NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Clinical Coverage Policy 3L and 3L-1 Personal Care Services (PCS) Benefit Program

Provider Manual

Updated/Effective: April 2025

Contents

Introduction: Program Overview

General Information

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

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

The amount of service provided is based on an assessment conducted by a Comprehensive Independent Assessment Entity (CIAE), known and referred to through the remainer of this manual as NCLIFTSS (Linking Individuals and Families to long-term services and supports) to determine the individual's ability to perform ADLs. The performance is rated on a five-point scale that includes totally independent, requiring cueing or supervision, requiring limited hands-on assistance, requiring extensive hands-on assistance, or totally dependent.

Beneficiaries are awarded prior approvals (PAs) for a number of service hours dependent on their assessed needs. Qualifying Medicaid beneficiaries who are 18 years or older may be authorized up to 80 hours of service per month. A Medicaid beneficiary who meets the eligibility requirements for PCS and other eligibility criteria mandated by N.C. Session Law 2013-306 H492v7.pdf (ncleg.net) may be authorized for up to 50 additional hours of Medicaid PCS per month for a total amount of up to 130 hours. Qualifying Medicaid beneficiaries under 21 years of age may be authorized for up to 60 hours of service per month, except if additional hours are approved under Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

PCS Beneficiary Qualification Requirements

The information in this section references Clinical Coverage Policy 3L and 3L-1 Section 3.0

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

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

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

AND reside in:

1. a private living arrangement (primary private residence);
2. a residential facility licensed by the State of North Carolina as an adult care home (ACH) as defined in G.S. 131D-2.1, a combination home as defined in G.S. 131E-101(1a); **or**
3. a group home licensed under Chapter 122C of the General Statutes and under 10A NCAC 27G .5601 as a supervised living facility for two or more adults whose primary diagnosis is mental

illness, a developmental disability, or substance abuse dependency and is eligible to receive PCS under the Medicaid State Plan.

Additional general program requirements include:

- The home environment is safe and free of health hazards for the beneficiary and the PCS provider(s) to receive and provide service;
- The residential setting has received inspection conducted by the Division of Health Service Regulation (DHSR);
- The place of service is safe for the beneficiary to receive PCS and for an aide to provide PCS;
- No third-party payer is responsible for covering PCS;
- No family or household member or other informal caregivers are available, willing, and able to provide the authorized services during the approved time frame.

The beneficiary must:

- Be referred by their Primary Care Physician, Attending Physician, Nurse Practitioner or Physician Assistant;
- Have a documented medical condition that supports the need for hands on assistance;
- Be certified as medically stable by the referring entity;
- Under on-going care of a physician for the condition or diagnosis causing the functional limitations;
- Have been seen by the referring entity within the previous 90 days;
- Have been screened for Serious Mental Illness (SMI). All Medicaid beneficiaries referred to or seeking admission into an Adult Care Home licensed under G.S. 131D-2.4 must be referred to an LME-MCO for the Referral Screening Verification Process (RSVP). Adult Care Homes licensed under G.S. 131D-2.4 must be referred to a Tailored Plan Transition Coordinator for the Referral Screening Verification Process. Adult Care Home providers licensed under G.S. § 131D-2.4 shall not receive a PCS assessment or prior approval without verification of a Referral Screening ID.

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

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

Information in this section references Clinical Coverage Policy 3L and 3L-1 Section 2.2

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiaries under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply if the provider's documentation shows that the requested service is medically necessary. Medically necessary services are provided in the most economic mode, if the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

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

1. That is unsafe, ineffective, experimental or investigational.

2. That is not medical in nature or not recognized as an accepted method of medical practice or treatment.

NOTE: Once the beneficiary turns 21 years of age, their approved EPSDT hours will cease, and PCS ends. A new DHB-3051 form should be submitted to NCLIFTSS PRIOR to the 21st birthday for the beneficiary to be assessed and, if approved, PCS to continue after they turn 21.

PCS Covered Tasks and Services

The information in this section references Clinical Coverage Policy 3L and 3L-1 Sections 3.3 and 3.4

PCS is a non-skilled service and should not be considered as a substitute for ongoing medical treatment. PCS includes the following tasks and services that need to occur at minimum, once per week:

1. Hands-on assistance to address unmet needs with qualifying ADLs;
2. Set-up, supervision, cueing, prompting, and guiding, when provided as part of the hands-on assistance with qualifying ADLs;
3. Assistance with home management IADLs that are directly related to the beneficiary's qualifying ADLs and essential to the beneficiary's care at home;
4. Assistance with medication when directly linked to a documented medical condition or physical or cognitive impairment as specified in **Subsection 3.2** of Clinical Coverage Policy 3L;
5. Assistance with adaptive or assistive devices when directly linked to the qualifying ADLs;
6. Assistance with the use of durable medical equipment when directly linked to the qualifying ADLs; or
7. Assistance with special assistance and monitoring needs (assistance with ADLs that require a Nurse aide II) and delegated medical monitoring tasks.

The following additional assistance may be approved under **EPSDT** criteria for beneficiaries under 21 years of age:

1. Supervision (observation resulting in an intervention) and monitoring (precautionary observation) related to qualifying ADLs;
2. Cueing, prompting, guiding, and coaching related to qualifying ADLs;
3. After school care if PCS tasks are required during that time and no other individuals or programs are available to provide this service, and;
4. Additional hours of service authorization.

Medication Assistance

Medicaid covers medication assistance when it is:

1. Delivered in a primary private residence and consists of medication self-administration assistance described in 10A NCAC 13J;
2. Delivered in an adult care home and includes medication administration as defined in 10A NCAC 13F and 13G; or
3. Delivered in a supervised living home and includes medication administration as defined in 10A NCAC 27G.

PCS Non-Covered Tasks and Services

The information in this section references Clinical Coverage Policy 3L and 3L-1 Section 4.2

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

1. Skilled nursing services provided by an LPN or RN;
2. Services provided by other licensed health care professionals;
3. Respite care;
4. Care of non-service-related pets and animals;
5. Yard or home maintenance work;
6. Instrumental Activities of Daily Living (IADLs) in the absence of associated Activities of Daily Living (ADLs);
7. Transportation;
8. Financial management;
9. Errands;
10. Companion sitting or leisure activities;
11. Ongoing supervision (observation resulting in an intervention) and monitoring (precautionary observation), except when approved under EPSDT as specified in Subsection 2.2 of Clinical Coverage Policy 3L;
12. Personal care or home management tasks for other residents of the household;
13. Other tasks and services not identified in the beneficiary's Independent Assessment and noted in their Plan of Care and;
14. Room and board.

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

Medicaid does not cover PCS when:

1. The initial independent assessment has not been completed;
2. The PCS is not documented as completed in accordance with this clinical coverage policy;
3. A reassessment has not been completed within 30 days of the end date of the previous prior authorization period because the beneficiary refused assessment, could not be reached to schedule the assessment, or did not attend the scheduled assessment;
4. The PCS is provided at a location other than the beneficiary's primary private residence or residential setting, except when EPSDT requirements are met as listed in Subsection 2.2 of Clinical Coverage Policy 3L and 3L-1;
5. The PCS exceeds the amount approved by NCLIFTSS;
6. The PCS is not completed on the date the service is billed;
7. The PCS is provided prior to the effective date or after the end date of the prior authorized service period;
8. The PCS is provided by an individual whose primary private residence is the same as the beneficiary's primary residence;
9. The PCS is performed by an individual who is the beneficiary's legally responsible person, spouse, child, parent, sibling, grandparent, grandchild, or equivalent step or in-law relationship to the beneficiary;
10. Family members or other informal caregivers are willing, able, and available on a regular basis adequate to meet the beneficiary's need for personal care;
11. The requested services consist of treatment or training related to behavioral problems or mental health disorders such as attention deficit disorder or oppositional defiant behavior;
12. The requested ADL assistance consists of activities that a typical child of the same chronological age could not safely and independently perform without adult supervision;
13. Independent medical information does not validate the assessment, which could cause PCS hours

to be reduced, denied, or terminated based on the additional information;

14. Providers subject to Electronic Visit Verification (EVV) who have not enrolled with an EVV solution as required by Section 12006 1903(l) of the 21st Century Cures Act.

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

    Note: PCS is not intended as a substitute for childcare, daycare, or afterschool care. PCS is not covered for infants or children when the personal care needs do not meet the medical necessity criteria, or the needs are a parental responsibility or are age-appropriate needs.

Medicaid does not cover PCS in licensed residential facilities when:

1. The beneficiary is ventilator dependent;
2. The beneficiary requires continuous licensed nursing care;
3. The beneficiary's physician certifies that placement is no longer appropriate;
4. The beneficiary's health needs cannot be met in the specific licensed care home, as determined by the residence; or
5. The beneficiary has other medical and functional care needs that cannot be properly met in a licensed care home, as determined by General Statues and licensure rules and regulations.

Role of NC Medicaid

NC Medicaid is the state agency that administers Medicaid and is responsible for overseeing the PCS Program. In adherence to the PCS Policy and its contract with NCLIFTSS, NC Medicaid is responsible for:

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

PCS Provider Stakeholder Information

Stakeholders should submit questions through the PCS mailbox at PCS_Program_Questions@dhhs.nc.gov.
To get involved call 919-855-4360 or email PCS_Program_Questions@dhhs.nc.gov.

Providers can also reach out to NCLIFTSS at: ncliftss@acentra.com

Role of NCLIFTSS

As the CIAE, NCLIFTSS is under contract with the North Carolina Department of Health Benefits (DHB), NC Medicaid, to conduct independent assessments for PCS. In accordance with the PCS Policy and the CIAE's contract with NC Medicaid, NCLIFTSS is responsible for:

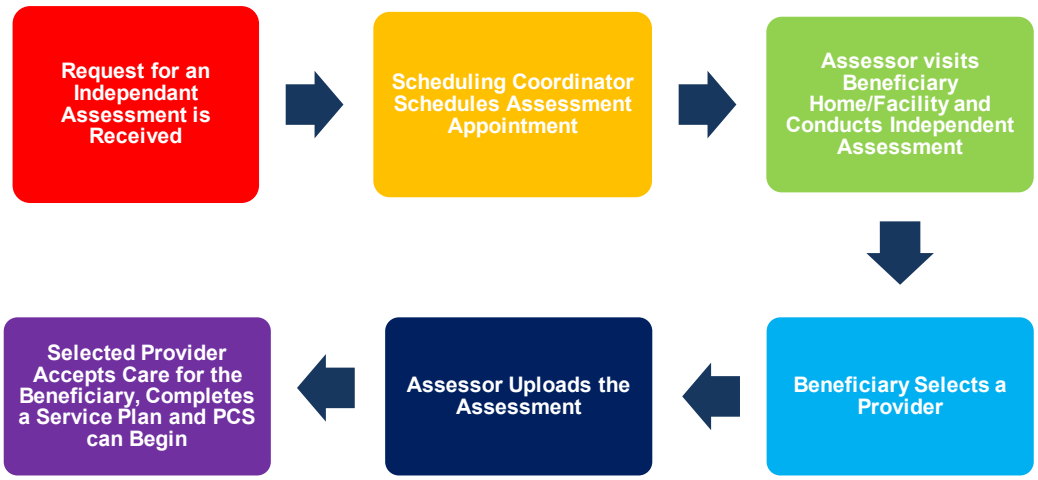
- Processing all PCS requests, including new referrals, expedited requests, change of status, and change of provider requests;
- Conducting all PCS assessments, including new admission assessments, annual reassessments, result of mediation assessments, and any other required assessments per policy or at the request of NC Medicaid;
- Determining the qualifying ADLs and the level of assistance required for each ADL task;
- Issuing notification letters to beneficiaries and PCS providers that inform them of the determination of need for PCS;
- Conducting provider training sessions and publishing educational resources in order to advise providers about the PCS program and its processes;
- Providing customer assistance through a customer support center for any inquiries regarding PCS;
- Maintaining a website which beneficiaries, physicians, providers, and other referral sources can access important announcements, educational materials, and PCS forms.

PCS Independent Assessment Completion Process Overview

The PCS independent assessment completion process executed by NCLIFTSS is complex and takes approximately 3-4 weeks to complete for each beneficiary requesting an independent assessment to be considered for PCS. Though complex, the process can be broken down into 6 main steps as follows:

1. **PCS Request** – The beneficiary's primary care or attending physician completes the DHB-3051 Request for Independent Assessment for Personal Care Services Form and sends it to NCLIFTSS for processing.
2. **Scheduling the Assessment** – Once a request is processed, a Scheduling Coordinator contacts the beneficiary or facility for those residing in an ACH and schedule a date for an Assessor to go to the beneficiary's home or facility to complete the independent assessment.
3. **Performing the Assessment** – On the scheduled appointment day, the Assessor goes to the beneficiary's home or facility and completes an assessment to determine if the beneficiary is eligible for PCS.
4. **Provider Selection and Acceptance** – At the conclusion of the assessment, the beneficiary is provided a randomized list of providers to select their provider of choice for services if approved for PCS.
5. **Assessment Review** – After the assessment is complete and uploaded into QiRePort, if applicable, the designated reviewer reviews the assessment. After the review is completed, and based on the assessment outcome, the assessment results are released to either the provider (outcome of hours being awarded) or the beneficiary (notification of denial).
6. **Provider Acceptance and Notification** – If it is determined the beneficiary is eligible for PCS, A request for service form is sent to the selected provider. The provider accepts or rejects the beneficiary's request. Once the provider accepts the beneficiary for care and completes a service plan, a formal notification is sent to the beneficiary and to the provider and PCS services may begin.

Assessment Process Diagram:



Chapter 1: Personal Care Service Provider Requirements

1.1 General Requirements

The information in this section references Clinical Coverage Policy 3L and 3L-1 Sections 6.0 and 7.0

To receive PCS referrals and to submit billing claims for services, providers must:

1. Meet Medicaid qualifications for participation;
2. Have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
3. Bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Providers must not bill for Medicaid PCS services provided by an individual with any of the following convictions on the criminal background check conducted in accordance with 6.0 of Clinical Coverage Policy 3L and 3L-1:

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

To be eligible to bill for procedures, products, and services related to the Clinical Coverage Policy 3L and 3L-1 policy, providers must be:

- ✓ A home care agency licensed by the North Carolina Division of Health Services Regulation (DHSR) to operate in the county or counties where the PCS Services are being provided;
- ✓ A residential facility licensed by the DHSR as an adult care home as defined in G.S. 131D-2, or a combination home as defined in G.S. 131E-101(1a); or
- ✓ A residential facility licensed under Chapter 122C of the General Statutes and defined under 10A NCAC 27G as a supervised living facility for two or more adults whose primary diagnosis is mental illness, a developmental disability, or substance use disorder.

  NOTE: Refer to Clinical Coverage Policy 3L and 3L-1 for complete listing of requirements.

1.2 Agency Staffing Requirements

In addition to the following requirements listed in Section 1.1, providers are also responsible for complying with all staffing requirements outlined by their respective North Carolina licensing entity and the North Carolina Board of Nursing at www.ncbon.com.

1.3 Registered Nurses (RNs)

PCS home care agencies must employ a qualified RN with a valid North Carolina license, who is responsible for the following:

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

NC Medicaid does not require special PCS certification training for RNs. However, providers must maintain compliance requirements outlined in the North Carolina Home Care Licensure Rules (10A NCAC 13J.1003) and by the North Carolina Board of Nursing at www.ncbon.com.

1.4 Supervision of PCS Aides

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

1. Supervising and ensuring that all services provided by the Aides under their supervision are conducted in accordance with Clinical Coverage Policy 3L, other applicable federal and state statutes, rules, regulations, policies and guidelines, and the provider agency's policies and procedures;
2. Supervision of the Provider Organization's CQI program;
3. Completion and approval of all service plans for assigned beneficiaries;
4. Implementing the service plan;
5. Maintaining complaint logs and service records in accordance with state requirements.

1.5 Supervisory Visits in Beneficiary Private Residences

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

1. Confirm the In-Home Aide is present and has been present as scheduled during the preceding 90 days;
2. Validate that the information recorded on the aide's service log accurately reflects his or her attendance and the services provided;
3. Evaluate the In-Home Aide's performance;
4. Identify any changes in the beneficiary's condition and need for PCS that may require a change of status review;
5. Identify and document any new health or safety risks that may be present in the home
6. Evaluate the beneficiary's satisfaction with services provided by the In-Home Aide and any services performed by the home care agency;
7. Review and validate the in-home aide's service records to ensure that:
    a. Documentation of services provided is accurate and complete;
    b. Services listed in the service plan have been implemented;
    c. Service plan deviations are documented;
    d. Services, dates, and times of services provided are documented on a daily basis;
    e. Separate logs are maintained for all beneficiaries;
    f. All occasions when the beneficiary was not available to receive services or refused

services for any reason are documented in the service record, including the reason the beneficiary was not available or refused services; and

g. On a weekly basis, the In-Home Aide and the beneficiary sign logs;

8. Document all components of the supervisory visits to include the date, arrival and departure time, purpose of visit, discoveries, and supervisor's signature.

1.6 Supervisory Visits in Residential Settings

The Residential PCS Provider must ensure a qualified professional conducts a supervisor visit to each beneficiary in accordance with 10 A NCAC 13F and 13G and 10A NCAC 27G. The Residential PCS provider must assure appropriate aide supervision by a qualified professional in accordance with 10A NCAC 13F and 13G, and 10A NCAC 27G.

1.7 PCS Aides

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

Additionally, Providers must not bill for Medicaid PCS services provided by an individual with any of the following convictions on the criminal background check conducted in accordance with 7.10(d.1) of the Clinical Coverage Policy 3L and 3L-1:

1. Felonies related to manufacture, distribution, prescription or dispensing of a controlled substance
2. Felony health care fraud;
3. Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd, or 3rd degree), fraud or theft against a minor or vulnerable adult;
4. Felony or misdemeanor patient abuse;
5. Felony or misdemeanor involving cruelty or torture;
6. Misdemeanor healthcare fraud;
7. Misdemeanor for abuse, neglect, or exploitation listed with the NC Health Care Registry; or
8. Any substantiated allegation listed with the NC Health Care Registry that would prohibit an individual from working in the healthcare field in the state of NC.

All In-Home and Residential Aides must meet the qualifications contained in the applicable North Carolina Home Care, Adult Care Home, Family Care Home, and Mental Health Supervised Living Licensure Rules (10A NCAC 13J, 13F and 13G, and 10A NCAC 27G). An individual file is maintained on all In-Home and Residential Aides that documents aide training, background checks, competency evaluations and provides evidence that the aide is supervised in accordance with the requirements specified in 10A NCAC 13J, 13F and 13G, and 10A NCAC 27G, (Clinical Coverage Policy 3L and 3L-1 Section 7.10).

Additionally, the agency may not assign an aide to provide services to a beneficiary when the aide is related to the beneficiary (legally responsible person, spouse, parents, siblings, grandparents, or other "step- "or "in-law" relationships) or in cases where the person lives with the beneficiary, regardless of relationship to the beneficiary (PCS Policy 3L, Subsection 4.2.2).

1.8 Non-Certified Personal Care Aides

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

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

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

1.9 Staff Development and Training

PCS Clinical Coverage Policy 3L and 3L-1 requires providers to offer an orientation based upon licensure rules for all new hire staff for In-Home and Residential Aides. This orientation should include an overview of the PCS Policy and the North Carolina Home Care Licensure Rules. The agency must also offer ongoing training pertaining to the job responsibilities of each employee as well as the requirements of the Clinical Coverage (PCS) Policy 3L and 3L-1. This includes skill and competency training for all personal care aides. The agency must keep records of all training activities and staff orientation sessions conducted. Competency training and evaluations of the required competencies for In-Home and Residential Aides must provide competency training and evaluations as specified in 10A NCAC 13F and 13G, and 10A NCAC 27G.

The agency administrator should be informed of regional training programs, conference calls and webinars which pertain to the PCS programs. These trainings may be offered by NC Medicaid, or its designee. Information regarding training sessions is published on the NC Medicaid Personal Care Services webpage (https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care/personal-care-services) and in the monthly Medicaid Bulletin. Information regarding training sessions sponsored by NCLIFTSS is available on their webpage NCLIFTSS | PCS under 'Training.' All staff members who have management responsibilities should plan to attend these regional training programs to ensure the agency is compliant with all rules and procedures.

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

Training for Additional Safeguards

In accordance with N.C. Session Law 2013-306; Caregivers who provide services to beneficiaries receiving additional safeguards require training in caring for individuals who have degenerative disease, characterized by irreversible memory dysfunction, which attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.

Providers must attest to the training of their caregiver staff to provide services by submitting the NC Medicaid-3085, Session Law (SL) 2013-306 PCS Training Attestation Form.

See Appendix A for the link to this form or visit: **https://medicaid.ncdhhs.gov/session-law-2013-306-pcs-training-attestation-form-nc-medicaid-3085-iapdf**

If providers do not have access to training curriculum that meets the aide training requirements of Session Law 2013-306, providers may use training made available through the NC Division of Health Service Regulation licensure section. The Alzheimer's and Dementia Caregiver Center offers free individual on-line care training in dementia care through the Alzheimer's Association.

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

1.10 Requirements for Aide Documentation

The provider organization accepting the referral to provide services must:

- ✓ Maintain documentation that demonstrates all aide tasks listed in the PCS service plan are performed at the frequency indicated on the service plan and on the days of the week documented in the service plan;
- ✓ Document aide services provided, to include, at minimum, the date of service, care tasks provided, and the aide providing the service; and
- ✓ Document all deviations from the service plan. This documentation must include, at minimum, care tasks not performed, and reason tasks were not performed.

NOTE: The Provider Interface provides an option for documenting aide services and task sheets. If a provider organization elects to use their own aide task worksheets, the worksheets must accurately reflect all aide tasks and schedule documented in the online PCS service plan, task by task.

Electronic Visit Verification

Providers Subject to Electronic Visit Verification (EVV) must comply with the requirements listed below:

a. Comply with Section 12006 1903 (l) of the 21st Century Cures Act and any subsequent amendments;
b. Register with the State's EVV solution or procure an alternate EVV solution. If provider selects alternate solution, the solution must be compliant with the 21st Century Cures Act and all state requirements;
c. Have written documentation they have informed beneficiaries of the EVV requirement in each beneficiary's file;
d. Ensure staff are trained on the use of the EVV system selected and maintain written documentation of initial and at least annual staff training in each employee's file.

Effective January 1, 2021, Providers are required to use an EVV solution to capture in-home aide visits through mobile application, telephony, or fixed visit verification devices. EVV visit verification validation components required by the 21st Century Cures act are listed below:

a. Type of service performed;
b. Individual receiving the service;
c. Date of the Service;
d. Location of Service delivery;
e. Individual providing the service; and
f. Time the service begins and ends.

1.11 PCS Online Service Plan

Providers must develop an online PCS service plan through the Provider Interface. The following requirements for the online PCS service plan must apply.

1. All NCLIFTSS referrals are transmitted to provider organizations through the Provider Interface. No mailed or faxed referrals are provided;
2. The provider organization accepting NCLIFTSS referral to provide PCS services must review NCLIFTSS independent assessment results for the beneficiary being referred and develop a PCS service plan responsive to the beneficiary's specific needs documented in NCLIFTSS assessment;
3. Provider organizations must designate staff they determine appropriate to complete and submit the service plan via the Provider Interface;
4. Each NCLIFTSS referral and assessment requires a new PCS service plan developed by the provider organization that is based on NCLIFTSS assessment results associated with the referral;
5. The service plan must address each unmet ADL, IADL, special assistance or delegated medical monitoring task need identified in the independent assessment, taking into account other pertinent information available to the provider;
6. The provider organization must ensure the PCS service need frequencies documented in the independent assessment are reflected accurately in the PCS service plan schedule as well as any special scheduling provisions such as weekend days documented in the assessment;
7. The provider organization must ensure that the beneficiary or their legally responsible person understands and, to the fullest extent possible, participates in the development of the PCS service plan;
8. Once the provider organization completes the service plan, the service plan must be validated by the Provider Interface for consistency with NCLIFTSS assessment, and related requirements for the service plan content;

   NOTE: For EPSDT beneficiaries, the provider organization must complete the service plan based on the NC Medicaid nurse review of the assessment and documents provided in accordance with Clinical Coverage Policy 3L and 3L-1, subsection 5.2.3.

9. The PCS service plan must be developed and validated within seven (7) business days of the Provider accepting receiving NCLIFTSS referral;
10. The provider organization must obtain written consent in the form of the signature of the beneficiary or their legally responsible person within 14 business days of the validated service plan. The written consent of the service plan must be printed out and uploaded into the Provider Interface;
11. The provider must make a copy of the validated service plan available to the beneficiary or their legally responsible person within three (3) business of a verbal request;
12. The PCS service plan is not a plan of care as defined by the applicable state licensure requirements that govern the operation of the provider organizations. Provider organizations are expected to complete a separate plan of care in accordance with licensure requirements as specified in 10ANCAC 13J, 10A NCAC 13F and 13G, and 10A NCAC 27G;
13. Provider organizations may enter PCS service plan revisions in the Provider Interface at any time if the changes do not alter the aide tasks or need frequencies identified in the corresponding NCLIFTSS assessment;
14. Provider organizations may continue to request a Change of Status review, as described in Subsection 5.4.6b, by NCLIFTSS if there has been a significant change that affects the beneficiary's need for PCS since the last assessment and service plan. Any Change of Status reassessment requires a new PCS service plan documented in QiRePort;
15. Provider organizations are reimbursed only for PCS authorized hours and services specified and scheduled in the validated PCS service plan;

16. Prior approval for PCS hours or units is not granted until the on-line PCS service plan is entered into and validated by the Provider Interface;
    NOTE: If an agency fails to complete their service plan timely and/or the beneficiary is discharged, changes providers, or becomes deceased, NC Medicaid will not authorize retro PAs for the beneficiary as PAs are not released until the service plan has been completed and beneficiary/legal guardian consent is required for service plan approval.

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

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

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

- Complete their own assessment to determine task and frequency need and reflect those needs in their manual service plan;
- The service plan must reflect service for the total hours approved;
- Use a template of their choice to create a manual service plan; and
- The manual service plan must be uploaded to 'Supporting Docs' within 7 business days of acceptance.

NOTE: Anytime a service plan must be completed outside of the system, a call is warranted to NCLIFTSS to process the assessment so PAs can be generated.

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

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

NOTE: In the two scenarios above, NCLIFTSS contacts the PCS Provider and gives them 1 day to complete the service plan before removal. Removal of the service plan results in non-compliance to the service plan requirement and subject the PCS Provider to a Program Integrity audit.

1.12 Referral Screening Verification Process (RSVP)

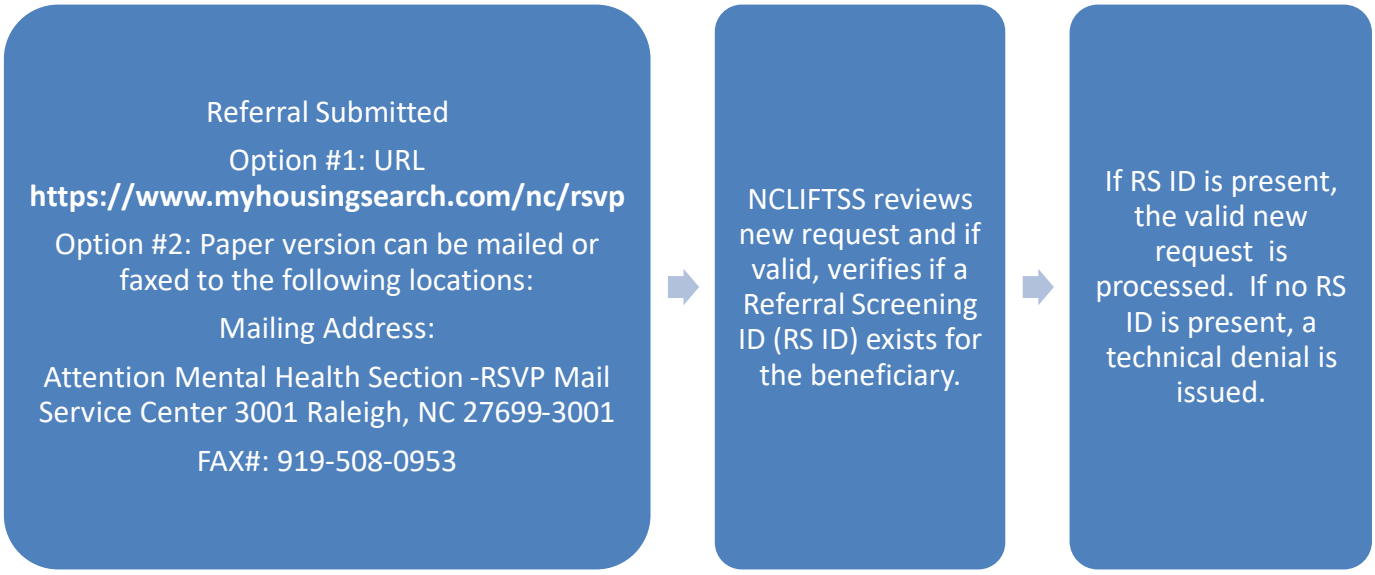
The Referral Screening Verification Process (RSVP) is a review of any individual who is being considered for admission into a Medicaid Certified Adult Care Home. As required by the US Department of Justice Settlement Agreement effective November 1, 2018, individuals requesting admission to Adult Care Homes (ACH) must be pre-screened for serious mental illness (SMI).

Clinical Coverage Policy 3L-1, Subsection 3.2.3 (b) requires that any Medicaid beneficiary who is referred to or seeking admission to Adult Care Homes licensed under NC General Statute (G.S.) 131D-2.4 and requesting PCS be screened for serious mental illness must comply with the Referral Screening Verification Process (RSVP). Providers must contact email - TCLD.Support@dhhs.nc.gov to verify whether a referral has already been submitted ID #.

Referral Screening ID Verification Process

NCLIFTSS verifies a Referral Screening has been submitted on every new ACH PCS request. Verification is confirmed through the emphasys system. If unable to verify a Referral Screening ID (RS ID) through the emphasys system, NCLIFTSS calls the facility to obtain a RS ID. If a RS ID is not required, NCLIFTSS requests the admission date (if prior to 1/1/13) through a copy of an FL2 or any other documentation that reflects the admission date or have the facility confirm they are a 5600a or 5600c.

If unable to obtain a RS ID within 3 business days of the PCS request, NCLIFTSS sends a letter of denial for PCS to the beneficiary. If the beneficiary still wishes to be considered for PCS, they may submit a new request after they have obtained a RS ID.



NOTE: Beneficiaries who reside in a 5600a or 5600c facility do no not require an RS ID. Beneficiaries who have a previous ACH PASRR prior to 11/1/18 for an ACH and enter a medical or psychiatric hospital, an acute or sub-acute rehabilitation facility, or a long-term acute care hospital for medical or psychiatric treatment, and return to the ACH after treatment, do not need an additional screen through the RSVP unless there has been a significant change in psychiatric or medical status (for those with SMI/SPMI). Beneficiaries who requested to transfer from one ACH to another AND already have an ACH PASRR prior to 11/1/18 can transfer if they are medically and psychiatrically stable without a RS ID.

To learn more about RSVP requirements, visit https://www.ncdhhs.gov/about/department-initiatives/transitions-community-living-initiative.

Prior Approval (PA) Effective Dates and RSVP

If a RS ID is effective on the date the PCS request is received or prior, PAs are effective the date the request is received. If the RS ID is received within 3 days from the request received date, then the PAs become effective the date the RS ID became effective; please see the following table for further detail:

Request	Completed?	Date NCLIFTSS Receives Request	RS ID Date on/before Received Date	PA Effective Date
12/01/2021	Yes	12/02/2018	Yes	Date NCLIFTSS RECEIVES the Request
Example		Sent on 12/02/2021	RS ID Date 11/25/2021	12/02/2021
12/01/2021	Yes	12/02/2021	No	Date RS ID became effective
Example		Sent on 12/02/2021	RS ID Date 12/05/2021	12/05/2021
NOTE: RS ID must be received within 3 days of Request Received or Request will not be processed.				

1.13 Change of Ownership

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

New PCS Beneficiaries

NCLIFTSS cannot issue prior approvals for new PCS beneficiaries who have selected a provider not enrolled in NC Tracks. Although NC Medicaid Provider Enrollment considers specific requests for retroactive effective dates of enrollment, providers are not guaranteed a retroactive effective date and are strongly encouraged to provide services only after they are enrolled as an NC Medicaid and/or NC Health Choice (NCHC) provider.

The provider should seek to enroll their NPI in NC Tracks as soon as possible. NC Medicaid does not retroactively authorize PCS for new beneficiaries. PCS authorization may begin when the provider is active in NC Tracks and a completed DHB-3051 Request for Independent Assessment Form is received by NCLIFTSS.

Providers should check their status of enrollment daily through NC Tracks. As soon as the provider is active, they should contact NCLIFTSS.

Current PCS Beneficiaries

When an agency takes over ownership of an existing agency and there are beneficiaries currently receiving PCS by the previous provider, the new owner needs to submit a Change of Provider Request (see Chapter 2 of this
Manual) within 30 days of the effective date of ownership change. Once a Change of Provider Request is

received, NCLIFTSS processes the request and starts the PAs to coincide with the effective date of changed ownership. If a Change of Provider Request is submitted after 30 days of the new ownership, NCLIFTSS processed the request, and the PAs are effective the date the request is received.

Submission of the DHB-3051 Request for Independent Assessment Form does not guarantee a commitment to award or authorize PCS. Each issue is reviewed on a case-by-case basis.

For questions regarding your application to become enrolled in NC Tracks or manage change requests submitted, contact NC Tracks at 800-688-6694 or by email at NCTracksprovider@nctracks.com. If directed to contact NC Medicaid, contact NC Medicaid Provider Enrollment at 919-855-4050.

1.14 Internal Quality Improvement Program

All PCS providers must have an established Internal Quality Improvement Program. The Quality Improvement Program should measure quality of care, service problems, and beneficiary satisfaction. The PCS provider must attest to an established Internal Quality Improvement Program annually (Section 7.7 of Clinical Coverage Policy 3L and 3L-1). A NC Medicaid-3136 Internal Quality Improvement Program Attestation Form must be completed by December 31st of each year and sent to NC Medicaid. When completing the 3136 forms, the provider must attest they have implemented and are in compliance with the following:

a. Develop, and update at least quarterly, an organizational Quality Improvement Plan or set of quality improvement policies and procedures that describe the PCS CQI program and activities;
b. Implement an organizational CQI Program designed to identify and correct quality of care and quality of service problems;
c. Conduct at least annually a written beneficiary PCS satisfaction survey for beneficiaries and their legally responsible person; and
d. Maintain complete records of all CQI activities and results.

Completed forms are required to be uploaded to QiRePort. For questions, contact 919-855-4360 or send an email to PCS_Program_Questions@dhhs.nc.gov.

See Appendix A for the link to this form or visit: **https://medicaid.ncdhhs.gov/quality-improvement-attestation-form-nc-medicaid-3136**

1.15 QiRePort - Provider Interface Overview

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

The provider portal can be accessed at: www.qireport.net and allows registered agencies to:

- Access electronic copies of independent assessment documents, referrals, and notification letters;
- Receive service referrals and accept/reject them electronically;
- Create required PCS beneficiary service plans;
- Manage servicing beneficiaries' accounts, including access to historical assessments and PAs;
- Submit discharges;
- Submit Change of Status: Non-Medical Requests;
- Manage servicing territories;
- Change provider billing numbers for clients who need to have their service transferred from one provider office to another within the same agency;

- Update/Correct Modifiers;
- Receive electronic notification once a current client has entered an appeal, as well as the status of the appeal once it is resolved; and
- Receive electronic notification of upcoming annual assessments for beneficiaries.

Portal Registration

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

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

Usage Requirements

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

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

Privacy Requirements

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

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

Portal Navigation and Usage

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

Chapter 2: Request for Independent Assessment for PCS

Beneficiaries requesting PCS must have their physician submit a DHB-3051Request for Independent Assessment for Personal Care Services Form to NCLIFTSS. The DHB-3051 form allows a beneficiary to be considered for:

- ✓ Approval for PCS;
- ✓ Change of Status: Medical or Change of Status: Non-Medical (increase or decrease of services or new primary private residence);
- ✓ Additional Safeguards;
- ✓ Change of Service Provider;
- ✓ Expedited Requests for PCS.

A link to the DHB-3051 form can be found in Appendix A of this manual or by visiting https://medicaid.ncdhhs.gov/request-services-and-instructions-dhb-3051/download?attachment Once completed, the DHB-3051 form can be submitted to NCLIFTSS via fax at 833-521-2626. Forms may also be sent via mail to 2000 Centregreen Way, Suite 220, Cary, NC 27513.

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

2.1 New Request for Independent Assessment for PCS

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

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

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

2.1.1 Completing a New Request

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

- **REQUEST TYPE:**

- Select New Request ;
- Date of Request;

- **Section A, Beneficiary Demographics** – Required fields are as follows:
  - Beneficiary's Name – as it appears on the Medicaid card;
  - Medicaid ID – Only those with active, full Medicaid are eligible for PCS; eligibility status is verified prior to the processing of any request for an independent assessment;
  - RS ID number (beneficiaries who reside in an Adult Care Home setting only);
  - Demographic Information - Beneficiary name, date of birth, contact information;
  - Indication if the beneficiary has an active Adult Protective Services Case;
  - Indicate where the beneficiary currently resides Note: Those being discharged from the hospital, a Skilled Nursing Facility, or part of the Transition to Community Living Initiative will be expedited.

- **Section B, Beneficiary's Conditions that Result in Need for Assistance with ADLs** – Required Identify the current medical diagnoses related to the beneficiary's need for assistance with qualifying Activities of Daily Living (bathing, dressing, mobility, toileting, and eating). List both the diagnosis and the COMPLETE ICD-10 Code.
  - Medical diagnosis with corresponding complete current ICD-10 diagnosis code for each diagnosis;
  - Indication if the diagnosis listed impacts the beneficiary's ability to perform their ADLs - Diagnoses must impact ADLs or the request for an independent assessment is not processed (Clinical Coverage Policy 3L and 3L-1 Subsection 5.4.2);
  - Date of Onset;
  - Based on clinical judgement, indicate ADL limitation expected duration;
  - Check if the beneficiary is medically stable;
  - Check if 24-hour caregiver availability is required.

Optional Attestation – If the criteria listed in this section is applicable to the beneficiary, the practitioner initials each line item that applies for consideration in the assessment for PCS.

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

- **Section C, Practitioner Information** – Required fields are as follows:
  - Attesting Practitioner's Name and Practitioner NPI;
  - Select one of the Practitioner Types;
  - Practice Information – Practice Name, NPI#;
  - Practice Contact Information;
  - Practitioner Attestation for Medical Need – Signature, Credentials and Date – Must be signed by a MD, NP, or PA. If credentials are not included or cannot be verified, the request is not processed;
  - Date of Last Visit to Referring Practitioner – The beneficiary must have seen their PCP within the last 90 days from the date NCLIFTSS receives the completed form to be eligible for PCS.

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

2.1.2 Expedited Request for PCS

Effective January 2014, NC Medicaid approved an expedited assessment process to provisionally approve beneficiaries for Medicaid PCS. The PCS expedited process determines beneficiary provisional eligibility and the authorized service level pending the completion of the full independent assessment

conducted by NCLIFTSS Assessors.

To be considered for an expedited assessment, a beneficiary must meet the following criteria:

- ✓ Be medically stable;
- ✓ Be eligible for full Medicaid or pending full Medicaid eligibility;
- ✓ Have a Referral Screening ID number on file;
- ✓ In the process of either:
  - Being discharged from hospitalization following a qualifying stay;
  - Being under the supervision of Adult Protective Services (APS);
  - Seeking placement after discharge from a skilled nursing facility; or
  - Be an individual served through the Transition to Community Living Initiative.

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

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

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

Expedited Assessment Completion Process

If eligibility requirements are met, a hospital discharge planner, skilled nursing facility discharge planner, Adult Protective Services (APS) worker, or LME-MCO Transition Coordinator may request an Expedited Assessment by faxing a completed Request for Independent Assessment for PCS DHB-3051 form (see Subsection 2.1.1 of this Manual for complete criteria) to NCLIFTSS at 833-551-2602 followed by a call to NCLIFTSS at 919-568-1717 or 833-522-5429 (toll free).

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

Once the fax is submitted, the requestor contacts NCLIFTSS Customer Service Center to follow up on the expedited request that was faxed. The Customer Service Team Member reviews and immediately approves or denies the expedited assessment based on eligibility requirements only.
If approved to move forward:

1. The caller is transferred to a Request Processor who processes the request;
2. Once processed, the Request Processor transfers the call to an NCLIFTSS nurse who conducts a brief telephone assessment comprised of fifteen questions directly related to the 5 ADLs;
3. If eligible for PCS based off the telephone assessment, the beneficiary is immediately awarded temporary hours for PCS services and a letter sent to the selected PCS Provider;
4. If a PCS Provider is not identified, NCLIFTSS provides a randomized list of providers for selection by the beneficiary and then sends a request for service to the selected provider;
5. Following the expedited process, NCLIFTSS contacts the beneficiary within 14 business days to schedule and complete a face-to-face independent assessment in the beneficiary's place of residence.

PCS Provisional Approval

A beneficiary approved through the expedited assessment process may receive up to 60 hours of services during the provisional period, not to exceed a 60-calendar day period. Beneficiaries will not receive PCS authorization without active Medicaid eligibility. If a beneficiary is provisionally approved for PCS through the expedited assessment process, but is determined not to be Medicaid eligible, NCLIFTSS holds the authorization for up to 60 calendar days. If after 60 days Medicaid eligibility is not approved, the

beneficiary receives a technical denial for PCS.

The PCS fast-track assessment process pre-authorizes up to 80 billable PCS hours for a Medicaid beneficiary to reduce revenue gaps experienced by the facility from admission to the date of the completed assessment. All qualifying conditions for a new referral or a change in status shall be met before the fast-track hours are awarded. The PCS hours are adjusted to the assessed needs upon the completion of the face-to-face assessment. The face-to-face assessment must be completed within three to five months of the pre-authorized hours. (*5.4.4 of policy 3L-1*)

2.1.3 Incomplete New Requests and Denials

If the request form is missing any of the required information listed in Subsection 2.1.1 of this Manual, NCLIFTSS faxes an "Unable to Process" notice to the referring entity to alert them that the request form is incomplete and missing required information. If a response is not received from the referring entity within two business days, NCLIFTSS files the form as incomplete. A denial notification is sent to the beneficiary and a copy is faxed to the practitioner.

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

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

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

2.2 Change of Status (COS) Requests

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

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

2.2.1 Completing a Change of Status: Medical Request

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

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

REQUEST TYPE:

- Select Change of Status: Medical;
- Date of Request;

Section A, Beneficiary Demographics – Required fields are as follows:

- Beneficiary's Name – as it appears on the Medicaid card;
- Medicaid ID – Only those with active, full Medicaid are eligible for PCS; eligibility status is verified prior to the processing of any request for an independent assessment ;
- RS ID number (beneficiaries who reside in an Adult Care Home setting only);
- Demographic Information - Beneficiary name, date of birth, contact information;
- Indication if the beneficiary has an active Adult Protective Services Case;
- Indicate where the beneficiary currently resides Note: Those being discharged from the hospital, a Skilled Nursing Facility, or part of the Transition to Community Living Initiative will be expedited.

Section B, Beneficiary's Conditions that Result in Need for Assistance with ADLs – Required fields are as follows:

- Medical diagnosis with corresponding complete current ICD-10 diagnosis code;
- Indication if the diagnosis listed impacts the beneficiary's ability to perform their ADLs. Diagnoses must impact ADLs or the request for an independent assessment are not processed (Clinical Coverage Policy 3L and 3L-1 Subsection 5.4.2);
- Date of Onset;
- Indicate expected duration of ADL limitation;
- Check if the beneficiary is medically stable;
- Check if 24-hour caregiver availability is required.

Optional Attestation – If the criteria listed in this section is applicable to the beneficiary, the Practitioner should hand initial each line item that applies for consideration in the assessment for PCS.

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

Section C, Practitioner Information – Required fields are as follows:

- Attesting Practitioner's Name and Practitioner NPI;
- Select one of the Practitioner Types;
- Practice Information – Practice Name, NPI# ;
- Practice Contact Information;
- Practitioner Attestation for Medical Need – Signature, Credentials and Date – Must be signed by a MD, NP, or PA. If credentials are not included or cannot be verified, the request is not processed;

- Date of Last Visit to Referring Practitioner – The beneficiary must have seen their PCP within the last 90 days from the date NCLIFTSS receives the completed form to be eligible for PCS.

Section D, Change of Status: Medical - The requesting practitioner must complete this section providing a detailed description of the:

- Specific change in medical condition; and
- Impact the change has on the beneficiary's ability to perform their ADLs.

2.2.2 Completing a Change of Status: Non-Medical Request

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

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

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

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

2.2.3 Incomplete Change of Status Requests and Denials

Change of Status request forms with missing information or are completed on the wrong form are not processed; this results in a delay of the independent assessment scheduling.

If the beneficiary's physician or the provider agency has submitted a Change of Status request form that is missing information required for processing, NCLIFTSS faxes an "Unable to Process" notice to the individual who submitted the request. If requested information is not provided in two business days, NCLIFTSS files the request as incomplete.

If the Change of Status request form is missing a description of the change in the client's condition and/or proper documentation of the need for a reassessment, NCLIFTSS issues a notice of denial that is sent to the beneficiary. If the provider submitted the request using the Provider Interface of QiRePort, a "Rejected" status appears on the "Requests Submitted" page. If the Provider clicks the hyperlink, the PCS request rejection reason can be viewed.

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

2.2.4 Disenrollment

When a beneficiary is disenrolling from a managed care plan and returning to Medicaid Direct, complete to following sections and fax to NCLIFTSS. Prior to the disenrollment date.

- **REQUEST TYPE:**
  - Select Managed Care Disenrollment;
  - Date of Request.

- **Section A, Beneficiary Demographics** – Required fields are as follows:
  - Beneficiary's Name – as it appears on the Medicaid card;
  - Medicaid ID – Only those with active, full Medicaid are eligible for PCS; eligibility status is verified prior to the processing of any request for an independent assessment;
  - RS ID number (beneficiaries who reside in an Adult Care Home setting only);
  - Demographic Information - Beneficiary name, date of birth, contact information;
  - Indication if the beneficiary has an active Adult Protective Services Case;
  - Indicate where the beneficiary currently resides Note: Those being discharged from the hospital, a Skilled Nursing Facility, or part of the Transition to Community Living Initiative will be expedited.

- **Section E: Managed Care Disenrollment** – Required fields are as follows:
  - Check the health plan name the beneficiary is disenrolling;
  - Enter the effective date of disenrollment;
  - Enter the current PCS hours;
  - Complete the current PCS provider information.

2.3 Requesting Additional Safeguards

A Medicaid beneficiary who meets the eligibility criteria in accordance with Clinical Coverage Policy 3L and 3L-1 Section 3.0 and Section 5.3 may be eligible for up to 50 additional safeguard hours of Medicaid PCS per month if the beneficiary:

- Requires an increased level of supervision (observation resulting in an intervention) as assessed during an independent assessment conducted by State Medicaid Agency or entity designated by State Medicaid Agency;
- Requires caregivers with training or experience in caring for individuals who have a degenerative disease characterized by irreversible memory dysfunction, which attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty learning, and the loss of language skills;
- Regardless of setting, requires a physical environment that addresses safety and safeguards the beneficiary because of the recipient's gradual memory loss, impaired judgment, disorientation, personality change, difficulty learning, and loss of language skill; and
- Medical documentation or verifiable information provided by a caregiver obtained during the independent assessment reflects a history of escalating safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.

To initiate the process for consideration of additional safeguard hours in addition to the base maximum allowance of PCS (80 hours), a beneficiary must have his/her Primary Care Physician or Attending Physician complete the optional attestation portion in Section B (Step 4) of the DHB-3051 form in addition to the required sections depending on type of request. Additional Safeguards may be requested with a New Request or a Change of Status: Medical. It is important for the Primary Care Physician or Attending Physician completing the request to note any pertinent medical diagnoses that may have caused the need for additional safeguards.

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

2.4 Change of Provider (COP) Requests

A PCS beneficiary has the right to change their PCS provider at any time. Only the beneficiary or a caregiver who has Power of Attorney or Legal Guardianship for the beneficiary can submit a Change of Provider request. A COP request may be submitted using the DHB-3051 form or the beneficiary may call the Customer Support Center for NCLIFTSS at 919-568-1717 or 833-522-5429 (toll free).

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

When providers are not able to meet the beneficiary's needs, the provider must:

- Notify the beneficiary and NCLIFTSS when one or more needed and requested services (including assessment) cannot be provided to a specific beneficiary within a time frame requested by the referral source and established by agency policy;
- Provide advance notification of at least 48 hours to the beneficiary or responsible party when service provision is to be reduced or terminated, except in cases where the beneficiary agrees with changes, there is a danger to a beneficiary or staff member, or the physician terminates services; and
- Make a referral to and coordinate with other appropriate agencies when the provider is unable to respond to a request for service promptly, or to continue to provide service.

2.4.1 Completing a Change of Provider Request via Phone

If the beneficiary wishes to change his/her provider, only approved persons may call the Customer Support Center with NCLIFTSS at 919-568-1717 or 833-522-5429 (toll free) to make this request. The caller is asked a series of questions before proceeding with processing the COP request to determine if the COP should be expedited or processed following the standard process. Once the purpose for change is understood, the Customer Support Specialist (CSS) asks about the new provider of choice. If the beneficiary does not have a provider selection, then the CSS generates a randomized provider list and recites the provider options in the order listed to assist with the selection process.

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

2.4.2 Completing a Change of Provider Request via the DHB-3051 Form

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

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

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

- **Beneficiary Demographics** – Required fields are as follows:
    - Date of Request;
    - Medicaid ID – Only those with active Medicaid are eligible for PCS; eligibility status is verified prior to the processing of any PCS request form;
    - Demographic Information - Beneficiary name, date of birth, contact information.

- **Section G, Change of Provider Request –** Required fields are as follows:
    - 'Requested by' indicated, along with name and contact information;
    - Status of PCS Service;
    - Beneficiary's Preferred Provider Section, including:
        - Setting Type;
        - Agency Name, Address, and Phone;
        - PCS Provider NPI#;
        - Facility License # and Date if applicable.

Once completed, the beneficiary or facility may fax the completed form to 833-521-2626 or mail it to NCLIFTSS 2000 CentreGreen Way, Suite 220, Cary, NC 27513.

2.4.3 Processing the Completed Change of Provider and Provider Acceptance

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

A new assessment is not required unless a change of status review is required. NCLIFTSS furnishes the new provider with a copy of the assessment and the new service authorization. The new PCS Provider develops and implements a service plan within 7 business days of accepting the referral (Clinical Coverage Policy 3L, Subsection 5.4.11).

Expedited Processing vs. Standard Processing

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

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

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

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

Change of Provider vs. New Requests

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

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

2.5 Reconsideration Request for Initial Authorization for PCS

A beneficiary, 21 years of age or older, who receives an initial approval for more than 0, but less than 80 hours per month may submit a Reconsideration Request Form to NCLIFTSS if they do not agree with the initial level of service determined (Clinical Coverage Policy 3L and 3L-1 Section 5.6).

To be considered for a reconsideration assessment, a beneficiary must meet the following criteria:

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

2.5.1 Completing the NC Medicaid-3114 Request for Reconsideration of PCS Authorization Form

In the case where a beneficiary wishes to have their initial approval of hours reconsidered, the beneficiary needs to complete the NC Medicaid-3114 Request for Reconsideration of PCS Authorization Form (see Appendix A for a link to the form and instructions). NCLIFTSS only accepts/processes forms that have been completed with the following required information:

- **Section A: Beneficiary Demographics** – Required fields are as follows:
  - Beneficiary Name (first and last);
  - Date of Birth;
  - Medicaid ID;
  - Contact Information.

- **Section B: Reconsideration –** Required fields are as follows:
  - The ADL(s) indicated that are not being supported by the current authorized hours; or
  - A brief description of why the beneficiary is requesting reconsideration.

- **Section C: Supporting Documentation –** Supporting documentation is required for processing of a reconsideration request.

- **Medicaid Beneficiary or Legal Guardian/POA signature**

  Once completed, the beneficiary may fax the completed form to 833-521-2626 or mail it to NCLIFTSS 2000 CentreGreen Way, Suite 220, Cary, NC 27513.

NOTE: Incomplete, illegible, or requests submitted without supporting documentation as indicated above, are not processed. A reconsideration request is not considered complete without supporting documentation as indicated in PCS Clinical Coverage Policy 3L and 3L-1 Section 5.6 (c and d).

2.5.2 The Reconsideration Process

a. After receiving an initial approval for an amount of hours more than 0, but less than 80 hours per month, a beneficiary must wait 30 calendar days from the date of notification to submit a Request for Reconsideration of PCS Authorization (NC Medicaid-3114);
b. The beneficiary must submit a Request for Reconsideration form, along with supporting documentation, to increase hours above the initial approval no earlier than 31 calendar days and no later than 60 calendar days from the date of the initial approval notification;
c. Upon receipt of a completed 3114 Form for additional hours, a nurse reviews the request and determines if a reassessment is required or if the previous assessment should be modified;
d. If a reassessment is required, the beneficiary receives a call from NCLIFTSS within 7 business days to schedule. If the nurse determines the previous assessment needs to be modified, modification will be executed within 3 business days;
e. If the reconsideration determines a need for additional PCS hours, additional hours are authorized under Clinical Coverage Policy 3L, *State Plan Personal Care Services (PCS)*. This constitutes an approval, and the beneficiary will receive this approval letter with no adverse notice or appeal rights provided;
f. If the reconsideration determines that the PCS hours authorized during the initial assessment are sufficient to meet the beneficiary's needs, an adverse decision is sent to the beneficiary with appeal rights.

Note: The above process does not apply to beneficiaries seeking the additional safeguard hours as documented in Subsection 5.3.1.b of Clinical Coverage Policy 3L and 3L-1 (see Appendix A for a link to the full policy).

2.6 Short-Term Increase Request for PCS (EPSDT)

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

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

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

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

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

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

All requests are to be submitted to NC Medicaid via fax at 919-715-0102. Requestors may contact NC Medicaid EPSDT nurse consultants with questions at 919-855-4360.

Chapter 3: Independent Assessment

In accordance with Clinical Coverage Policy 3L and 3L-1 Subsection 5.4.2, once ordered by the beneficiary's physician, the PCS assessment is performed by an NCLIFTSS Assessor at the beneficiary's primary private residence or residential facility. The requirements for the PCS Eligibility Assessment are as follows (Clinical Coverage Policy 3L and 3L-1, Subsection 5.4.3):

- ✓ All PCS assessments to determine beneficiary eligibility and authorized service level are conducted by NCLIFTSS Assessors using a standardized process and assessment tool provided or approved by NC Medicaid;
- ✓ Independent Assessors perform all PCS assessments;
- ✓ All assessments are conducted face to face in the beneficiary's home or residential facility;
- ✓ As directed by NC Medicaid assessments/reassessments may be conducted telephonically (5.4.3 of 3L-1);
- ✓ In-home assessments include an assessment of the beneficiary's home environment to identify any health or safety risks to the beneficiary or to the PCS aides who provide the services. Assessments in residential facilities shall include verification of a valid facility license.

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

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

Admission Assessment

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

Annual Assessment

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

Expedited Assessment

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

Change of Status: Medical or Change of Status: Non-Medical Assessment

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

ROM - Assessment as a Result of a Mediation or Appeal

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

Turning 21 Assessment

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

NOTE: PAs approved under EPSDT will end on the 21st birthday. A lapse in service will occur if a new DHB-3051 is received AFTER the 21st birthday and PAs will not be made retroactive to cover the lapsed period. To prevent a lapse in service, the beneficiary should submit a new DHB-3051 Form to the CIAE 30 days PRIOR to their 21st birthday.

Reconsideration Reassessment

A beneficiary, 21 years of age or older, who receives an initial approval for more than 0, but less than 80 hours per month may submit a Request for Reconsideration of PCS Authorization (NC Medicaid-3114) form to NCLIFTSS if they do not agree with the initial level of service determined. If the 'Reconsideration Request Review Nurse' determines a reassessment is required to determine level of need, then a reconsideration reassessment is scheduled.

3.1 The Assessment Scheduling Process

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

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

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

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

NOTE: If a beneficiary is not available for their assessment within 30 days of the indicated due date, the beneficiary may be issued a technical denial with appeal rights and denied PCS. Should that occur, the beneficiary will be required to submit a new Request for Independent Assessment (DHB-3051) to restart the process.

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

3.1.1 Cancellations and Reschedules

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

NOTE: A beneficiary may reschedule any given assessment up to three times. After the third reschedule, the beneficiary may be issued a technical denial with appeal rights and denied PCS. Should that occur, the beneficiary will be required to submit a new Request for Independent Assessment (DHB-3051) to restart the process.

3.1.2 No-Shows

If a beneficiary is unavailable for their scheduled assessment or a “no-show,” then the Independent Assessor leaves a door hanger informing the beneficiary of the missed visit and directing them to call NCLIFTSS to reschedule. If a call is not received, NCLIFTSS follows up with the beneficiary to reschedule. If contact is not successful, a technical denial with appeal rights is issued for PCS.

NOTE: A “no show” is defined as any appointment that is not cancelled/rescheduled prior to the Assessor showing up to the appointment location on the scheduled date and time. The Independent Assessor remains at the home or facility for 15 minutes after the scheduled appointment time in hopes that the beneficiary arrives and is able to participate in the assessment. If a beneficiary is a no-show twice, a technical denial with appeal rights is issued for PCS. If they wish to still be considered for PCS, the beneficiary will be required to submit a new Request for Independent Assessment (DHB-3051) to restart the process.

3.2 Conducting the Independent Assessment

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

On the day of the scheduled appointment and before conducting the assessment, the Independent Assessor reviews the ‘Medicaid PCS Beneficiary Participation Guide’ with the beneficiary. This form outlines the rights the beneficiary has regarding the independent assessment and their responsibility to

fully participate in completing the assessment (see Appendix A for a link to the complete form). Following the review of the participation guide, the beneficiary is asked to sign a consent form that gives the Assessor permission to conduct the independent assessment.

The beneficiary can expect the assessment to take between 60 - 90 minutes. The Assessor asks questions about various daily activities and the beneficiary's ability to perform these activities. The Assessor requires the beneficiary to demonstrate these activities to determine level of ability.

NOTE: The beneficiary is not required to undress, bathe, or toilet. The Assessor asks them to demonstrate or simulate these tasks fully clothed.

In detail and in accordance with Clinical Coverage Policy 3L and 3L-1 Subsection 5.4.9, during the Assessment, the Assessor evaluates and documents the following factors for each qualifying ADL:

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

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

3.3 The Independent Assessment Tool

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

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

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

a. Outlining tasks for each of the qualifying ADLs;
b. The medical diagnosis or diagnoses causing the need for PCS;
c. Any exacerbating medical symptoms or conditions that may affect the ability of the beneficiary to perform the ADLs; and
d. A rating of the beneficiary's overall self-performance capacity for each ADL, as summarized in the following table:

Beneficiary's Self-Performance Rating	Description
0 – Totally able	Beneficiary is able to self-perform 100% of activity, with or without aids or assistive devices, and without supervision or assistance setting up supplies and the environment
1 – Needs verbal cueing or supervision only	Beneficiary is able to self-perform 100% of the activity, with or without aids or assistive devices, and requires supervision, monitoring, or assistance retrieving or setting up supplies or equipment

Beneficiary's Self-Performance Rating	Description
2 – Can do with limited hands-on assistance	Beneficiary is able to self-perform more than 50% of the activity and requires hands-on assistance to complete remainder of activity
3 – Can do with extensive hands-on assistance	Beneficiary is able to self-perform less than 50% of the activity and requires hands-on assistance to complete remainder of activity
4 – Cannot do at all (full dependence)	Beneficiary is unable to perform any of the activity and is totally dependent on another individual to perform all of the activity

The Assessor enters the level of assistance needed for each demonstrated task into the assessment tool. A standard amount of time is then indicated for each day that ADL assistance is needed. The authorized monthly time is calculated automatically once the completed assessment is uploaded.

The total hours authorized are based on the ADLs with which the beneficiary requires assistance, the amount of assistance needed and the number of days per week PCS is needed. No time is authorized for ADL tasks that the beneficiary performs independently or for tasks for which the beneficiary requires only verbal cueing and supervision, or already has assistance. For more information on the assessment design and service level determinations, please see Appendix A in Clinical Coverage Policy 3L and 3L-1.

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

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

4.1 Provider Selection

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

1. Present the beneficiary with a randomized list of licensed, eligible PCS providers in the beneficiary's county;
2. Inquire if the beneficiary has any preferred PCS provider(s), which may include the current provider, if they so choose;
3. If the beneficiary does not have a preferred PCS provider(s), then the Assessor would direct the beneficiary to the presented randomized provider list to select;
4. If unable to select a preferred PCS provider at the time of the assessment, the Assessor will make a note in the call/visit log requesting that a random provider list be mailed to the beneficiary. This will generate a notice to the call center and the list will be mailed out. At minimum at least 3 follow up call attempts will be made over the next 30 days from NCLIFTSS call center representatives in an effort to obtain a provider choice;
5. If unable to make a provider selection within 30 days, the PCS request will be removed and a new request will need to be resubmitted if the beneficiary still wishes to be considered for PCS.

If the beneficiary qualifies for the PCS Program and a provider choice was made, NCLIFTSS sends the referral to the beneficiary's first choice service provider. If the provider declines or does not respond to the referral within 2 business days, NCLIFTSS calls the first-choice provider to inform them they have been sent a referral and response is needed. If NCLIFTSS is not able to successfully contact the first choice PCS provider within 5 business days or they do not respond to the referral, NCLIFTSS rejects the referral on behalf of the provider and sends the referral to the beneficiary's second choice of provider and if necessary, to the beneficiary's third choice of provider. For cases when the beneficiary offers only one choice of provider and this provider does not respond to the referral or declines it, NCLIFTSS contacts the beneficiary by telephone to request another provider choice. If unable to contact the beneficiary, NCLIFTSS sends a letter to the beneficiary requesting they make a new provider selection. If a new provider selection is not made within 30 days, then the request is removed, and a new request would be required if the beneficiary wished to still be considered for PCS.

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

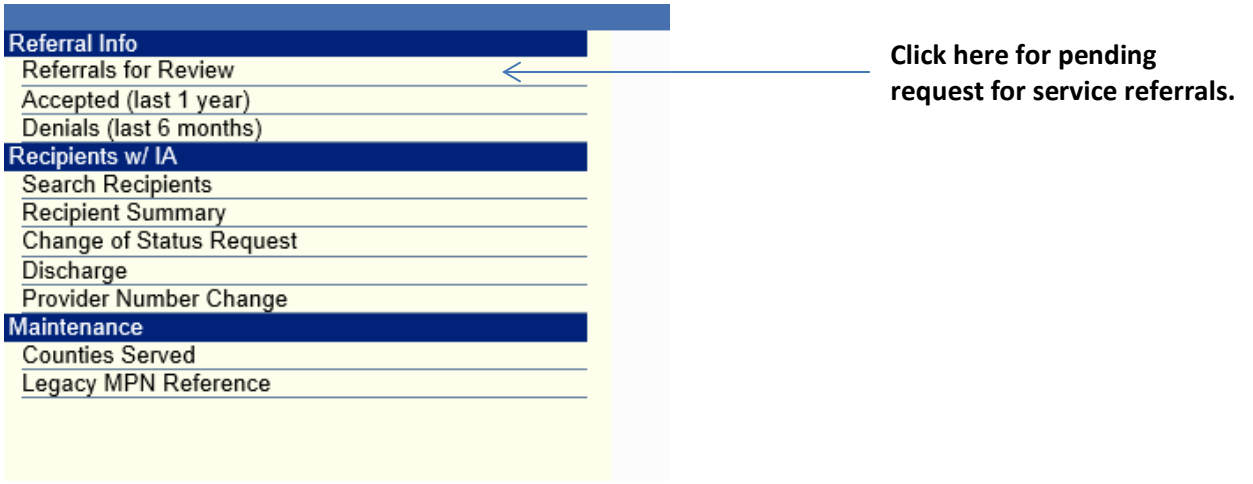
4.2 Responding to a Referral

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

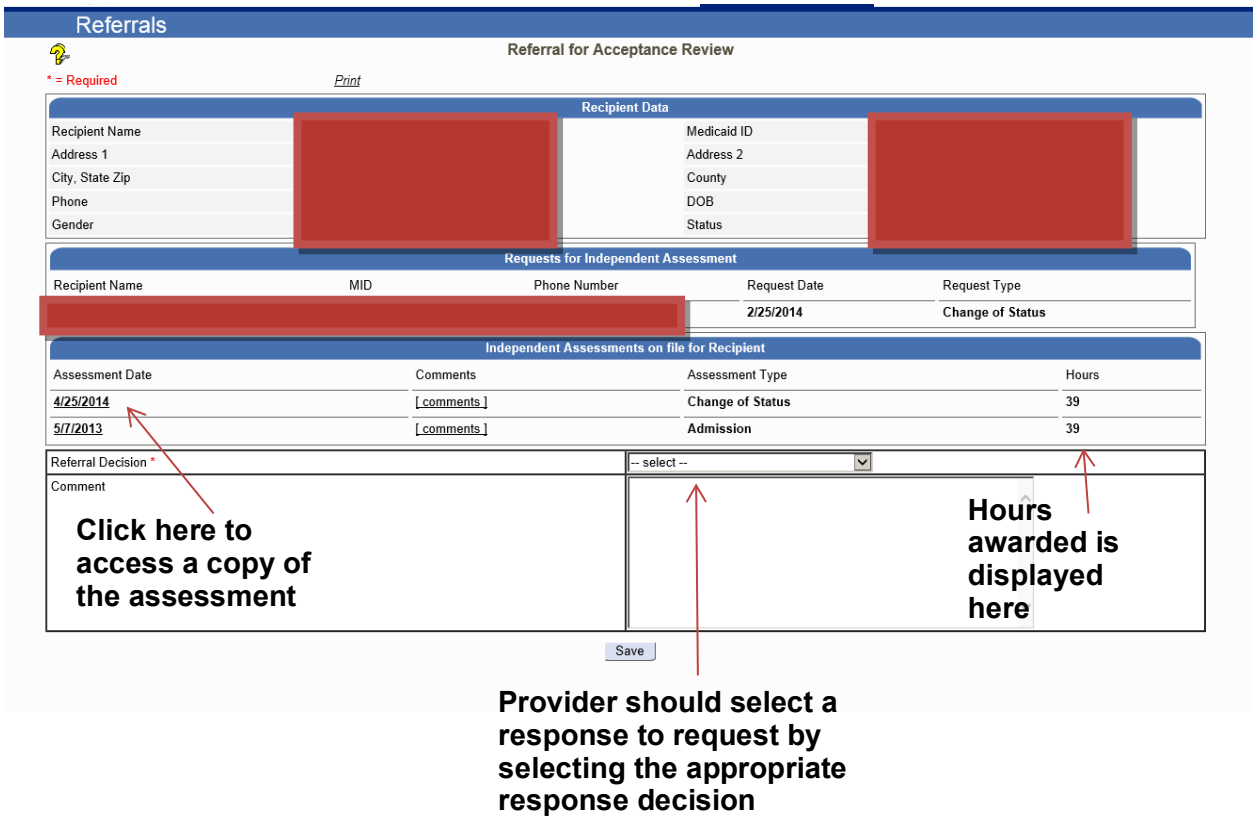
NOTE: The referral notice is not an authorization to begin services for the beneficiary. Providers should always refer to the decision notice to determine the effective date of the service authorization.

Responding to a Referral through QiRePort

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



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



NOTE: Providers are expected to accept/reject referrals within 2 business days. If the PAs end for a beneficiary and the PCS Provider does not accept within 2 business days of the referral, NC Medicaid will not authorize retro pay for the lapsed period.

4.3 Referral and Decision Notices

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

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

An "adverse decision notice" indicates a reduction in the service authorization or a denial of services. If a beneficiary chooses to contest Medicaid's decision, the adverse decision notice also contains instructions for the appeal process. The beneficiary's copy of this notice contains a Request for Hearing Form, which the beneficiary must complete to begin the appeal process (see Chapter 5 of this Manual for more information on the appeal process). The Request for Hearing Form is not included in the provider's copy of the notice. NCLIFTSS sends adverse decision notices to beneficiaries by regular USPS mail that is trackable but does not require a signature. This enables NC Medicaid and NCLIFTSS to verify that the beneficiary received the notice.

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

- **Notice of Decision on Initial Request for Medicaid Services:** This notice may indicate an

approval or a denial of services and is issued to beneficiaries who received an independent assessment following a new referral for PCS services. It is also issued to beneficiaries who could not be reached to schedule an assessment or who missed two scheduled assessment appointments following a new referral. If the notice indicates a denial in services, it specifies the reason for the denial. The beneficiary's copy includes instructions for filing an appeal and the Request for Hearing Form.

- **Notice of Change in Services**: This notice is issued to beneficiaries who were previously receiving PCS services and who are authorized for a reduced number of hours based on the most recent independent assessment. The beneficiary's copy includes instructions for filing an appeal and the Request for Hearing Form.
- **Notice of Decision on a Continuing Request for Medicaid Services**: This notice is issued to beneficiaries who are approved for continued services following a reassessment.
- **Notice of Denial in Services: This** notice is issued to beneficiaries who were previously receiving PCS services and have now been determined not to qualify for PCS based on the most recent independent assessment. It is also issued to beneficiaries for whom a continuing request for services is denied for any of the following reasons, but not limited to:

    - The beneficiary missed two scheduled independent assessment appointments;
    - The beneficiary rescheduled their appointment for an assessment more than 3 times;
    - The beneficiary was unavailable for an assessment 30+ days from the indicated due date;
    - NCLIFTSS was unable to contact the beneficiary for independent assessment scheduling;
    - The Change of Status request submitted for the beneficiary was denied because it was missing a description of the change in the client's condition and/or documentation of the need for a reassessment, or because the described change in the client's condition did not warrant a reassessment. This letter serves as notice that the requested reassessment is denied; however, authorization at the current service level will continue; or
    - The beneficiary account in NC Tracks now reflects as PCS ineligible due to the Medicaid status or that they are receiving duplicative services making them ineligible for PCS.

Chapter 5: The Appeal Process

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

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

The following is sent to the beneficiary only:

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

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

5.1 Steps in the Appeal Process

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

1. The beneficiary completes the Medicaid Services Beneficiary Hearing Request Form, the last page of the decision notice;
   Note: Only the beneficiary or his/her legal guardian can make the decision to appeal. Providers may assist the beneficiary by mailing or faxing the completed form to the Office of Administrative Hearings (OAH).
2. The beneficiary calls or sends the completed forms by mail or fax to OAH at the number or address on the Medicaid Services Beneficiary Hearing Request Form;
   a. The appeal must be filed within 10 calendar days of the date of the notice, to avoid an interruption in service for a continuing request for service;
   b. If the beneficiary files an appeal on day 11 through day 30 from the date of the notice, services will be reinstated the date the appeal is filed (received by OAH);
   c. If the beneficiary appeals after day 30, maintenance of service does not apply;
   d. The beneficiary may represent themself in the appeal process, ask a family member or friend to speak for him/her, assign another spokesperson, or obtain an attorney to provide representation. On the appeal form, the beneficiary may designate a representative and provide contact information for the representative;
3. If the beneficiary needs a quick decision because their life, health, or ability to attain, maintain or regain maximum function is in danger, an "expedited" State Fair Hearing can be requested.
   a. The beneficiary can request an expedited State Fair Hearing by mail, by fax or by making a phone call to OAH using the contact information provided on the Medicaid Services Beneficiary Hearing Request Form included on the Notice;
   b. When the beneficiary requests an expedited appeal, they must give information to show why an expedited hearing is needed;
      i. This information must be from an appropriately licensed medical professional and be new information not included in the original service request;
   c. If the request is approved, the expedited State Fair Hearing occurs as quickly as possible after OAH receives the case file. The administrative law judge uses all reports and updates available at the time of the State Fair Hearing;
   d. If the expedited State Fair Hearing request is denied, the beneficiary still has a State Fair

Hearing and decided in the standard timeline;

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

5.2 Mediation

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

In addition to the beneficiary, the mediation session includes:

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

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

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

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

Judge. If the beneficiary declines to participate in mediation, the mediator will report this outcome to OAH, and the case will proceed to hearing.

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

5.3 Court Hearing and Final Agency Decision

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

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

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

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

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

5.4 Superior Court Judicial Review

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

5.5 Maintenance of Service (MOS)

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

To qualify for Maintenance of Service, the beneficiary must:

1. Have been receiving services at the time of the adverse decision. A beneficiary who receives a denial following a new referral to the PCS Program is not eligible for MOS;

2. Be eligible for the type of Medicaid that covers PCS services. If the beneficiary has a lapse in Medicaid eligibility, he or she cannot receive MOS until Medicaid eligibility is restored.

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

Here are examples of these two scenarios:

No Lapse in Service:

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

Lapse in Service:

A beneficiary who was authorized for 70 hours of service per month from the previous independent assessment receives a Notice of Denial in services. The notice is dated February 16 (the same date it was mailed) and is effective on February 27. The beneficiary mails the Request for Hearing Form to OAH, and it is received on March 2 (more than 10 days after the notice was mailed). Medicaid will authorize MOS for 70 hours (the previous service level) for this beneficiary effective March 2.

Since the Request for Hearing Form was received after the effective date of the denial, but before 30 days, the service authorization will be interrupted from February 27 – March 1. Although this beneficiary's appeal was submitted in a timely manner, the denial went into effect before the MOS authorization.

5.6 Change of Provider Requests During the Appeal Process

If a beneficiary wishes to change providers while the appeal is pending, the MOS authorization is transferred to the new provider. The new provider will not receive a copy of this assessment since the beneficiary is contesting the most recent independent assessment. In this case, the provider agency RN should write the plan of care for the authorized MOS hours based on a discussion with the beneficiary about his or her need for assistance.

The provider continues to base the beneficiary's care on this plan of care until NCLIFTSS notifies the provider the appeal has been resolved. At that point, the provider needs to revise the plan of care based on awarded hours or discharge the client as appropriate.

Chapter 6: Billing

General Dynamics Information Technology (GDIT) is the current designated contractor responsible for the processing of all Medicaid claims, which includes claims for PCS. NC Tracks is the Medicaid billing system used by GDIT to receive and process all claims. NCLIFTSS issues prior approval for services based on the independent assessment results, and QiRePort transmits the authorization to NC Tracks to authorize payment of eligible PCS provider claims.

6.1 Prior Approval

Once an eligible beneficiary is awarded hours under the PCS program (following an assessment or a settlement through the appeals process), a 'Prior Approval' (PA) is issued. The PA reflects the total PCS hours awarded per month. In accordance with Clinical Coverage Policy 3L and 3L-1 Subsection 5.2.2, to be approved for PCS payment, the beneficiary:

- ✓ Obtains a Physician Referral, and attestation, when applicable;
- ✓ Obtains a Referral Screening ID if seeking admission to, or residing in, an adult care home licensed under G.S.131D-2.4;
- ✓ Receives an independent assessment from NCLIFTSS;
- ✓ Meets minimum program admission requirements;
- ✓ Obtains a service authorization for a specified number of PCS hours per month; and
- ✓ Obtains an approved service plan from the provider.

EPSDT Additional Requirements for PCS

Medicaid may authorize services that exceed the PCS service limitations if determined to be medically necessary under EPSDT based on the following documents submitted by the provider before PCS is rendered:

- ✓ Work and school verification for the beneficiary's caregiver, legal guardian, or power of attorney. PCS may not cover all time requested by caregiver for work and school that exceed full-time hours;
- ✓ Verification from the Exceptional Children's program per county if PCS is being requested in school setting;
- ✓ Health record documentation from the beneficiary's physician, therapist, or other licensed practitioner;
- ✓ Physician documentation of primary caregiver's limitation that would prevent the caregiver from caring for the beneficiary; and/or
- ✓ Any other independent records that address ADL abilities and need for PCS.

NOTE: If additional information does not validate the assessment, PCS hours may be reduced, denied, or terminated based on additional records.

Prior Approval Effective Dates

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

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

If a beneficiary requesting admission to an Adult Care Home, Licensed under G.S. 131D-2.4, has not complied with Referral Screening Verification Process (RSVP), retroactive prior approval does not apply. PCS authorization is effective the date beneficiary receives their RS ID.

Example 1:

Request Date:	08/01/2022
NCLIFTSS Received Date:	08/26/2022
Effective Date	08/01/2022

Example 2:

Request Date:	08/01/2022
NCLIFTSS Received Date:	09/12/2022
Effective Date	09/12/2022

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

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

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

NOTE: Providers are expected to accept/reject referrals within 2 business days. If the PAs end for a beneficiary and the PCS Provider does not accept within 2 business days of the referral, NC Medicaid will not authorize retroactive pay for the lapsed time.

6.2 Reimbursement

IHC Reimbursement

To receive reimbursement for PCS, the beneficiary must have full Medicaid, which provides reimbursement for PCS. It is the responsibility of the servicing PCS provider to verify each Medicaid beneficiary's eligibility every time service is rendered (Clinical Coverage Policy 3L and 3L-1 Section 2.1 (b)).
NOTE: A beneficiary may have been approved for PCS and a prior approval awarded, but if their Medicaid is not active, does not provide coverage for PCS, or they have since been enrolled in another state program that cannot be administered in conjunction with PCS, reimbursement will be denied. Providers must verify each Medicaid beneficiary's eligibility each time a service is rendered.
For those with active Medicaid, visit Personal Care Services (PCS) Fee Schedule | NC Medicaid (ncdhhs.gov) to find the current reimbursements rates.

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

Billing Codes and Modifiers

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

Procedure Code	Modifier	Program Description
99509	HA	Personal Care Services, Private Residences, Beneficiaries Under 21 Years
99509	HB	Personal Care Services, Private Residences, Beneficiaries 21 Years and Older

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

A. Claim Type
Professional (CMS-1500/837P transaction)

B. International Classification of Diseases, Ninth Revisions, Clinical Modification (ICD-10-CM) Codes
Provider(s) must report the ICD-10-CM diagnosis code(s) to the highest level of specificity that supports medical necessity. Provider(s) must use the current ICD-10-CM edition and any subsequent editions in effect at the time of service. Provider(s) must refer to the applicable edition for code description as it is no longer documented in the policy. **Effective October 1, 2015,** the provider must use ICD-10 code sets for reporting.

C. Code(s)
Provider(s) selects the most specific billing code that accurately and completely describes the procedure, product, or service(s) provided. In cases where the beneficiary has multiple ICD-10 (diagnosis) codes listed on the referral and/or independent assessment, the provider should submit billing using the code that is most relevant to the beneficiary's need for ADL assistance from an in-home aide. Provider(s)

use(s) the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), ICD-10-CM diagnosis codes, and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) refer to the applicable edition for the code description as it is no longer documented in the policy.

ACH Reimbursement

Attachment A: Claims-Related Information

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

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

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

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

CPT Code(s)
99509

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

Providers	Modifier(s)
Adult Care Homes	HC
Combination Homes	TT
Special Care Units	SC
Family Care Homes	HQ
Supervised living Facilities for adults with MI/SA	HH
Supervised living Facilities for adults with I/DD	HI

E. Billing Units

Daily Rate

F. Place of Service

PCS is provided in the beneficiary's congregate facility licensed by the State of North Carolina as an Adult Care Home, a family care home, a combination home, or a supervised living facility for adults with intellectual disabilities, developmental disabilities, or mental illness.

G. Co-payments

For Medicaid refer to Medicaid State Plan:

https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

H. Reimbursement

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

6.3 Denied Claims

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

1. Did I complete a service plan for the most current assessment for the beneficiary? (Verify in QiRePort.) **NOTE:** PAs will not be made retro if a service plan is not completed timely and/or the beneficiary is discharged or becomes deceased prior to completion of the service plan if outside of the 7-day allotted period to complete the service plan;
2. Does the beneficiary have active Medicaid? (Verify through NC Tracks.);
3. Does the beneficiary have an active PA? (Verify through NC Tracks.);
4. Does the modifier on the PA match the modifier assigned in NC Tracks? (Verify through the QiRePort Provider Portal.);
5. Have I already billed for all approved hours this month? (Verify in NC Tracks.);
6. Am I billing within the approved effective dates? (Verify in NC Tracks.)

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

Chapter 7: Internal Quality Improvement Program

In accordance with Clinical Coverage Policy 3L and 3L-1, Section 7.7, Internal Quality Improvement Program. Providers serving beneficiaries receiving PCS are required to complete and adhere to an organizational Quality Improvement Plan or set of quality improvement policies and procedures.

What is Quality Improvement?
"Quality improvement (QI) is a systematic, formal approach to the analysis of practice performance and efforts to improve performance." – *American Academy of Family Physicians*

Understanding and properly implementing QI is essential to a well-functioning agency or facility and is necessary for any agency or facility interested in improving efficiency, beneficiary safety and satisfaction, and clinical outcomes.

7.1 Establishing a Quality Improvement Program

Here are 6 steps to help kick start any Quality Improvement Program:

1. **Establish a culture of quality in your agency or facility.** The organization, processes, and procedures should support and be integrated with QI efforts. The culture of an agency, attitudes, behaviors, and actions, reflect how passionately the team embraces quality. The QI culture looks different for every agency/facility, but may include establishing dedicated QI teams, holding regular QI meetings, or creating policies around QI goals;

2. **Determine and prioritize potential areas for improvement.** Identify and understand the ways the agency/facility could improve. Examine the client population (e.g., to identify barriers to care or groups of high-risk patients) and the agency/facility operations (e.g., to identify management issues such as low morale or poor communication);

3. **Collect and analyze data.** Data collection and analysis lie at the heart of quality improvement. Data will help the organization understand how well the systems work, identify potential areas for improvement, set measurable goals, and monitor the effectiveness of change. It is important to collect baseline data before beginning a QI project, commit to regular data collection, carefully analyze results throughout the project, and make decisions based on analysis;

4. **Communicate your results.** Quality improvement efforts should be transparent to staff, physicians, and beneficiaries. Communicate project needs, priorities, actions, and results to everyone (beneficiaries included). When a project is successful, celebrate and acknowledge that success;

5. **Commit to ongoing evaluation.** Quality improvement is an ongoing process. A high-functioning agency/facility strives to continually improve performance, revisit the effectiveness of interventions, and regularly solicit beneficiary and staff feedback;

6. **Spread your successes.** Share lessons learned with others to support wide-scale, rapid improvement that benefits all beneficiaries and the health care industry.

   Source: American Academy of Family Physicians,
   Basics of Quality Improvement (aafp.org)

Quality Improvement Models and Tools

Quality improvement models present a systematic, formal framework for establishing QI processes in your agency/facility. Examples of common QI models include the following:

- ✓ **Model for Improvement, Plan-Do-Study-Act:**
  - **Plan -** Develop the QI plan as related to the organization's priorities, mission, goals, population served, services provided and customer needs. Always consider external or regulatory requirements.
  - **Do -** Implement the plan as a defined map or guide for the organization-wide Quality Program. Document identified problems and unexpected events observed.
  - **Study –** Ask questions such as:
    - Did we do what we said we were going to do? Why or why not?
    - What are the results?
    - How can we improve?
    - What is working really well?
    - What needs to be modified?
  - **Act -** Act on what was learned:
    - Revise the plan as needed;
    - Monitor the plan on a regular and defined basis;
    - Determine if the plan was successful at meeting or exceeding your expectations;
    - Address the items that need improvement;
    - Communicate results; and
    - Evaluate or update quarterly.

NOTE: Per Clinical Coverage Policy 3L and 3L-1 7.7(a), a PCS Provider is required to develop and update, at least quarterly, an organizational quality improvement plan or set of quality improvement policies and procedures that describe the PCS CQI program and activities.

- ✓ **Six Sigma:** a method of improvement that strives to decrease variation and defects.

- ✓ **Lean:** an approach that drives out waste and improves efficiency in work processes so that all work adds value.

Sources:

- American Academy of Family Physicians, Basics of Quality Improvement (aafp.org)
- Institute for Healthcare Improvement, http://www.ihi.org/
- American Society for Quality, https://asq.org/

7.2 Quality Improvement and PCS

In accordance with Clinical Coverage Policy 3L and 3L-1, Section 7.7 (e), PCS Providers must submit by December 31 of each year an attestation that they are in compliance with "a" through "d" of Subsection 7.7. This requirement should be fulfilled by completing the NC Medicaid-3136 Quality Improvement Attestation Form (see Appendix A for a link to this form). When completing the form, the PCS Provider is attesting that they:

a. Develop, and update at least quarterly, an organizational Quality Improvement Plan or set of quality improvement policies and procedures that describe the PCS CQI program and activities;
b. Implement an organizational CQI Program designed to identify and correct the quality of care and quality of service problems;
c. Conduct at least annually a written beneficiary PCS satisfaction survey for beneficiaries and their legally responsible person; and

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

e. Cooperate with and participate fully in all desktop and on-site quality, compliance, prepayment, and post- payment audits that may be conducted by NC Medicaid or a DHHS designated contractor.

7.2.1 Developing an Organizational Quality Improvement Plan

What is a quality improvement plan?

A quality improvement plan is a detailed work plan of an organization's activities of quality improvement. A quality improvement plan should explain how your organization manages, deploys, and reviews quality services. It should be updated regularly and include your organization's quality priorities and how you measure your performance/improvement.

Key Elements for an Effective QI Plan

The plan should describe:
- ✓ The mission, values, goals, and objectives;
- ✓ How the organization selects, manages, and monitors all QI projects;
- ✓ Methodologies used;
- ✓ Communication to staff on the plan, any updates, and results; and
- ✓ Staff training and education.

Common Barriers that Impact an Effective QI Plan

When any of the following are weak within an organization, the effectiveness of its quality improvement plan may be jeopardized:

- ✓ Resources (financial, staff, etc.);
- ✓ Ongoing communication and feedback;
- ✓ Periodic re-evaluation;
- ✓ Staff interest or training;
- ✓ Accountability of the QI Committee;
- ✓ Focus on QI priorities/changes.

7.2.2 Implementing your CQI Plan

Once you have developed your QI plan, you are ready to pick a project and implement your plan.

Picking a QI Project

To identify a project in which to execute the QI plan, outline the following:

1. Determine priorities based on your customers' needs;
2. Determine the sample size;
3. Identify the QI committee and assign roles and responsibilities;
4. Establish process for achieving customer input;
5. Determine key measurement;
6. Evaluate and communicate results.

Ensuring compliance to Clinical Coverage Policy 3L and 3L- 1 should always be on the list of QI projects. There are several requirements outlined in Clinical Coverage Policy 3L and 3L-1 that providers must

adhere to maintain compliance and prevent consequences of violation and/or fail an internal audit. Here are some suggested QI projects that focus on Clinical Coverage Policy compliance:

- ✓ **Required Aide Training** – Define how to ensure aides are compliant in the following areas:
  - Beneficiary Rights
  - Confidentiality and privacy practices
  - Personal care skills, such as assistance with the following ADLs:
    - Bathing;
    - Dressing;
    - Mobility;
    - Toileting;
    - Eating.
  - In-home and Residential Care Aides providing services to beneficiaries receiving hours in accordance with Session Law 2013-306, have training or experience in caring for individuals who have a degenerative disease characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.

    NOTE: Providers must submit an attestation to NC Medicaid that they comply with this requirement. The attestation form (NC Medicaid-3085) and instructions are located on the NC Medicaid PCS webpage and a link is in Appendix A of this Manual.

  - Documentation and reporting of beneficiary accidents and incidents;
  - Recognizing and reporting signs of abuse and neglect; and
  - Infection control.

- ✓ **Documentation of Supervisory Visits -** Documentation of Supervisory visits is audited based on PCS Clinical Coverage Policy 3L, Subsection 7.10 b. (1-9); The in-home PCS provider must ensure that a qualified RN Nurse Supervisor conducts a RN Supervisor visit to each beneficiary's primary private residence location every 90 calendar days (Note: a seven-calendar day grace period is allowed). Two visits within 365 calendar days (from start of service) must be conducted when the in-home aide is scheduled to be in the primary private residence.

  For this project, lay out how the organization ensures the RN Supervisor does the following:

  - Confirm that the in-home aide is present or has been present as scheduled during the preceding 90 calendar days;
  - Validate that the information documented on the aide's service log accurately reflects his or her attendance and the services provided;
  - Evaluate the in-home aide's performance;
  - Identify any changes in the beneficiary's condition and need for PCS that may require a change of status review;
  - Request a change of status review if the beneficiary's service plan exceeds or no longer meets the beneficiary's needs for ADL assistance;
  - Identify any new health or safety risks that may be present in the primary private residence;
  - Evaluate the beneficiary's satisfaction with services provided by the in-home aide and the services performed by the home care agency.
  - Review and validate the in-home aide's service records to ensure that:
    1. Documentation of services provided is accurate and complete;
    2. Services listed in the service plan have been implemented;
    3. Deviations from the service plan are documented;

4. Dates, times of service, and services provided are documented daily;
5. Separate logs are maintained for each beneficiary;
6. All occasions when the beneficiary is not available to receive services or refused; services for any reason are documented in the service record along with the reason the beneficiary was not available or refused services; and
7. Logs are signed by the in-home aide and the beneficiary after services are provided on a weekly basis.

- Document all components of the supervisory visits: the date, arrival and departure time, purpose of visit, findings, and supervisor's signature.

Other sample projects may include:

- ✓ Conducting self-audits, measuring results, improve, and repeat;
- ✓ Analyze your timeliness for conducting discharges;
- ✓ Evaluate if service plans are done and uploaded timely; or
- ✓ Conduct aide competency testing.

7.2.3 Conducting an Annual Survey

Satisfaction surveys are a valuable tool for continued feedback that allow PCS Providers to serve their clients and meet their needs. Surveys are a way to help Providers gain an understanding of their client's expectations and concerns so that service can be improved.

When designing a survey, focus questions on how well the service your agency provides meets your client's needs or how satisfied they are with various aspects of the service offered. The feedback can highlight problems that the organization is not aware of, providing the opportunity to respond and take remedial action.

Sample Questions for a Satisfaction Survey:

- Was a plan of care reviewed and approved by you before starting services?
- Does the aide arrive at his/her scheduled time on the appropriate scheduled days?
- Is the aide polite and professional at all times?
- Does the aide assist with all approved services as indicated in the plan of care?
- Is the agency responsive to your questions and needs?
- How would you rate the customer service provided by our agency?

Per Clinical Coverage Policy 3L, the satisfaction survey must be presented in written form. Here are some suggestions on how to provide a survey in written form:

- Mail a survey to the beneficiary and provide a self-addressed envelope for return;
- Provide the written survey in hand when the aide provides services; or
- Provide the written survey in hand when the nurse conducts their quarterly visits.

7.2.4 Maintaining Complete Records

Keeping good records is particularly important to any business. Whether required or not, good record keeping results in several benefits for the business, some of which are as follows:

- Gives the information needed to run the business and help it grow;
- Helps identify the business's strengths and weaknesses;
- Helps manage the business's changes and improvements;

- Assists in the management and monitoring for compliance of various policies; and
- Allows quick access to records in case of r an NC Medicaid internal audit or an audit by the Office of Compliance/Program Integrity (OCPI).

Business records can be maintained manually or electronically. Make sure the system t used is easy to manage, well organized, and kept up to date, rather than letting the paperwork pile up.

7.3 Completing the 3136 Form

PCS Providers must submit the Internal Quality Improvement Program Attestation Form 3136 to NC Medicaid by December 31st of each year certifying compliance with "a" through "e" of Clinical Coverage Policy 3L and 3L-1, Section 7.7. A link to this form with instructions can be found in Appendix A. To ensure the form is accepted at time of submission, it is important that the form be filled out in its entirety; forms cannot be processed with missing information. When completing the form, PCS Providers should:

- ✓ Indicate which of the general Provider cohort designations fit their organization;
- ✓ Complete all fields of the 'Submitter Information' section, printing clearly;.
- ✓ Review each requirement before initialing each item individually in the area provided;
- ✓ Initial items "a" through "d" to certify compliance with Clinical Coverage Policy 3L and 3L-1, Section 7.7;
- ✓ Complete signature and date.

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

Key Points to Remember:

- The 3136 form is required to be submitted to NC Medicaid by December 31st **EACH** year;
- There is no standard regarding the format of the required CQI documents;
- All documents are not required to be submitted to NC Medicaid, just the NC Medicaid-3136 Form; and
- Providers who are non-compliant with submission of the NC Medicaid-3136 are subject to audit by NC Medicaid and referral to OCPI.

Appendix A: Links to Documents and Resources

- DHB-3051 Request for Independent Assessment for PCS Form:
  - **Link**: https://medicaid.ncdhhs.gov/request-services-and-instructions-dhb-3051/download?attachment
- Medicaid PCS Beneficiary Participation Guide:
  - **Link:** https://ncliftss.acentra.com/wp-content/uploads/sites/2/2024/03/NC-PCS-Beneficiary-Participation-Guide.pdf
- Provider Registration for PCS Agency or Facility Use of QiRePort Form and Instructions:
  - **Link:** https://www.qireport.net
- Clinical Coverage Policy 3L and 3L-1
  - **Link:** 3L, State Plan Personal Care Services (PCS) | NC Medicaid; NC Medicaid: 3L-1
- NC Medicaid-3085 PCS Training Attestation Form and Instructions:
  - **Link: https://medicaid.ncdhhs.gov/session-law-2013-306-pcs-training-attestation-form-nc-medicaid-3085-iapdf**
- NC Medicaid-3136 Internal Quality Improvement Program Attestation Form and Instructions:
  - **Link: https://medicaid.ncdhhs.gov/quality-improvement-attestation-form-nc-medicaid-3136**
- NC Medicaid-3114 Request for Reconsideration of PCS Authorization Form and Instructions:
  - **Link:** https://medicaid.ncdhhs.gov/instructions-request-reconsideration-pcs-authorization-nc-medicaid-3114/download?attachment

Appendix B: Provider Resources and Contact Information

NCLIFTSS Operations Quick Reference Contact List			
Name/Department	**Phone No.**	**Web address**	**Description**
Office of the Administrative Hearings/OAH	984-236-1850 Fax: 984-236-1871		Verify if appeal has been received; Update phone number for appeal during mediation hearing
Attorney General's office/ AG's office	919-814-0203 Fax: 919-715-3100		Status of ROM assessment; Changes that needs to be made when the appeal went to IMPASSE
NC Medicaid/ PCS/EPSDT	919-855-4360	Personal Care Services (PCS) | NC Medicaid (ncdhhs.gov)	Questions about clinical policy and program guidelines for PCS program as well as provide information regarding ongoing EPSDT cases.
NC Medicaid Provider Reimbursement	919-814-0060	Fee Schedules | NC Medicaid (ncdhhs.gov)	Questions regarding PCS rate changes
Program Integrity	800-662-7030 or 877-362-8471	Office of Compliance & Program Integrity (OCPI) | NC Medicaid (ncdhhs.gov)	File complaints regarding: Medicaid Fraud, Waste, and Abuse
CAP/DA	919-855-4340 Fax: 919-715-0052	Community Alternatives Program for Disabled Adults (CAP/DA) | NC Medicaid (ncdhhs.gov)	Community Alternatives Program for Disabled Adults
CAP/C	919-855-4340 Fax: 919-715-0052	Community Alternatives Program for Children (CAP/C) | NC Medicaid (ncdhhs.gov)	Community Alternatives Program for Children
Provider Services	919-855-4050 (Automated System)	NC Medicaid: Provider Information (ncdhhs.gov)	Questions regarding Enrollment Issues, Community Care of NC Carolina Access Questions, Onsite Visits, Fingerprinting
Recipient Services	919-855-4000	Recipients - Recipients (nc.gov)	Recipient Eligibility Policy, Medicaid Covered Services to Recipients, Claims Analysis, General Health Choice, and Medicaid Information
Local DSS Offices	Look up by County	Local DSS Directory | NCDHHS	Beneficiary assistance with Medicaid (includes enrollment and eligibility)
Department of Health and Human Services Customer Service (DHHS) Center	800-662-7030	NC DHHS: North Carolina Department of Health and Human Services	Links callers to information on Medicaid, Health Choice, Resources for Army Veterans, Food Stamps, Medicare, Social Security, Mental Health/SA, Community Health Issues
VieBridge	888-705-0970	QiRePort	Technical Support for QiRePort
NC Medicaid Provider Enrollment	800-688-6696 Fax: 855-710-1965	Provider Enrollment - Provider Enrollment (nc.gov) E-Mail: NCTracksprovider@nctracks.com	NCTracks provider enrollment

NCLIFTSS Operations Quick Reference Contact List			
Name/Department	**Phone No.**	**Web address**	**Description**
NCTracks	800-688-6696 Fax: 800-688-6696	Home of NCTracks - Home of NCTracks	Questions regarding claim denials, how to bill for services, PCS payments
NCTracks Automated Response System	800-723-4337		Medicaid enrollment, eligibility, service limits, check write information, DPH PA status, or coverage information for beneficiaries
NCLIFTSS	833-522-5429 or 919-568-1717 **Fax:** 833-521-2626 **Address:** 2000 CentreGreen Way, Suite 220, Cary, NC 27513	Personal Care Services - North Carolina LIFTSS	NCLIFTSS
DHSR: Acute and Home Care Licensure and Certification	Acute and Home Care Licensure and Certification 919-855-4620 Adult Care: 919-855-3765	Division of Health Service Regulation (ncdhhs.gov)l	Questions regarding home care licensure or certification (facility and agency licensure requirements)
NC Board of Nursing	919-782-3211	Home | North Carolina Board of Nursing (ncbon.com)	For questions or information on NC Nursing qualifications and licensures (RN, CNA, PCS license requirements)
Medicaid Transportation Coordinator	919-855-4000	Medicaid Transportation | NC Medicaid (ncdhhs.gov)	Transportation to Medical appointments
RSVP	Stacey Lee 919-715-2056 or Tamara Smith 919-715-2228	Referral Screening Verification Process (RSVP)	Questions pertaining to the RSVP process
NC Medicaid PASRR Help Desk	888-245-0179 or 919-813-5550 Fax 919-224-1072	Preadmission Screening Resident Review (PASRR) Program Update | NC Medicaid (ncdhhs.gov) PASRR_Support.pdf (ncdhhs.gov)	PASRR related questions
North Carolina Medicaid Uniform Screening Tool (NCMUST)	888-245-0179	NC MUST - Login (ncdhhs.gov)	An automated interface for referring and admitting agencies to communicate and manage PASRR screens in a self-service application.

Appendix C: Commonly Used Acronyms

~~Appendix D: Manual Implementation and History~~

Abbreviation	Description
ADL	Activity of Daily Living
ACH	Adult Care Home
APS	Adult Protective Services
AG	Attorney General
COP	Change of Provider
COS	Change of Status
CMS	Centers for Medicare and Medicaid Services
DHB	Division of Health Benefits
DHHS	Department of Health and Human Services
EVV	Electronic Visit Verification
IA	Independent Assessment
IADL	Instrumental Activities of Daily Living
CIAE	NCLIFTSS
IAE	Independent Assessment Entity
IHC	In-Home Care
NCLIFTSS	Linking Individuals to Long-Term Services and Supports
MID	Medicaid Identification Number
MOS	Maintenance of Service
NR	New Referral
OAH	Office of Administrative Hearings
OCPI	Office of Compliance and Program Integrity
PA	Prior Approval
PASRR	Pre-Admission Screening and Resident Review
PCS	Personal Care Services
PDN	Private Duty Nursing
POA	Power of Attorney
POC	Plan of Care
QiR	QiRePort
RS ID	Referral Screening Identification
RSVP	Referral Screening Verification Process
SNF	Skilled Nursing Facility
SP	Service Plan
TCLI	Transitions to Community Living Initiative
TD	Technical Denial
VB	VieBridge

Original Effective Date: October 2014

History:

Date	Section Revised	Change
May 2015	Provider Manual – Cover Page	"May 2015"
May 2015	Contents Page 2; Chapter 2:	"Request for Independent Assessment for PCS"
May 2015	Contents Page 2; Chapter 2.1	"New Request for Independent Assessment for PCS…"
May 2015	Contents Page 3; Appendix A:	"Request for Independent Assessment for PCS"
May 2015	Contents Page 3; Appendix B:	"Medicaid PCS Beneficiary Participation Guide"
May 2015	Contents Page 3; Appendix F added:	"DMA 3136 Internal Quality Improvement Program Attestation Form"
May 2015	Contents Page 3; Appendix G	"Appendix G: Provider Resources and Contact Information"
May 2015	Page 6; Heading, "Additional general program requirements include:" (last bullet)	"…will not receive PCS without verification of an ACH PASRR number."
May 2015	Page 7; Personal Care Services; first sentence; add'l information at the end	"…tasks and services that needs to occur at minimum, once per week:"
May 2015	Page 7; Personal Care Services; #4; deleted information	"4…causing the functional limitations requiring the PCS"
May 2015	Page 7; Personal Care Services; under EPSDT criteria; #1; add'l information	"1 …and monitoring (precautionary observation) related to qualifying ADLs;"
May 2015	Page 7; Personal Care Services; under EPSDT criteria; #2; add'l information	"2…and coaching related to qualifying ADL's:
May 2015	Page 7; Medication Assistance; first sentence revised	"Medicaid shall cover medication assistance when it is:"
May 2015	Page 7; Medication Assistance; #1 deleted	"1. Directly linked to a documented medical condition or physical or cognitive impairment causing the functional limitations requiring the PCS;"
May 2015	Page 8; "NOTE" revised to read	"A beneficiary may not receive PCS and another substantially equivalent federal or state funded in conjunction with another substantially equivalent Federal or State funded service. Examples of equivalent services include home health aide services and in-home aide services in the Community Alternatives Programs (CAP/Disabled Adults, CAP/Children, CAP/Choice, and CAP Innovations. This restriction also includes any other federal or state funded service that provides hands-on assistance with ADLs."
May 2015	Page 8; under the heading: Medicaid	"8. The PCS is provided by an individual whose primary private residence is the same as the beneficiary's primary residence;"

Date	Section Revised	Change
	does not cover Personal Care Services (PCS) when; #8 revised to read	
May 2015	Page 10; under the heading PCS Independent Assessment Completion Process Overview; first para	"…for each beneficiary who requests an independent assessment to be considered for PCS."
May 2015	Page 10; under the heading PCS Independent Assessment Completion Process Overview; #1 revised to read	1. "1. PCS Request – The beneficiary has their primary care physician or attending physician complete the DMA Form 3051 Request for Independent Assessment for Personal Care Services and send it to LHC-NC for processing.
May 2015	Page 10; under the heading PCS Independent Assessment Completion Process Overview; #6 revised to read	6. Provider Acceptance and Notification – If it is determined that the beneficiary is eligible for personal care services; the selected provider will be sent a request for service form to accept or reject the beneficiary's request. Once the provider accepts the beneficiary for care and completes a service plan, a formal notification is sent to the beneficiary and to the provider and PCS services may begin.
May 2015	Page 11; 1.1 General Requirements; #2, #3 and #4 revised to read	1. Have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; 2. Bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity; and 3. Ensure any individual delivering Medicaid PCS does not have any of the following findings on their background check: a. 1. felonies related to manufacture, distribution, prescription or dispensing of a controlled substance; b. 2. felony health care fraud; c. 3. more than one felony conviction; d. 4. felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd, or 3rd degree), fraud or theft against a minor or vulnerable adult; e. 5. felony or misdemeanor patient abuse; f. 6. felony or misdemeanor involving cruelty or torture; g. 7. misdemeanor healthcare fraud; h. 8. misdemeanor for abuse, neglect, or exploitation listed with the NC Health Care Registry; or i. 9. any substantiated allegation listed with the NC Health Care Registry that would prohibit an individual from working in the healthcare field in the state of NC.
May 2015	Page 12; 1.4 Supervision of PCS Aides; #3 and #4 revised to read	3. Completion and approval of all service plans for assigned beneficiaries; 4. Implementing the service plan;
May 2015	Page 13; 1.5 Supervisory Visits in Beneficiary Private	5…"beneficiary's service plan exceeds and/or no longer meets the beneficiary's needs for ADL assistance."

Date	Section Revised	Change
	Residences; The RN Supervisor shall; #5 revised to read	
May 2015	Page 13; 1.5 Supervisory Visits in Beneficiary Private Residences; The RN Supervisor shall; #8b and #8c revised to read	8a. Services listed in the service plan have been implemented; 8b. Service plan deviations are documented;
May 2015	Page 14; 1.7 PCS Aides; 2nd para added to sentence	…" (legally responsible person, spouse, parents, siblings, grandparents,"
May 2015	Page 15; 1.11 Requirements for Aide Documentation; section revised to read	The provider organization accepting the referral to provide services shall: ✓ Maintain documentation that demonstrates all aide tasks listed in the PCS service plan are performed at the frequency indicted on the service plan and on the days of the week documented in the service plan; ✓ Document aide services provided, to include, at minimum, the date of service, care tasks provided, and the aide providing the service; and ✓ Document all deviations from the service plan; this documentation shall include, at minimum, care tasks not performed, and reason tasks were not performed. ✓ The Provider Interface provides an option for documenting aide services and task sheets. If a provider organization elects to use their own aide task worksheets, the worksheets must accurately reflect all aide tasks and schedule documented in the online PCS service plan, task by task.
May 2015	Page 16 and Page 17; 1.12 PCS; title and section revised to read	1.12 PCS On-line Service Plan 1. All IAE referrals are transmitted to provider organizations through the Provider Interface. No mailed or faxed referrals are provided; 2. b. The provider organization accepting the IAE referral to provide PCS services shall review the IAE independent assessment results for the beneficiary being referred, and develop a PCS service plan responsive to the beneficiary's specific needs documented in the IAE assessment; 3. c. Provider organizations shall designate staff they determine appropriate to complete and submit the service plan via the Provider Interface. 4. d. Each IAE referral and assessment shall require a new PCS service plan developed by the provider organization that is based on the IAE assessment results associated with the referral; 5. e. The service plan must address each unmet ADL, IADL, special assistance or delegated medical monitoring task need identified in the independent assessment, taking into account other pertinent information available to the provider; 6. f. The provider organization shall ensure the PCS service need frequencies documented in the independent assessment are accurately reflected in the PCS service plan schedule as well as any special scheduling provisions such as weekend days documented in the assessment; 7. g. The provider organization shall ensure that the beneficiary or their legally responsible person understands and, to the fullest

Date	Section Revised	Change
		extent possible, participates in the development of the PCS service plan; 8. h. The provider organization shall obtain the written consent of the beneficiary or their legally responsible person to the proposed PCS service plan. The written consent must be reported in the PCS service plan documentation included in the Provider Interface; 9. i. Once the provider organization completes the service plan, the service plan must be validated by the Provider Interface for consistency with the IAE assessment and related requirements for the service plan content; 10. j. The PCS service plan must be developed, validated and agreed to by the beneficiary or their legally responsible person within three (3) business days of receiving the IAE referral or notice of service authorization via the Provider Interface, or by the date requested by the beneficiary, whichever is later; the provider shall make a copy of the validated service plan available to the beneficiary or their legally responsible person within 2 business days of a verbal request; 11. k. The PCS service plan is not a plan of care as defined by the applicable state licensure requirements that govern the operation of the provider organizations. Provider organizations are expected to complete a separate plan of care in accordance to licensure requirements as specified in 10ANCAC 13J, 10A NCAC 13F and 13G, and 10A NCAC 27G. 12. . Provider organizations may enter PCS service plan revisions in the Provider Interface at any time as long as the changes do not alter the aide tasks or need frequencies identified in the corresponding IAE assessment; 13. m. Provider organizations may continue to request a Change of Status Review, as described in Subsection 5.4.6b, by the IAE if there has been a significant change that affects the beneficiary's need for PCS since the last assessment and service plan. Any Change of Status reassessment requires a new PCS service plan documented in QiRePort; 14. n. Provider organizations shall be reimbursed only for PCS authorized hours and services specified and scheduled in the validated PCS service plan; and, 15. o. Prior approval for PCS hours or units is not granted until the on-line PCS service plan is entered into and validated by the Provider Interface.
May 2015	Page 17; 1.13 Section; 2nd para, 2nd sentence; revised to read	Adult Care Home providers licensed under G.S. 131D-2.4 will not receive PCS prior approval to render or bill for PCS without verification of an ACH PASRR number. ACH PASRR numbers are 10 digits followed by any of the following letter codes:
May 2015	Page 18; *added a formatted table* for the Authorization Codes & Corresponding Time Frames/Restrictions	See table.
May 2015	Page 18; PASRR Verification; NOTE revised to read	NOTE: Beneficiaries who reside in a 5600a or 5600c facility do no not require a PASRR. Beneficiaries who have been admitted into an ACH prior to January 1, 2013, regardless of payer source (Private, Medicaid, or pending Medicaid) require no PASRR even if the beneficiary subsequently becomes Medicaid-eligible; however, if there is a change in status or if the

Date	Section Revised	Change
		beneficiary moves to another facility and requires Personal Care Services, a PASRR is required.
May 2015	Page 19; Section number only changed to read	1.14 QiRePort, Provider Interface Overview
May 2015	Page 19; Section 1.14; changes in bulleted items to read	▪ Access electronic copies of independent assessment documents, referrals, and notification letters; ▪ Receive service referrals and accept/reject them electronically; ▪ Create required PCS beneficiary service plans; ▪ Manage servicing beneficiaries' accounts, including access to historical assessments and PA's; ▪ Submit discharges; ▪ Submit Non-Medical Change of Status Requests; ▪ Manage servicing territories; ▪ Change provider billing numbers for clients who need to have their service transferred from one provider office to another within the same agency; ▪ Update/Correct Modifiers; ▪ Receive electronic notification once a current client has entered an appeal, as well as the status of the appeal once it is resolved.
May 2015	Page 21; Chapter 2; Title change to read	Chapter 2: Request for Independent Assessment for Personal Care Services
May 2015	Page 21; Chapter 2; first para; revised to read	Beneficiaries requesting Personal Care Services must submit a Request for an Independent Assessment for PCS 3051 form to IAE. The 3051 form allows a beneficiary to be considered for:
May 2015	Page 21; Chapter 2; √2 revised and √3 deleted	✓ Change of Status Medical/Non-Medical (increase or decrease of services)
May 2015	Page 21; Chapter 2; third para revised to read	Once received, all requests for an independent assessment are reviewed and processed within 2 business days. If a beneficiary, physician, or PCS provider wishes to inquire about the receipt and status of a PCS request, IAE asks they call AFTER the 2 business day processing period.
May 2015	Page 21; 2.1 title changed	2.1 New Request for an Independent Assessment for PCS
May 2015	Page 21; 2.1 Section; NOTE: Sentence two revised to read	NOTE: If a beneficiary is already enrolled in the PCS Program, a new referral should not be requested. A Change of Status Medical/Non-Medical request form should be submitted if a beneficiary requires another independent assessment due to a change in medical condition or functional status.
May 2015	Page 21 and Page 22; Section 2.1 Completing a New Request; first para revised to read	In order for the 3051 request for an independent assessment form to be approved for eligibility and processed timely, all required sections of the form must be completed and legible. Incomplete request forms may result in a delay of processing or denial of the request for an independent assessment. To ensure the 3051 PCS request form is processed timely, the following sections of the referral form must be completed by a physician only:
May 2015	Page 22; Section 2.1.1; Section A and Section B revised to read	√ Section A, Beneficiary Demographics – Required fields are as follows: • Date of Request • Medicaid ID – Only those with active Medicaid are eligible for PCS. Eligibility status is verified prior to the processing of any request for an independent assessment • Demographic Information - Beneficiary name, date of birth, contact information • ACH PASRR number (beneficiaries who reside in an Adult Care Home

Date	Section Revised	Change
		setting only) • Indication if the beneficiary has an active Adult Protective Services Case √ Section B, Beneficiary's Conditions that Result in Need for Assistance with ADLs– Required fields are as follows: • Medical diagnosis with corresponding complete current diagnosis code • Indication if the diagnosis listed impacts the beneficiary's ability to perform their ADLs - Diagnoses must impact ADLs or the request for an independent assessment will not be processed(Clinical Coverage Policy 3L, section 5.4.2) • Date of Onset • Indicate expected duration of ADL limitation • Check if the beneficiary is medically stable • Check if 24-hour caregiver availability is required Optional Attestation – If the criteria listed in this section is applicable to the beneficiary, the Practitioner should hand initial each line item that applies for consideration in the assessment for PCS; typed initials are not accepted.
May 2015	Page 22 and Page 23; Section 2.1.1; NOTE (s) and Section C revised to read	Note: Diagnosis Header Codes will not be accepted. The complete current diagnosis code ex. XXX.X or XXX.XX associated with the identified medical diagnosis must be present. √ Section C, Practitioner Information– Required fields are as follows: • Date of Last Visit to Referring Practitioner– The beneficiary must have seen their PCP within the last 90 days to be eligible for PCS • Attesting Practitioner Name and NPI# • Practice Information – Name, NPI#, and contact phone number • Practitioner Attestation for Medical Need – Signature, Credentials, and Date – Must be signed by a MD, NP, or PA. If credentials are not included or cannot be verified, the request will not be processed. NOTE: A PCS provider may assist a beneficiary in the completion of the 3051 form, but responsibility of submission of the form to IAE rests with the beneficiary and the referring practitioner.
May 2015	Page 23; 2.1.2 Expedited Request for Personal Care Services; √ 3 revised to read	Have an ACH Preadmission Screening and Resident Review (PASRR) number on file*
May 2015	Page 23; 2.1.2 Expedited Request for Personal Care Services; NOTE revised	NOTE: *PASRR is required for beneficiaries seeking admission to an Adult Care Home licensed under G.S. 131 D-2.4.
May 2015	Page 23; 2.1.2 Expedited Request for Personal Care Services; NOTE revised; second bullet	An Adult Protective Services (APS) Worker; or
May 2015	Page 23; "The Expedited Assessment Completion Process" Heading; first para revised	"If eligibility requirements are met, a hospital discharge planner, skilled nursing facility discharge planner or Adult Protective Services (APS) worker may request an Expedited Assessment by faxing a completed Request for an Independent Assessment for PCS 3051 form (see section 2.1.1 for complete criteria) to IAE at 833-521-2626 followed by a call to IAE at 919-568-1717 or 833-522-5429 (toll free)."

Date	Section Revised	Change
May 2015	Page 24; Personal Care Services Provisional Approval; first para; third sentenced to word addition	"If a beneficiary is provisionally approved for PCS through the expedited assessment process, but is determined not to be Medicaid eligible, IAE will hold the authorization for up to 60 calendar days."
May 2015	Page 24; 2.1.3 Incomplete New Requests and Denials; first para revised, and bullets eliminated; revised to read	…" A denial notification will be sent to the beneficiary and a copy is faxed to the practitioner.
May 2015	Page 24; 2.1.3 Incomplete New Requests and Denials; second para; bulleted item added	**Diagnosis does not impact the ADLs**
May 2015	Page 25; first para revised to read	…"or caregiver status that causes the need for assistance to increase or decrease. For any change of status that is due to a change in medical condition, a Change of Status Medical request may be submitted by a practitioner only. For any change in status that is due to a change in the beneficiary's environmental condition, location, or caregiver status, the beneficiary, beneficiary's family, or legally responsible person; residential provider, home care provider; or beneficiary's physician may submit a Change of Status Non-Medical request A Medical and Non-Medical Change of Status request may be submitted anytime by the approved referring entity when appropriate."
May 2015	Page 25; 2.2.1 Completing a Change of Status Request; title change	2.2.1 Completing a Change of Status Medical Request

May 2015	Page 25; 2.2.1 Completing a Change of Status Medical Request; revised	"A Change of Status Medical Request may only be submitted by a practitioner any time a beneficiary has a change in medical condition and their treating practitioner feels an increase or decrease in PCS should be evaluated. In order to submit a Change of Status Medical request, the practitioner must complete the Request for Independent Assessment for PCS form (3051) and fax or mail a copy to IAE.
		The following sections are required fields that should be completed when submitting a COS Medical Request:
		• Section A, Beneficiary Demographics – Required fields are as follows:
		  • Date of Request
		  • Medicaid ID – Only those with active Medicaid are eligible for PCS. Eligibility status is verified prior to the processing of any request for an independent assessment
		  • Demographic Information - Beneficiary name, date of birth, contact information
		  • Indication if the beneficiary has an active Adult Protective Services Case
		• Section B, Beneficiary's Conditions that Result in Need for Assistance with ADLs – Required fields are as follows:

Date	Section Revised	Change
		• Medical diagnosis with corresponding complete current diagnosis code • Indication if the diagnosis listed impacts the beneficiary's ability to perform their ADLs - Diagnoses must impact ADLs or the request for an independent assessment will not be processed(Clinical Policy 3L, section 5.4.2) • Date of Onset • Indicate expected duration of ADL limitation • Check if the beneficiary is medically stable • Check if 24-hour caregiver availability is required Optional Attestation – If the criteria listed in this section is applicable to the beneficiary, the Practitioner should hand initial each line item that applies for consideration in the assessment for PCS; typed initials are not accepted. Note: Diagnosis Header Codes will not be accepted. The complete current diagnosis code ex. XXX.X or XXX.XX associated with the identified medical diagnosis must be present. • Section C, Practitioner Information – Required fields are as follows: • Date of Last Visit to Referring Practitioner– The beneficiary must have seen their PCP within the last 90 days in order to process a COS Medical Request • Attesting Practitioner Name and NPI# • Practice Information – Name, NPI#, and contact phone number • Practitioner Attestation for Medical Need – Signature, Credentials, and Date – Must be signed by a MD, NP, or PA. If credentials are not included or cannot be verified, the request will not be processed. Section D, Change of Status: Medical–The requesting practitioner must complete this section providing a detailed description of the specific change in medical condition and the impact the change has on the beneficiary's ability to perform their ADLs.
May 2015	Page 26 and Page 27; 2.2.2 Completing a Change of Status Non-Medical Request; section revised to read	2.2.2 Completing a Change of Status Non-Medical Request Providers who are registered to use the Provider Interface of QiRePort may complete a Change of Status Non-Medical request and submit the form online through the portal. All other requestors may complete the Request for an Independent Assessment for Personal Care Services (3051) form and fax or mail a copy to IAE. When submitting the 3051 form, the requestor must complete page 3 only, filling out the top demographic section and section E with the required fields being as follows: • Beneficiary Demographics – Required fields are as follows: • Date of Request • Medicaid ID – Only those with active Medicaid are eligible for PCS. Eligibility status is verified prior to the processing of any PCS request form. • Demographic Information - Beneficiary name, date of birth, contact information • Section E, Change of Status: Non-Medical – Required fields are as follows: • Request By along with Requestor Name

Date	Section Revised	Change
		• PCS Provider NPI#, Name, and Phone • Reason for non-medical change requiring a reassessment checked • Non-medical change described in detail and how the change impacts the beneficiary's ability to perform ADLs Note: DMA or its designee retains sole discretion in approving or denying requests to conduct a change of status reassessment. It is important that the description section include documentation of the change in the beneficiary's medical condition, informal caregiver availability, environmental condition that affects the individual's ability to self-perform, the time required to provide the qualifying ADL assistance and the need for reassessment. Change of status assessments are face-to-face assessments that are conducted by the designated IAE.
May 2015	Page 27; 2.2.2; revised #	2.2.3 Incomplete Change of Status Requests and Denials
May 2015	2.3 Change of Provider (COP) Requests; first para revised to read	A PCS beneficiary has the right to change their PCS provider at any time. Only the beneficiary or a caregiver who has Power of Attorney or Legal Guardianship for the beneficiary can submit a Change of Provider request. A COP request may be submitted using the 3051 form or the beneficiary may call the Customer Support Center for IAE at 919-568-1717 or 833-522-5429.
May 2015	Page 28; 2.3.1 Completing a Change of Provider Request via Phone; first sentence, word change	If the beneficiary wishes to change his/her provider, only approved persons may call the Customer Support Center with IAE at 919-568-1717 or 833-522-5429 (toll free) to make this request.

May 2015	Page 28; 2.3.2 Completing a Change of Provider Request via the 3051 Form; revised to read	Though strongly encouraged to call the Customer Support Center for all COP requests, a beneficiary may also submit their Change of Provider request by using the 3051 form.
		NOTE: Only in cases where a beneficiary is moving from one facility to another may the facility submit a Change of Provider request on behalf of the beneficiary.
		
		When submitting the 3051 form, the beneficiary must complete page 3 only, filling out the top demographic section and section F with the required fields being as follows:
		• Beneficiary Demographics – Required fields are as follows:
		  • Date of Request
		  • Medicaid ID – Only those with active Medicaid are eligible for PCS. Eligibility status is verified prior to the processing of any PCS request form.
		  • Demographic Information - Beneficiary name, date of birth, contact information
		• Section F, Change of Provider Request – Required fields are as follows:
		  • 'Requested by' indicated, along with name and contact information
		  • Reason for Provider Change
		  • Beneficiary's Preferred Provider Section, including:
		  ▪ Setting Type
		  ▪ Agency Name, Address, and Phone
		  ▪ PCS Provider NPI#
		  ▪ Facility License # and Date if applicable

May	Page 29; 2.3.3	A new assessment shall not be required unless a change of status has

Date	Section Revised	Change
2015	Processing the Completed Change of Provider and Provider Acceptance; second para revised to read	occurred. The IAE shall furnish the new provider with a copy of the assessment and the new service authorization. The new PCS Provider shall develop and implement a service plan within 3 business days of receiving notice of service authorization or by the date requested by the beneficiary, whichever is later (Clinical Policy 3L, section 5.4.11).
May 2015	Page 30; 2.4 Requesting Additional Safeguards; second para revised and √'s eliminated	To initiate the process for consideration of additional safeguard hours in addition to the base maximum allowance of PCS (80 hours), a beneficiary must have his/her Primary Care Physician or Attending Physician complete the optional attestation portion in Section B of the 3051 form in addition to the required sections depending on type of request. Additional Safeguards may be requested with a new request or a change of status medical.
May 2015	Page 30; bottom of page, last para revised to read	"It is important for the Primary Care Physician or Attending Physician completing the request to note any pertinent medical diagnoses that may have caused the need for additional safeguards."
May 2015	Page 30 and Page 31; NOTE revised to read	"NOTE: At the discretion of DMA or IAE, additional medical documentation may be requested in order to validate the physician attestation. A beneficiary does NOT have to be a current PCS recipient in order to be considered for additional safeguards."
May 2015	Page 31; Chapter 3 The Independent Assessment; 4th bullet revised to read	Change of Status Medical/Non-Medical Assessment
May 2015	Page 32; Change of Status title revised to read	Change of Status Medical/Non-Medical Assessment
May 2015	Page 34; 3.2 Conducting the Independent Assessment; second para revised to read	On the day of the scheduled appointment and before conducting the assessment, the Independent Assessor will review the Medicaid PCS Beneficiary Participation Guide with the beneficiary. This form outlines the rights the beneficiary has regarding the independent assessment and their responsibility to fully participate in completing the assessment (please see Appendix B for the complete form). Following the review of the Participation Guide, the beneficiary will be asked to sign a consent form that gives the Assessor permission to conduct the independent assessment.
May 2015	Page 45; Chapter 6; 6.1 Prior Approval; revised to read	Once a beneficiary who has been deemed eligible is awarded hours under the PCS program following an assessment or a settlement through the appeals process, a 'Prior Approval' (PA) is issued. The PA will reflect the total hours awarded monthly for PCS. In accordance with Clinical Policy 3L, section 5.2.2, in order to be approved for PCS payment, the beneficiary shall: ✓ Obtain a Physician Referral; and attestation, when applicable; ✓ Obtain an ACH PASRR screen if seeking admission to, or residing in, an adult care home licensed under G.S. 131D-2.4; ✓ Receive an independent assessment from the IAE. ✓ Meet minimum program admission requirements; ✓ Obtain a service authorization for a specified number of PCS hours per month; and ✓ Obtain an approved service plan from the provider. EPSDT Additional Requirements for PCS: Medicaid may authorize services that exceed the PCS service limitations if determined to be medically necessary under EPSDT based on the following documents submitted by the provider before PCS is rendered:

Date	Section Revised	Change
		✓ Work and School verification for the beneficiary's caregiver, legal guardian, or power of attorney. PCS may not cover all time requested by caregiver for work and school that exceed full-time hours. ✓ Verification from the Exceptional Children's program per county if PCS is being requested in school setting. ✓ Health record documentation from the beneficiary's physician, therapist, or other licensed practitioner; and ✓ Physician documentation of primary caregiver's limitation that would prevent the caregiver from caring for the beneficiary.
May 2015	Page 46; Prior Approval Effective Dates; first para revised to read	DMA has authorized retroactive prior approval for PCS that were approved on or after January 1, 2013. Retroactive prior approval will only be applied to initial requests for PCS. The retroactive effective date for authorization will be the request date on the Request for Independent Assessment for Personal Care Services 3051 form, provided the date is not more than 10 calendar days from the date that IAE (IAE), IAE, received a completed request form. If the request is received by IAE more than 10 calendar days from the request date on the request form, the authorization will be effective the date IAE received the form. If the initial request is missing information, the received date will not be effective until the correct information is provided to process the referral.
May 2015	Page 47; 6.2 Reimbursement; NOTE; added statement of policy	NOTE: A beneficiary may have been approved for PCS and a prior approval awarded, but if their Medicaid is not active, or does not provide coverage for PCS, or they have since been enrolled in another state program that cannot be administered in conjunction with PCS, reimbursement will be denied. Providers shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
May 2015	Page 49; 6.3 Denied Claims; numbers 3 and 5 grammar revised to read	3. Does the modifier on the PA match the modifier assigned in NC Tracks? (verify through the QiRePort Provider Portal) 5. Am I billing within the approved effective dates? (verify in NC Tracks)
May 2015	Page 51 and 52 revised form and Appendix B	Replacement of NEW FORM – EFFECTIVE 2/1/2015 *("Request for Independent Assessment for Personal Care Services (PCS) Attestation of Medical Need")*
May 2015	Page 66; Appendix D: Clinical Coverage Policy 3L; important notice added	Important: This provider manual will be updated with the finalized 3L policy June 1, 2015
May 2015	Page 105; Appendix F; title addition	"Appendix F: Provider Resources and Contact *Information*:"
July 2015	Cover	Effective date changed from May 2015 to July 2015
July 2015	Table of Contents 1.12	Plan of Care (POC) changed to Online Service Plan
July 2015	Table of Contents 1.14 added	[Title] "Change of Ownership"
July 2015	Table of Contents 1.15	Section 1.15 added
July 2015	Table of Contents; Appendices	Appendix F changed to read: "Provider Resources and Contact Information"
July 2015	Page 6; Additional general program requirements include	Second and Third bullet changed to read: "The residential setting has received inspection conducted by the Division of Health Service Regulation (DHSR):" and third bullet reads: "The place of service is safe for the beneficiary to receive PCS and for an aide to provide PCS;"

Date	Section Revised	Change
July 2015	Page 8; #13	The word “authorized” changed to read: “identified”
July 2015	Page 9; #11	The words “or mental health disorders” inserted
July 2015	Page 11; Chapter 1; #4	Changed to read: “Providers shall not bill for Medicaid PCS services provided by an individual with any of the following convictions on the criminal background check conducted in accordance with 7.10 (d.1) of Clinical Coverage Policy 3L:
July 2015	Page 11; Chapter 1: 4c	4c is removed from policy
July 2015	Page 13; The RN Supervisor Shall; #5	#5 is removed from policy
July 2015	Page 15; 1.10 Staff Development and Training; 1st paragraph	Revised last sentence to read: “Competency training and evaluations of the required competencies for In-Home and Residential Aides must provide competency training and evaluations as specified in 10A NCAC 13F and 13G, and 10A NCAC 27G”
July 2015	Page 16; 1.12 PCS On-line Service Plan	Revised to change: 7. Once the provider organization completes the service plan, the service plan must be validated by the Provider Interface for consistency with the IAE assessment, and related requirements for the service plan content. 8. Note: For EPSDT beneficiaries, the provider organization must complete the service plan based on the DMA nurse review of the assessment and documents provided in accordance with Subsection 5.2.3. DMA nurse guidance will be provided to the provider organization prior to acceptance of the referral and in the service plan. 9. i. The PCS service plan must be developed and validated within seven (7) business days of the Provider accepting receiving the IAE referral. 10. j. The provider organization shall obtain the written consent in the form of the signature of the beneficiary or their legally responsible person within 14 business days of the validated service plan. The written consent of the service plan must be printed out and uploaded into the Provider Interface; 11. k. The provider shall make a copy of the validated service plan available to the beneficiary or their legally responsible person within three (3) business of a verbal request. 12. l. The PCS service plan is not a plan of care as defined by the applicable state licensure requirements that govern the operation of the provider organizations. Provider organizations are expected to complete a separate plan of care in accordance to licensure requirements as specified in 10ANCAC 13J, 10A NCAC 13F and 13G, and 10A NCAC 27G. 13. m. Provider organizations may enter PCS service plan revisions in the Provider Interface at any time as long as the changes do not alter the aide tasks or need frequencies identified in the corresponding IAE assessment; n. Provider organizations may continue to request a Change of Status Review, as described in Subsection 5.4.6b, by the IAE if there has been a significant change that affects the beneficiary’s need for PCS since the last assessment and service plan. Any Change of Status reassessment requires a new PCS service plan documented in QiRePort; o. Provider organizations shall be reimbursed only for PCS authorized hours and services specified and scheduled in the validated PCS service plan; and, p. Prior approval for PCS hours or units is not granted until the on-line PCS service plan is entered into and validated by the Provider Interface.
July	Page 18; 1.14	New section added, “Change of Ownership”

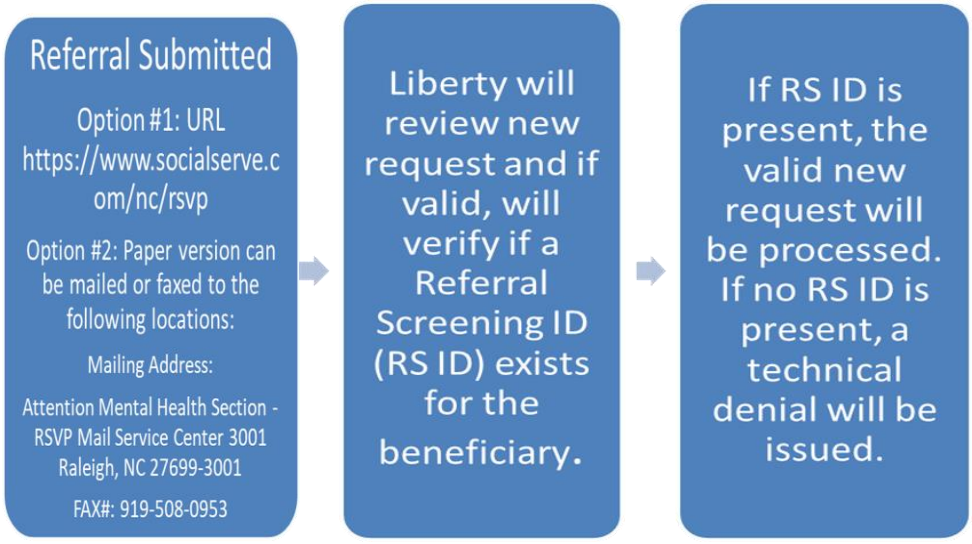
Date	Section Revised	Change
2015		
July 2015	Page 19	Heading revised to read: "1.15 QiRePort – Provider Interface Overview"
July 2015	Page 28; second paragraph; last sentence	Revised to read: "The new PCS Provider shall develop and implement a service plan within 7 business days of accepting the referral (Clinical Policy 3L, section 5.4.11)."
July 2015	Page 38; bullet "Notice of Denial in Services", last reason	Revised reason reads: "The beneficiary account in NC Tracks now reflects as PCS ineligible due to the Medicaid status or that they are receiving duplicate services making them ineligible for PCS."
July 2015	Page 47; 6.3 Denied Claims; #1	Revised to read: "Did I complete a service plan for the most current assessment for the beneficiary? (verify in QiRePort)
July 2015	Page 55; Medicaid Personal Care Services Beneficiary Participation Guide	Updated form replaced prior version
July 2015	Page 91-111; Table of Contents	Prior policy replaced with updated policy amended June 10, 2015
July 2015	Page 117; Appendix	Appendix change from 'G' to 'F'
Sept. 2015	Page 1; Date	Month changed to September for version control
Sept. 2015	Page 16; Section 1.12	Details were added for exceptions to drafting a Service Plan within QiRePort
Sept. 2015	Page 19; Section 1.14 "Change of Ownership"	New Section Added
Sept. 2015	Page 20; Section 1.15 "Internal Quality Improvement Program"	New Section Added
Sept. 2015	Page 20; Section 1.16 "Provider Interface Overview"	Section number changed from 1.15 to 1.16
Sept. 2015	Page 104; Appendix F	New Appendix, Inserted the 'DMA 3136 Internal Quality Improvement Program Attestation Form and Instructions'
Sept. 2015	Page 107: Appendix G	Appendix letter changed from F to G
Aug. 2016	Page 9, Intro. – 'PCS Non-Covered Tasks and Services'	Add #13. "Independent medical information does not validate the assessment, PCS hours may be reduced, denied, or terminated based on the additional information."
Aug. 2016	Page 13, Section 1.7 PCS Aides	Additional criteria added, bullet points 1 - 8
Aug. 2016	Page 17, Section 1.12 PCS Online Service Plan	Note: If an agency fails to complete their service plan and the beneficiary is discharged, changes providers, or becomes deceased, DMA will not authorize retro PAs for the beneficiary as PA's will not be released until the service plan has been completed and beneficiary/legal guardian consent is required for service plan approval.
Aug. 2016	Page 21, Section 1.16 QiRePort – Provider Interface Overview	Bullet add – "Receive electronic notification of upcoming annual assessments for beneficiaries."
Aug.	Page 25, Section	Criteria Add – "Be an individual served through the transition to community

Date	Section Revised	Change
2016	2.1.2 Expedited Request for PCS	living initiative," being submitted by "An approved LME-MCO Transition Coordinator."
Aug. 2016	Page 32, Section 2.5 – Reconsideration Request for Initial Authorization for PCS	New section added.
Aug. 2016	Page 33, Section 2.5.2 – The Reconsideration Process	New section added.
Aug. 2016	Page 35, Chapter 3 – The Independent Assessment	Added section titled 'Reconsideration Assessment'
Aug. 2016	Page 36, Section 3.1 The Assessment Scheduling Process	Language adds – "After receipt, the Scheduling Coordinator (SC) will attempt to reach the beneficiary and/or an identified third party, or if in a facility, the facility director, or persons responsible for scheduling such assessments and schedule the assessment."
Aug. 2016	Page 41, Section 4.2 Responding to a Referral	NOTE: Providers are expected to accept/reject referrals within 2 business days. If the PA's end for a beneficiary and the PCS Provider did not accept within 2 business days of the referral, DMA will not authorize retro pay for the lapsed time period.
Aug. 2016	Page 48, Section 6.1 Prior Approval	EPSDT Additional Requirements for PCS, bullet add and note - Any other independent records that address ADL abilities and need for PCS. NOTE: If additional information does not validate the assessment, PCS hours may be reduced, denied, or terminated based on additional records.
Aug. 2016	Page 49, Section 6.1 Prior Approval	PA Effective Dates adds for Reconsideration and note add - NOTE: Providers are expected to accept/reject referrals within 2 business days. If the PA's end for a beneficiary and the PCS Provider did not accept within 2 business days of the referral, DMA will not authorize retro pay for the lapsed time period.
Aug. 2016	Appendix G	Changed to 'DMA 3114 Request for Reconsideration of PCS Authorization Form and Instructions'
Aug. 2016	Appendix H	Changed from G to H
Aug. 2017	Page 7, note added	Once the beneficiary turns 21 years of age, their approved EPSDT hours will cease, and PCS will end. A new 3051 form should be mailed to IAE PRIOR to the 21st birthday in order for the beneficiary to be assessed and if approved, PCS to continue after they turn 21.
Aug. 2017	Page 19, Section 1.13	Prior Approval (PA) Effective Dates and PASRR, table updated
Aug. 2017	Page 25, Section 2.1.2	If eligibility requirements are met, a hospital discharge planner, skilled nursing facility discharge planner, Adult Protective Services (APS) worker, or LME-MCO Transition Coordinator…
Aug. 2017	Page 33, Section 2.6	New section added
Aug. 2017	Page 50 , Section 6.1	Prior Approval Effective Dates; changed from 10 days to 30 days. Updated examples.
Aug. 2017	Appendix B	Medicaid PCS Beneficiary Participation Guide; form updated
Aug. 2017	Appendix D	Clinical Coverage Policy 3L; updated
Jan.	Provider Manual –	"January 2019"

Date	Section Revised	Change
2019	Cover Page	
Jan. 2019	Provider Manual – All Pages	Replace Division of Medical Assistance (DMA) with NC Medicaid
Jan. 2019	Table of Contents, Section 1.13	Replace Pre-Admission Screening and Annual Resident Review (PASRR) with Referral Screening Verification Process
Jan. 2019	Table of Contents	Added Chapter 7: Internal Quality Improvement Program
Jan. 2019	Appendix D	Clinical Coverage Policy 3L updated
Jan. 2019	Appendix E	NC Medicaiid-3085 Form and Instructions-updated
Jan. 2019	Appendix F	NC Medicaiid-3136 Form and Instructions-updated
Jan. 2019	Page 6, Additional general program requirements include	Eleventh bullet changed to read: "Have been screened for Serious Mental Illness (SMI). All Medicaid beneficiaries referred to or seeking admission into an Adult Care Home licensed under G.S. 131D-2.4 must be referred to an LME-MCO for the Referral Screening Verification Process (RSVP). Adult Care Home providers licensed under G.S. 131 D-2.4 will not receive PCS assessment or prior approval to bill PCS without verification of a Referral Screening ID.
Jan. 2019	Page 8, PCS Non-Covered Tasks and Services, PCS does NOT include the following services	#6 changed to read: "Instrumental Activities of Daily Living"
Jan. 2019	Page 8, PCS Non-Covered Tasks and Services	Revised note to read: A beneficiary may not receive PCS and another substantially equivalent Federal or State funded service. Examples of equivalent services include but are not limited to home health aide services and in-home aide services in the Community Alternatives Programs (CAP/Disabled Adults, CAP/Children, CAP/Choice, and CAP Innovations and Private Duty Nursing (PDN).
Jan. 2019	Page 8, Medicaid does not cover Personal Care Services (PCS) when	#4. The PCS is provided at a location other than the beneficiary's primary private residence or residential setting, except when EPSDT requirements are met as listed in Subsection 2.2;
Jan. 2019	Page 9, Role of the PCS Provider Stakeholder Group	Sentence 2, 4, 5, 6 Revised: The NC Department of Health & Human Services (DHHS) convenes on a bi-monthly basis with community stakeholders to engage and seek their input. The meetings are designed to share project status, gather input, and identify next steps. Stakeholder meetings are held bi-monthly on the third Thursday of the month 1:00 p.m.-3:00 p.m. Meeting agendas, handouts, and minutes are available for download on the PCS webpage at https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care/personal-care-services. Items and concerns you would like addressed during the stakeholder meetings should be submitted at least two weeks in advance of the regularly scheduled meetings with a notation "FOR STAKEHOLDER MEETING."
Jan. 2019	Page 9, Role of IAE (IAE)	5th bullet: Change publish to publishing
Jan. 2019	Page 11, Section 1.1 General Requirements	3rd √ revised: A residential facility licensed under Chapter 122C of the General Statutes and defined under 10A NCAC 27G as a supervised living facility for two or more adults whose primary diagnosis is mental illness, a

Date	Section Revised	Change
		developmental disability, or substance use disorder.
Jan. 2019	Page 15: Section 1.10	NC Medicaid website update: https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care/personal-care-services
Jan. 2019	Page 15: Section 1.11, Revised first paragraph	Providers shall develop an online PCS service plan through the Provider Interface. The following requirements for the online PCS service plan must apply.
Jan. 2019	Page 15: Section 1.11 Added #1	All IAE referrals are transmitted to provider organizations through the Provider Interface. No mailed or faxed referrals are provided;
Jan. 2019	Page 15: Section 1.11	Renumbered statements 2-15
Jan. 2019	Page 16: Section 1.11, #8, Note revised to read	NOTE: For EPSDT beneficiaries, the provider organization must complete the service plan based on the NC Medicaid-nurse review of the assessment and documents provided in accordance with Subsection 5.2.3.
Jan. 2019	Page 18: Section 1.13, Heading revised	Referral Screening ID Verification Process (RSVP)
Jan. 2019	Page 17: Section 1.12, Added RSVP Process	The Referral Screening Verification Process (RSVP) is a review of any individual who is being considered for admission into a Medicaid Certified Adult Care Home. As required by the US Department of Justice Settlement Agreement effective November 1, 2018, individuals requesting admission to Adult Care Homes (ACH) must be pre-screened for serious mental illness (SMI). Clinical Coverage Policy 3L (3.2.3b) requires that any Medicaid beneficiary who is referred to or seeking admission to Adult Care Homes licensed under G.S. 131D-2.4 and requesting Personal Care Services (PCS) be screened for serious mental illness through referral to an LME-MCO for the Referral Screening Verification Process (RSVP). Adult Care Home providers licensed under G.S. 131D-2.4 will not receive a PCS assessment or prior approval without verification of a Referral Screening ID. **Referral Screening ID Verification Process** IAE will verify a Referral Screening has been submitted on every new ACH PCS request. Verification is confirmed through the Social Serve system. If unable to verify a Referral Screening ID (RS ID) through the Social Serve system, IAE will call the facility in an attempt to obtain a RS ID. If a RS ID is not required, IAE will request the admission date (if prior to 1/1/13) through a copy of an FL2 or any other documentation that reflects the admission date or have the facility confirm they are a 5600a or 5600c. If unable to obtain an RS ID within 3 business days of the PCS request, IAE will send a letter of denial for PCS to the beneficiary. If the beneficiary still wishes to be considered for PCS, they may submit a new request after they have obtained a RS ID.

Acentra will review new request and if valid, will verify if a Referral Screening ID (RS ID) exists for the beneficiary.

Date	Section Revised	Change
		 **NOTE:** Beneficiaries who reside in a 5600a or 5600c facility do no not require an RS ID. Beneficiaries who have a previous ACH PASRR prior to 11/1/18 for an ACH and enter a medical or psychiatric hospital, an acute or sub-acute rehabilitation facility, or a long-term acute care hospital for medical or psychiatric treatment, and return to the ACH after treatment, do not need an additional screen through the RSVP unless there has been a significant change in psychiatric or medical status (for those with SMI/SPMI). Beneficiaries who requested to transfer from one ACH to another AND already have an ACH PASRR prior to 11/1/18 can transfer if they are medically and psychiatrically stable without an RS ID. To learn more about RSVP requirements, visit https://www.ncdhhs.gov/about/department-initiatives/transitions-community-living-initiative. **Prior Approval (PA) Effective Dates and RSVP** If a RS ID is effective on the date the PCS request is received or prior, PAs will be effective the date the request is received. If the RS ID is received within 3 days from the request received date, then the PAs will become effective the date the RS ID became effective; please see the following table for further detail:
Jan. 2019	Page 19, Section 1.13 Prior Approval table	Updated table with new effective dates for RSVP
Jan. 2019	Page 20, Section 1.13, 6th para revised	Submission of the NC Medicaid- 3051 Request for Independent Assessment form does not guarantee commitment to award or authorize PCS. Each issue will be reviewed case by case.
Jan. 2019	Page 20, Section 1.13, 7th para, last sentence, phone number corrected	919-855-4050.
Jan. 2019	Page 20, Section 1.14, 1st para revised	It is required that all PCS providers have an established Internal Quality Improvement Program. The Quality Improvement Program should measure quality of care, service problems, and beneficiary satisfaction. The PCS provider is required to attest to an established Internal Quality Improvement

Date	Section Revised	Change
		Program annually (section 7.7 of Clinical Coverage Policy 3L). An NC Medicaid-3136 Internal Quality Improvement Program Attestation Form must be completed by December 31st of each year and sent to NC Medicaid. When completing the 3136 form, the provider must attest that they have implemented and are in compliance with the following:
Jan. 2019	Page 23, Section 2.1.1, first para	"In order for the NC Medicaid-3051…"
Jan. 2019	Page 24, Section 2.1.1, Section A, 4th bullet, 5th bullet	• RS ID number (beneficiaries who reside in an Adult Care Home setting only) • Indication if the beneficiary has an active Adult Protective Services Case.
Jan. 2019	Page 24, Section 2.1.1, Section B, 1st bullet, 4th bullet	• Medical diagnosis with corresponding complete current ICD-10 diagnosis code for each diagnosis • Indication of expected duration of ADL limitation
Jan. 2019	Page 25, Section 2.1.2, 3rd √	Have a Referral Screening ID number on file*
Jan. 2019	Page 25, Section 2.1.2, 4th bullet	Capitalize- Transition to Community Living Initiative
Jan. 2019	Page 25, Section 2.1.2, Revised Note:	NOTE:*RS ID is required for beneficiaries seeking admission to an Adult Care Home licensed under G.S. 131 D-2.4
Jan. 2019	Page 25, Section 2.1.2, The Expedited Assessment Completion Process, 1st para, Note revised	NOTE: Expedited assessments for beneficiaries seeking placement in an ACH (not 5600s) will require an RS ID for the processing of an expedited request.
Jan. 2019	Page 27, Section 2.2.1, Section A, 4th bullet	Indication if the beneficiary has an active Adult Protective Services Case
Jan. 2019	Page 27, Section 2.2.1, Section B, 1st bullet	Medical diagnosis with corresponding complete current ICD-10 diagnosis code
Jan. 2019	Page 27, Section 2.2.1, Section C, 1st bullet	Date of Last Visit to Referring Practitioner–The beneficiary must have seen their PCP within the last 90 days from the date IAE receives the completed form, in order to process a COS Medical Request
Jan. 2019	Page 35, Chapter 3, 1st para, 1st sentence	In accordance with Clinical Coverage Policy 3L, section 5.4.2,once ordered by the beneficiary's physician, the PCS assessment shall be performed by an IAE Assessor at the beneficiary's primary private residence or residential facility.
Jan. 2019	Page 36, Turning 21 Assessment, Note added	**NOTE:** PAs approved under EPSDT will end on the 21st birthday. A lapse in service will occur if a new 3051 is received AFTER the 21st birthday and PAs will not be made retro to cover the lapsed period. In order to prevent a lapse in service, the beneficiary should submit a new NC Medicaid-3051form 30 days PRIOR to their 21st birthday to the IAE.
Jan. 2019	Page 36, Reconsideration Request, 1st sentence revised	A beneficiary, 21 years of age or older, who receives an initial approval for more than 0, but less than 80 hours per month may submit a Request for Reconsideration of PCS Authorization form to the IAE if they do not agree with the initial level of service determined
Jan. 2019	Page 40, Section 4.1, #4, 2nd sentence	"The Assessor will follow up by phone…."
Jan. 2019	Page 44, Chapter 5, Revised heading	"The following is sent to the beneficiary only:"
Jan.	Page 47, Section	(within eight days of the date of the notice)

Date	Section Revised	Change
2019	5.5, No Lapse in Service	
Jan. 2019	Page 49, Chapter 6: Billing, 1st para	General Dynamics Information Technology (GDIT) is the current designated contractor responsible for the processing of all Medicaid claims, which includes claims for PCS. NC Tracks is the Medicaid billing system used by GDIT to receive and process all claims.
Jan. 2019	Page 49, Section 6.1, 2nd √	✓ Obtain a Referral Screening ID if seeking admission to, or residing in, an adult care home licensed under G.S. 131D-2.4;
Jan. 2019	Page 50, Prior Approval Effective dates, 2nd para	If a beneficiary requesting admission to an Adult Care Home, Licensed under G.S. 131D-2.4, has not been referred to an LME-MCO for the Referral Screening Verification Process (RSVP), retroactive prior approval does not apply. PCS authorization will be made effective the date beneficiary receives their RS ID.
Jan. 2019	Page 51, Section 6.2 Table updated	8/1/2017-12/31/17 $3.88 per 15 minutes ($15.52 per hour) 1/1/2018-current $3.90 per 15 minutes (15.60 per hour)
Jan. 2019	Page 52, Section 6.3, #1 Note added	**NOTE:** PAs will not be made retro if a service plan is not completed timely and/or the beneficiary is discharged or becomes deceased prior to completion of the service plan if outside of the 7-day allotted period to complete the service plan.
Jan. 2019	Page 54, Chapter 7 – new chapter added	**Chapter 7: Internal Quality Improvement Program** In accordance to Clinical Coverage Policy 3L Section 7.7 Internal Quality Improvement Program, Providers serving beneficiaries receiving PCS are required to complete and adhere to an organizational Quality Improvement Plan or set of quality improvement policies and procedures. **What is Quality Improvement?** "Quality improvement (QI) is a systematic, formal approach to the analysis of practice performance and efforts to improve performance." – *American Academy of Family Physicians* Understanding and properly implementing QI is essential to a well-functioning agency or facility and is necessary for any agency or facility interested in improving efficiency, beneficiary safety and satisfaction, and clinical outcomes. **7.1 Establishing a Quality Improvement Program** Here are 6 steps to help kick start any Quality Improvement Program: 7. **Establish a culture of quality in your agency or facility.** Your organization, processes, and procedures should support and be integrated with your QI efforts. The culture of an agency, attitudes, behaviors, and actions, reflect how passionately the team embraces quality. The QI culture looks different for every agency/facility, but may include establishing dedicated QI teams, holding regular QI meetings, or creating policies around your QI goals. 8. **Determine and prioritize potential areas for improvement.** You will need to identify and understand the ways in which your agency/facility could improve. Examine your client population (e.g., to identify barriers to care or groups of high-risk patients) and your agency/facility operations (e.g., to identify management issues such as low morale or poor communication).

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9. **Collect and analyze data.** Data collection and analysis lie at the heart of quality improvement. Your data will help you understand how well your systems work, identify potential areas for improvement, set measurable goals, and monitor the effectiveness of change. It is important to collect baseline data before you begin a QI project, commit to regular data collection, carefully analyze your results throughout the project, and make decisions based on your analysis.

10. **Communicate your results.** Quality improvement efforts should be transparent to your staff, physicians, and beneficiaries. Communicate your project needs, priorities, actions, and results to everyone (beneficiaries included). When a project is successful, celebrate and acknowledge that success.

11. **Commit to ongoing evaluation.** Quality improvement is an ongoing process. A high-functioning agency/facility will strive to continually improve performance, revisit the effectiveness of interventions, and regularly solicit beneficiary and staff feedback.

12. **Spread your successes.** Share lessons learned with others to support wide-scale, rapid improvement that benefits all beneficiaries and the health care industry as a whole.

Source: American Academy of Family Physicians, https://www.aafp.org/practice-management/improvement/basics.html

Quality Improvement Models and Tools

Quality improvement models present a systematic, formal framework for establishing QI processes in your agency/facility. Examples of common QI models include the following:

- ✓ **Model for Improvement, Plan-Do-Study-Act:**
  - **Plan** - Develop the QI plan as related to the organization's priorities, mission, goals, population served, services provided and customer needs. Always consider external or regulatory requirements.
  - **Do -** Implement the plan as a defined map or guide for the organization-wide Quality Program. Document identified problems and unexpected events observed.
  - **Study –** Ask questions such as –
    - Did we do what we said we were going to do? Why or why not?
    - What are the results?
    - How can we improve?
    - What is working really well?
    - What needs to be modified?
  - **Act -** Act on what was learned –
    - Revise the plan as needed;
    - Monitor the plan on a regular and defined basis;
    - Determine if the plan was successful at meeting or exceeding your expectations;
    - Address the items that need improvement;
    - Communicate results; and
    - Evaluate or update quarterly.

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NOTE: Per Clinical Coverage Policy 3L 7.7(a), a PCS Provider is required to develop and update, at least quarterly, an organizational quality improvement plan or set of quality improvement policies and procedures that describe the PCS CQI program and activities.

- ✓ **Six Sigma:** is a method of improvement that strives to decrease variation and defects.
- ✓ **Lean:** is an approach that drives out waste and improves efficiency in work processes so that all work adds value.

Sources:

American Academy of Family Physicians, https://www.aafp.org/practice-management/improvement/basics.html
Institute for Healthcare Improvement, http://www.ihi.org/
American Society for Quality, https://asq.org/

7.2 Quality Improvement and PCS

In accordance with Clinical Coverage Policy 3L, section 7.7 (e), PCS Providers shall submit by December 31 of each year an attestation that they are in compliance with a – d of the 7.7 subsection. This requirement should be fulfilled by completing the NC Medicaid-3136 Quality Improvement Attestation Form (see appendix F for form sample). When completing the form, the PCS Provider is attesting that they shall –

a. Develop, and update at least quarterly, an organizational Quality Improvement Plan or set of quality improvement policies and procedures that describe the PCS CQI program and activities;
b. Implement an organizational CQI Program designed to identify and correct the quality of care and quality of service problems;
c. Conduct at least annually a written beneficiary PCS satisfaction survey for beneficiaries and their legally responsible person; and
d. Maintain complete records of all CQI activities and results.

7.2.1 Developing an Organizational Quality Improvement Plan

What is a quality improvement plan?

A quality improvement plan is a detailed work plan of an organization's activities of quality improvement. A quality improvement plan should explain how your organization manages, deploys, and reviews quality services. It should be updated regularly and include your organization's quality priorities and how you measure your performance/improvement.

Key Elements for an Effective QI Plan

The plan should describe:

- ✓ The mission, values, goals, and objectives;
- ✓ How the organization will select, manage, and monitor all QI projects;
- ✓ Methodologies that will be used;
- ✓ Communication to staff on the plan, any updates, and results; and
- ✓ Staff training and education.

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Common Barriers that Impact an Effective QI Plan

When any of the following cease to exist in an organization, the effectiveness of its quality improvement plan may be jeopardized –

- ✓ Resources (financial, staff, etc.)
- ✓ Ongoing communication and feedback
- ✓ Periodic re-evaluation
- ✓ Staff interest or training
- ✓ Accountability of the QI Committee
- ✓ Focus on QI priorities/changes

7.2.2 Implementing your CQI Plan

Once you have developed your QI plan, you are ready to pick a project and implement your plan.

Picking a QI Project

In order to identify a project in which to execute your QI plan, you will first need to outline the following –

1.Determine priorities based on your customer needs
2.Determine the sample size
3.Identify the QI committee and assign roles and responsibilities
4.Establish process for achieving customer input
5.Determine key measurement
6.Evaluate and communicate results

Ensuring compliance to clinical coverage policy should always be on your list of QI projects. There are several requirements outlined in Clinical Coverage Policy 3L that providers must adhere to in order to maintain compliance and prevent consequences of violation and/or fail an internal audit. Here are some suggested QI projects that focus on Clinical Coverage Policy compliance: –

- ✓ **Required Aide Training** – How do you ensure your aides are compliant in the following areas –
  - Beneficiary Rights;
  - Confidentiality and privacy practices;
  - Personal care skills, such as assistance with the following ADLs:
    - Bathing
    - Dressing
    - Mobility
    - Toileting
    - Eating
  - In-home and Residential Care Aides providing services to beneficiaries receiving hours in accordance with Session Law 2013-306, have training or experience in caring for individuals who have a degenerative disease characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired

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judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.
NOTE: Providers shall submit an attestation to NC Medicaid that they are in compliance with this requirement. The attestation form (NC Medicaid--3085) and instructions are located on the NC Medicaid PCS webpage.
- Documentation and reporting of beneficiary accidents and incidents;
- Recognizing and reporting signs of abuse and neglect; and
- Infection control.

✓ **Documentation of Supervisory Visits -**
Documentation on Supervisory visits is audited based on PCS Clinical Coverage Policy Section 7.10 b. (1-9); The in-home PCS provider shall ensure that a qualified RN Nurse Supervisor conducts a RN Supervisor visit to each beneficiary's primary private residence location every 90 calendar days (Note: a seven-calendar day grace period is allowed). Two visits within 365 calendar days must be conducted when the in-home aide is scheduled to be in the primary private residence.
For this project, you will want to lay out how you ensure the RN Supervisor has done the following:
- Confirm that the in-home aide is present or has been present as scheduled during the preceding 90 calendar days;
- Validate that the information documented on the aide's service log accurately reflects his or her attendance and the services provided;
- Evaluate the in-home aide's performance;
- Identify any changes in the beneficiary's condition and need for PCS that may require a change of status review;
- Request a change of status review if the beneficiary's service plan exceeds or no longer meets the beneficiary's needs for ADL assistance;
- Identify any new health or safety risks that may be present in the primary private residence;
- Evaluate the beneficiary's satisfaction with services provided by the in-home aide and the services performed by the home care agency;
- Review and validate the in-home aide's service records to ensure that:
    1. Documentation of services provided is accurate and complete;
    2. Services listed in the service plan have been implemented;

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3. Deviations from the service plan are documented;
4. Dates, times of service, and services provided are documented on a daily basis;
5. Separate logs are maintained for each beneficiary;
6. All occasions when the beneficiary is not available to receive services or refused services for any reason are documented in the service record along with the reason the beneficiary was not available or refused services; and
7. Logs are signed by the in-home aide and the beneficiary after services are provided on a weekly basis

- Document all components of the supervisory visits: the date, arrival and departure time, purpose of visit, findings, and supervisor's signature.

Other sample projects may include –

- Conducting self-audits, measuring results, improve, and repeat;
- Analyze your timeliness for conducting discharges;
- Evaluate if service plans are done and uploaded timely; or
- Conduct aide competency testing.

7.2.3 Conducting an Annual Survey

Satisfaction surveys are a valuable tool for continued feedback that allow PCS Providers to serve their clients and meet their needs. Surveys are a way to help Providers gain an understanding of their client's expectations and concerns so that service can be improved.

When designing a survey, you should focus your questions on how well the service your agency provides meet your client's needs or how satisfied they are with different aspects of the service you offer. The feedback can highlight problems that you were not aware of, giving you the opportunity to respond and take remedial action.

Sample Questions for a Satisfaction Survey –

- Was a plan of care reviewed and approved by you before starting services?
- Does the aide arrive at his/her scheduled time on the appropriate scheduled days?
- Is the aide polite and professional at all times?
- Does the aide assist with all approved services as indicated in your plan of care?
- Is our agency responsive to your questions and needs?
- How would you rate the customer service provided by our agency?

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Per clinical coverage policy 3L, the satisfaction survey must be presented in written form. Here are some suggestions on how to provide a survey in written form –

- Mail a survey to the beneficiary and provide a self-addressed envelope for return;
- Provide the written survey in hand when the aide provides services; or
- Provide the written survey in hand when the nurse conducts their quarterly visits.

7.2.4 Maintaining Complete Records

Keeping good records is very important to any business. Whether required or not, good record keeping results in several benefits for your business, some of which are as follows-

- Gives you the information you need to run your business and help it grow;
- Helps identify the strengths and weaknesses in your business;
- Helps manage changes and improvements in your business;
- Assists in the management and monitoring for compliance of various policies; and
- Allows quick access to records in case you are selected for a NC Medicaid internal audit or an audit by the Office of Compliance/Program Integrity (OCPI).

Business records can be maintained manually or electronically. Make sure the system that is used is easy to manage, well organized, and kept up to date, rather than letting the paperwork pile up.

7.3 Completing the 3136 Form

PCS Providers shall submit the Internal Quality Improvement Program Attestation Form 3136 to NC Medicaid by December 31st of each year certifying compliance with “a” through “d” of Clinical Coverage Policy 3L Section 7.7.A copy of this form with instructions can be found in Appendix F. To ensure the form will be accepted at time of submission, it is important that the form be filled out in its entirety; forms cannot be processed with missing information. When completing the form, PCS Providers should:

- ✓ Indicate which of the general Provider cohort designations fit their organization.
- ✓ Complete all fields of the ‘Submitter Information’ section, printing clearly.
- ✓ Review each requirement before initialing each item individually in the area provided.
- ✓ Initial items “a” through “d” to certify compliance of Clinical Coverage Policy 3L Section 7.7.
- ✓ Complete signature and date.

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		NOTE: Forms should not be submitted prior to the completion of requirements which include continuous quality improvement programs and activities conducted at least quarterly. **Key Points to Remember –** ▪ The 3136 form is required to be submitted to NC Medicaid by December 31st **EACH** year; ▪ There is no standard regarding the format of the required documents; ▪ All documents are not required to be submitted to NC Medicaid, just the NC Medicaid-3136 Form; and ▪ Providers who are non-compliant with submission of the NC Medicaid-3136 are subject to audit by NC Medicaid and referral to OCPI.
Jan. 2019	Page 67, Appendix B, updated web link	https://files.nc.gov/ncdma/documents/files/3L_4.pdf
Jan. 2019	Page 72, Appendix D	Clinical Coverage Policy 3L; updated
Jan. 2019	Page 107 Appendix E	NC Medicaid-3085 PCS Training Attestation Form and Instructions; updated
Jan. 2019	Page 109 Appendix F	NC Medicaid-3136 Internal Quality Improvement Form and Instructions; updated
Jan. 2019	Page 113 Appendix H	Provider Resources and Contact Information; updated
June 2022		Where applicable, changed tense from future to present.
June 2022	1.10 Requirements for Aide Documentation	Added ***Electronic Visit Verification*** Information
June 2022	Appendices	Examples of Forms and References removed and replaced with links to the specific sites.
June 2022	Section 2	Changes made to reflect updated DHB-3051-ia form
June 2022	Section 5	Changes made to reflect OAH contact information and expedited appeal process.
Feb. 2023	Page 18, Section 1.12	Updated RSID Website
Feb. 2023	Page 27, Section 2.2.1	Clarification to Section D, Change of Status: Medical
Feb. 2023	Page 60, Appendix B	Updated RSVP website link
Nov. 2024	Page 36, Chapter 3	Added telephonic assessment process, per policy 3L (5.4.3)
Dec. 2024	Provider Manual	Update all pages to include IAE, update
Dec. 2024	Page 25, Section 2.1.2	Updated expedited ACH policy per 3L-1
Dec. 2024	Page 8	PCS Stakeholder Initiative updated
April 2025	Provider Manual	Update to NCLIFTSS and reflect updates from the new Policy 3L and 3L-1 Manuals