> Enemas <input type="checkbox"/> Clean perineum _____ <input type="checkbox"/> Changing _____			
24. ADL Continence		<input type="checkbox"/> Daily urinary incontinence <input type="checkbox"/> Day/night urinary incontinence <input type="checkbox"/> Diapers <input type="checkbox"/> Disposable underwear <input type="checkbox"/> Daily bowel incontinence <input type="checkbox"/> Bowel/Toileting program _____			
25. Personal hygiene		<input type="checkbox"/> Comb hair <input type="checkbox"/> Brush teeth <input type="checkbox"/> Clean dentures <input type="checkbox"/> Wash/dry face and hands <input type="checkbox"/> Braid or set hair _____ <input type="checkbox"/> Shave _____ <input type="checkbox"/> Oral care _____			
26. Delegated medical monitoring and treatments		<input type="checkbox"/> Assistance with self-administration of: <input type="checkbox"/> a. Pre-poured medications <input type="checkbox"/> Reminders needed <input type="checkbox"/> b. BP: _____ Notify agency RN if BP is > _____ or < _____ c. Blood Sugars: _____ Notify agency if BS is > _____ or < _____ <input type="checkbox"/> d. ROM _____ <input type="checkbox"/> e. Other monitoring/treatment (specify) _____ <input type="checkbox"/> Delegated medication task(s) _____			
27. IADL	Meal Preparation	Meal prep: <input type="checkbox"/> a. 1 meal _____ <input type="checkbox"/> b. 2 meals _____ <input type="checkbox"/> c. Set-up only <input type="checkbox"/> d. Take out trash _____ <input type="checkbox"/> e. Wash dishes & tidy after meal <input type="checkbox"/> f. Clean kitchen _____ <input type="checkbox"/> g. Other _____			
IADL Home Mgt.	28. Bathroom	29. Bedroom/Living areas		30. General	
	<input type="checkbox"/> a. Tidy after Bath <input type="checkbox"/> b. Clean Bathroom _____	<input type="checkbox"/> a. Make bed _____ <input type="checkbox"/> b. Sweep _____ <input type="checkbox"/> c. Dust _____ <input type="checkbox"/> d. Keep free of clutter _____ <input type="checkbox"/> e. Tidy _____		<input type="checkbox"/> a. Laundry _____ <input type="checkbox"/> b. Change bed linens _____ <input type="checkbox"/> c. Mop _____ <input type="checkbox"/> d. Vacuum _____ <input type="checkbox"/> e. Check smoke alarm _____	
		31. Errands/Misc			
		<input type="checkbox"/> a. Grocery shop _____ <input type="checkbox"/> b. Pick up medicine/medical supplies _____ <input type="checkbox"/> c. Pay utility bill _____ <input type="checkbox"/> d. Reading/Writing/Reporting _____			

PATIENT FIRST & LAST NAME:		MEDICAID ID#:	ASSESSMENT DATE:
Other Client Information			
Check the appropriate box that applies to the patient.			
32.	Respiration	<input type="checkbox"/> Normal <input type="checkbox"/> Dyspneic with minimal exertion <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Mechanical Oxygen: <input type="checkbox"/> Continuous _____ (O ₂ rate) <input type="checkbox"/> Intermittent <input type="checkbox"/> Nebulizer Treatments _____ <input type="checkbox"/> Dyspneic or noticeably short of breath with minimal exertion during ADL performance and requires continuous use of oxygen	
33.	Endurance	<input type="checkbox"/> Pt. is never short of breath (SOB) <input type="checkbox"/> Pt. is SOB when walking > 20 feet or climbing stairs <input type="checkbox"/> Patient is SOB when walking < 20 feet and/or dressing self or using commode <input type="checkbox"/> Pt is SOB w/minimal exertion (i.e. eating, talking, performing ADLs, agitation) <input type="checkbox"/> Pt is SOB at rest <input type="checkbox"/> Pt has generalized weakness <input type="checkbox"/> Pt has hx/high risk for falls	
34.	Pain: 7-day look-back	Location of pain: _____ Severity of Pain: Rate 0 - 10: 0=no pain and 10=worst pain _____ Pain frequency: <input type="checkbox"/> No pain <input type="checkbox"/> Pain < daily <input type="checkbox"/> Pain daily <input type="checkbox"/> Presence of continuous and/or substantial pain interfering with individual's activity or movement Pain control: <input type="checkbox"/> No pain <input type="checkbox"/> Pain improved w/medication <input type="checkbox"/> No pain relief or improvement w/medication <input type="checkbox"/> Other pain mgmt. _____	
35.	Cognitive Skills for Daily Decision Mkg:	<input type="checkbox"/> Independent (decisions consistent/reasonable) <input type="checkbox"/> Modified independence (some difficulty in new situations only) <input type="checkbox"/> Moderately impaired (decisions poor, cues/supervision required) <input type="checkbox"/> Severely impaired (never/rarely makes decision) <input type="checkbox"/> Patient requires step-by-step verbal prompting <input type="checkbox"/> MR/DD _____ (level) <input type="checkbox"/> Due to cognitive functioning, individual requires extensive assistance in routine situations. Individual is not alert and oriented or is unable to shift attention and recall directions more than half the time.	
36.	Behavior:	<input type="checkbox"/> Cooperative <input type="checkbox"/> Passive <input type="checkbox"/> Physically abusive <input type="checkbox"/> Verbally abusive <input type="checkbox"/> Wanders <input type="checkbox"/> Injures self/others/property <input type="checkbox"/> Non-responsive	
37.	Vision:	<input type="checkbox"/> Adequate for daily activities <input type="checkbox"/> Limited (sees large objects) <input type="checkbox"/> Very limited (blind) Client uses: <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts	
38.	Hearing:	<input type="checkbox"/> Adequate for daily activities <input type="checkbox"/> Hears loud sounds/voices <input type="checkbox"/> Very limited (deaf) Client uses: <input type="checkbox"/> Hearing aids	
39.	Speech:	<input type="checkbox"/> Normal <input type="checkbox"/> Slurred <input type="checkbox"/> Weak <input type="checkbox"/> Other impediment: specify _____ Primary language(s) spoken: _____	
40.	Communication Method:	<input type="checkbox"/> Speech <input type="checkbox"/> Gestures <input type="checkbox"/> Writing <input type="checkbox"/> Assistive Device: specify type _____ <input type="checkbox"/> Client unable to write; have client make mark here: _____ Nurse's initials: _____	
41. Patient's perception of what he/she thinks their needs are: (in patients own words)			
42. Has the patient executed an advance directive (living will or durable power of attorney)? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify location of original doc.: _____			
43. Is there a DNR order? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was DNR order discussed with pt.? <input type="checkbox"/> Yes <input type="checkbox"/> No Has a copy of the DNR been obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, has the MD been contacted to obtain copy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
44. SAFETY ASSESSMENT: Is the patient's home adequate or suitable to carry out the Plan of Care according to your agency's policies? <input type="checkbox"/> Yes <input type="checkbox"/> No Water? <input type="checkbox"/> Yes <input type="checkbox"/> No Telephone? <input type="checkbox"/> Yes <input type="checkbox"/> No Heating? <input type="checkbox"/> Yes <input type="checkbox"/> No Cooling? <input type="checkbox"/> Yes <input type="checkbox"/> No Electric capability sufficient? <input type="checkbox"/> Yes <input type="checkbox"/> No Smoke alarm? <input type="checkbox"/> Yes <input type="checkbox"/> No Fire extinguisher? <input type="checkbox"/> Yes <input type="checkbox"/> No If O ₂ is in use, have safety precautions been included on Plan of Care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Safety devices in bathroom? <input type="checkbox"/> Yes <input type="checkbox"/> No Patient emergency #s in clear view? <input type="checkbox"/> Yes <input type="checkbox"/> No Has patient been instructed on the use of DME? <input type="checkbox"/> Yes <input type="checkbox"/> No List the DME company used: _____ Specify what DME is already used in the home: _____ Specify what DME has been ordered: _____			
45. Are there sources (family, friends, programs, or other agencies) available to meet the ADL and IADL needs? <input type="checkbox"/> Yes, please explain: <input type="checkbox"/> No, please explain reason(s) for inability to assist:			

NURSE ASSESSOR CERTIFICATION

I certify that I, and no one else, have completed the above in-home assessment of the patient's condition. I understand falsification as: "an individual who certifies a material and false statement in this assessment will be subject to investigation for Medicaid fraud and will be referred to the NC Board of Nursing for investigation."

- Based on the assessment, I have determined that the patient needs hands on assistance with Personal Care due to the patient's medical condition. I have developed the plan of care to meet those needs.
 I have determined that the patient does not meet the criteria for personal care services.

PRINT RN NAME

RN SIGNATURE

Date Signed:

Time in /out of home

PATIENT FIRST & LAST NAME:	MEDICAID ID#:	ASSESSMENT DATE:
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PLAN OF CARE

If the assessment indicates that the patient has medically-related personal care needs requiring PCS, show the plan for providing care beside the day(s) services are needed. Write in the category # of the assigned task(s) that is designated on the assessment. The key below lists the category numbers. Write in the time (in 15 minute increments or in hours) required for each day. Do not include tasks that are performed by the family or others; include only the tasks that the PCS provider performs (unmet needs).

46. Additional time needed; check numbered block for the category (from page 3) extra time is needed and document information specific to client needs in the space below for exceptions to time and task guidance. 32 33 34 35 36 37 38 39 40

ADL #	ADL Name		Monitoring	IADL #	IADL Name
19	Mobility	25	Personal Hygiene	27	Meal preparation
20	Eating			28	Home Mgt. Bathroom
21	Bathing			29	Home Mgt. Bedroom/Living areas
22	Dressing				
23	Toileting	26	Delegated Medical Monitoring	30	Home Mgt. General
24	Continence			31	Home Mgt. Errands

Day of the Week	Task(s) To Be Accomplished Specify the category # and the amount of time required for each task (i.e. # 19: 15 minutes)		Total Time per Day <i>(in 15 min increments or in hours)</i>
	ADL	IADL	
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

47. Goals/Objectives: The need for PCS is expected to change OR end on ___/___/____. If no change is expected, state why:

48. Order obtained to assess the patient for hands on assistance needs with:

___mobility ___eating ___bathing ___dressing ___toileting ___continence.

Who conveyed/obtained this verbal order? _____ / _____ Order date: ___/___/___

49. Order was obtained to start/continue PCS: ___ days a week for hands on assistance needs with:

___mobility ___eating ___bathing ___dressing ___toileting ___continence.

Who conveyed/obtained this verbal order? _____ / _____ Order date: ___/___/___

PHYSICIAN CERTIFICATION

I certify that I am the patient's primary physician and the patient is under my care and has a medical diagnosis with associated physical/mental limitations warranting the provision of the Personal Care Services in the above plan of care. I understand falsification as: "an individual who certifies a false statement in this plan may be subject to investigation for Medicaid fraud and will be referred to the North Carolina Board of Medicine."

I have determined that the patient does NOT meet the criteria for Personal Care Services.

ATTENDING PHYSICIAN'S SIGNATURE _____

DATE _____
Carolina Access #: _____

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

1. <input type="checkbox"/> PCS-Plus Initial Request <input type="checkbox"/> PCS-Plus Reauthorization Request		DMA Prior Approval <i>Authorization for _____ hours/month*</i> <i>*Cannot exceed a total of 80 hours/month.</i> Effective from: _____ to: _____ Date Request Reviewed: _____ RN Signature: _____	
Date of Request: _____ Request Submitted by: _____ Total Number of PCS Hours/Month Requested: _____ hours/month Duration of PCS-Plus Request*: _____ days From: _____ To: _____ <i>*PCS-Plus authorizations cannot exceed 180 days. To request an extension, submit a new PCS-Plus Request Form at least one week before the PCS-Plus authorization expires.</i>			
2. Provider Agency Information			
Agency Name: _____		PCS Provider #: _____	
Address: _____		Phone: _____ Fax: _____	
		Email: _____	
3. Medicaid Recipient Information			
Last Name: _____		First Name: _____ Middle Name: _____	
Address: _____		County: _____	
Phone Number: _____		Medicaid ID # (MID): _____	
Date of Birth: _____			
Currently on PCS? <input type="checkbox"/> Yes <input type="checkbox"/> No* <i>If no, agency RN must follow DMA procedures for PCS assessment and obtaining MD approval.</i>			
Physician Name: _____		Phone Number: _____ Date DMA-3000 Signed: _____	
4. Specify Primary and Secondary Diagnosis:			
If a medical or cognitive condition is being used to qualify for PCS-Plus, the assessment must document at least one of the following (check all that apply):			
<input type="checkbox"/> Presence of continuous and/or substantial pain interfering with individual's activity or movement <input type="checkbox"/> Dyspneic or noticeably short of breath with minimal exertion during ADL performance and requires continuous use of oxygen <input type="checkbox"/> Due to cognitive functioning, individual requires extensive assistance with performing ADLs. Individual is not alert and oriented or is unable to shift attention and recall directions more than half the time. <input type="checkbox"/> Bowel incontinence more often than once daily <input type="checkbox"/> Urinary incontinence during the day and night <input type="checkbox"/> Not Applicable			
5. List Current Medications (include medication name, dose, frequency, and route of administration)			
6. Limitations in Activities of Daily Living (ADLs)			
Rate the individual's ADL Self-Performance and ADL Support Provided using the scores below			
A. ADL Self-Performance Scores		ADL Self-Performance	ADL Support Provided
0. INDEPENDENT: No help or oversight needed.			
1. SUPERVISION: Oversight, encouragement or cueing needed.			
2. LIMITED ASSISTANCE: Individual highly involved in activity; receives help in guided maneuvering of limbs or other non-weight bearing assistance.			
3. EXTENSIVE ASSISTANCE: While individual performs part of activity, help of the following is needed: <i>weight-bearing support OR substantial or consistent hands-on assistance with eating, toileting, bathing, dressing, personal hygiene, or self-monitoring of meds.</i>			
4. FULL DEPENDENCE: Full performance of activity by another.			
B. ADL Support Provided Scores			
0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+persons physical assist			
a Bed Mobility	Moving to and from lying position, turning side-to-side and position body while in bed.		
b Transfer	Moving to and between surfaces: bed, chair, wheelchair, standing position. (Exclude to/from bath/toilet)		
c Ambulation	Note assistive equip. (walker, wheelchair, hooyer lift); self-sufficiency once in chair. Assistive Equip: _____		
d Eating	Taking in food by any method, including tube feedings. Therapeutic Diet: _____		
e Toilet Use	Using the toilet (commode, bedpan, urinal); transferring on/off toilet, cleaning self after toilet use, changing pads/diapers, managing any special devise required (ostomy or catheter), and adjusting clothes.		
f Bathing	Taking full-body bath/shower, sponge bath, transferring in/out of tub/shower. (Exclude washing back/hair)		
g Dressing	Laying out clothes, retrieving clothes from closet, putting clothes on and taking clothes off.		
h Personal Hygiene	Combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands, and perineum. (Exclude baths and showers)		
i Self-Monitoring	Self-monitoring of pre-poured medications, glucometers, etc.		
7. Nurse Aide II Tasks (specify task and frequency below)			
8. Nurse Assessor Certification			
I certify that the above information reflects this Medicaid recipient's condition and that the recipient's DMA-3000 was signed by the attending physician on (specify date) _____ to obtain authorization for PCS.			
Print Name: _____		Signature: _____ Date: _____	