

Table of Contents

1.0	Description of the Procedure, Product, or Service.....	1
1.1	General Description	1
1.2	Program Parameters	1
1.3	Alternative to Institutionalization	1
1.4	PCS Policy Definitions and Acronyms.....	1
2.0	Eligible Recipients.....	3
2.1	General Provisions.....	3
2.2	EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age	3
2.3	Personal Care Services for Pregnant Women	4
3.0	When the Procedure, Product, or Service is Covered.....	4
3.1	General Criteria.....	4
3.2	Specific Criteria	4
4.0	When the Procedure, Product, or Service Is Not Covered.....	5
4.1	General Criteria.....	5
4.2	Specific Criteria	5
4.3	Non-Covered Tasks	6
4.4	Cueing, Prompting, Guiding, or Coaching	6
5.0	Requirements for and Limitations on Coverage.....	6
5.1	Prior Approval	6
5.2	Authority to Conduct PCS Assessments, Reassessments, Change of Status Reviews, Service Authorizations, and Related Administrative Tasks.....	7
5.3	Requirement for Qualifying Activities of Daily Living (ADLs)	7
5.4	Requirement for Physician Referral.....	7
5.5	Requirements for PCS Assessments,	8
5.6	Requirements for PCS Reassessments.....	8
5.7	Requirements for PCS Change of Status Reviews.....	9
5.8	Requirements for PCS Assessment and Reassessment Tools.....	9
5.9	Determination of the Recipient’s ADL Self-Performance Capacities	9
5.10	Minimum Requirement for Admission to and Continuation of PCS.....	11
5.11	Minimum Requirement for Admission to and Continuation of PCS-Plus.....	11
5.12	Requirement for Service Authorization	11
5.13	Daily Limit for PCS.....	11
5.14	Requirements for Selecting and Changing PCS Providers	11
5.15	Requirements for PCS Plan of Care.....	12
5.16	Nurse Aide Tasks.....	12
6.0	Providers Eligible to Bill for the Procedure, Product, or Service	12
7.0	Additional Requirements	13
7.1	Compliance	13
7.2	Assessment Tools, Plans of Care, and Forms	13

7.3	Automated Reporting.....	13
7.4	Telephony	14
7.5	Marketing Prohibition.....	14
7.6	DMA Compliance Reviews	14
7.7	Internal Quality Improvement Program.....	14
7.8	Quality Improvement, Utilization Review, Pre- and Post-Payment Audits.....	14
7.9	Recipient Health, Welfare, and Safety.....	15
7.10	Provider Staffing Requirements and Qualifications	15
	7.10.1 Plan of Care	15
	7.10.2 RN Supervision.....	15
	7.10.3 In-Home Aides.....	17
	7.10.4 Staff Development and Training.....	17
8.0	Policy Implementation/Revision Information.....	18
Attachment A:	Claims-Related Information	22
A.	Claim Type	22
B.	Diagnosis Codes	22
C.	Revenue and Procedure Codes.....	22
D.	Modifiers.....	22
E.	Billing Units.....	22
F.	What May be Billed.....	22
G.	Place of Service	22
H.	Co-Payments.....	22
I.	Reimbursement	22
Attachment B:	ADL Assessment Design and Methodology.....	23
1.	Assessment Information.....	23
2.	Determination of the Number of PCS Hours	28

1.0 Description of the Procedure, Product, or Service

1.1 General Description

Personal Care Services (PCS) provided under this Medicaid Program include a range of hands-on human assistance provided to persons of all ages with disabilities and chronic conditions to enable them to accomplish tasks that they would ordinarily do for themselves if they were not disabled. These PCS are primarily intended to provide person-to-person hands on assistance by a paraprofessional aide in the recipient's home with common activities of daily living (ADLs) that, for this program are eating, dressing, bathing, toileting, and mobility.

1.2 Program Parameters

These Medicaid services are based on the assessed level of the recipient's functional limitations and need for assistance in performing the ADLs listed above. Services are provided on a scheduled and intermittent basis to supplement other community services that may be available and the care, assistance, and support provided by the recipient's family and other informal caregivers.

1.3 Alternative to Institutionalization

Medicaid in-home PCS does not require the recipient to meet Medicaid nursing facility level of care requirements to participate and are generally not adequate in scope and amount to replace facility-based services for recipients who require ongoing care,, supervision, or monitoring by a nurse or other health care professional. This program is appropriate for recipients whose needs for assistance can be safely met in the home by family members and other informal caregivers supported by scheduled visits by specially trained PCS aides.

1.4 PCS Policy Definitions and Acronyms

Activities of Daily Living (ADLs) means the physical functions that an individual performs each day and, as used in this Policy, are bathing, dressing, toileting mobility, and eating

Change of Status Review means a reassessment required because of a significant change in the participant's need for assistance with the qualifying activities of daily living (ADLs)

Continuous Quality Improvement (CQI) means the process of designing program monitoring and evaluation activities, identifying program problems and deficiencies, correcting or remediating those problems and deficiencies, and continually improving the quality of care and services provided by the PCS Program

Division of Health Services Regulation (DHSR) means the state agency responsible for licensing and regulating home care agencies

Division of Medical Assistance (DMA) means the state Medicaid agency

Early Periodic Screening, Diagnostic, and Treatment Services (EPSDT) means Medicaid's child health program that covers medically necessary health care services to children under 21 even when those services are not available under the State's Medicaid Plan to the rest of the Medicaid population

Functional Limitation means a limitation in the individual's capacity to perform ADLs independently because of a physical or cognitive impairment.

HIPAA means Health Insurance Portability and Accountability Act of 1996 that provides federal regulations for the protection and security of confidential health information

In-Home Aide or PCS Aide Services means hands-on assistance by a paraprofessional that assists individuals to perform activities of daily living, as defined in this Clinical Coverage Policy

Independent Assessment Entity (IAE) means an organization under contract to DMA to perform PCS assessments and related activities that is not a provider of PCS or affiliated in any way with any PCS Provider Organization

Instrumental Activities of Daily Living (IADLs) means light housekeeping tasks directly related to the approved ADL assistance specified on the recipient's plan of care, such as or changing bed linen after a bed bath,

Nursing Services means professional services provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of a registered nurse

Personal Care Services (PCS) Aide or In-Home Aide means an individual who is a paraprofessional and who provides hands-on assistance to recipients receiving personal care services under this Clinical Coverage Policy

Personal Care Services (PCS) means a Medicaid home care program that provides up to 60 hours a month of In-Home Aide services to meet the recipient's medically-related personal care needs

Personal Care Services Plus (PCS-Plus) means a Medicaid home care program that provides up to an additional 20 hours of In-Home Aide services when medically necessary and prior approved by DMA

Program Reassessment or Continuation Review mean the reassessment of the PCS program participant conducted prior to the end of his or her current authorization period to determine if he or she continues to qualify for PCS and to determine the amount of PCS to be provided

Provider Organization or PCS Provider means a public or private entity that is licensed as a home care agency by the North Carolina Division of Health Services Regulation and enrolled with Medicaid to furnish in-home Personal Care Services to Medicaid recipients

Recipient means an individual qualified for Medicaid who is receiving PCS benefits

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

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 recipients 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/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 recipient'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 recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure that is:

- a. Unsafe, ineffective, or experimental/investigational.
- b. 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/or 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 will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT and Prior Approval Requirements

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/basicmed/>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

2.3 Personal Care Services for Pregnant Women

Medicaid covers PCS under its Pregnant Women Program when prior approved by Medicaid or its designee and when the qualified recipient:

- a. Has been confined to a bed by an obstetrician for a pregnancy-related condition; and
- b. Has a pre-existing medical condition exacerbated by pregnancy that requires hands-on assistance with personal care tasks

3.0 When the Procedure, Product, or Service is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

3.1 General Criteria

Medicaid covers procedures, products, and services related to this policy when they are medically necessary and the procedure, product, or service:

- a. Is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the recipient's needs;
- b. Can be safely furnished and no equally effective and more conservative or less costly treatment is available statewide; and
- c. Is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

Medicaid covers PCS for eligible recipients when all of the following are true.

- a. The home environment is safe and free of health hazards for the recipient and PCS provider(s), as determined by an in-home environmental assessment conducted by Medicaid or its designee.
- b. The home is adequately equipped to implement needed services.
- c. There is no other third-party payer responsible for covering Personal Care Services or similar in-home aide services.
- d. There is no available, willing, and able household member to provide the authorized services on a regular basis.
- e. The required Personal Care Services are directly linked to a documented medical condition or conditions causing the functional limitations requiring the PCS.
- f. The recipient is under the ongoing direct care of a physician for the medical condition(s) causing the functional limitations.

- g. The recipient is medically stable and does not require continuous monitoring by a licensed nurse or other licensed health care professional.

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

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when:

- a. The recipient does not meet the eligibility requirements listed in Section 2.0;
- b. The recipient does not meet the medical necessity criteria listed in Section 3.0;
- c. The service duplicates another provider's service, including in-home aide services provided under Medicaid waiver programs, private duty nursing, state block grants, and other state and local programs that provide hands-on assistance with ADLs;
- d. Another home and community-based service is provided to the recipient at the same time on the same day.
- e. The service provided is in a service location other than the recipient's private residence;
- f. The service provided is not in accordance with this Clinical Coverage Policy;
- g. The service is experimental, investigational, or part of a clinical trial; or
- h. The service does not comply with all applicable federal and state statutes, rules, regulations, policies, and guidelines pertaining to Medicaid in-home PCS.

4.2 Specific Criteria

North Carolina Medicaid does not cover PCS when:

- a. The recipient's primary need is housekeeping or homemaking;
- b. The PCS provided in the month exceeds the amount approved by the IAE;
- c. The assigned ADL assistance is not completed on the date billed;
- d. The PCS are provided by a live-in aide;
- e. The PCS are performed by an individual who is the recipient's spouse, child, parent, sibling, grandparent, grandchild, or equivalent step or in-law relationship to the recipient;
- f. There are willing and able family members or other informal caregivers available on a regular basis adequate to meet the recipient's need.

4.3 Non-Covered Tasks

Medicaid does not cover certain services and tasks under this program, including, but not limited to:

- a. Skilled nursing services provided by a LPN or RN;
- b. Services provided by other licensed health care professionals;
- c. Care of non-service-related pets and animals;
- d. Yard or home maintenance work;
- e. Medical and non-medical transportation;
- f. Child care, day care, or after school care;
- g. Assistance with homework;
- h. Money management;
- i. Companion sitting or leisure activities;
- j. Shopping or other errands;
- k. Continuous monitoring or ongoing recipient supervision; and
- l. Personal care or home management tasks for other residents of the household.

4.4 Cueing, Prompting, Guiding, or Coaching

Cueing, prompting, guiding, or coaching may be provided as part of the hands-on assistance to recipients for the qualified ADLs, but do not constitute a covered service in and of themselves.

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

5.1 Prior Approval

- a. Prior approval by DMA or its designee is required for:
 1. Women covered under the Medicaid Pregnant Women Benefit; and
 2. Children covered under the Medicaid Early Periodic Treatment, Screening, Diagnosis, and Treatment (EPSDT) Program when the child requires more than 80 hours of PCS per month.
- b. For Personal Care Services under basic PCS up to 60 hours per month and for PCS-Plus up to 80 hours per month, for cases other than Medicaid for Pregnant Women and EPSDT, the independent assessment conducted by DMA or the designated Independent

Assessment Entity and the resulting Service Authorization shall constitute prior approval for the number of hours specified in the Service Authorization.

5.2 Authority to Conduct PCS Assessments, Reassessments, Change of Status Reviews, Service Authorizations, and Related Administrative Tasks

- a. All PCS assessments, reassessments, and change of status reviews shall be conducted by DMA or the IAE designated by DMA.
- b. PCS Provider Organizations are not authorized to perform PCS assessments for the purpose of authorizing services. Such assessments include initial assessments of recipients referred to PCS, continuing need reviews or reassessments, and change of status reviews. All recipients requiring a PCS authorization assessments must be referred to the IAE.
- c. PCS Providers may not initiate services until the service authorization is received from DMA or the designated IAE and the plan of care is approved by DMA or the designated IAE.
- d. DMA or the designated IAE shall determine the qualifying ADLs, the level of assistance required for each, and the amount and scope of PCS to be provided, according to the criteria provided in **Section 5.8** and **Section 5.9**, of this Clinical Coverage Policy.
- e. DMA, or the designated IAE, shall determine the end date for approval of services and the date of the next reassessment that shall be no later than 365 days from the approval date or a shorter period of time based on the recipient's chronic or continuing acute condition and expectation for improvement in the recipient's medical condition causing the need for PCS.

5.3 Requirement for Qualifying Activities of Daily Living (ADLs)

Under this Medicaid Program, PCS are provided to Medicaid recipients who qualify for coverage and have documented need for hands-on assistance with:

- a. Bathing ,
- b. Dressing,
- c. Toileting,
- d. Mobility, and
- e. Eating.

5.4 Requirement for Physician Referral

- a. The recipient must be referred to PCS by his or her primary care or attending physician.
- b. The recipient is responsible for contacting his or her primary care or attending physician and requesting a referral for Medicaid in-home PCS.
- c. If the recipient has not been seen by his or her physician during the preceding 90 days, he or she must schedule an office visit to request Medicaid in-home PCS.
- d. A recipient participating in Community Care of North (CCNC) must be referred for PCS by his or her designated primary care physician, except as described in section (g.) below

- e. If a recipient does not have a primary care physician, he or she must get a referral from the physician who is providing the care and treatment for the medical condition(s) causing the functional limitations requiring PCS.
- f. Once ordered by the recipient's physician, the PCS Assessment shall be performed by an IAE RN Assessor at the recipient's home. An environmental risk assessment of the recipient's home shall also be performed at this time.
- g. If the recipient is an inpatient in a medical facility such as a hospital, rehabilitation center, or nursing facility, his or her attending physician may order the PCS through the facility's discharge planning office. A written copy of the order must be placed in the recipient's medical record and, if requested, must be provided to the IAE.
- h. The recipient may receive the PCS assessment in the inpatient medical facility by an IAE RN Assessor. If the recipient qualifies for PCS, the RN Assessor will have to complete a home risk evaluation before he or she can be authorized for services.
- i. Primary care and attending physicians referring patients for PCS must complete the PCS on-line referral form and submit the form to the IAE via the Internet. The referral form must be complete and provide:
 - 1. Physician authorization for the IAE to perform a PCS Assessment; and
 - 2. The medical diagnosis or diagnoses causing the need for personal care assistance.

5.5 Requirements for PCS Assessments,

- a. All PCS assessments shall be conducted by DMA or RNs affiliated with the Independent Assessment Entity (IAE) using a standardized process and assessment tool provided or approved by DMA.
- b. All PCS assessments shall be performed by individual RN assessors.
- c. All assessments for new admissions to the PCS Program shall be face to face and conducted in the recipient's home or at the inpatient medical facility if the recipient is being evaluated for PCS as part of the discharge planning process.
- d. In-home assessments shall include an assessment of the recipient's home environment to identify any health or safety risks to the recipient or to the PCS Aides who will provide the services.
- e. Physician attestation that the approved PCS are medically necessary.

5.6 Requirements for PCS Reassessments

- a. All reassessments for continuing authorization of PCS shall be conducted by DMA and the designated IAE.
- b. Reassessments may vary in type and frequency depending on the recipient's level of functional disability and his or her prognosis for improvement or rehabilitation, as determined by the IAE.
- c. Reassessment frequency shall be determined by the IAE as part of the new referral assessment process.
- d. Reassessments shall be conducted on a face-to-face basis.

- e. Physician attestation that the approved PCS are medically necessary.
- f. Reassessments may be waived by the IAE if the recipient's condition is not expected to change.

5.7 Requirements for PCS Change of Status Reviews

- a. All Change of Status Reviews shall be conducted by DMA or the designated IAE.
- b. Change of status reviews may be requested at any time by the recipient, recipient's family, guardian, or legally responsible person; home care provider; or recipient's physician.
- c. Requests for Change of Status Reviews shall include documentation that supports the need to conduct the reassessment.
- d. Change of status reviews shall be conducted by DMA or the designated IAE on a face-to face basis by RN assessors.
- e. Physician attestation that the PCS approved after a change of status are medically necessary.

5.8 Requirements for PCS Assessment and Reassessment Tools

PCS Assessment and Reassessment tools shall be provided or approved by DMA and shall be designed to accomplish the following in a valid and consistent manner:

- a. Determine the recipient'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 changes in the recipient's medical condition, overall health status, living conditions, or need for PCS.
- e. Identify existing or potential recipient risks or conditions that require interventions or services in addition to, or as an alternative to PCS;
- f. Provide the basis for plan of care development;
- g. Determine if children under the age 21 meet the requirements for services under EPSDT;
- h. Support PCS program utilization and compliance reviews; and
- i. Support PCS program quality assessment and continuous quality improvement activities.

5.9 Determination of the Recipient's ADL Self-Performance Capacities

The assessment tool shall be a standardized ADL assessment that shall include the following components for each of the qualifying ADLs:

- a. ADL definition for each of the qualifying ADLs;
- b. A review of the type(s) and severity of the medical diagnosis or diagnoses causing the need for the PCS and any exacerbating medical conditions or symptoms that may affect the ability of the recipient to perform the ADLs;
- c. A review with family members, if present at the time of assessment, of the recipient's ability to perform ADLs, the amount of assistance required, and any

physical or cognitive limitations or symptoms that may affect his or her ability to complete ADL and associated IADL tasks;

A recipient's overall self-performance capacity will be rated, as summarized in the table below.

Recipient's Self-Performance Rating	Description
0 – Totally able	Recipient is able to self-perform 100 percent of activity, with or without aids or assistive devices and without supervision or assistance setting up supplies and environment
1 – Needs verbal cueing or Supervision Only	Recipient is able to self-perform 100 percent of activity, with or without aids or assistive devices, and requires supervision, monitoring, or assistance retrieving or setting up supplies or equipment
2 – Can do with limited hands-on assistance	Recipient 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	Recipient 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	Recipient is unable to perform any of the activity and is totally dependent on another to perform all of the activity

- d. ADL review factors used for each qualifying ADL to include:
1. Recipient capacities to self perform specific ADL tasks organized into Nurse Aide I and Nurse Aide II categories;
 2. Recipient capacities to self-perform selected IADL tasks incidental to each ADL;
 3. Use of assistive devices;
 4. Availability, willingness, and capacities of family members and other informal caregivers to provide assistance to the recipient to perform ADLs;
 5. Availability of other home and community-based services and supports;
 6. Medical conditions and symptoms that affect ADL self-performance and assistance time; and
 7. Environmental conditions and circumstances that affect ADL self-performance and assistance time;

5.10 Minimum Requirement for Admission to and Continuation of PCS

To qualify for admission to PCS and continuation of PCS, the recipient must meet all the requirements of this Clinical Coverage Policy and require limited or greater hands-on assistance to perform at least two of the qualifying ADLs, as determined by the PCS Assessment.

5.11 Minimum Requirement for Admission to and Continuation of PCS-Plus

A qualified recipient may be authorized up to an additional 20 hours of PCS under PCS-Plus if the recipient requires extensive assistance with three qualifying ADLs or is fully dependent for two qualifying ADLs when such need is exacerbated by a medical condition(s) or symptoms; the absence of available, willing and able caregivers; or environmental circumstances that affect the time necessary to complete the authorized ADL assistance.

5.12 Requirement for Service Authorization

The amount of PCS shall be determined by DMA or the IAE based on the PCS Assessment as follows:

- a. Up to 80 hours per month for program eligible adults; and
- b. As required for children under age 21, who qualify for PCS Program coverage under EPSDT.

5.13 Daily Limit for PCS

- a. A recipient receiving PCS under this Clinical Coverage Policy is limited to a maximum of 3.5 hours per day.
- b. A recipient receiving PCS-Plus under this Clinical Coverage Policy is not limited to 3.5 hours per day.
- c. For a recipient age 21 or under, the 3.5 hour per day limit may be waived if:
 1. The recipient has been approved for and is receiving services under EPSDT; and
 2. The additional hours are prior approved by DMA or its designee.

5.14 Requirements for Selecting and Changing PCS Providers

- a. Nurse assessors shall assist the recipient to select a home care agency to provide the PCS. This process shall include the following steps:
 1. Each recipient approved for PCS shall select at least three providers from a randomized list of available providers that are licensed to serve the county where he or she resides;
 1. The IAE shall make a referral to the recipient's first choice of PCS Provider;
 2. If the provider does not accept the referral, the IAE shall make a referral to the second provider on the recipient's list and, if necessary the third provider on the list.
- b. If the recipient requires Nurse Aide II tasks, the home care agency selected to provide the services must have this level of expertise available.

- d. The recipient may change his or her PCS Provider during the course of the authorized service period by notifying the IAE of the desired change. A new assessment shall not be required unless a change of status review is requested.
- e. The IAE shall furnish the new provider with a copy of the assessment, and service authorization.
- f. The new PCS Provider shall be required to conduct a home visit, develop a new plan or care, and submit the plan of care to the IAE for approval.
- g. The new PCS Provider shall not initiate services until the plan of care is approved by the IAE.
- h. Providers must notify the IAE of any discharges as they occur via an on-line reporting mechanism.
- i. Recipients shall certify, in a manner prescribed by DMA, that they have exercised their right to choice of provider and have not been offered any gifts or service-related inducements to choose any specific provider organization.

5.15 Requirements for PCS Plan of Care

- a. The home care agency selected by the recipient to provide the PCS shall develop the plan of care on a web-based form provided by DMA and submit this plan to IAE for review and approval via the Internet.
- b. The plan of care shall be based on the PCS assessment and the home risk assessment conducted by the IAE and must reflect exactly the number of authorized hours of PCS to be provided each month.
- c. Approval notifications shall be generated and sent to the recipient, the home care provider, and the referring physician.
- d. Personal Care Services shall not be initiated until the plan of care is approved by the IAE.
- e. Once the plan of care is approved, the service start date shall be the date of the provider agency's initial RN home visit.
- f. Providers shall furnish only those services specified in the plan of care in the amount specified in the plan of care.
- g. The home care agency must follow the plan of care, once approved. Changes in the plan of care that may be required because of changes in the recipient's health status, level of functional disability, or life circumstances must be preceded by a Change of Status Reassessment by the IAE.

5.16 Nurse Aide Tasks

In addition to the specified assistance with ADLs and IADLs allowed under this Clinical Coverage Policy, qualified PCS Aides may also provide Nurse Aide I and Nurse Aide II tasks specified by the North Carolina Board of Nursing as described in 21 NCAC 36.0403 and as specified in the recipient's approved plan of care.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall:

- a. Be licensed by the North Carolina Division of Health Services Regulation (DHSR) as a home care agency in the county or counties where the PCS are being provided.
- b. Meet Medicaid's qualifications for participation;
- c. Be currently enrolled with North Carolina Medicaid as a home care agency that provides PCS;
- d. Bill only for procedures, products, and services that are within the scope of the provider's clinical practice, as defined by the appropriate licensing entity.
- e. Comply with all applicable federal and state statutes, rules, regulations, policies, and guidelines for Medicaid billing.

7.0 Additional Requirements

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

7.1 Compliance

Providers shall:

- a. Comply with all applicable federal, state, and local laws; regulations; and agreements pertaining to PCS;
- b. Maintain the privacy, confidentiality, and security of all protected health information in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- c. Comply with all requirements and guidelines pertaining to PCS contained in Medicaid program manuals, memoranda, and bulletins; and
- d. Maintain all home care service records as specified in 10A NCAC 13J.1402.

7.2 Assessment Tools, Plans of Care, and Forms

Providers shall utilize only those assessment tools, plan of care formats, report formats, surveys, and related documents provided or approved by DMA.

7.3 Automated Reporting

Providers shall utilize all available Internet-based assessments POCs, forms, reports, surveys, and other documents provided by DMA to submit information to DMA, the PCS Independent Assessment Entity, the recipient's physician, and other individuals or organizations designated by DMA.

7.4 Telephony

Providers may utilize telephony and other automated systems to document the provision of PCS. Guidelines for the use of telephony are provided in the January 2009 general Medicaid bulletin (<http://www.ncdhhs.gov/dma/bulletin/0109bulletin.htm#tele>).

7.5 Marketing Prohibition

Agencies providing PCS under this Medicaid Program are prohibited from offering gifts or service related inducements of any kind to entice recipients to choose it as their PCS Provider.

7.6 DMA Compliance Reviews

The PCS Provider Organization shall:

- a. Cooperate with and participate fully in all desktop and on-site quality, compliance, prepayment, and post-payment audits that may be conducted by DMA or its designee;
- b. Meet DMA requirements for addressing identified program deficiencies, discrepancies, and quality issues through the DMA corrective action process and any overpayment recovery or sanctioning process imposed by DMA's Program Integrity Section; and
- c. Maintain all clinical records and billing documentation in an accessible location in a manner that will facilitate regulatory reviews and post payment audits.

7.7 Internal Quality Improvement Program

The PCS Provider Organization shall:

- a. Develop, and update at least quarterly, an organizational Quality Improvement Plan or set of quality improvement policies and procedures that describe the home care agency's CQI program and activities;
- b. Implement an organizational continuous quality improvement (CQI) program designed to identify and correct quality of care and quality of service problems;
- c. Maintain complete records of all CQI activities and results; and
- d. Provide these documents to DMA or its designee upon request in conjunction with any on-site or desktop quality improvement review.

7.8 Quality Improvement, Utilization Review, Pre- and Post-Payment Audits

The PCS Provider Organization shall cooperate with and participate fully with DMA's quality improvement, utilization review, and pre- and post-payment audits, including, but not limited to:

- a. Provider on-site reviews, evaluations, and audits;
- b. Desktop reviews;
- c. Targeted record reviews;
- d. Recipient in-home reviews;
- e. Recipient satisfaction surveys;
- f. Retroactive utilization and medical necessity reviews;
- g. Quality of care and quality of service reviews and evaluations;

- h. Program Integrity prepayment and post-payment reviews;
- i. Reviews of recipient complaints; and
- j. Reviews of critical incident reports.

7.9 Recipient Health, Welfare, and Safety

The PCS Provider Organization shall:

- a. Implement and demonstrate compliance with all Client Rights and Responsibilities, as specified in 10A NCAC 13J.1007.1007;
- b. Report to the IAE and DMA any home safety risks identified during the 90-day RN Supervisor visits;
- c. Maintain an internal recipient complaint log and utilize the DMA uniform complaint form to forward all complaints by PCS recipients to DMA;
- d. Utilize the DMA Internet-based uniform complaint form to report all recipient complaints to DMA;
- e. Utilize the DMA Internet-based uniform critical incident reporting form to report all incidents involving recipients that have, or appear to have, implications for the health, welfare, and safety of the recipient and forward all such reports to DMA; and
- f. Ensure that all incidents involving alleged, suspected, or observed recipient abuse, neglect, or exploitation are reported immediately to DMA, the county Department of Social Services, and the Division of Health Services Regulation as required in GS 131E-256(g).

7.10 Provider Staffing Requirements and Qualifications

7.10.1 Plan of Care

- a. Develop, consistent with guidelines provided by the DMA, a detailed, person-centered plan of care based on the independent PCS assessment, home risk evaluation, and other pertinent information available to the provider;
- b. Submit this plan of care to the IAE for review and approval;
- c. Implement the approved plan of care in the amount authorized by the IAE;
- d. Provide services in accordance with the approved plan of care; and
- e. Request a change of status review whenever the recipient, because of a significant change in his or her health status, appears to require additional PCS, or no longer requires the approved amount of PCS.

7.10.2 RN Supervision

The PCS Provider shall provide a qualified and experienced RN to supervise PCS, who shall be responsible for:

- a. Supervising and ensuring that all services provided by the PCS Aides under his or her supervision are conducted in accordance with this Clinical Coverage Policy, other applicable federal and state statutes,

rules, regulations, policies and guidelines and the provider agency's policies and procedures.

- b. Supervising the Provider Organization's CQI program;
- c. Completing or approving all plans of care for assigned recipients submitted to IAE;
- d. Implementing the approved plan of care;
- e. Maintaining service records and complaint logs in accordance with state requirements;
- f. Conducting RN Supervisor visits to each recipient's home every 90 calendar days (Note: a seven day grace period is allowed). Two visits each year must be conducted when the PCS Aide is scheduled to be in the home. The RN Supervisor shall:
 1. Confirm that the In-Home Aide is present or has been present as scheduled during the preceding 90 days;
 2. Validate that the information documented on the aide's service log accurately reflects his or her attendance and the services provided;
 3. Evaluate the In-Home Aide's performance;
 4. Identify any changes in the recipient's condition and need for PCS that may require a change of status review;
 5. Request a change of status review if the recipient's plan of care exceeds or no longer meets the recipient's needs for ADL assistance;
 6. Identify any new health or safety risks that may be present in the home,
- g. Evaluating the recipient's satisfaction with services provided by the In- Home Aide and the services performed by the home care agency.
- h. Reviewing and validating the in-home aide's service records to ensure that:
 1. Documentation of services provided is accurate and complete;
 2. Services listed in the plan of care have been implemented;
 3. Deviations from the plan of care are documented;
 4. Dates, times of service, and services provided are documented on a daily basis;
 5. Separate logs are maintained for all recipients;
 6. All occasions when the recipient was not available to receive services or refused services for any reason are documented in the service record, including the reason the recipient was not available or refused services; and

7. Logs are signed by the in-home aide and the recipient after services are provided on a weekly basis.
 - i. Documenting all components of the supervisory visits to include the date, arrival and departure time, purpose of visit, findings and supervisor's signature.

7.10.3 In-Home Aides

The Provider shall ensure that:

- a. Criminal background checks are conducted on all In-Home Aides before they are hired.
- b. In-Home Aides hired not listed on the North Carolina Health Care Registry as being under investigation or as having a substantiated finding of previous client abuse or neglect, misappropriation of client property, diversion of client or facility/program drugs, or fraud as an employee of one of the reporting health facility types.
- c. In-Home aides under investigation for those reasons listed in Section b above do not work with recipients until the investigation is completed and the individual is cleared of any crime or misconduct.
- d. All In-Home Aides meet the qualifications contained in the North Carolina Home Care Licensure Rules (10A NCAC 13J.1107);
- e. An individual file is maintained on all In-Home Aides that documents aide training and competency evaluations and provides evidence that the aide meets the competency standards provided in 10 NCAC 13J .1107 and .1110 and is competent to carry out all assigned tasks .

7.10.4 Staff Development and Training

The PCS Provider Organization shall:

- a. Provide a new employee orientation for all new PCS Aides and other agency employees that includes information on state rules pertaining to home care agencies and the requirements of this Clinical Coverage Policy;
- b. Develop, implement, and manage an ongoing staff development and training program appropriate to the job responsibilities of agency staff;
- c. Provide competency training and evaluate the required competencies for In-Home Aides at least annually;
- d. Maintain comprehensive records of all staff orientation and training activities; and
- e. Ensure that agency directors, administrative personnel, RN nurse supervisors, and other agency personnel with management responsibilities attend regional training programs conducted by DMA or its designee.

8.0 Policy Implementation/Revision Information

Original Effective Date: October 1, 2001

Revision Information:

Date	Section	Change
11/1/05	Section 1.0	Services must be linked to the identified need and medical condition and must be authorized by the primary MD or PA/NP working under MD supervision.
11/1/05	Section 2.2	Adds special provision for recipients under the age of 21.
11/1/05	Section 3.2	Service must be directly related to medical condition, be medically necessary and be identified in the PCS PACT-plan of care. Adds: If the recipient does not receive the service the medical condition will deteriorate.
11/1/05	Section 3.2.1	Minimal requirement set at 2 ADL needs, tasks are identified in the PCS PACT and there must be no other family members available who can meet the need(s). Recipient must not be able to do the task independently and task must be included in the POC.
11/1/05	Section 3.2.2	Defines medically stable
11/1/05	Section 3.3	Adds specific examples of coverage criteria for pregnant women and cross references to the prior approval process
11/1/05	Section 3.4	Adds clarification specific to the coverage of infants and children and requires linking need to the medical condition and disallows if needs are parental responsibility or are not age appropriate.
11/1/05	Section 4.6	Clarifies non-covered services such as school transportation, homework assistance, pet care, yard work, and housework for other household residents.
11/1/05	Section 5.1	Updates the reduction in hours from legislated change in 2002; adds PCS-Plus provisions from 2003
11/1/05	Section 5.4	Identified and defines the covered tasks.
11/1/05	Section 5.4.1	Provides time guidance in developing plan of care
11/1/05	Section 5.4.2	Identifies mechanism for time exemption
11/1/05	Section 5.5	Identifies delegated monitoring tasks.
11/1/05	Section 5.7	Identifies home management tasks and links to medical need and POC, addresses economy of tasks in multi-recipient homes, defines essential errands, limits bill paying to utilities and addresses the expectation for aide to multi-task.
11/1/05	Section 6.1	Home care license must be current.
11/1/05	Section 6.2	Must have a separate and distinct provider number for each site and use the number in billing. Must submit a cost report.
11/1/05	Section 6.3.1	RN must successfully complete DMA approved certification training.
11/1/05	Section 6.3.2	In-home aides must meet DFS licensure specifications.
11/1/05	Section 7.1	Clarifies MD authorization for assessment.

Date	Section	Change
		Prohibits the direct solicitation of clients for services. Requires documentation of verbal orders. Requires signature by physician of verbal orders within 60 days. Provides process for use of fax/electronic signatures.
11/1/05	Section 7.2	Requires signature of physician on PACT within 60 days of order for assessment.
11/1/05	Section 7.3	Clarifies assessment and reassessment requirements.
11/1/05	Section 7.3.3	Requires reassessment after a lapse in service for more than seven service days.
11/1/05	Section 7.3.4	Requires reassessment when there is a significant change in recipient's condition. Identifies additional indicators for RN supervisor to detect changes in recipient's condition.
11/1/05	Section 7.4.1	Requires the use of the PCS PACT form.
11/1/05	Section 7.4.2	Requires certification and attestation by RN assessor.
11/1/05	Section 7.7	Notes the shared responsibility by RN, physician and provider for assuring the accuracy of the assessment and the plan of care. Requires the provider to initiate POC within 14 calendar days.
11/1/05	Section 7.8.1	Requires POC change if recipient's needs require an increase or decrease by 60 minutes or more per week in the total assigned time.
11/1/05	Section 7.8.2	Defines non-significant changes.
11/1/05	Section 7.8.3	Requires POC revision when PCS-Plus is prior approved to account for the additional time and tasks in PCS Plus.
11/1/05	Section 7.9	Supervision frequency is changed from 60 to 90 days. Identifies the required elements of a supervisory visit.
11/1/05	Section 7.11.2	Provides a mechanism for the use and storage of electronic records.
11/1/05	Section 7.12	Establishes the criteria telephony systems including system standards and security requirements.
11/1/05	Attachment A	Adds wage and hour requirements for rounding billing units (7/8 rule).
11/1/05	Attachment B	Provides task definitions and time guidance for both personal care and home management tasks.
11/1/05	Attachment C	Outlines a QA program that will be a component of the global DMA plan and consistent with CMS standards in the Domains of Quality. Defines the shared responsibility of all stakeholders. Establishes a program for agency self audit, targeted record reviews, educational reviews and focus studies.
11/1/05	Attachment D	Provides a suggested format for studying the key aspects of services.
11/1/05	Attachment E	Provides an acceptable example of an agency policy regarding the reassessment of clients for services.

Date	Section	Change
11/1/05	Attachment F	PACT is required form for PCS assessment and authorization.
12/1/05	Section 2.2	The Web address for DMA's EDPST policy instructions was added to this section.
12/1/06	Sections 2 through 5, 7	A special provision related to EPSDT was added.
5/1/07	Sections 2 through 5, 7	EPSDT information was revised to clarify exceptions to policy limitations for recipients fewer than 21 years of age.
5/1/07	Attachment A	Added UB-04 as an accepted claims form.
8/1/07	Sections 6.1, 7.3.3, 7.8.1, and Attachment D	Changed the name of Division of Facility Services (DFS) to Division of Health Service Regulation (DHSR).
8/1/07	Throughout	Updated language to DMA's current standard.
8/1/07	Section 1.0	Revised description.
	Subsection 2.2	Updated URLs.
8/1/07	Subsection 3.2	Changed title to "Specific Criteria" and updated list.
8/1/07	Subsection 3.3	Added list of Activities of Daily Living.
8/1/07	Subsection 3.4	Added a statement that range-of-motion exercises and nurse aide tasks are included in the service.
8/1/07	Subsection 3.5	Added definitions of supervision, limited and extensive assistance, and full dependence.
8/1/07	Subsection 3.6	Added definitions for specific levels of PCS and the corresponding maximum number of hours per month.
8/1/07	Subsection 4.3	Added to the list of non-covered services: skilled nursing services provided by an LPN or RN; non-hands-on assistance with ADLs; child care, day care, or after school care; money management; and shopping or other errands
8/1/07	Subsection 4.4	Added a statement that cueing, prompting, guiding, and coaching. are not in themselves PCS.
8/1/07	Subsections 5.2 through 5.8	Added requirements for managed care, referrals, independent assessments, physician authorization, recipient choice, provider responsibilities, and reassessments.
8/1/07	Section 7.0	Added requirements for internal quality review and specified qualifications for RN supervisors and in-home aides (live-in aides are not covered). Added requirements for staff development and training; compliance reviews; quality assurance, post-payment reviews, and utilization review; ensuring recipients' health, welfare, and safety; assessment tools, plans of care, and forms; automated reporting; and telephony
4/1/10	Section 1.0	Revises the Description of Services to emphasize that the Medicaid PCS benefit provides basic paraprofessional services only and is not sufficient in scope or amount of service to provide an alternative to institutionalization

Date	Section	Change
		Benefit is intended to supplement family care and other services available in the community
		Adds definitions and acronyms to Policy
4/1/10	Section 2.0	Revises the conditions under which Pregnant Women can receive PCS
4/1/10	Section 4.0	Cueing, prompting, guiding, and coaching added to list of non-covered services
4/1/10	Section 5.0	This Section was rewritten to include all the requirements to support implementation of PCS independent assessment
4/1/10	Section 7.0	Additional Requirements added to include: Compliance Assessment Tools, Plans of Care, and Other Forms Automated Reporting Telephony
4/1/10	Section 7.0	Added provider requirements for: Plan of Care RN Supervision In-Home Aides Staff Development and Training
4/1/10	Attachment C, D, E	Attachments C, D & E were removed from the policy
6/1/11	Throughout	Policy termination date

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)

B. Diagnosis Codes

Providers shall bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Revenue and Procedure Codes

Code	Description	Notes
RC599		End date 7/31/04
S5125	Up to 60 hours of PCS per month	Effective date 8/1/04
99509	All claims for recipients authorized to receive greater than 60 hours of PCS per month	Effective date 8/1/04

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

1 unit of service = 15 minutes.

PCS follows wage and hour requirements for rounding billing units (7/8 rule).

F. What May be Billed

PCS Providers may bill for the following when accomplished according to Medicaid policies and procedures and documented in the recipient's service record. Providers may bill for the time:

- a. The RN spends in the recipient's home developing the plan of care;
- b. The RN spends for supervisory visits; and
- c. The PCS in-home aide spends in the recipient's home providing the tasks during the times specified in the recipient's Plan of Care.

G. Place of Service

PCS is provided in the recipient's private residence and cannot be provided in a nursing home, assisted living facility, or other health care facility.

H. Co-Payments

Co-payments are not required for PCS.

I. Reimbursement

Providers shall bill their usual and customary charges.

Attachment B: ADL Assessment Design and Methodology

1. Assessment Information: The following information is reviewed to determine the recipient’s level of need for PCS in each of the qualifying ADLs

	ADL Categories				
ADL Self-Performance Evaluation Factors	Bathing/Hygiene	Dressing	Toileting/Contenance	Mobility	Eating
Medical Conditions					
Environmental Conditions					
ADL Task Evaluation					
Assistive Devices					
Informal Caregivers					
Other Supports/Services					
Other Modifiers					
Exacerbating Medical Conditions and Symptoms	Bathing/Hygiene	Dressing	Toileting/Contenance	Mobility	Eating
Tremors					
Hemiplegia					
Paraplegia					
Hemiparesis					
Continuous O2					
Seizure Activity					
Manual Dexterity					
Impaired ROM					
Grasp Strength					
Pain					
Impaired Vision					
Attention Deficit					
Hyper/Hypotonia					
Use of Assistive Devices					
Morbid Obesity					

Exacerbating Medical Conditions and Symptoms (continued)	Bathing/Hygiene	Dressing	Toileting/Contenance	Mobility	Eating
Muscular Endurance					
Shortness of Breath					
Nonresponsive					
Cognitive Deficits					
Daily Incontinence					
Bed/Chair Bound					
Skin Integrity					
Presence of Wound					
Self Neglect					
Noncompliance					
Balance					
Gait Abnormality					
Peripheral Edema					
Nurse Assistance I (NA I) Tasks	Bathing/Hygiene	Dressing	Toileting/Contenance	Mobility	Eating
Shower transfer in and out		Fasteners	Hygiene	Transfer to and from bed	Ability to feed self
Sponge bath		Put on shoes/socks	Adjusting clothes	Transfer to and from chair	Ability to cut food
Shampoo		Dress/remove lower body clothes	Remove pads or briefs	Ambulation to and from room and through doorways	Utensil usage
Oral care		Dress/remove lower body clothes	Catheter care	Turn/position self in bed	Self-administration of meds
Brush/style hair		Prosthetic devices	Condom catheter	Turn/position self in chair	Restrictions or special diets
Wash face		Splints	Self-management bladder	Ability to walk up and down stairs	Force fluids

Nurse Assistance I (NA I) Tasks (Continued)	Bathing/Hygiene	Dressing	Toileting/ Continence	Mobility	Eating
	Shave	Therapeutic stockings	Incontinence	Ambulation on uneven surfaces	
	Clean dentures	Ace bandages	Ability to follow toileting program and retraining	Passive/active ROM	
	Brush teeth/floss				
	Skin care				
	Nail care				
	Apply makeup				
Nurse Assistance II (NA II) Tasks	Bathing/Hygiene	Dressing	Toileting/ Continence	Mobility	Eating
	Sterile dressing changes for wounds older than 48 hours	Suctioning	Catheterization and irrigation	Oxygen setup	Feeding tube
	Wound irrigation		Ostomy care and irrigation	Monitor flow rate	Gastrostomy feeding/care
	IV site care peripheral		Breakup/removal of fecal impaction	Suction	Tube feeding clamping/removal
	Trach care		Suctioning		Oral/ng tube
	Suctioning		Enema/douche		IV site change dressing change
			Insert rectal tube		Monitor IV flow
					D/c IV infusions
					Assemble flush tubing
					Suction

IADL Task Evaluation	Bathing/Hygiene	Dressing	Toileting/ Continence	Mobility	Eating
	Prepare bath	Retrieve clothing	Care/clean commode, bedpan, or urinal	Clear pathways	Food prep, chop, puree
	Hang towels	Launder soiled clothing	Disposed of soiled diaper and/or other incontinence garments	Minimize clutter	Wipe surfaces
	Replace bath supplies		Tidy bathroom	Return all equipment to original location	Wash dishes and utensils used during eating
	Rinse/wash basin		Empty trash generated during toileting		Empty trash from meal preparation
	Make bed				
	Change linens				
	Clear pathways				
Assistive Devices	Bathing/Hygiene	Dressing	Toileting/ Continence	Mobility	Eating
	Shower chair	Sock reacher aide	Elevated toilet seat	Walker/stroller	Adaptive eating utensils and dishes
	Grab bars	Button hook device	Bedside commode	Rollator	Tube feeding supplies
	Long-handled scrub brush	Velcro shoes	Urinal	Straight or quad cane	Pump
	Handheld shower		Bedpan	Wheelchair – manual or electric	IV pole, bag, tubing, etc.
	Tub bench		Transfer board	Scooter	
	Transfer bench			Hoyer lift	
				Transfer board	
				Strander	

Assistance by Informal Care givers	Bathing/Hygiene	Dressing	Toileting/Continance	Mobility	Eating
Other Services and Supports Available to Recipient	Bathing/Hygiene	Dressing	Toileting/Continance	Mobility	Eating
Other Modifiers	Bathing/Hygiene	Dressing	Toileting/Continance	Mobility	Eating
Lack of indoor plumbing	X		X		X
No hot water	X		X		X
Inaccessible bathroom facilities	X		X		
Communication issues	X	X	X	X	X
Behavioral issues	X	X	X	X	X
Infestation of home	X	X	X	X	X
Threatening/neglected animals in home	X	X	X	X	X
Lack of cleaning supplies			X		X
No laundry facilities	X	X			
No available clean clothing		X			
Broken/unsafe equipment				X	
Clutter or blocked pathways				X	X
Inadequate cooking facilities					X
No electricity					X
Lack of food/inability to obtain food					X
Others					

2. Determination of the Number of PCS Hours

1. RN assessor conducts in-home evaluation of individual's ability to self-perform Bathing, Dressing, Mobility, Toileting, and Eating ADL tasks, with use of assistive devices, when applicable. Using information from interview, observation, and medical documentation, assessor will score individual's ability to self-perform each ADL as Moderate (individual is highly involved in activity and requires limited hands-on non-weight bearing assistance), Low (individual performs less than 50% of activity and requires substantial hands-on and/or weight-bearing assistance), or Dependent (individual requires full performance of activity by another). Nurse Assessor also evaluates patient need for assistance with essential IADLs, home environment conditions, patient exacerbating medical conditions and symptoms, and other formal and informal resources available to assist with ADLs.
2. ADLs for which individual has *unmet* need for *hands-on* assistance are rank ordered from lowest (Dependent) to highest (Moderate) self-performance level. Base hours are assigned using the following table:

Base Hours Table

ADL	ADL Self-Performance Level		
	Moderate (>50%)	Low (<50%)	Dependent (0%)
1. (lowest self-performance)	10	16	20
2.	10	16	20
3.	4	8	12
4.	4	8	12
5. (highest self-performance)	4	8	12

Time is not assigned for ADLs in which individual is independent, with or without supervision or assistive devices, or for ADL needs fully met by other available formal or informal resources.

3. Base Hours are reduced by appropriate percentage to reflect any formal and informal resources available to assist with qualifying ADLs.
4. Additional time not to exceed 25% of hours in Step 3 may be authorized for exacerbating conditions and symptoms affecting time required for patient to self-perform and for aide to assist with ADLs.
5. If total assigned time is not sufficient to perform needed ADL tasks and associated essential IADLs, additional time not to exceed 25% of hours in Step 3 may be authorized.
6. Total service hours authorized per month may not exceed 80.