Clinical Policy: State Plan Personal Care Services

Reference Number: WNC.CP.209 Coding Implications
Last Review Date: Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

State Plan Personal Care Services (PCS) provide Personal Care Services in the Member's living arrangement by paraprofessional aides employed by licensed home care agencies, licensed adult care homes, or home staff in licensed supervised living homes. For the remainder of this policy, State Plan PCS is referenced as PCS.

Policy/Criteria[1]

I. WellCare of North Carolina® **shall cover** PCS only for a Member who meets:

A. **One** of the criteria in **both 1 and 2**:

1. Has a medical condition, disability, or cognitive impairment and demonstrates unmet needs for, **at a minimum**:
   a. three of the five qualifying activities of daily living (ADLs) with limited hands-on assistance.
   b. two ADLs, one of which requires extensive assistance;
   c. two ADLs, one of which requires assistance at the full dependence level
2. Resides in:
   a. A private living arrangement (primary private residence);
   b. 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**
   c. 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 personal care services under the Medicaid State Plan.

B. The following criteria:

1. The home environment is safe and free of health hazards for the Member and PCS provider(s), as determined by an in-home environmental assessment conducted by a WellCare of North Carolina Care Manager;
2. The residential facility setting has received inspection conducted by the Division of Health Service Regulation (DHSR);

3. The place of service is safe for the Member to receive PCS and for an aide to provide PCS;
4. No other third-party payer is responsible for covering PCS;
5. No family or household member or other informal caregiver is available, willing, and able to provide the authorized services during those periods of time when the services are provided;
6. The required PCS are directly linked to a documented medical condition or physical or cognitive impairment causing the functional limitations requiring the PCS;
7. The Member is under the ongoing direct care of a physician for the medical condition or diagnosis causing the functional limitations; **and**
8. The Member is medically stable and does not require continuous care, monitoring (precautionary observation), or supervision (observation resulting in an intervention) by a licensed nurse or other licensed health care professional.

C. Screening for Serious Mental Illness (SMI) in Adult Care Homes licensed under G.S. 131D-2.4

1. Effective November 1, 2018, any Medicaid Member referred to or seeking admission to Adult Care Homes licensed under G.S. 131D-2.4 must be referred to an LME-MCO for the Referral Screening Verification Process (RSVP). WellCare of North Carolina will require that the Adult Care Home providers licensed under G.S. 131D-2.4 has the RSVP completed prior to receiving a PCS assessment or prior approval of PCS services.

II. WellCare of North Carolina® shall cover **ANY** of the following Personal Care Services needs that occur at minimum, once per week:

A. Hands-on assistance to address unmet needs with qualifying ADLs;
B. Set-up, supervision, cueing, prompting, and guiding, when provided as part of the hands-on assistance with qualifying ADLs;
C. Assistance with home management Instrumentals of Daily Living (IADLs) that are directly related to the Member's qualifying ADLs and essential to the Member's care at home;
D. Assistance with medication when directly linked to a documented medical condition or physical or cognitive impairment;
E. Assistance with adaptive or assistive devices when directly linked to the qualifying ADLs;
F. Assistance with the use of durable medical equipment when directly linked to the qualifying ADLs; **or**
G. Assistance with special assistance (assistance with ADLs that requires a Nurse aide II) and delegated medical monitoring tasks.

III. WellCare of North Carolina® may approve **ANY** the following additional assistance if **EPSDT** criteria met for a Member under 21 years of age:

A. Supervision (observation resulting in an intervention) and monitoring (precautionary observation) related to qualifying ADLs;

B. Cueing, prompting, guiding, and coaching related to qualifying ADLs;
C. After school care if PCS tasks are required during that time and no other individuals or programs are available to provide this service; **or**
D. Additional hours of service authorization.

IV. WellCare of North Carolina® shall cover *medication assistance* when it is:
A. Delivered in a primary private residence and consists of medication self-administration assistance described in 10A NCAC 13J;
B. Delivered in an adult care home, and provides medication administration as defined in 10A NCAC 13F and 13G; **or**
C. Delivered in supervised living homes and provides medication administration as defined in 10A NCAC 27G.

V. WellCare of North Carolina® **shall not** cover PCS when:
A. The initial care management assessment has not been completed;
B. The PCS is not documented as completed in accordance with this clinical coverage policy;
C. Reassessment has not been completed within 30 calendar days of the end date of the previous prior authorization period because the Member refused assessment, could not be reached to schedule the assessment, or did not attend the scheduled assessment;
D. The PCS is provided at a location other than the Member's primary private residence or residential setting, except when EPSDT requirements are met;
E. The PCS exceeds the amount approved by WellCare of North Carolina;
F. The PCS is not completed on the date the service is billed;
G. The PCS is provided prior to the effective date or after the end date of the prior authorized service period;
H. The PCS is provided by an individual whose primary private residence is the same as the Member's primary private residence;
I. The PCS is performed by an individual who is the Member's legally responsible person, spouse, child, parent, sibling, grandparent, grandchild, or equivalent step or in-law relationship to the Member;
Note: Spouses are expected to provide care for each other unless medical documentation, work verification, or other information indicates otherwise.
J. Family members or other informal caregivers are willing, able, and available on a regular basis adequate to meet the Member's need for personal care;
K. 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;
L. 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; **or**
M. If independent medical information does not validate the assessment, PCS hours may be reduced, denied, or terminated based on the additional information.

N. 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.

VI. WellCare of North Carolina® **shall not** cover PCS in *licensed residential facilities* when:
A. The Member is ventilator dependent;
B. The Member requires continuous licensed nursing care;
C. The Member's physician certifies that placement is no longer appropriate;
D. The Member's health needs cannot be met in the specific licensed care home, as determined by the residence; **or**
E. The Member has other medical and functional care needs that cannot be properly met in a licensed care home, as determined by NC General Statutes and licensure rules and regulations.

Note: WellCare of North Carolina® shall allow time for the development and execution of a safe and orderly discharge prior to PCS termination.

VII. WellCare of North Carolina® **shall not** cover **ANY** of the following services under PCS:
A. Skilled nursing services provided by an LPN or RN;
B. Services provided by other licensed health care professionals;
C. Respite care;
D. Care of non-service-related pets and animals;
E. Yard or home maintenance work;
F. IADLs in the absence of associated ADLs;
G. Transportation;
H. Financial management;
I. Errands;
J. Companion sitting or leisure activities;
K. Ongoing supervision (observation resulting in an intervention) and monitoring (precautionary observation), except when approved under EPSDT;
L. Personal care or home management tasks for other residents of the household;
M. Other tasks and services not identified in the Member's Care Management assessment and noted in their Service Plan; **and**
N. Room and board.

VIII. WellCare of North Carolina® **shall not** cover PCS when rendered concurrently with Private Duty Nursing (PDN).

Background[1]
The amount of prior approved service is based on an assessment conducted by a WellCare of North Carolina Care Manager to determine the Member's ability to perform Activities of Daily Living (ADLs). The five qualifying ADLs for the purposes of this program are **bathing, dressing, mobility, toileting, and eating**.
Member performance is rated as:

- totally independent;
- requiring cueing or supervision;
- requiring limited hands-on assistance;
- requiring extensive hands-on assistance;
- totally dependent.

I. Monthly Service Hour Limits

A. The following hour limits apply to a Member who meets PCS eligibility requirements and coverage criteria in this policy:
   1. A Member under 21 years of age may be authorized to receive up to **60** hours of service per month; **and**
   2. A Member age 21 years and older may be authorized to receive up to **80** hours of service per month.

B. A Member who meets the eligibility criteria in this policy and **ALL** the criteria provided below is eligible for **up to 50 additional** hours of PCS per month for a total amount of the maximum hours approved by a WellCare of North Carolina Care Management assessment and a service plan:
   1. Requires an increased level of supervision (observation resulting in an intervention) as assessed during an assessment conducted by a WellCare of North Carolina Care Manager;
   2. Requires caregivers with 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 learning, and the loss of language skills;
   3. Regardless of setting, requires a physical environment that addresses safety and safeguards the Member because of the Member's gradual memory loss, impaired judgment, disorientation, personality change, difficulty learning, and loss of language skill; **and**
   4. Health record documentation or verifiable information provided by a caregiver obtained during the Care Manager assessment reflects a history of escalating safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.

II. Electronic Visit Verification

A. Electronic Visit Verification Requirements (EVV) Minimum Requirements
   1. Comply with Section 12006 1903 (l) of the 21st Century Cures Act and any subsequent amendments.

2. 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.
3. Provider agencies must have written documentation that they have informed members of the EVV requirement in each Member's file.
4. Provider agencies must ensure staff are trained on use of the EVV system selected and maintain written documentation of initial and at least annual staff training in each employee's file.

B. Electronic Visit Verification (EVV) Technology Options and Requirements
1. Effective January 1, 2021, providers are required to use an Electronic Visit Verification 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.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
99509	Home visit for assistance with activities of daily living and personal care

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original Approval date.	04/21	06/21
Added EVV information to criteria and background	07/21	08/21
Reviewed CPT codes.	08/22	08/22
NCHC verbiage removed from NC Guidance Verbiage.	04/23	04/23
Annual review.	08/23	08/23
Annual Review. Removed HCPCS & ICD-10 code boxes.		

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy. No: 3L State Plan Personal Care Services (PCS). Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published June 1, 2023. Accessed April 2, 2024.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

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.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the 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, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary

"to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

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 - as applicable to the service provided:
   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.
   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 - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

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

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.