Clinical Policy: State Plan Personal Care Services (PCS) Provided in Congregate Settings

Reference Number: WNC.CP.298 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) are provided in congregate settings for a Medicaid Member 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 Personal Care Services in Congregate Settings is referenced as PCS.

Policy/Criteria[1]

I. WellCare of North Carolina® shall cover State Plan Personal Care Services (PCS) Provided in Congregate Settings when the Member meets the following specific criteria and other items in this section:

A. Has a **medical or mental condition, disability, or cognitive impairment** and demonstrates unmet needs for, at a minimum:
1. Three of the five qualifying activities of daily living (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.

B. Resides in:
1. A congregate facility licensed by the State of North Carolina as an Adult Care Home (ACH) as defined in NC G.S. §131D-2.1, a combination home as defined in NC G.S. § 131E-101; **OR**
2. A group home licensed under Chapter 122C of the General Statutes and under 10A NCAC 27G .5601 (b)(2) 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.

C. In addition to the specific criteria in Criteria I.A. **and** I.B. of this policy, the following criteria must be met:

1. The congregate setting is safe and free of health hazards for the Member and PCS provider(s), as determined by a facility environmental assessment conducted by NC Medicaid or a DHHS designated contractor;
2. The congregate 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 or mental 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; **AND**

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

II. Personal Care Services

A. WellCare of North Carolina® **shall cover** the following Personal Care Services that 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 Instrumentals of Daily Living (IADLs) that are directly related to the Member's qualifying ADLs and essential to the Member's care at their private residence;
4. Assistance with medication when directly linked to a documented medical condition or physical or cognitive impairment as specified in Criteria I.;
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 (assistance with ADLs that requires a Nurse aide II) and delegated medical monitoring tasks.

III. WellCare of North Carolina® **shall cover** medication assistance when it is:
- **A.** Delivered in an Adult Care Homes, and provides medication administration as under 10A NCAC 13F and 13G; **OR**
- **B.** Delivered in supervised living homes and provides medication administration under 10A NCAC 27G.

IV. WellCare of North Carolina® **shall not** cover Personal Care Services in Congregate Settings when:
- **A.** The initial Care Management assessment has not been completed;
- **B.** The PCS is not documented as completed according to this clinical coverage policy;
- **C.** A reassessment has not been completed within 30 calendar days of the end date of the previous prior authorization period because the Member refused the assessment, could not be reached to schedule the assessment, or did not attend the scheduled assessment;

Note: *A delayed scheduling of a Care Management reassessment does not impact the continuous coverage of PCS while the reassessment is being arranged.*

- **D.** The PCS is provided at a location other than the Member's primary congregate living setting;
- **E.** The PCS exceeds the amount approved by the Care Management assessment;
- **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 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;
- **I.** 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;
- **J.** Independent medical information does not validate the assessment, PCS hours may be reduced, denied, or terminated based on the additional information.

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

V. WellCare of North Carolina® **shall not** cover PCS in a licensed congregate facility 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.*

VI. WellCare of North Carolina® **shall not** cover **ANY** of the following services under PCS:
- **A.** Skilled nursing services provided by a Licensed Practical Nurse (LPN) or Registered Nurse (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.** Instrumental activities of daily living (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);
- **L.** Other tasks and services not identified in the Member's Independent Assessment and noted in their Service Plan; **AND**
- **M.** Room and Board.

VII. Additional Criteria Not Covered
- **A.** WellCare of North Carolina® shall not cover PCS when rendered concurrently with another substantially equivalent Federal or State funded service. Services equivalent to PCS are:
  1. Home health aide services and in-home aide services in the Community Alternatives Programs (CAP/Choice, CAP/Disabled Adults) **AND**;
  2. Private Duty Nursing (PDN).

Background[1]

I. Prior Approval:
- **A.** WellCare of North Carolina® shall require prior approval for State Plan Personal Care Services (PCS) Provided in Congregate Settings. The provider shall obtain prior approval before rendering State Plan Personal Care Services (PCS) Provided in Congregate Settings.
- **B.** The amount of prior approved service is based on an assessment conducted by a 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**.

C. Member performance is rated as:

1. Totally independent;
2. Requiring cueing or supervision;
3. Requiring limited hands-on assistance;
4. Requiring extensive hands-on assistance; **or**
5. Totally dependent.

Member's Self- Performance Rating	Description
0 – Totally able	Member is able to self-perform 100 percent of activity, with or without aids or assistive devices, and without monitoring or assistance setting up supplies and environment
1 – Needs verbal cueing or monitoring only	Member is able to self-perform 100 percent of activity, with or without aids or assistive devices, and requires, monitoring, or assistance retrieving or setting up supplies or equipment
2 – Can do with limited hands-on assistance	Member is able to self-perform more than 50 percent of activity and requires hands-on assistance to complete remainder of activity
3 – Can do with extensive hands-on assistance	Member is able to self-perform less than 50 percent of activity and requires hands-on assistance to complete remainder of activity
4 – Cannot do at all (full dependence)	Member is unable to perform any of the activity and is totally dependent on another to perform all of the activity

II. Additional Limitations or Requirements

A. Monthly Service Hour Limits

1. The following hour limits apply to a Member who meets PCS eligibility requirements and coverage criteria in this policy:
   a. A Member 18 years of age and older may be authorized to receive up to 80 hours of service per month.
2. A Medicaid Member 18 years of age who meets the eligibility in Criteria I. of 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 the State Plan according to an independent assessment and a service plan.
   a. Requires an increased level of supervision (observation resulting in an intervention) as assessed during an Care Management assessment;
   b. 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;

c. 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**
d. Health record documentation or verifiable information provided by a caregiver obtained during the Care Management assessment reflects a history of escalating safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.

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 2025, 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

MODIFIERS - Provider(s) shall follow applicable modifier guidelines:

Providers	Modifiers(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

PLACE OF SERVICE - PCS is provided in the member'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.

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date		

References

1. State of North Carolina Medicaid Clinical Coverage Policy No:3L-1 State Plan Personal Care Services (PCS) Provided in Congregate Settings. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published April 1, 2025. Accessed April 4, 2025.

North Carolina Guidance

Eligibility Requirements

1. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
2. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
3. 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

- 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:

I. that is unsafe, ineffective, or experimental or investigational.

II. 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

- 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.
- **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:

i. meet Medicaid qualifications for participation;
ii. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
iii. 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:

- 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.
- 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.
- 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
- Modifiers - Providers shall follow applicable modifier guidelines.
- Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
- Co-payments -
  For Medicaid refer to Medicaid State Plan:
  https://medicaid.ncdhhs.gov/meetingsnotices/medicaid-state-plan-public-notices

- 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.