Personal Care
Services **
Restructured 2005

What is PCS ?

Medicaid Personal Care Services (PCS) covers the services of an aide (unlicensed assistive personnel-UAP) in the recipient’s home to assist with the recipient’s personal care needs which are directly linked to a medical condition. Recipients must have a minimum of ***two*** Activities of Daily Living (ADL) deficits identified in an assessment.

PCS Eligibility and Criteria

Eligible recipients:

- Regular Medicaid (BLUE card); or
- Medicaid for Pregnant Women (PINK card) with medical condition related to pregnancy - Requires prior approval

- PCS must be directly linked to a medical condition resulting in at least two ADL deficits requiring hands-on assistance; RN assessment.
- ADL’s (Katz) – bathing/hygiene, dressing, eating, toileting, mobility and incontinence
- Needs must be met in in the Plan of Care (POC)
- Must be authorized by the recipient’s primary physician.
- PCS services are provided in the patient’s home.

Service Limitations

- PCS services are limited to **3.5** hours per day and no more than 60 hours per month which includes the in-home aide direct care, RN clinical supervisor assessment, reassessments and supervisory visits that can be billed to Medicaid.

- In assigning time to tasks, the agency uses the DMA time guidance. The RN may document the need for additional time (a time exception) on the PCS PACT Form or other supporting documents are required when deviating from DMA time guidance for tasks.

- IADL's (instrumental activities of daily living) are home management/housekeeping tasks may be included in the clients plan of care when linked to the clients medical needs. The ADL task time must exceed IADL task time.

Time and Task Guidance

- Time and task guidance gives clarity to definition of an activity and a timeframe for planning.
  - Example – eating (ADL) is taking food in by any method. The time estimate to do this task is addressed time guidance. Exceptions to the time and task guidance are documented to justify additional time needed. IADL tasks and times are also provided.
- A scoring system consistent with MDS is used. This scoring system aligns “basic” PCS criteria to PCS Plus criteria. The scores provide a common framework to assess and identify client needs and functional health which can be compared to other care settings.

PCS-Plus

- PCS-Plus is an enhancement to the PCS program for recipients who have a qualifying medical condition and personal care needs that exceed the service limit for PCS.
- Up to an additional 20 hours of PCS per month are available with prior approval from DMA. *MDs or designees do not have the authority to approve the 20 additional hours.*
- PCS-Plus requires specific criteria:
  - 4 ADL impairments requiring extensive assistance/dependence, or
  - 3 ADL impairments and specified physical limitations
  - Special criteria include: cognitive impairment, NA II tasks, SOB with oxygen dependence.

PCS Criteria–Other

- PCS services cannot be in excess of identified needs nor primarily intended for the convenience of the recipient, caretaker or provider.
- Without PCS, the recipient's medical condition would deteriorate.
- Medically stable means that the recipient does not have a need, pertaining to the PCS plan of care, for continuous monitoring and evaluation by a licensed professional.
- MPW recipients have additional conditions for coverage and require EDS MD prior approval. Additional documents for PA are required.
- PCS for infants and children must not replace parental responsibilities or normal age appropriate tasks; must be linked to a medical condition. PCS is not a substitute for child care, day care or after school care.

PCS Process: Referral

- Referrals may come from a variety of sources – but a physician's order for in-home RN assessment is required. Verbal orders must be signed by MD in 60 days.
- Direct solicitation by the PCS provider to recipients or their representatives is prohibited.
  - *Examples: Provider going door to door and seeking assessments, having agency representatives in MD offices and clinics and approaching clients, employees who change employment agencies and coerce clients to move to a new provider.*
- Only the PCS certified RN* who visits the recipient in the home may do the initial assessment or the annual reassessment and complete the PCS PACT form. (*Documented, on-line completion of a written based competency.)
- DMA upholds the client's right to choose an agency.

PCS PACT

- PCS PACT is the basis for determining recipient qualification for PCS. Must paint a clear picture of the recipient's functioning in each ADL, the related need for assistance and the expected duration of the need.
- The PCS provider must prepare the PCS PACT for authorization and physician signature and obtain the primary physician's authorization to start services. Verbal orders to start services must be signed within 60 days of a verbal authorization.
- A consulting physician or specialist such as a surgeon, hospitalist, or neurologist may not authorize the service.
- An authorization (signed PCS PACT Form) from the recipient's primary physician must be present for all PCS services billed to Medicaid.
- An electronic signature may be used if the provider's process is compliant with all laws, rules and regulations.

PCS PACT

- Basic data, demographics, diagnosis and medications
- Assessment and scored (qualifying) ADLs with observations
- Other assessment documentation (respirations, endurance, pain, cognitive ability)
- Includes IADLs – which are secondary and related to the ADLs and medical condition

Assessment

- PCS PACT must be completed prior to the start of PCS services and at least every 365 days, as long as the recipient receives PCS.
- PCS may be discontinued if agency or MD determines the client no longer needs PCS. A 2-day notice is required by DFS unless there are documented safety issues or it is client choice.
- The RN assessor certifies by signature on the PCS PACT that he/she completed in-home assessment, determined the need for PCS, and developed the plan of care.
- Individuals who certify a material and false statement are subject to investigation for Medicaid fraud and referred for investigation.
- The PCS provider is also responsible for the accuracy of the PACT.

Time and Tasks Individualize the Plan

- Time and task guidance defines the ADL and IADL activities (tasks) and identifies an estimated time to complete the task.
- Plan is developed considering the tasks needed to meet identified and individualized needs of the client.
- Agency documents the reason for extended time (pain, SOB, cognitive impairment, etc.) and addresses such in the plan of care. Plan is continually evaluated at supervisory visits.

Primary MD Orders: Authorize the Plan

- PCS must be provided under a plan of care (last page PCS PACT).
- MD certifies the medical condition and approves the plan.
- No backdating is allowed.
- Range of hours (2-3 hours/day) may not be used on the POC.
- Plan must include ADL tasks to meet needs and may include related IADL tasks.
- IADL tasks are laundry, light housekeeping, linen, essential errands, and meal preparation.
- Weekly personal care time must exceed weekly home management time.
- PCS provider should initiate care within 14 calendar days of the physician's authorization on the PCS PACT form.
- Once authorized, the services are approved for 365 days, *unless a significant change or lapse in service occurs.*

Staff Qualifications

- Only the RN who successfully completes DMA-approved training may perform PCS assessment and supervision.
- In-home aides in PCS cannot be the recipient's spouse, child, parent, sibling, grandparent or grandchild. This includes an equivalent step or in-law relationship to the recipient.
- In home aides must meet DFS qualification standards. The RN responsible for developing the plan of care and supervising the care validates the UAP's competence
- Any time an RN delegates a task to staff, the RN is responsible for validating that the staff have the competency to complete the task.

When Services Are **Not** Covered

- When the recipient's primary need is housekeeping and/or homemaking.
- When the recipient is a Medicare or Medicaid Hospice patient.
- Home management tasks completed for other residents of the household.
- Care of non-service related pets and animals or yard/home maintenance (other than cleaning a pathway for in-home safety).
- PCS covered transportation is only for essential shopping/errands such as picking up prescriptions, food items and/or paying essential bills that cannot be paid through the mail. NO MEDICAL TRANSPORTATION
- Companion/sitter services, continuous monitoring and ongoing supervision is not covered.
- Skilled nursing services
- A recipient may not receive PCS and another substantially equivalent federal or state funded service on the same day.

Limitations on Service

- PCS tasks include NA I NCBON approved tasks, NA II NCBON approved tasks and delegated medical monitoring of non-skilled medical tasks to the in-home aide by the RN clinical supervisor in accordance with NCBON requirements.
- In-home aide home management tasks are indicated on the recipient's plan of care from the list of covered tasks from the DMA policy (time and tasks and BON reference). These tasks must be related and incidental to the recipient's personal care needs as indicated on the PCS PACT form.
- Home management tasks cannot be completed for others living in the household.
- Home management tasks should not exceed the time budgeted for personal care.

Supervision of Services

- RN clinical supervisor conducts supervisory visit in recipient's home with the recipient present within 90 days of the initial assessment and at least every 90 days thereafter.
- Required elements of the Supervisory visit including noting any changes in the recipient's medical condition, the aide's performance and the recipient's level of satisfaction.
- On-site supervisory visits in the recipient's home with the in-home aide present must be conducted at least twice a year.
- Other strategies are to be used to supervise and monitor PCS such as review of in-home aide logs, telephonic contact and case conference.

Re- Authorization of Services

- If the PCS provider has not discharged the recipient, a reassessment is required following a lapse in PCS due to institutionalization or an unplanned lapse in PCS greater than seven service days or discharge of the recipient for any reason.
- PCS may only be resumed following these circumstances after the RN has conducted a reassessment.
- The RN may conduct the reassessment in the recipient’s home or by collecting information from a discharge planner, primary physician or other licensed health professional providing care.

Reassessment and Ongoing Services

- A reassessment may also be indicated when there are significant changes in the recipient's condition (improvement or decline).
- The POC must be revised when there are significant changes.
- Significant changes occur when the RN has identified additions or deletions to personal care tasks based on an assessment of needs that results in an increase or decrease by 60 minutes or more per week in the total weekly assigned time.
- Re-assessment and re-authorization is required at least annually if there are no changes/lapses in service.

In-Home Aide Visits & Documentation

- The aide service log should reflect services as delivered per the POC or discrepancies must be documented.
- The log has required elements including the date, time services began and ended, the tasks provided, and the aide signature.
- At least weekly the recipient must sign the service log – but only after services are delivered.
- The recipient should be instructed to sign the log ONLY when it is accurate and complete. If there are discrepancies the recipient should contact the agency, case manager or if unresolved, the PI Unit.

Required Documentation

- PCS PACT/authorization for services
- RN certification
- RN supervisory visits
- Aide logs
- QA plan/includes agency self audit and complaint logs
- Telephony standards (if applicable)

Quality Assurance Program

- QA provides a prospective review for PCS.
- Until the implementation of the QA program, the only PCS reviews were post payment reviews by Program Integrity.
- QA establishes measurable benchmarks for quality services and communicates quality standards in a measurable format.
- Response to concerns of the program
  - Internal: Providers, DMA
  - External: Media, legislature

If you measure it, it will improve.

Stakeholders Share the Quality Responsibility

- The Division of Medical Assistance (DMA) and Medicaid providers have a shared responsibility for assuring that PCS is a quality service and provided to Medicaid recipients in accordance with program policies.
- QA plan includes an agency self audit, State level audits for newly enrolled providers, focused audits on identified client attributes or diagnoses, validation visits and desk reviews.