

**Division of Medical Assistance
Personal Care Services Frequently Asked Questions**

1. Is an order from the primary physician necessary for reassessing existing clients for the PACT form?

Answer: A physician's order to assess current clients in order to complete the new PACT form is not required. However, if the PCS PACT form completion falls at the time of the annual reassessment, the physician's order to continue services is required (see **section 7.3.2** of the PCS policy). All PCS PACT forms must be signed by the physician.

2. Is a physician's order necessary to reassess when a client is discharged from a hospital, SNF or rehab and the attending physician gives an order to resume Personal Care Services? Is it necessary to obtain the primary physician's authorization before reassessing the client?

Answer: A physician's order is not necessary to reassess a client who has had a lapse in service due to institutionalization or another unplanned lapse in PCS. If the reassessment results in significant changes in the plan of care, a physician's order is necessary to resume PCS. Additionally, the primary physician's certification on the PACT form must be obtained. (See **sections 7.3.3 and 7.8.1-7.8.3** of the PCS policy.) Also refer to the answer to question 15 regarding physician orders.

3. The policy prohibits home management time from exceeding the personal care activity time. One of our clients needs 1.5 hours of personal care time each day and weekly laundry as one of the home management tasks. The client does not own a washer or dryer and lives 30 minutes from the nearest laundry facility. The PCS policy only allows a maximum of 60 minutes for washing, drying, folding and putting away laundry. In this client's case, the travel time to the laundry facility takes all of the allowable time for laundry. Additionally, we cannot exceed the 1.5 hours of personal care time and there would not be enough time for other crucial home management tasks. What do we do?

Answer: **Section 5.7, 2** of the PCS policy states that the time for home management tasks cannot exceed the weekly personal care time. It is therefore necessary to look at the required tasks on a weekly basis. In the above example, the aide is providing 1.5 hours of personal care time five days per week (7.5 hours total). Home management time cannot exceed 7.5 hours. It appears that the laundry task including driving would take approximately 2 hours per week, which is less than the personal care time. There should be time for other home management task time without exceeding the personal care time. Another option could include doing the laundry every 2 weeks.

However, should a task create an exception to the time guidance, the exception should be documented in field 38 on the PACT form.

4. The assessment doesn't fully address the problems with some mental health clients. Does supervision qualify clients to keep their PCS?

Answer: All clients must qualify for PCS using the criteria contained in **section 3.2, Medical Necessity**. A client must require assistance with a minimum of two Activities of Daily Living (ADLs). The required assistance must be directly related to a medical condition. **Section 4.6, 6** states that continuous monitoring or ongoing client supervision is a non-covered task.

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

Answer: The referral date is the date an agency receives a referral from any source. A verbal or written order is then required from the primary physician to perform an assessment. After an RN finds through the assessment that the client is appropriate for PCS, another order from the primary physician is required to begin services. In summary, two orders are required. Verbal orders must be signed within 60 days. Fields 47 and 48 on the PACT form address the order to assess the client for services and the order to begin PCS.

6. Please provide information on the aide levels and the types of clients that the aides can care for. How does one assign the correct aide level based on ADLs?

Answer: Section 6.3.2 of the PCS policy provides information on in-home aide qualifications and refers readers to Division of Facility Services North Carolina Administrative Code 10A NCAC 13J.1110. These rules require that both in-home aides subject to occupational licensing laws and those not subject to occupational licensing laws **demonstrate competence for any client care activities they are assigned to perform.** The PCS policy requires that a registered nurse perform an assessment, share responsibility with the PCS provider for the accuracy of the plan of care and supervise the provision of personal care services.

The North Carolina Board of Nursing (NCBON) states that “as with all patient care activities that a licensed nurse assigns to other licensed personnel and/or delegates to unlicensed personnel, the licensed nurse is held accountable for assuring that the licensed nurse or unlicensed personnel is competent in safely performing the assigned and/or delegated activities. It is important to remember that under nursing law the licensed nurse may only delegate to unlicensed personnel those common, repetitive tasks which frequently recur in the daily care of a client or group of clients, and which do not require the professional judgment of a licensed nurse. Patient-care activities that are done infrequently should not be delegated by the licensed nurse to unlicensed personnel.” (www.ncbon.com - “Responses to Frequently Asked Questions, Delegation of Non-Nursing Functions to Unlicensed Personnel”)

Remember to assess the client’s entire situation in assigning the appropriate level of in-home aide to ensure the aide is competent to safely carry out the plan of care. While DMA has not prescribed a standardized competency checklist, a PCS provider would be expected to produce documentation of the process used to assure competencies of all assigned or delegated personal care activities. Information on establishing competencies can be found at the following websites:

http://facility-services.state.nc.us/approved_comp_evaluators.pdf

<http://facility-services.state.nc.us/skills.pdf>

<http://www.dhhs.state.nc.us/aging/inhtools.level2.pdf>

**** Please note the Division of Facility Services is considering recommending changes to In-Home Aide qualifications for licensed Home Care Agencies. Be on the look out for these changes in licensure rules as they may affect PCS in-home aide qualifications.

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

Answer: A decision to discharge and reopen as a new admission (new consents, etc.) depends on provider agency policy and home care licensure rules. **Section 7.3.3** of the PCS policy addresses when a reassessment is necessary due to a lapse in service greater than 7 days. Additional pertinent policy sections include **7.3.4, 7.3.5 and 7.8.1 through 7.8.3.**

8. Please explain how scores were determined in the example of client Mary Hope from the PCS training in November.

Answer: Page 2 of the PACT form, sections A and B have the numbers necessary to score fields 19-30. For field “#21 Nutrition,” **the PACT form used in the training for client Mary Hope contained an error in the ADL self performance and support needed columns.** The client should have been scored a “0” since meal preparation and set-up are not ADL deficits. The client should have scored a “0” under ADL Support Provided because the aide did no hands on assistance and only prepared the meal. “Meal preparation and set-up only” are IADLs and are not scored on the PACT form. Ambulation was a ‘2’ because the aide had to give hands on assistance to steady gait but did not bear weight for the client. Remember you do not score IADLs, even though you may be assigning tasks related to IADLS. You only score ADLs.

9. If a primary care physician provides a hand written order to begin services, is it still necessary to get another verbal order after the RN completes the assessment? If you do not have to get another order, do you leave questions 47 & 48 blank on the DMA 3000?

Answer: **Section 7.1** of the PCS policy states that it is necessary to obtain an order, either verbal or written, before services begin after the RN assessment has found the client appropriate for PCS. A total of two physician orders are necessary, one to conduct an initial assessment and one to begin services.

10. How should providers judge the amount of time a nursing assistant spends in the home? Is there a guideline for each task to be performed? Is there a master sheet available providing time limits for each task?

Answer: **Section 5.4 and 5.4.1** of the PCS policy refers readers to **Attachment B: Time Guidance for Personal Care and Home Management Tasks.** This attachment provides the time guidance for Personal Care and Home Management tasks.

11. Please explain ADLs as related to PCS. What are IADLs?

Answer: **Activities of Daily Living (ADLs)** refers to six activities - **bathing, dressing (includes grooming), ambulation/transfers (mobility), eating, toileting and bowel/bladder incontinence** - that reflect a person’s capacity for self-care. These are activities that a person is normally able to perform independently for themselves. Clients on the PCS program need either assistance with their ADLs or need to have the ADL performed for them.

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The PCS policy states that a client must have deficits in a minimum of two of the above Activities of Daily Living (ADLs) and need assistance with these ADLs through PCS. The deficits must be linked to a medical condition.

The PACT form contains the six ADLs as well as other personal care tasks. These other personal care tasks are not one of the six ADLs but are personal care tasks that may be associated with an ADL deficit. For example, assistance needed with personal hygiene is a personal care task associated with either a deficit in bathing or dressing. It is not one of the six ADL deficits.

Another ADL is bowel/bladder incontinence. If a client is incontinent of the bladder and needs assistance cleaning or changing themselves, that is an ADL deficit.

Toileting is an ADL deficit. If a client has normal bladder function, but needs assistance toileting – either cleaning himself/herself or needing actual assistance using the toilet and/or bedside commode and cleaning himself/herself – that is an ADL deficit.

A client independent with using the toilet (does not need help using the toilet and/or cleaning himself/herself) would not have an ADL deficit in toileting. A client just needing the bedside commode emptied does not have an ADL deficit if he/she can use the bedside commode independently. Emptying the bedside commode would be a home management task.

Another ADL example: A client needs help bathing and ambulates independently with a walker. Assuming that none of the other six ADLs are deficits requiring assistance through PCS, does this client have two ADL deficits requiring assistance in order to qualify for PCS? No, he/she does not. The client only has one ADL deficit requiring assistance – bathing. Because the client walks independently with the walker requiring no assistance, there is no ambulation ADL deficit requiring PCS assistance. If the aide needed help to get the walker in place, assist the client to stand and walk with the client to ensure safety, the client would have an ADL deficit in ambulation because the aide actually provides limited assistance while the client is ambulating with the walker.

Caution must be taken not to confuse ADLs with Instrumental Activities of Daily Living (IADLs). IADLs are home management and support tasks, such as bill paying. For example, a client who cannot eat independently and must be fed orally or by a tube has an ADL deficit in eating. A client who can feed himself/herself but needs a meal prepared or groceries purchased, does not have an ADL deficit in eating. Rather, he/she has an identified need for a home management task to be performed. Meal preparation or grocery shopping is a home management task and not an ADL deficit that can be used as one of the two ADL deficits necessary to qualify for PCS. Meal preparation and grocery shopping are IADLs.

Another IADL example: A client needs help bathing and dressing and cleaning the bathroom. Cleaning the bathroom is a home management task or an IADL, not an ADL.

Remember – IADL tasks are not scored on the PCS PACT. They are documented with the most rational and reasonable ADL that demonstrates the link between the task and a functional deficit created by a medical condition.

12. If a nurse determines that a client's needs cannot be met during the time guidance limitations but documents why an exception was made to the PCS policy guidelines, what is likely to be DMA's response?

Answer: DMA requires that time guidance exceptions be documented in field #38 of the PACT form. Documentation should be clear enough to indicate why the client needed the extra time. The PACT form should contain adequate information to support the client's need for extra time. See #38 in the field instructions for completing the PACT form and **section 5.4.1** in the PCS policy.

13. Is there a problem with doing a separate aide assignment sheet that has some additional information that the aides need (directions to client's home) that is easier to read?

Answer: Section 7.7 of the PCS policy states that in addition to the plan of care, the provider may develop a more detailed aide assignment from the plan of care. However, Medicaid payment for in-home services is limited to the tasks identified in the plan of care (POC). Caution should be taken to assure that the assigned aide tasks match the PACT POC.

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

Answer: History indicates that most clients miss at least one day out of every month due to doctor appointments or other occurrences. However, if in the last week of the month there is not enough time left to provide regularly scheduled PCS hours on all days and there is no family member or other caregiver to provide the personal care, the agency could decrease the hours per day for that week to allow enough time for the aide to provide personal care each day and perform most of the scheduled home management tasks. The reasons that scheduled tasks are not done should be documented on the flow sheet or assignment sheet. There does not have to be a permanent change in the plan of care since there is no lapse of service; documentation in the record should reflect the reason for the time adjustment.

15. When are physician orders required for PCS?

Answer: A verbal or written order to assess a client, also known as the referral order, is required for the initial assessment (but not for reassessments). A verbal or written order is also needed to begin or continue services after the initial assessment and annual reassessment.

Agencies should also consider getting a verbal order or written order to continue services following a lapse in service greater than 7 days and following discharge from an institution. The client's needs are likely to have changed and the physician will need to indicate if the client is still appropriate for PCS services. However, DMA PCS policy does not require that a verbal order be obtained in these circumstances. Agencies should also follow home care licensure rules and obtain physician orders for medical treatment interventions when required.

Significant revisions to the plan of care require a physician certification authorizing services on the PACT form (**section 7.8.1** of the PCS policy).

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A physician's order is also required for delegated medical monitoring when the Nurse Practice Act requires physician orders, such as an invasive procedure like blood sugar checks delegated to an aide.

Verbal or written orders do not take the place of the physician's authorization on the POC. The physician's authorization on the POC must always be obtained when policy requires that. See **section 7.0** of the PCS policy.

16. In scoring Field #30, Self Monitoring, on the PACT form, is it necessary to allot time for a task, or is it permissible not to score it and still provide time for it?

Answer: All fields #19 - #30 require a score. A score of '0'-'1' indicates no hands on help is needed. Therefore, there would be no need for a task assignment and no time allotment.

If the client scores '2'-'4' and a personal care or home management task is assigned, time would need to be allotted for the tasks using the time guidance attachment in the PCS policy. To qualify for PCS, a recipient must require assistance with a minimum of two ADL deficits. (Scores of '2' in two ADLs - bathing, eating, toileting, dressing, ambulation/transfers (mobility), bowel/bladder incontinence.) The last column on page 2 of the PACT form provides a space for the assessor to check if PCS assistance is needed based on the assessment and scoring of columns A and B. The task meeting the identified ADL deficit must occur in the plan of care. The unmet ADLs must be identified on the PCS PACT form and must be addressed in the recipient's plan of care. (See **sections 3.2.1 and 7.4.1** in the PCS policy)

A detailed instruction sheet for completing the PCS PACT form is available at:
<http://info.dhhs.state.nc.us/olm/forms/dma/dma-3000I.pdf>

17. A client who lives in a very rural area requires about 1 hour and 35 minutes a week for grocery shopping. This results in the weekly home management task time exceeding the weekly personal care task time. Is it acceptable to just document an exception to this in the clinical record? If we adjust the schedule to do the grocery shopping every two weeks, the weekly home management task time still exceeds the weekly personal care task time per week. Is this permissible since the monthly home management task time would be less than the monthly personal care task time?

Answer: Weekly home management time cannot exceed weekly personal care time. See **section 5.7. 2** of the PCS policy. Exceptions to the time guidance must be documented in field #38 of the PACT form.

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

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

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

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

20. Some clients require such specialized care that they do not see any physician other than their specialist, who handles all their needs. For example, a terminal client sees only their oncologist and a client on dialysis sees only the dialysis physician. Since these physicians prescribe the majority of the medications and have the most contact with the clients, can they be considered the primary care physician? This seems to align with DMA's guideline that the physician who knows the most about the client and who has the most contact with the client actually orders PCS services.

Answer: The primary physician is either the Carolina Access physician or the physician who treats the client for routine medical problems. There may be times when the primary physician is a specialist because he/she treats the client for all of their medical problems and manages the client's medications, i.e., a dialysis client whose primary physician is a nephrologist. A primary care physician is the lead provider for the client's total medical needs. Document, for example, who the client would see for the flu or a respiratory infection, etc.

21. Dusting, mopping and related home management tasks are linked to the client's respiratory status on the PCS PACT form. However, a client with a stroke or poor endurance might not be able to complete these tasks either. If a client has normal respirations, could these home management tasks be provided as long as an exception is documented in field 38 on the PACT form?

Answer: Yes, the exception could be explained in field # 38 as long as it is clearly documents that the task is due to the client's medical condition.

If the client's respirations are normal the need for these tasks could be supported by poor endurance and documented on the PACT form and explained in field 38. For example: "Due to the client's poor endurance, assistance is needed one time a week with mopping and dusting."

22. If a client is already on PCS plus, is it necessary to redo the assessment to complete the PCS PACT form? Is it necessary to resubmit information for prior approval for PCS plus? If the PACT assessment indicates the same or more hours does the client just continue with the same PCS Plus prior approval previously issued?

Answer: All clients receiving PCS or PCS plus must be reassessed and a new PACT form completed by 3/01/06. If a client already has prior approval for PCS-Plus, the provider continues with the approval until the next reauthorization date at which time the new PACT assessment should be sent to the DMA if requested by the PCS nurse consultant. PCS Plus hours may not exceed 80 hours per month.

23. Do all nurses working in the PCS program have to take the Nursing certification?
Answer: Yes, all RN's who work in the PCS program must successfully complete the PCS RN certification available on line through AHEC connect. (www.aheconnect.com/ahhc). The RN has until 2/28/06 to complete the on line certification. Newly hired nurses must be certified before performing PCS assessments or providing PCS supervision.
24. When can we expect to see DMA staff conducting on site validation visits referred to in the QA plan or other QA activities?
Answer: DMA staff is preparing to conduct on site visits beginning in early February 2006. The visits will include a review of the agency self audit of key aspects of care. DMA will also conduct focus reviews, which may include record reviews.