

Personal Care Services (PCS) Frequently Asked Questions (FAQs)

I. General Questions

1. What are the clinical coverage policies –where are they located?

Answer: Clinical coverage policies are PCS program requirements which include: Description of services, eligible recipients when services are covered, and service requirements. They are located on the DMA website 3C (PCS) and 3J (PCS-Plus) (07/2007)

Clinical Coverage Policies: <http://www.ncdhhs.gov/dma/mp/>

Revised PACT: <http://info.dhhs.state.nc.us/olm/forms/dma/dma-3000-i.pdf>

2. How many hours does PCS provide?

Answer: PCS maximum limits are 60 hours a month and no more than 3.5 hours per day. This includes all assessments, reassessments and supervisory visits. Remember, the time provided should be based on the nursing assessment of the individual's needs. See **Policy 3C Section 5.1.** (07/2007)

Remember: These important notes as it relates to services for clients less than 21 years of age.

Important Note: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions and without meeting the specific criteria in this section when such services are medically necessary to correct, ameliorate and maintain a defect, physical and mental illness or a condition identified through a screening examination. For additional information about EPSDT, see Section 2.2 of PCS policy or visit the DMA Web sites specified below.

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

EPSDT Provider Page: <http://www.ncdhhs.gov/dma/epsdt/>

Refer to Clinical Coverage Policy 3J for specific requirements and additional information on the PCS-Plus program.

Clinical Coverage Policies: <http://www.ncdhhs.gov/dma/mp/>

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3. When would we need prior approval (PA)?

Answer: Prior Approval is required to start PCS-MPW at anytime

If you are applying for more than 60 hours of PCS for PCS Plus and/or EPSDT PCS services when it is more than 60 hours or the services are in excess of hours or does not meet PCS specific criteria you would need prior approval. (07/2007, revised 8/2008, 11/2008)

4. Please explain ADL's as related to PCS. What are IADLs?

Answer: Activities of Daily Living (ADLs) refers to six activities - bathing, dressing (includes grooming), mobility (ambulation/transfers), eating, toileting and bowel/bladder incontinence that reflect a person's capacity for self-care. These are activities that a person is normally able to perform independently for themselves. Clients on the PCS program need either hands on assistance with their ADL's or need to have the ADL performed for them. The PCS policy states that a client must have deficits in a minimum of two of the above Activities of Daily Living (ADL's) and need assistance with these ADLs through PCS. The deficits must be linked to a medical condition.

The PACT form contains the six ADL's as well as other personal care tasks. These other personal care tasks are not one of the six ADL's but are personal care tasks that may be associated with an ADL deficit. For example, assistance needed with personal hygiene is a personal care task associated with either a deficit in bathing or dressing. It is not one of the six ADL deficits. Another ADL is bowel/bladder incontinence. If a client is incontinent of the bladder and needs assistance cleaning or changing themselves, that is an ADL deficit. Toileting is an ADL deficit. If a client has normal bladder function, but needs assistance toileting— either cleaning himself/herself or needing actual assistance using the toilet and/or bedside commode and cleaning himself/herself – that is an ADL deficit. A client independent with using the toilet (does not need help using the toilet and/or cleaning himself/herself) would not have an ADL deficit in toileting. A client just needing the bedside commode emptied does not have an ADL deficit if he/she can use the bedside commode independently. Emptying the bedside commode would be a home management task. Another ADL example: A client needs help bathing and ambulates independently with a walker. Assuming that none of the other six ADLs are deficits requiring assistance through PCS, does this client have two ADL deficits requiring assistance in order to qualify for PCS? No, he/she does not. The client only has one ADL deficit requiring assistance – bathing. Because the client walks independently with the walker requiring no assistance, there is no ambulation ADL deficit requiring PCS assistance. If the aide needed help to get the walker in place, assist the client to stand and walk

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with the client to ensure safety, the client would have an ADL deficit in ambulation because the aide actually provides limited assistance while the client is ambulating with the walker.

Caution must be taken not to confuse ADLs with Instrumental Activities of Daily Living (IADLs). IADLs are home management and support tasks, such as bill paying. For example, a client who cannot eat independently and must be fed orally or by a tube has an ADL deficit in eating. A client who can feed himself/herself but needs a meal prepared or groceries purchased, does not have an ADL deficit in eating. Rather, he/she has an identified need for a home management task to be performed. Meal preparation or grocery shopping is a home management task and not an ADL deficit that can be used as one of the two ADL deficits necessary to qualify for PCS. Meal preparation and grocery shopping are IADLs. Another IADL example: A client needs help bathing and dressing and cleaning the bathroom. Cleaning the bathroom is a home management task or an IADL, not an ADL. Remember – IADL tasks are not scored on the PCS PACT. They are documented with the most rational and reasonable ADL that demonstrates the link between the task and a functional deficit created by a medical condition. (7/2007)

5. How do you submit questions via email regarding the Compliance Review Program?

Answer: Please send to: PCSQuestions@thecarolinascener.org. Questions regarding audit requests, process and audit findings will be answered by CCME staff. Clinical policy questions will be forwarded to the Division of Medical Assistance Clinical Policy section. (12/2007)

Questions may be submitted to DMA Clinical Policy by fax to 919 715 2628 or you contact a PCS policy consultant by telephone @ 919 855 4360. (12/2007)

6. How are the timelines for Prior Approval (PA) determined for PCS Plus?

Answer: The initial Prior Approval for PCS plus is based on the date it is submitted to DMA and the date of the PACT authorization. PCS Plus prior approval is not retroactive. If a PCS plus request is submitted early in the month, prior to the 15th day, it is made effective for the date the PACT was signed in the month /or the first day of current month if signed in the previous month. When a provider submits the PCS PLUS PA request late in the month, after the 15th day, the PA is started for the next month **unless** the provider requests a specific date based on patient's needs.

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In PCS Plus PA reauthorizations, the PACT expiration date is considered as you must be eligible for PCS with a signed PACT to be eligible for the extended hours for PCS PLUS. Authorization periods are up to 180 days, depending on the client diagnosis and condition, dates needs expected to change and PACT expiration. (6/2008)

II. Clinical Policy:

PACT Assessment and Authorization

7. What if a PCS provider determines either by phone when taking the referral or during the assessment visit that the client does not need PCS?

Answer: If a PCS provider determines by phone that a client is not qualified for PCS, no further steps are necessary. This should be explained to the caller.

If determined during the RN assessment visit, pages 1-3 of the PACT should be completed and kept on file for 5 years if billing for the documented assessment time.

In this latter instance, per DHSR rules, the client should be notified that he/she does not meet the program criteria. The best practice would include notification of the referral source and PCP who authorized the assessment. (12/2006)

8. What does a PCS provider do if a verbal order is given to initiate PCS but not to assess?

Answer: If a PCS provider receives a verbal order to initiate/start PCS but not to assess, the provider should make clear to the Primary Care Physician (PCP) that an assessment will be done to assess for services. After the PACT and plan of care are done a second order to start services will be needed. If the assessment indicates a need for PCS, the second, separate order must be obtained to initiate PCS. See **Policy 3C Section 7.1, #2 and #3** (12/2006)

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Remember, you need two orders – the first one for the initial assessment and the second after the assessment to start service based on the needs identified at the assessment.

9. What should the PCS provider do with a single Primary Care Physician (PCP) order for “assess and start PCS”?

Answer: The orders to assess for and start PCS are always two separate orders. The order to start PCS is always after the RN assessment, completion of the PACT. The primary care physician has approved the PACT and plan of care. If you have a single order, contact PCP after the assessment and obtain the second order to start services.

(12/2006)

10. Is the MD (PCP) signature required on the PACT form at annual review?

Answer: Yes, the MD (PCP) or FNP or PA under the supervision of the PCP is required on the PACT at least annually for service authorization.

See **Policy 3C Section 7.2** (07/2007)

11. The start of care (PCS) must happen within 14 days of “what”?

Answer: PCS must be started within 14 days of the primary care physician’s order to initiate care as documented on the PCS PACT form. See **Policy 3C Section 7.7** (12/2007)

12. Is it permissible to use the hospital discharge (D/C) orders to perform an initial assessment for PCS?

Answer: No, unless the order for PCS at discharge is from the primary care physician (PCP). A hospitalist or consulting physician can not order PCS services. An order from a PCP is required to perform an assessment for PCS for a client who was not receiving PCS before hospitalization. (12/2006, revised 6/2008)

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13. Can a physician in the same group and who is covering for the primary care physician sign for the primary care physician?

Answer: Yes, on a limited basis. A physician in the same group as the primary care physician can sign for the primary care physician only in extenuating circumstances when the primary care physician is unavailable during the 60-day time frame required for signing the PACT. Extenuating circumstances may include rural health clinics, clinical rotations for dialysis or medical care clinics at medical centers and if the primary care physician is out of town/work for an extended period of time. (12/2006, revised 6/2008)

14. Can a specialist physician order PCS?

Answer: No, An order to assess or initiate PCS must come from the primary care physician. While there are probably instances when a specialist might be an individual's primary care physician, this is not generally the case.

See **Policy 3C Section 7.1** (7/2007)

15. Some clients require such specialized care that they do not see any physician other than their specialist, who handles all their needs. For example, a terminal client sees only their oncologist and a client on dialysis sees only the dialysis physician. Since these physicians prescribe the majority of the medications and have the most contact with the clients, can they be considered the primary care physician?

Answer: The primary physician is either the Carolina Access physician or the physician who treats the client for routine medical problems. There may be times when the primary physician is a specialist because he/she treats the client for all of their medical problems and manages the client's medications, i.e., a dialysis client whose primary physician is a nephrologist. A primary care physician is the lead provider for the client's total medical needs. The provider should document this (example of notes, who the client would see for the flu or a respiratory infection, etc.) See **Policy 3C Section 7.2** (12 /2006)

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16. Can a specialist like an orthopedist order PCS?

Answer: No, an order to assess or initiate PCS must come from the primary care physician. While there are probably instances when a specialist might be an Individual's primary care physician, this is not generally the case. See **Policy 3C Section 7.1** (12/2006)

17. Is a PCP order required to complete the annual reassessment for existing PCS clients?

Answer: No, An order from the primary care physician is not required to reassess an active client at the annual reassessment due date. (12/2006)

*Remember; if the PCS PACT form completion falls at the time of the annual reassessment, the physician's order to continue services is required (see **Policy 3C Section 7.3.2** of the PCS policy). If the signed PACT is not received by the PCS provider before the annual reassessment due date, a verbal order is necessary to continue services. (**Policy 3C Section 7.3.2**) (12/2006)*

*If the re-assessment indicates a significant change in the patient's condition or a significant change in the plan of care, increase or decrease of 60 minutes a week, an order should be obtained to change the plan of care see **Policy 3C Section 7.8** (revised 6/2008)*

18. If a client changes doctors before the annual PACT assessment is due, do we need to have the new PCP sign old PACT or complete a new PACT?

Answer: Neither, the PACT authorizes services for up to 365 days from the date of RN assessment. The new PCP will be responsible for signing any subsequent changes and the annual recertification with the PACT /POC. A best practice would be to communicate with the new PCP of existing services authorized. (7/2007, revised 6/2008)

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19. What constitutes a verbal order and who can receive a verbal order for PCS services?

Answer: Verbal order guidelines and eligible professionals who can receive verbal orders are dictated by the North Carolina Board of Nursing. The verbal order standards in PCS are outlined on section 48 for referral and 49 for authorization of services. The Division of Health Services Regulations also has regulations specific to the requirements. (12/ 2006 and 12/07 with PACT edit)

See www.ncbon.com.

See <http://www.ncdhhs.gov/dhsr/ahc/index.html>

[10A NCAC 13J .1302](#) [ORDERS](#)

20. When are physician orders required for PCS?

Answer:

- A verbal or written order to assess a client (commonly called a referral order) is required for the initial assessment. A referral order is not required for reassessments.
- A verbal or written order is also needed to begin or continue services after the initial assessment and annual reassessment.
- Significant revisions to the plan of care require a physician certification authorizing services on the PACT form (**Section 7.8.1** of the PCS policy).
- A physician's order is also required for delegated medical monitoring when the Nurse Practice Act requires physician orders, such as an invasive procedure like blood sugar checks delegated to an aide.

Agencies should also follow DHSR Home Care Licensure and BON rules and obtain physician orders for medical treatment interventions when required.

*Remember: Verbal or written orders do not take the place of the physician's authorization on the PACT Plan of Care (POC). The physician's signature on the PACT POC must always be obtained. See **Section 7.0** of the PCS policy. (6/2008)*

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21. Regarding the annual certification date—does the PCP signature need to be received before the annual certification date? I know reassessment needs to be done by the date but do we also need signature from PCP by this date?

Answer: Yes. If the signature is not obtained before this date (annual certification) you may obtain a verbal order to continue the services. Remember, without the verbal order or signed order, you are providing services without the primary care physician's authorization. Any physician order must be signed within 60 days of the verbal order date. See **Policy 3C Section 7.2.** (07/2007)

22. Clarify the process for annual reassessment, completing the PACT and the MD order.

Answer: Follow the initial assessment process with the exception that you do not need an order to assess since the client is currently receiving services. Remember to reassess and obtain physician authorization before the date of the annual assessment. See **Policy 3C Section 7.2, 7.3.** (07/2007)

23. Whenever a client has been discharged but then services are reopened does the client have to be reassessed?

Answer: Yes. This client is treated as a new client. (07/2007)

24. Is a physician's order necessary to reassess when a client is discharged from a hospital, SNF or rehabilitation facility and the attending physician gives an order to resume Personal Care Services?

Answer: A physician's order is not necessary to reassess a client who has had a lapse in service due to institutionalization or another unplanned lapse in PCS. However,

- If the reassessment results in significant changes in the plan of care, a physician's order is necessary to implement the revised plan of care. Additionally, the primary physician's certification on the PACT form must be obtained. (See **sections 7.3.3 and 7.8.1-7.8.3** of the PCS policy.)
- If there are no changes in the plan of care and patient's condition, a PCP order is not required.

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25. If you have a client who has a mechanically altered diet (chop, puree, grind, thickened) and requires feeding, do we need a separate order for the diet or is the PACT sufficient?

Answer: No, the PACT is sufficient. The provider should specify the diet on the PACT, section 20. The PCP authorizes the diet order when the PACT is signed. A separate order is NOT required. (7/2007)

26. The plan of care may take 30- up to 60 days to get signed—do we wait that long to start services for the client?

Answer: No, if you have a verbal order to start the services after the assessment you can certainly start. If your PACT is not signed within 60 days, you are at risk of noncompliance from day 61 till the day it is signed. Remember, the PCS provider should initiate care within 14 calendar days of the physician's authorization as documented on the PACT form and plan of care. If care is not initiated within 14 days of the authorization, the client must be reassessed. See **Policy 3C Section 7.2**. (07/2007)

27. Do we have our RN correct the original PACT form when a problem is identified?

Answer: No, you cannot alter or change an original, signed document. Always make corrections as you find them. Corrections may be done on a copy with the changes dated and signed. In circumstances where corrections require a physician's signature such as significant changes in the plan of care, then you must send the corrected PACT form to the physician. (7/2007)

28. How do you make a change or correction to a PACT after the PCP signs and the change does not alter the weekly time by an additional 60mins or a decrease in 60 minutes in the weekly time.?

Answer: Make a copy of the PACT/POC, document the changes, sign and date the changes, place in chart. Be sure the aide assignment logs also reflect the changes you have made.

Remember, if the change involves a pharmaceutical or treatment regimen that requires a physician authorization you need to obtain this order/signature (7/2007)

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III. PACT: Documentation and Assessment

29. Is the referral date the date a client, friend or family calls with information stating a client needs PCS or is the referral date the date the primary physician gives orders to assess the client?

Answer: The referral date is the date an agency receives a referral from any source. A verbal or written order is then required from the primary physician to perform an assessment. (7/2007)

30. Do we list family members on the PACT form as a source of current care since they are not reimbursed by state, local federal monies?

Answer: Yes, see section 15 of the PACT which requests current care. Section 45 of the PACT requests information about the sources available to meet the ADL and IADL needs. Detailed instructions for completing the PACT are available at

<http://info.dhhs.state.nc.us/olm/forms/dma/dma-3000-i.pdf>. (07/2007)

31. When you do your annual assessment for PCS, can you include “PCS services” under current care since you have been providing this service for the past year?

Answer: Yes, list PCS as current care. See field 15 of the PACT Instructions.

<http://info.dhhs.state.nc.us/olm/forms/dma/dma-3000-i.pdf>. (07/2007)

32. If you checked “yes” for field # 45 (Are there resources - family, friends, programs or other agencies available to meet the ADL and IADL needs), does that mean that they do not need services?

Answer: This would depend on your findings

- If you have indicated **all** the client's needs are already being met by other sources, then personal care services are not necessary.

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- If you have identified unmet needs, then these are included in the service. The need identification is documented in the third column of page 2 of the PACT assessment (07/2007)

Detailed instructions for completing the PACT are available at <http://info.dhhs.state.nc.us/olm/forms/dma/dma-3000-i.pdf>.

33. Devices needed, in field 44 of the PACT —is that what they need and have or what they need and don't have?

Answer: Field 44 of the PACT requests information about DME already used in the home and what is being ordered. Throughout the assessment the nurse is evaluating client ADL, self performance and support provided with assistive equipment. For example, field 19 (ADL Mobility) requires assessment of equipment the client is using. Detailed instructions for completing the PACT are available at <http://info.dhhs.state.nc.us/olm/forms/dma/dma-3000-i.pdf>. (07/2007)

34. In the PACT in field 47, you anticipate an improvement after 6 months of service; do you make out another PACT form at that time or just reassess and stay with your original PACT?

Answer. **Yes**, a new PACT reassessment would be indicated in the time frame you identified at assessment as when you anticipated needs may change or client may improve. Based on the RN findings at reassessment you update the plan of care, continue the services or discharge the recipient.

35. What is entered in fields 48 (Order to assess the patient for hands on assistance with ADL's) on the PACT form for existing PCS clients?

Answer: "Not applicable" should be entered in field 48 for the reassessment of a current patient.

36. What is entered in fields 49 (order to start /continue PCS) on the PACT form for existing PCS clients?

Answer: Field 49 documents primary care physician authorization on the PACT for clients already receiving PCS. The signature of the primary care physician is

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required to continue services past the annual reassessment due date. If the signed PACT is not received by the PCS provider by the annual reassessment due date, a verbal order is required to continue services. It may be documented in field 49 of the PACT. (7/2007)

37. Do you need to send the doctor an order for the additional PCS+ hours when the Prior Approval is received from DMA?

Answer: Policy 3C Section 7.8.3 addresses plan of care revisions based on PCS Plus approval. It would depend if:

- The plan must be revised to reflect the additional time. A PCP order is not required for the PCS plus additional time if the plan changes do not include a treatment or pharmaceutical regimen. (12/2006)
- A PCP order would be required in any plan of care change that requires the implementation of a pharmaceutical or medical treatment regimen. (12/2006)

38. If the Primary Care Physician does not check off boxes to certify or not certify PCS on the PACT, do I need to send it back to the Primary Care Physician?

Answer: Yes, the Primary Care Physician needs to indicate authorization or not. **However**, the agency may contact the primary care physician and document the verbal clarification to certify or not certify for the personal care services. (6/2008)

39. If a patient has more than one diagnosis should all diagnoses be listed on the PACT or only the primary diagnosis?

Answer: You would start with the primary diagnosis and include the medical diagnosis which are relevant to the PCS needs to reflect a clear picture of the patient's needs. (6/2008)

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IV. PACT Scoring

40. Out of a 5 day service week, the aide changes the patient's diaper 2-3 times per week—how would you score?

Answer: The MDS scoring, applied to PCS considers the majority of the time. For example, 2 out of 5 days is not the majority, however 3 of the 5 days is a majority. Using your professional judgment to determine the trend. (07/2007)

Detailed instructions for completing the PACT are available at <http://info.dhhs.state.nc.us/olm/forms/dma/dma-3000-i.pdf>.

41. How do you score eating if it's not a tube feeding?

Answer: Use your PACT Instructions considering self-performance scores. If the level of assistance requires hands-on assistance with eating; they can be a score of 2 or more. If they need more than 50% assistance the score would be consistent with 3, extensive assistance. There is always a scenario when a recipient could even be scored as independent with a tube feeding. (07/2007)

Detailed instructions for completing the PACT are available at <http://info.dhhs.state.nc.us/olm/forms/dma/dma-3000-i.pdf>.

42. How do you score daily incontinence?

Answer: Field 24 of the PACT addresses the assessment of incontinence. You would check the frequency of incontinence, and then how much assistance the patient needs to manage the incontinence.

43. If the patient needs hands on assistance, a helping hand, to stand up before using a walker how do you score them in mobility self performance?

Answer: Transfer score 2, limited assistance (12/2006)

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44. If client can walk independently on normal level surfaces, but requires physical assistance to go up and down stairs secondary to bone spurs, how do you score this?

Answer: We would need more information such as whether stairs in the home, how often do they need to use the stairs, is the bathroom upstairs, etc. to best answer this question. You score the client how they do most of the time (12/2006)

45. If a patient is assessed to have a self performance score of '2' for toileting or '2' for bathing due to a need to transfer to toilet or tub/shower, is that a qualifying ADL for PCS?

Answer: ADLs toileting and bathing represent more than just transferring. If a score of '2' or higher has been determined for ADL mobility, transferring alone cannot be used under ADL toileting or ADL bathing for qualifying. The rationale is the transfer need is captured on your mobility scoring. The ADL toileting and ADL bathing represent all toileting and bathing skills, not just transferring. (12/2006)

46. When a patient can't wash back/legs is that enough of a bath to qualify for the an ADL deficit for bathing

Answer: Washing the back alone is not a qualifying ADL for Bathing. Washing legs alone is not a qualifying ADL for Bathing. Together they compromise a considerable amount of the Bathing task being completed and constitute a qualifying ADL. Definitions for the tasks are included in the time and task guidance in attachment B of the PCS clinical policy. (7/2007)

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V. PCS Criteria and PACT Documentation

47. If client lives alone and receives PCS Mon-Fri and there's no family or support to help on the weekends, will the client still qualify?

Answer: Yes. Remember if the client is scored with 3's and 4's, you should evaluate if the recipient is safe over the weekend. You could be putting the recipient at-risk by excluding them from other services in order to sign them up for PCS. If scored with limited assistance, they could be safe over the weekend. *Remember, do not staff for the agency's convenience. (07/2007)*

48. Can meal preparation be considered as an ADL if a person has dementia and would not receive food?

Answer: No, meal preparation is an IADL. (07/2007, revised 6/2008)

49. If a patient needs "set-up" for a meal only, then how come the score is not a "2"? Our concern is without the set up the patient would not eat?

Answer: A score of 2 indicates "hands on" help as opposed to set-up. Any meal preparation is an IADL, not ADL. You can set up and prepare meals for the client in your plan of care, but meal set-up alone is not a qualifying ADL deficit. (A score of 1 is set up and no hands on for eating (a score of 2 or higher). In this example you must identify 2 ADL deficits (mobility, bathing, dressing, toileting, and continence) requiring hands on assistance to qualify for PCS. Eating, in this example is not hands on qualifying ADL and therefore you have not identified an ADL deficit to qualify the client in eating with set up only. (07/2007)

Remember PACT and scoring instructions are available at <http://info.dhhs.state.nc.us/olm/forms/dma/dma-3000-i.pdf>

50. Can a PCS patient qualify for services if they need any 2 ADL's, but not necessarily a bath?

Answer: Yes, the criteria are hands on assistance with 2 of the six universally recognized ADL's. See clinical policy 3-c, section

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51. Would a client with mental impairment like schizophrenia or dementia that requires assistance via prompting only qualify for services?

Answer:

- No, prompting and supervision is a score of 1 which does not meet criteria. In this example, PCS would not be appropriate. An appropriate referral for this client's needs would be mental health services.
- Yes, if the patient needs a minimum score of 2 which is limited hands on assistance in at least two of the six universally recognized ADL's. In some cases the patient may have impairments which may require hands on assistance as assessed by the RN. (07/2007)

52. If the client bathes themselves, but due to obesity is unable to wash, dry or inspect their feet for abrasions (as may be indicated for a patient with diabetes) and uses a shower chair, what is the score?

Answer: Foot care alone does not indicate a score of 2 for bathing. Please see Time and Task guidance for definitions of tasks as well as time indicators. (07/2007)

53. Does a score of 1 stop qualification for PCS services?

Answer: If you **only** have scores of 1, a recipient does not qualify for PCS services. PCS qualifications are a score of 2, limited hands on assistance or more in at least 2 qualifying ADL's. See **Policy 3C Section 3.2.1**. (07/2007)

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VII. Supervision

54. Clarify the PCS supervision requirement of the aide and patient in the home.

Answer:

- **Patient:** After the initial assessment, client supervision, face to face is required at least every 90 days from initial assessment date and every 90 days, counting from the most recent supervisory visit. **See Policy 3-C Section**
- **Aide:** Of those every 90 day visits, two of those visits must occur with the aide present. See **Policy 3C Section 7.9.** (07/2007)

Remember: DHSR also has specific requirements for in home aide supervision. 90 days is not the same as 3 (three) months

55. Does the weekly aide service log need to be signed by RN supervisor?

Answer: No, there is no PCS/DMA requirement for the RN to “sign off” weekly on the aide note.

*Remember **Policy 3C Section 7.9:** RN supervision requires the RN review the aide service log during supervision.*

A best practice would be for the RN to regularly review the service logs as a supervision strategy and to keep abreast of the implementation of the plan of care and any changes in care or patient. (7/2007, revised 6/2008)

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56. If a patient goes into the hospital within the 90 day supervisory period and the RN has to reassess the patient, does the 90 days start over or continue from the 1st assessment visit date?

Answer: If the client is in the hospital during the time a supervisory visit is due, that supervisory visit needs to be completed as soon as the client returns home. In this case, the reassessment after hospitalization should be completed face to face and the supervisory visit, including the supervision of the aide should be documented. Each supervisory visit then restarts the 90-day supervisory time clock. (7/2007)

57. Can the supervisory visit be completed early?

Answer: Yes, remember the policy is for each visit to be completed within 90 days and each visit restarts the 90 day clock. (7/2007)

58. If you identify at the RN supervisory visit that the client does not need or qualify for PCS, can you discharge immediately or do you have to give notice?

Answer: A 48 hour notice must be given in accordance with DHSR, Home Care Licensure rules. If the client does not meet the criteria for PCS you can always offer them the option to pay, privately for home management services. Remember, you can not bill Medicaid PCS for home management only See Policy 3-C, section 4.1, letter B and E (6/2008)

59. At what point is the client discharged if they continue to say they do not need personal care or refuse personal care?

Answer: If this is a trend in services and /or the aide service logs do not document personal care, it should be addressed with the patient. If the patient refuses the ADL care in the plan of care as identified on your PACT, they should be given notice of discharge as they do not meet PCS criteria. See clinical policy 3-c, section 3.2.1- When services are covered and clinical policy 3-c- 4.1, c and e- when services are not covered. (6/2008)

Personal Care Services (PCS) Frequently Asked Questions (FAQs)

60. If the RN identifies safety issues in the patient's condition and/or home, is client PCS eligible?

Answer: Policy 3C Section 3.1 "services are to be safely furnished".

If the RN determines the client is unsafe (if the nurse has documented in field 44 of the PACT that services can not be safely provided) the patient should not be admitted for service. The RN should consider a protective service referral. While the patient may be eligible considering the need for hands on assistance with 2 ADL's, the service must be provided in a safe environment. The RN must determine if the plan of care can be carried out for the client by the staff. If the safety issues are identified or during the service such as in reviewing aide service logs or from aide reports the RN should consider a protective service referral. The PCP should be notified of discharge and safety issues if discharged.

Remember, your agency policy and practice should address patient and staff safety. (6/2008)

61. At the end of the service year, a supervision visit will be due a couple of weeks before the PACT form is due. Can we just do the PACT form early and not write up the supervision visit?

Answer: No, the supervision requirements address additional information, such as satisfaction with care. The additional information in supervision need to be addressed. You can note "see assessment" in areas of supervisory note which are duplications. See c

linical policy 3-c, Section 7.9 (6/2008)

VII. Staff Qualification

62. Please clarify the statement that the aide can't be a family member.

Answer: PCS Clinical policy, 3C Section 6.3.2 defines family members who can not work with the client: Spouse, Mother, Father, sibling, grandparent or grandchild or like relationship. (12/2006)

<p style="text-align: center;">Personal Care Services (PCS) Frequently Asked Questions (FAQs)</p>

63. The patient lives with the aide, but aide is not family member, can we provide PCS with this aide?

Answer: The only requirement at this time is related to specific family members as specified in **Policy 3C Section 6.3.2**. This is an agency policy decision.
(7/2007)

64. How do you determine if a PCS client requires a NA I listed on the DHHS NA Registry (sometimes referred to as a CNA) or In-Home Aide?

Answer: DMA PCS clinical coverage policy states that agencies are to follow the NC Home Care Licensure Rules in determining the In-home aide assignments- this is found in PCS policy - **6.3.2 PCS In-Home Aide Qualifications**

“In-home aides must meet the in-home aide qualifications stated in the N.C. Rules Governing the Licensure of Home Care Agencies (**10A NCAC 13J.1107**).The provider is responsible for assuring that the aide assigned to provide care is competent to carry out the assigned tasks.”

The licensure rules instruct you to make decisions regarding using a nurse aide listed on the NC nurse aide registry (a nurse aide I) when you need the aide to provide extensive assistance or more to the client. The definitions used for extensive and limited assistance in Home Care licensure rules are consistent with the ones used on the PCS PACT form.

What this means, is when you have a patient who is scoring no higher than 2s in Self Performance scores on the PACT form meaning the client only needs limited assistance, then a nurse aide listed on the NC registry is not required.

Patients scoring 3s and 4s or a combination of 2s, 3s and/or 4s would need a nurse listed on the NC registry (a nurse aide I) because they have the need for some extensive assistance.

Personal Care Services (PCS) Frequently Asked Questions (FAQs)

65. Do all nurses working in the PCS program have to take the Nursing certification?

Answer: Yes, all RN's who work in the PCS program must successfully complete the PCS RN certification prior to working independently. The certification is available online through AHEC connect.
(www.aheconnect.com/ahhc).

66. Where can we find clear guidelines re: how much assistance aides can give in medication administration?

Answer: The N.C. Board of Nursing provides guidelines for the role of unlicensed assistive personnel (UAP) in assisting with self medication.
www.ncbon.com (7/2007)

VIII. PACT: Plan of Care

67. On a particular day documented on the POC, can IADL time exceed ADL time?

Answer: Yes, so long as ADL time exceeds IADL time on a weekly basis. See **Policy 3C Section 5.7** (07/2007)

68. Does the Assessing RN check the 3rd column if the patient has an identified ADL deficit and needs help in that area but the family provides that particular task?

Answer: No, the RN checks the third column when a need is identified and to be met by the agency in the plan of care. See PACT instructions @ <http://info.dhhs.state.nc.us/olm/forms/dma/dma-3000-i.pdf>. (7/2007)

<p style="text-align: center;">Personal Care Services (PCS) Frequently Asked Questions (FAQs)</p>

69. How do you specify extra time allotted for ADL and Home management tasks that exceed time guidance, Attachment B Time and Task Guidance in PCS clinical policy?

Answer: Justification for additional time needed is documented in field 46 of the PACT. For example, if additional time to complete the bath and assist with toileting is needed due to pain, document this in field 46 of PACT (07/2007)

70. Can you make an adjustment in time on the next day if the time was short for the day before? (I.e. a MD appointment, bad weather)

Answer: Yes; you can change the time and tasks to meet the patient's needs. You can not exceed the 3.5 /daily limit in these adjustments. The deviation documentation should address the changes in the plan and time to meet the patients needs, not the needs of the agency or staff. Remember, the plan must be "person centered" which addresses client needs. It is not permissible for the aide /agency to "make up time" for aide/agency financial rationale. See Clinical Policy 7.8.2- Non significant temporary revisions in the plan of care

71. If a service is given on a different day other than on a regularly scheduled day, can the service be billed?

Answer: Yes, if there is documentation of the deviation in the record as to why you have made a temporary change on the POC.

Remember there should be no duplication of services. See clinical policy 3-c, section 7.8.2

72, What if you change times by 20 minutes one month then change times by 40 more minutes the next month?

Answer: You have to have a new MD signature because you have adjusted the time from his last PACT authorization by more than 60 minutes (total).

<p style="text-align: center;">Personal Care Services (PCS) Frequently Asked Questions (FAQs)</p>

73. Where is the frequency of the number # of days that service is provided in the guidelines?

Answer: PCS services for adults allows 60 hrs a month and up top 3.5 hours a day. The Nursing Assessment identifies the recipient's needs. The nurse uses the Time and Task Guidance, attachment B to the PCS clinical policy to develop a plan of care to meet those identified needs. There is specific guidance in the frequency of IADL task in the guidance. If you need additional time or increased frequency of tasks based on the patients needs you should document this in field 46. See also clinical policy 3-C section 5.7

See also instructions for completing the PACT.

<http://info.dhhs.state.nc.us/olm/forms/dma/dma-3000-i.pdf>.

(07/2007)

74. A frail elderly client cannot tolerate the shower or tub, but receives a full body bath in the bathroom. Since this is a full body bath and not a partial sponge bath, is it correct that the time allotted for this activity is up to 30 minutes? It is unclear if the policy requires a full body bath only be given in the bed.

Answer: Time should be allotted on whether the client is receiving a partial bath or a full bath, not the location of the bath. (12/2006)

75. Can you use "as requested" on the POC? (For example, errands 1 time a month as requested by client)?

Answer: No, document as a temporary change in POC.

Remember: Do not use terminology PRN because you do not leave the decision making up to the aide, which exceeds their scope of practice. See **Policy 3C Section 7.8**. (07/2007)

Personal Care Services (PCS) Frequently Asked Questions (FAQs)

76. If 'PRN' is not permissible when assigning tasks in the POC, how are tasks assigned that may not always occur on a designated day, i.e., PCS client only wants laundry done when the basket is full so as not to waste water/electricity?

Answer: Each task must be assigned to a day. If a task is not performed on the assigned day (missed service), this should be documented as a temporary revision to the plan of care. See **Policy 3C Section 7.8.2** (7/2007)

77. How are 'one time/month' tasks documented?

Answer: Infrequent tasks should be incorporated in the POC as a temporary revision to the POC. See **Policy 3C Section 7.8.2** (7/2007)

78. Is it appropriate to assign time on the plan of care for client ADL needs with a score of 1, supervision, oversight, encouragement or cueing ?

Answer: Once they qualify for PCS with hands on assistance in two of the six universally recognized ADL's, you could budget some additional time for other ADL needs scored as a "1", supervision or oversight. You identify needs by checking columns on the PACT form. Remember, for observation alone you would not need the maximum amount of time in the plan of care to supervise or cue the task.

A Best practice would be to utilize field 46 in the PACT to document the need. (07/2007, revised 6/2008)

79. How do you know where to document IADLs and time?

Answer: Page 2 of the PACT, fields 27 through 31, the nurse identifies IADL tasks. On page 4 of the PACT, Plan of Care, the nurse indicates IADL tasks and time in the column indicated. (07/2007)

<http://info.dhhs.state.nc.us/olm/forms/dma/dma-3000-i.pdf>.

Detailed instructions for completing the PACT are available at <http://info.dhhs.state.nc.us/olm/forms/dma/dma-3000-i.pdf>.

<p style="text-align: center;">Personal Care Services (PCS) Frequently Asked Questions (FAQs)</p>

80. If a patient scores 0/1 for eating, is it acceptable to assign time for meal prep/kitchen cleanup under IADLs?

Answer: Once they qualify for the service with 2 ADL deficits you can include IADL tasks in the plan of care. (07/2007)

81. Can we attach an additional sheet to the PACT for IADLs?

Answer: Yes, make sure to note on the PACT you have included attachments. Include in your total time per day the IADL time totals on page four of the PACT.

82. Can daily tasks deviate from the POC, i.e., can Monday tasks be switched with Wednesday tasks?

Answer: Yes, temporary changes in daily POC tasks may occur as long as Documentation explains the change. See **Policy 3C Section 7.8.2** (12/ 2006)

83. When is it appropriate to revise only the POC (page 4 of PACT) and not redo the entire PACT form?

Answer: The POC may be revised without re-doing the PACT when there is a non significant temporary or permanent revision, when PCS-Plus is approved or when the primary care physician gives a verbal order to make a significant change (increase or decrease by 60 minutes per week) in the total weekly assigned time or add or delete personal care task(s). These changes are documented on a copy of the original POC (page 4 of PACT). The verbal order is documented in field 47 of the PACT. A supplemental order may also be used to document the physician's verbal orders. All orders must be signed by the physician within 60 days. See **Policy 3C Section 7.8.1** (12/2006)

84. If a client is hospitalized and subsequently goes to a rehabilitation facility and PCS is placed on hold for 33 days, is it best to discharge the client and do a totally new admission (new admission means completing new admission consents and POC)?

Answer: A decision to discharge and reopen as a new admission (new consents, etc.) depends on provider agency policy. **Section 7.3.3** of the PCS policy

<p style="text-align: center;">Personal Care Services (PCS) Frequently Asked Questions (FAQs)</p>

addresses when a reassessment is necessary due to a lapse in service greater than 7 days. Additional pertinent policy sections include **7.3.4, 7.3.5 and 7.8.1 through 7.8.3.**

85. For PCS-Plus, do you show the additional 20 hours on your PCS-Plus form and place the hours on page 4 of the PACT ?

Answer: Yes, when PCS-Plus is prior approved by DMA, the plan of care must be amended with the additional time and tasks that reflect the start of PCS-Plus services. The RN documents these revisions to the plan of care by completing a new plan of care or revising a copy of the current plan of care, signing and dating the revisions. See **Policy 3C Section 7.8.3** (07/2007)

The best practice is to notify the PCP of the changes in the POC and the additional hours authorized by DMA. .

86 Can you do errands and transportation under Medicaid?

Answer: Yes, You can do “essential errands” as per the policy. They are identified as IADL activities. Remember, medical transportation is not allowed during PCS time. See clinical policy 3-C, attachment B, time and task guidance.

87. Can you do medical transportation?

Answer: No, medical transportation is not allowed during PCS time.

<p style="text-align: center;">Personal Care Services (PCS) Frequently Asked Questions (FAQs)</p>

IX. Service Management

88. If a patient requests to be placed on “hold” for several weeks, is a new PACT necessary if there are no changes? If a patient is on hold when the supervisory visit is due is a new PACT necessary if there are no changes?

Answer: No, it is not necessary to complete a new PACT if there are no changes. Remember, if a supervisory visit is due, it must be completed prior to resuming services. In either case you should have documentation demonstrating contact was made which concluded there were no changes in the patient’s condition. (07/2007)

89. Is there a “transfer” process for PCS and /or PCS plus when a patient chooses to change agencies, so there is not a break in services?

Answer: NO, Additionally, PCS Plus service authorization is linked to the provider number and does not transfer to the new agency. The new agency treats the patient as a new referral and requests PCS Plus if the need is identified.

90. Is it permissible to use the hospital discharge orders to continue PCS services at discharge from the hospital?

Answer : If the client was receiving PCS prior to hospitalization, the PCS provider should at a minimum contact the hospital discharge planner, primary care physician, or other licensed health professional providing care to determine whether any significant changes occurred in the client’s condition that would impact the POC. Contact with the PCS recipient should also occur. Significant changes require a reassessment and order from the primary care physician.

See **Policy 3C Section 7.1 #2** (7/2007, revised 6/2008)

Personal Care Services (PCS) Frequently Asked Questions (FAQs)

91. Is it allowable for a client to accompany the aide to the laundromat if it does not add more time to the task?

Answer: The decision to allow clients to ride with the aide is defined by agency policy. DMA reimburses for the time that it takes to accomplish the task.

DMA 1/2006

92. If a family member has the day off and does the patient's bath and gets patient dressed before aide arrives leaving only housekeeping to be done, should the aide stay and do the IADLs? If yes, then she would not stay the entire allotted time for that day.

Answer: Yes, it would be permissible as long as doing the IADLs only on one day does not result in the total ADL time being less than the total IADL time over the course of a week. The agency would need to document the temporary change in the plan of care. The aide would not need stay the entire allotted time for that day as the tasks in the POC were done. (7/2007, revised 6/2008)

Best Practice- Evaluate the trends in this scenario. For example if it were a few times a year it would not be a trend and acceptable. However, if this occurred weekly or several times a month the provider RN should re-evaluate the client's needs and frequency.

93. What should be done about months that have 31 days in order to stay within the 60 hour monthly limit of PCS hours and still be in compliance with the plan of care?

Answer: History indicates that most clients miss at least one day out of every month due to doctor appointments or other occurrences. However, if in the last week of the month there is not enough time left to provide regularly scheduled PCS hours on all days and there is no family member or other caregiver to provide the personal care, the agency could decrease the hours per day for that week to allow enough time for the aide to provide personal care each day and perform most of the scheduled home management tasks. The provider would follow the process outlined in a change of the plan of care (**Policy #7.8.2**)

The reasons that scheduled tasks are not done should be documented on the flow sheet or assignment sheet. There does not have to be a permanent change in the plan of care since there is no permanent change of service; documentation

Personal Care Services (PCS) Frequently Asked Questions (FAQs)

in the record should reflect the reason for the time adjustment, the patient agrees and how the needs are met. (7/2007, revised 6/2008)

94. When a client moves (e.g. goes from one home to another) is a new PACT required?

Answer: No, Policy does not require a new PACT , however the agency should update their assessment with the new address, assessment of the home environment to insure it is adequate to meet needs and revise the plan as indicated based on the changes in the home and supports. (6/2008)

95. How do you provide service to two (2) recipients in the same home? Do you use 2 different aides or 1 aide working with each patient at a little at a time?

Answer: Staffing strategies are an agency management issue. Remember, PCS/Medicaid services are a 1:1 service; You can use 2 aides in the home or staff with 1 aide and specify individual needs on your PACT plan of Care in the time and tasks on **each** plan of care.

Remember, as the time and task guidance indicates you would want to acknowledge multi tasking and you would not to duplicate home management tasks on the 2 separate plans of care. For example, you would not vacuum twice .Meal preparation, based on patient specific type of diet may be individualized to each plan of care. **See clinical policy 3-C, attachment B (6/2008)**

96. If we stay an extra 15 minutes, for example to clean up an “accident”, do we have to take off somewhere else to avoid going over 60 hours?

Answer: You will only be reimbursed 60 hours month or 3.5 hours day for PCS, so it is the agency decision to deviate from the plan of care and make a temporary change in the POC, **See clinical policy 3-c, section 7.8.2 (6/2008)**

97. If you have a client that has only 2 days a week of service and they miss one of those days, do you have to go by the “7 day guideline” and reassess before restarting care?

<p style="text-align: center;">Personal Care Services (PCS) Frequently Asked Questions (FAQs)</p>

Answer: This applies to seven (7) service days in an unplanned lapse in service. If the client goes out of town with family for a week, this is a planned lapse in service and does not apply unless they have a change in condition or needs. See clinical policy 3-C, section 7.3.3

X. Service Management: Coordination Hospice Home Health

98. What if Hospice is coming for Palliative Care (ex. pain management) only and not providing any personal care?

Answer: Medicaid recipients on Medicaid or Medicare B hospice may not receive PCS. The Hospice regulations require Hospice to provide the needed aide services. See **Policy 3C Section 4.2**

Remember: The patient must elect Hospice services; in some instances they may select PCS instead of Hospice. (12/2006)

99. Can a patient receive PCS services when Home Health is also visiting the client 1time a week for skilled services? (E.g.-PT, OT, RN)

Answer: Yes, Policy 3C Section 4.3 specifies a recipient may not receive PCS or another substantially equivalent state or federal funded service on the same day. For example, a Physical therapist is not a like service to an in home aide.

(12/2006)

Remember: The patient must be medically stable in order to qualify for PCS.

100. If you are seeing the patient in the morning prior to going to adult day care, can they get PCS services?

Answer: Yes, if the program is Adult Day Care. No, if the program is Adult Day Health. Remember, Adult Day Health covers bathing and personal care services, so it is a like service and duplication. (07/2007)

<p style="text-align: center;">Personal Care Services (PCS) Frequently Asked Questions (FAQs)</p>

101. Can a PCS client live in a boarding home?

Answer: Yes, if this is the client's primary residence. Remember it can not be a licensed home, such as an Adult Care Home and/or Group Home.

XI. QUALITY ASSURANCE /UR, INCLUDING PCS CCME REVIEWS

102. Are the letters that The Carolinas Center for Medical Excellence (CCME) sends to PCS providers notifying them of an upcoming review sent by certified mail?

Answer. No, the letters that CCME sends to PCS providers notifying them of an upcoming review are sent by the U.S. Postal Service, regular mail. (12/2006)

103. What do PCS providers need to have available for CCME's agency review?

Answer: A list is sent with the letter of notification to the PCS provider. The PCS providers need to have available for CCME's agency review the following:

- PCS recipient chart ,with supervisory notes, in-home aide logs, and PACT
- Agency Self-audit of patient records
- Complaint logs.
- Agency QA plan which may include the agency plan of correction
- RN PCS certification of training

(12/2006, revised 6/2008)

<p style="text-align: center;">Personal Care Services (PCS) Frequently Asked Questions (FAQs)</p>

104. If a PCS provider serves less than 25 recipients, how many recipients will be reviewed?

Answer: If a PCS provider serves less than 25 recipients, CCME will review all of the recipients. (12/2006)

105. Is a PCS provider always in the selection pool, even after being reviewed?

Answer: A PCS provider is in the selection pool until review after which they will not be selected again for a year, unless there are other events that require review before the normal random selection process. (12/2006)

106. If there is a disagreement about PCS policy interpretation between a PCS provider and CCME's reviewer, who should the PCS provider contact?

Answer: If there is a disagreement about PCS policy interpretation, the PCS provider should contact Alisha Brister with CCME at 919-380-9860, ext. 2018. DMA will be consulted if necessary. (12/2007)

107. If the (CCME) nurse reviewer found that a patient did not meet criteria for PCS, will the agency have to reimburse DMA for PCS services paid?

Answer:

- A claims adjustment may be indicated if the agency reassesses the patient and confirms the patient was not eligible for services. The agency should review and determine if claims adjustments are indicated by reviewing the documentation from the reassessment, previous RN supervisory visits and the aide service logs which reflect personal care and services.
- No, if the provider disputes the finding of eligibility/criteria. The dispute should include reassessment of the patient, reviewing the previous supervisory visit and the in home staff log. This dispute should be reported with the corrective action plan. (6/2008)

Personal Care Services (PCS)

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The letter of review findings is mailed to the agency 60 days after the review is completed. The letter includes guidance in completing a corrective action plan and any disputes on findings.

108 .When doing quarterly audit of aide service notes, how far back (weeks/ months) do you suggest reviewing?

Answer: CCME looks at up to 6-12 months of services (supervision and PACT authorization); DMA recommends a minimum of 2 quarterly cycles to be able to identify trends (e.g. aide service logs, supervision). A longer period, such as a year is indicated when looking for PACT assessment (365 days). (6/2008)

109. When a chart is pulled for review, how far back inside that chart do they review to the last PACT form, the last year, any specific time frame?

Answer: CCME goes back one year during compliance reviews. Program Integrity can perform retrospective payment reviews for up to 5 years (12/2007)

110. What if the CCME reviewer scores a recipient differently in one ADL area than the PCS provider?

Answer: A difference of scoring in one ADL area alone does not determine non-compliance. The entire PACT, supervisory notes, aide logs and other supporting documentation are used to determine compliance. (12/2007)

111. What process is present to ensure consistency among CCME reviewers?

Answer: CCME has an Inter-Rater Reliability program that monitors the degree to which two reviewers complete a review and obtain the same results. (7/2007)

112. Can we request CCME to come do a review of our agency?

Answer: No, The CCME reviews are randomly selected through a computer program. (07/2007)

Personal Care Services (PCS) Frequently Asked Questions (FAQs)

113. The RN's PCS certification that the CCME reviewer needs to see—is that just a copy of our PCS certificate?

Answer: Yes, the reviewer is measuring the PCS key aspect of staff qualifications with the PCS certificate which is printed out once you complete the AHEC Connect PCS certification course. (07/2007)

XII. Education

114. How can someone's name be placed on CCME's mailing list for future PCS seminars?

Individuals can be placed on CCME's email distribution list for notification of seminars by sending their email address to Alisha Brister at abrister@thecarolinascenter.org

XIII. Record Retention and requirements

115. How long should a PCS provider keep records of inactive PCS clients for review by CCME?

PCS policy requires that PCS records be maintained for a minimum of 5 years. (See **Section 7.11.1** (12/2006))

116. If you realize part way through the assessment that the client is not going to meet the criteria for PCS, do you have to complete the entire PACT form?

Answer: No, however if you plan to bill for the assessment time you must complete pages 1-3. **See PCS 3-C, Attachment A** Claims related information, letter E, What may be billed.

Personal Care Services (PCS) Frequently Asked Questions (FAQs)

117 If the aide documents on the service note in the wrong spot, do we need to throw that service note away and start over or can the aide fix their mistake on the original service note?

Answer: Agency policy should establish requirements for documentation. Medicaid requires the notes to be legible, signed See Policy 3-C section 7.11 Recordkeeping requirements. Generally, the accepted standard to correct an error in documentation: strike a single line through the error, initial it, and date the entry. A record should not be corrected by an individual other than the individual who made the entry. (6/2008)

See <http://www.ncdhhs.gov/dhsr/ahc/index.html>

[10A NCAC 13J .1400 Service Records,](#)

118. Does DMA plan to provide a standardized aide log?

Answer: No, DMA has specific policy standards on what is included in the aide log. See **Policy 3C Section 7.10.** (1/2006)

XIV. Miscellaneous Questions

119. Where can we get a complete list of ICD9 codes?

Answer: ICD9 codes references are available through most medical reference suppliers. You can find this reference by doing an internet search using ICD9 Code. (12/2006)

120. Can clients go with the in home aide on essential errands, such as to the grocery store?

Answer: Transportation for essential errands, such as to grocery, and to pick up medications are approved tasks. There is no requirement to transport the client, this is a nursing judgment based on client need and safety in developing the POC. The RN completes the assessment and develops the POC based on identified needs. If the RN determines the need for essential errands it may be

<p style="text-align: center;">Personal Care Services (PCS) Frequently Asked Questions (FAQs)</p>

included in the POC. The agency must have policies in place regarding transportation. This policy should be communicated to the patient at the time of care planning. See clinical policy 3-c, Attachment B, Time and Tasks guidance

121. Can the agency office re take the client to MD appt as long as the time is not being billed?

Answer: What an agency does out side of PCS billed time is the responsibility of the agency and of not in the domain of PCS policy.

Remember: You can not use this as an enticement for PCS services.

122. Is a computerized telephonic aide sheet acceptable?

Answer: Yes telephony criteria are specified in **Policy 3C Section 7.12**

123. If you have a lapse in MD signatures on the pact (i.e. the MD signed the PACT last year on the 10th but did not give the verbal order or sign a PACT this year until the 15th), can you bill Medicaid for these dates of service?

Answer: Clinical Policy 3-C, Section 4.1 indicates what can not be billed. Section 4.1 indicates services can not be billed when not provided in accordance with policy. (6/2008)

124 Can people appeal denials of PCS+?

Answer: Yes, DMA sends the “Due process” requirements and procedures with every denial letter to the patient and the agency who requested the services. This letter reviews the specifics of the appeal process. The recipient has the right to appeal any negative decision. (11/08)

<p style="text-align: center;">Personal Care Services (PCS) Frequently Asked Questions (FAQs)</p>

XV EPSDT

125. Do you bill EPSDT the same way as PCS?

Answer: The approval letter sent from DMA approving PCS under EPSDT will include specific instructions for billing. The steps to bill are:

- Step 1- Bill monthly for all approved hours of service using the PCS-Plus billing code (99509)
- Step 2- Once the agency receives a denial for all hours over 80 for that month send or fax the RA and service dates to the DMA PCS office; attention Evelyn Newkirk(Administrative Assistant)
- Step 3- A letter requesting that EDS do a manual override for payment will be sent to EDS from the PCS office at this time.
- Step 4- Until further notice this procedure must be completed monthly to receive payments

126. Do nursing assistants need to have special (pediatric) training under EPSDT?

Answer: PCS does not specify pediatric experience or qualifications. Please review BON criteria for delegation and DHSR guidance for staffing qualifications. The RN assessing the individual documents the individual's ability. NA II tasks need to be completed by a NA II or NA I with additional training. Always remember, the RN delegating any tasks to any paraprofessional must verify the individual has the knowledge and skills to independently complete the task and the patient is stable, See **Policy 3C Section 6.3.2.**, also BON Interpretative guide on delegation www.ncbon.com.

127. What does DMA send back to you authorizing hours under EPSDT?

Answer: An approval letter which details the hours and certification period will be mailed to the patient (parent/guardian) the agency will receive an approval letter from DMA which details the hours approved and certification period.

<p style="text-align: center;">Personal Care Services (PCS) Frequently Asked Questions (FAQs)</p>

128 Do you need Prior Approval for PCS under EPSDT criteria?

Answer: PA for PCS services is required when services are requested for more than 60 hours or the services are in excess of hours or does not meet PCS specific criteria you would need prior approval.

129. What documentation is required for EPSDT approval?

Answer: The agency needs to submit the completed PACT, PCS Plus form, EPSDT justification (template available at <http://www.ncdhhs.gov/dma/epsdt/>)

If additional information is needed or any of the documentation is incomplete a request for additional information will be returned via fax to the provider. The provider has 15 days to submit the information. If the information is not completed or DMA staff is not contacted in the 15days, the request will be denied.

EPSDT Provider Page: <http://www.ncdhhs.gov/dma/epsdt/>

130. Can PCS be provided in a school?

Answer Yes. Remember, you must coordinate services with the school administration and school staff.

Personal Care Services (PCS) Frequently Asked Questions (FAQs)

XVI Agency Transitions

131. When an agency is acquired or merges with another agency what is the process for reassessment and authorization to minimize gaps in services and maintain compliance?

See: Agency Transition Guidance

PCS/ DMA Guidelines for Agency Transitions:

Changes in Address/Contact, Ownership, Partnership, Consolidations and Closing.

The Division of Medical Assistance (DMA) requires a separate PCS provider number for each licensed site. An agency must be licensed by the Division of Health Service Regulation (DHSR) for In Home Aide Services to apply and maintain a Medicaid PCS Provider number. The provider signs the Provider Enrollment which specifies the conditions of participation for Medicaid.

In order to bill DMA for PCS services the provider must have a signed, current provider agreement or an interim contractual arrangement with another DMA enrolled provider for billing services. Interim billing agreements are usually outlined in acquisition, merger or separation of agency/service contracts.

The Provider Enrollment Agreement requires notification of DMA/DHSR for:

- Change in Address- physical and billing address (includes phone, fax contacts)
- Change in Administrator/ responsible individual who has entered in the Provider Enrollment agreement (DMA only)
- Change in owner (includes merger with another enrolled agency, change in ownership > 5%, Separation of agencies and ownership)

<p style="text-align: center;">Personal Care Services (PCS) Frequently Asked Questions (FAQs)</p>

- Consolidation and closing of agency and/or sites

Contact/Location Change: The Agency should notify DMA Provider enrollment, in writing of a change in address for the Physical agency site and/or billing site, change in phone number or contact information such as a fax and PO Box. The notification should be done 30 days prior to the effective date of the change.

Consolidation of Agency Physical Sites

The agency should notify DMA Provider enrollment in writing, 30 days in advance of the consolidation of 2 enrolled sites. Once the transition is completed the provider should notify DMA to terminate the provider number. This should be no longer than 1 year.

The agency must maintain compliance with DHSR requirements re: distance and geographic areas served. (DHSR)

Client management:

The clients should be notified in advance of contact information and any changes. No client re-assessment is required. The responsibility for the care and compliance with DMA /DHSR policy is the responsibility of the consolidated (primary) site.

The provider should update the PACT with the change in provider number at the next re-assessment. The client's record should include a notation of the transfer from one physical site to another, or amend the PACT by making a copy, striking through the old provider number and adding the updated provider number and dating/initialing the entry.

Billing should be transferred to the primary site provider number with the transition.

<p style="text-align: center;">Personal Care Services (PCS) Frequently Asked Questions (FAQs)</p>

Change in Agency Administrator/responsible Individual: The Agency should submit an updated, signed provider enrollment a provider number, agreement within 30 days of the change in responsible individual. The agreement should be signed by the new responsible individual. The responsibility for the care and compliance with DMA policy is now the responsibility of this individual.

The provider enrollment agreement is available on line at

<http://www.ncdhhs.gov/dma/provenroll/>

Change in Ownership: The agency (site, license) is acquired by another provider

“New” Owners

The change in ownership notification should be submitted in writing to DMA provider enrollment and DHSR 30 days in advance of the sale.

In many acquisitions the sale agreement specifies the provider transition details of personnel and client management billing management and record management.

General guidelines:

Billing Management: The new provider may bill for the services during the transition period on the “old” or existing provider number if specified in the contract/sale agreement. The new provider should apply for a new provider number immediately. This may take several weeks to process. Once the new number is assigned, the old number should not be used for any billing beyond the sale date.

It is common for a buyer or seller to maintain the old number for management of debt. The details should be addressed in the sale agreement. The number can be kept active for up to 12 months for the closed/sold agency to complete management of old debt and outstanding billing.

Personal Care Services (PCS) Frequently Asked Questions (FAQs)

Remember: Medicaid can audit a closed agency and client records should be maintained and accessible for 5 years.

Client Management: The client should be notified of the change in ownership and provided information regarding the new owners operating procedures. This should include consent for release of information, financial information, client rights information including complaint process, choice of provider and all contact information. The client should be given a choice to continue with the new agency or choose another provider. The notification and documentation of choice is the responsibility of the seller. This should be addressed in the sale agreement.

The Primary Care Physician, who authorized the services in the PACT, should be notified of the provider change. The agency should obtain a new PACT and the PCP signature at the reassessment. The PACT authorization/PCS plus authorization does not “transfer” from one provider to another.

Re-assessment- The new agency is responsible for the care and service integrity from the day of acquisition forward. The clients should be re-assessed as soon as possible, no later than the next scheduled supervisory visit (no longer than 90 days after the acquisition). The responsibility for the care and compliance with DMA /DHSR policy is the responsibility of the new owner from date of sale, forward. If there is any reduction or change in services the client is to be notified. DHSR (.1107) PCS Plus authorization should be requested immediately with the reassessment.

Record Management: The sale agreement should address storage and maintenance of client clinical and billing records.

Records are to be stored for the required retention period (5 years). Responsibility for archiving and record storage and access should be specified in the conditions of the sale agreement. If not specified it is the seller’s responsibility.

Personnel: The new agency is responsible by the first day of operation to verify the qualifications of all staff, upholding the provider written policies for hiring. The PCS nurse certification is linked to the RN and not the agency therefore is transferred in the agency qualification/hiring process.

<p style="text-align: center;">Personal Care Services (PCS) Frequently Asked Questions (FAQs)</p>

Change in Partnership:

The provider must notify DMA and DHSR in writing 30 days in advance for a change of more than 5% of an agency partnership.

The client should be notified of the change in partnership and provided information regarding the change if policies are changed. This should include financial, rights including complaint, choice process and all contact information.

The client does not need to be re-assessed. The responsibility for the care and compliance with DMA/ DHSR policy is now the responsibility of the new partnership/owner from the date of change, forward.

Closure of an Agency and/or Discontinuation of PCS Enrollment:

The provider must notify DMA/DHSR in writing 30 days in advance for a closure of agency or discontinuation of service type, such as PCS.

The client must be notified 48 hours in advance of the closure and given notice for choices in other providers and termination of services. The Primary Care physician is also notified.

When an agency closes, DMA must be notified in writing. This notification must also include where the records of the recipients will be stored for the required retention period (5 years)

If the client chooses a new provider the client is treated like a new admission to the provider. There is NO transfer process for PCS or PCS plus from one agency to another.

DMA Provider Services: 919-855-4050

DMA Clinical Policy – PCS: 919-855 4360