



**Personal Care Services Webinar  
Training for Licensed Adult Care Home  
Providers and Licensed Home Care  
Providers**

**Thursday, November 25, 2012**

**10:00am – 11:30am**

Kimberlee Hyman

HCBS Educator and Support Specialist



## Webinar Objectives

- ❖ Overview of transition assessments, beneficiary notices and appeal rights
- ❖ Key transition requesting processes for new admissions, change of provider and change of status
- ❖ Requirements for plan of care development and aide documentation
- ❖ Overview of program codes, modifiers, and CMS 1500
- ❖ Understand the provider interface registration process for QiReport



# The Carolinas Center for Medical Excellence

Effective **January 1, 2013**, Medicaid personal care services for beneficiaries will be provided under a consolidated Personal Care Services (PCS) benefit.

Clinical Coverage Policy 3L, Personal Care Services, has been revised based on public comments.

**A 15-day reposting for public comment through November 24, 2012:**

<http://www.ncdhhs.gov/dma/mpproposed/index.htm>.





**Q. During the transition is there a difference between ACH and IHC eligibility determination?**

**A. No. Eligibility determinations for all beneficiaries will be made on the basis of the most recent independent assessment, conducted within the previous 12 months.**



ACH

- Ongoing independent assessments
- Continued assessments for new admissions and change of status through the end of 2012



- Last independent assessments
- Continued assessments for current beneficiaries through the end of 2012
- Continue with current authorization level



## The Carolinas Center *for* Medical Excellence

100 Regency Forest Drive, Suite 200, Cary, NC 27518-8598 • 919.461.5500 • 800.682.2650 • www.thecarolinascenter.org

### NOTICE OF DECISION ON A CONTINUING REQUEST FOR MEDICAID SERVICES

October 15, 2012

Mr. Lewis N. Clark  
123 Exploration Avenue  
Somewhere, NC 12345

Mike N. Ike  
123456789M  
Sabta Maria Home Care Facility  
678 Compass Drive  
Nightingale, NC 27785

RE: Lewis N. Clark  
MID: 000-00-0000K  
Service Requested: Personal Care Services

Dear Mr. Lewis Clark:

Effective January 1, 2013, N. C. Medicaid will no longer offer services under the In-Home Care (IHC) and Adult Care Home Personal Care Services (ACH-PCS) programs. Personal care services for beneficiaries residing in private living arrangements and licensed ACH facilities will instead be provided under a new, consolidated Personal Care Services (PCS) benefit. Licensed ACH facilities include Adult Care Homes, Family Care Homes, Supervised Living Group Homes, and Combination Homes with ACH beds.

Pursuant to N.C. Session Law 2012-142, Sections 10.9F.(b) and 10.9F.(c); North Carolina State Plan for Medical Assistance; and Division of Medical Assistance (DMA) Clinical Coverage Policy 3L, PCS covers hands-on assistance with Activities of Daily Living (ADLs), including bathing, dressing, mobility, toileting, and eating. PCS may also include assistance with related home management tasks, medications, adaptive or assistive devices, and durable medical equipment. **PCS does not cover transportation or errands.** The full list of covered and non-covered services can be found in Division of Medical Assistance (DMA) Clinical Coverage Policy 3L, which is available at: <http://www.dhhs.state.nc.us/dma/mp/index.htm>.

As required by the North Carolina State Plan for Medical Assistance; N.C. Session Law 2012-142, Sections 10.9F.(b) and 10.9F.(c); and Division of Medical Assistance (DMA) Clinical Coverage Policy 3L, all Medicaid beneficiaries receiving Personal Care Services must be referred by their primary or attending physician and receive an independent assessment by a registered nurse or social worker affiliated with DMA or the Independent Assessment Entity (IAE) designated by DMA. The Carolinas Center for Medical Excellence (CCME) is the IAE designated by DMA to conduct independent assessments.

**Usted tiene treinta (30) días para apelar esta decisión. Tiene que enviar su solicitud dentro de diez (10) días para continuar los servicios sin interrupción. Si necesitas ayuda para leer y entender la carta, por favor contáctese con el 1-800-662-7030. DIGA AL OPERADOR QUE LA NOTIFICACION DMA 2002PCS-Transition.**

DMA 2002PCS Transition [Select One: HB HC HH HI HA SC TT]

# TRANSITION NOTIFICATIONS

## Notice of Decision on a Continuing Request For Medicaid Services

| <b>Beneficiary's Self-Performance Rating</b>  | <b>Description</b>   |
|---|--|
| 0 – Totally able                              | Beneficiary is able to self-perform 100 percent of activity, with or without aids or assistive devices, and without supervision or assistance setting up supplies and environment                          |
| 1 – Needs verbal cueing or supervision only   | Beneficiary is able to self-perform 100 percent of activity, with or without aids or assistive devices, and requires supervision, monitoring, or assistance retrieving or setting up supplies or equipment |
| 2 – Can do with limited hands-on assistance   | Beneficiary 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 | Beneficiary 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)        | Beneficiary is unable to perform any of the activity and is totally dependent on another to perform all of the activity  |

CCME completed your assessment on «assessmentdate». After reviewing the assessment results, Medicaid approved «hours» hours of PCS per month until the earlier of «FL2 or reassessmentdate» or the next assessment completed by DMA or the LAL designated by DMA. This is [select one: an increase, no change] to the service hours you currently receive.

Your approved service level is based on your assessed self-performance levels and days of unmet need for assistance with the five qualifying Activities of Daily Living (ADLs). Your assessed self-performance levels and days of unmet need for assistance with the five qualifying ADLs are as follows:

| ADL       | Self-Performance Level                    | Days of Unmet Need per Week |
|-----------|---|-----------------------------|
| Bathing   | Totally able without assistance           | 0-7                         |
| Dressing  | Needs verbal cueing or supervision only   | 0-7                         |
| Mobility  | Can do with limited hands-on assistance   | 0-7                         |
| Toileting | Can do with extensive hands-on assistance | 0-7                         |
| Eating    | Cannot do at all                          | 0-7                         |

This approval of services is effective **January 1, 2013**. The above named provider was selected by you and will be providing these services. If you wish to select a different provider, please contact CCME at 1-800-228-3365.

Sincerely,

Independent Assessment Department  
The Carolinas Center for Medical Excellence  
1-800-228-3365

C: Provider

# TRANSITION NOTIFICATIONS

## Notice of Decision on a Continuing Request For Medicaid Services



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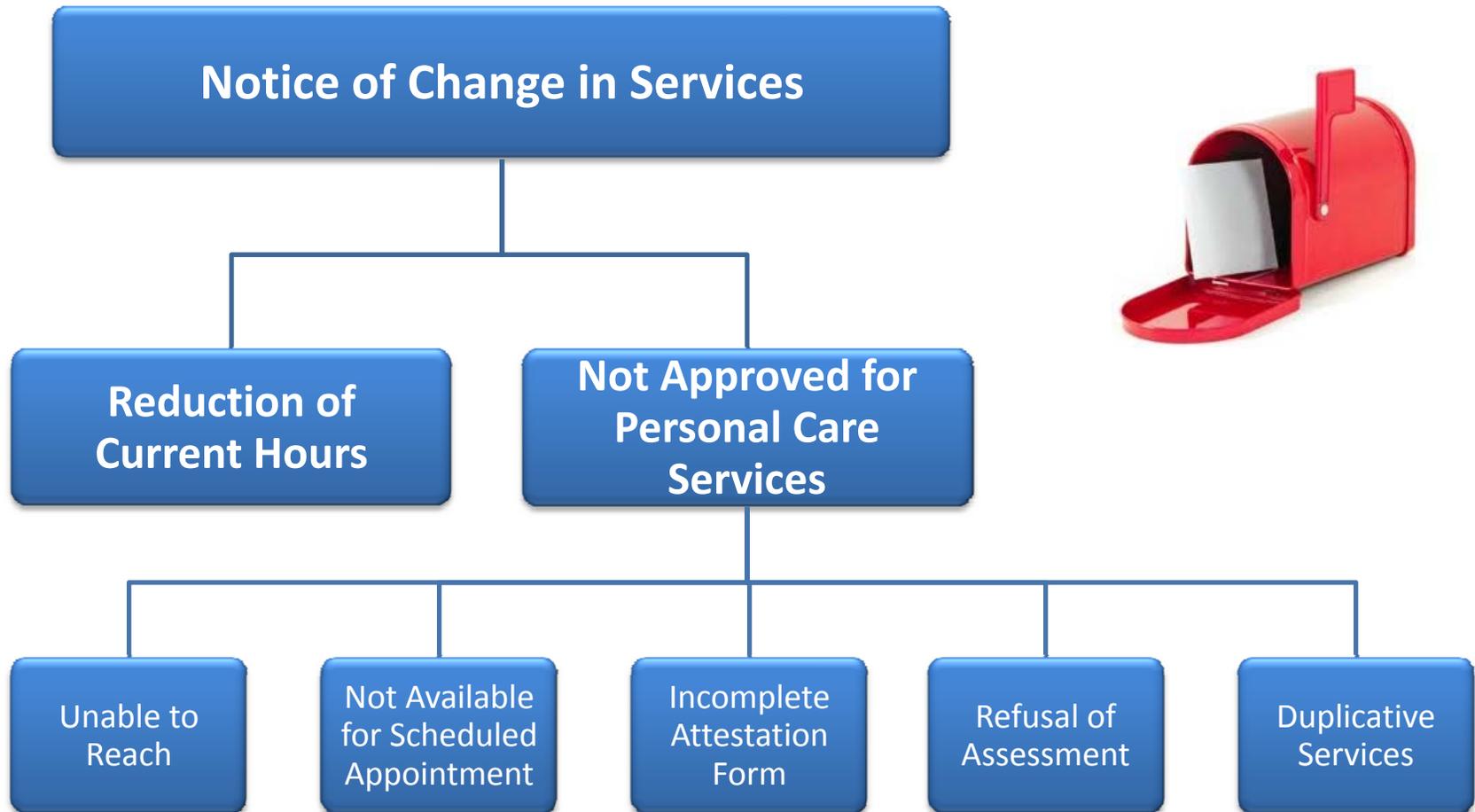
As required by the North Carolina State Plan for Medical Assistance; N.C. Session Law 2012-142, Sections 10.9F.(b) and 10.9F.(c); and Division of Medical Assistance (DMA) Clinical Coverage Policy 3L, all Medicaid beneficiaries receiving Personal Care Services must be referred by their primary or attending physician and receive an independent assessment by a registered nurse or social worker affiliated with DMA or the Independent Assessment Entity (IAE) designated by DMA. The Carolinas Center for Medical Excellence (CCME) is the IAE designated by DMA to conduct independent assessments.

**Usted tiene treinta (30) días para apelar esta decisión. Tiene que enviar su solicitud dentro de diez (10) días para continuar los servicios sin interrupción. Si necesitas ayuda para leer y entender la carta, por favor contáctese con el 1-800-662-7030. DIGA AL OPERADOR QUE LA NOTIFICACION DMA 2002PCS-Transition.**

DMA 2002PCS Transition [Select One: HB HC HH HI HA SC TT]

# TRANSITION NOTIFICATIONS

## Notice of Change in Services



This letter explains why this decision was made and tells you how to appeal if you disagree.

This decision is based on the authority granted to the North Carolina Department of Health and Human Services by Title XIX of the Social Security Act and its implementing regulations, the North Carolina State Plan for Medical Assistance, N.C.G.S. §108A-25(b), §108A-54, N.C. Session Law 2012-142, Sections 10.9F.(b) and 10.9F.(c), 10A NCAC 22O .0301, and Clinical Coverage Policy #3L, Personal Care Services, which can be found at: <http://www.dhhs.state.nc.us/dma/mp/index.htm>.

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION.** To appeal, you must complete and file the attached Medicaid Beneficiary Services Hearing Request form asking for a hearing with the Office of Administrative Hearings (OAH).

**YOU HAVE UNTIL JANUARY 30, 2013, TO FILE THE REQUEST FOR HEARING. IF YOUR SERVICES ARE BEING STOPPED OR CHANGED, YOU MUST FILE THE APPEAL NO LATER THAN JANUARY 10, 2013, FOR YOUR SERVICES TO CONTINUE WITHOUT INTERRUPTION AT THE CURRENT AUTHORIZED LEVEL IF LESS THAN 80 HOURS OR, OR UP TO A MAXIMUM OF 80 HOURS PER MONTH AS ALLOWED PER PCS POLICY #3L.**

To learn more about the hearing process, please call OAH at 919-431-3000, Medicaid at 919-855-4350, or the toll free CARE-LINE at 1-800-662-7030, Monday-Friday, 8:00 a.m.-5:00 p.m. To speak with a Medicaid staff person about this decision, call the name and telephone number listed at the end of this notice.

### **FILING THE APPEAL REQUEST**

- To file for a hearing, you must submit a **completed hearing request form** (enclosed only in the beneficiary's mailing). You can also get a duplicate hearing request form by calling the Division of Medical Assistance at 919-855-4350 or the toll free CARE-LINE at 1-800-662-7030 and ask for your call to be transferred to Clinical Policy and Programs, the Appeals Section.
- Mail or fax the completed hearing request form to Clerk of Court, Office of Administrative Hearings. The addresses and fax numbers are on the hearing request form.
- If you file your appeal **on or before January 30, 2013** and you remain otherwise eligible for Medicaid, your service(s) will be reinstated during the appeal unless you choose not to maintain your service(s).
- If you file your appeal **on or before January 30, 2013**, you will receive authorization for payment for services during the appeal even if you change providers and even if you do not file the appeal on or before January 10, 2013. Services will be provided at the same level you are receiving now or the level that was requested by your provider, up to a maximum of 80 hours per month, whichever is less.



# Appeal Rights

# Appeals: Maintenance of Service

- Timely appeal is filed
- Maintain the same hours of service the day before the Notice of Change in Service letter was mailed
- A beneficiary is eligible to receive services while the appeal is pending

# TRANSITION REQUESTS

## New Admissions

N.C. Department of Health and Human Services – Division of Medical Assistance  
**PERSONAL CARE SERVICES (PCS) FOR LICENSED ADULT CARE HOME RESIDENTS**  
**INDEPENDENT ASSESSMENT REQUEST FOR NEW ADMISSIONS**

**Licensed Adult Care Home Provider:** Use this form to report Medicaid beneficiaries admitted to your facility **after** CCME's initial visit to conduct independent eligibility assessments for the January 1, 2013 Consolidated PCS program. Report only Medicaid recipients admitted to your facility who require a PCS eligibility assessment. Do not use this form if CCME's initial visit to your facility is still in the future.

Send completed form to CCME via fax at **877-272-1942**, or mail to:  
**CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598.**  
 Receipt may be confirmed with CCME at **800-228-3365**. E-mail questions to **PCSAssessment@thecarolinascener.org**.

**PLEASE COMPLETE ALL FIELDS.**

**Section A. Facility Information** *Complete all fields.*

Today's Date: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy)

Facility Name: \_\_\_\_\_ Medicaid Provider Number \_\_\_\_\_

Facility Contact Person: \_\_\_\_\_ Contact Position: \_\_\_\_\_

Facility Fax Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Facility Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ County: \_\_\_\_\_

**Section B. New Admissions** *List each new admission on a separate line, and complete all fields.*

|     | Medicaid ID# | First Name | Last Name | Date of Birth<br>(mm/dd/yyyy) | Admission Date<br>(mm/dd/yyyy) |
|-----|--------------|------------|-----------|-------------------------------|--------------------------------|
| 1.  | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 2.  | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 3.  | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 4.  | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 5.  | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 6.  | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 7.  | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 8.  | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 9.  | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 10. | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 11. | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 12. | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 13. | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 14. | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 15. | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 16. | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 17. | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 18. | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 19. | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 20. | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |

*Attach additional sheet to report more than 20 New Admissions.*

**IMPORTANT:**  
 Also initiate completion of the PCS Medical Attestation Form (DMA Form-3065) immediately for each New Admission listed above. The required PCS Medical Attestation Form is available at <http://www.ncdohhs.gov/DMA/pcs/pas.html>.

# TRANSITION REQUESTS

## Change of Provider

N.C. Department of Health and Human Services – Division of Medical Assistance  
**PERSONAL CARE SERVICES (PCS) FOR LICENSED ADULT CARE HOME RESIDENTS**  
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**PLEASE COMPLETE ALL FIELDS.**

**Section A. Facility Information** *Complete all fields.*

Today's Date: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy)  
 Facility Name: \_\_\_\_\_ Medicaid Provider Number \_\_\_\_\_  
 Facility Contact Person: \_\_\_\_\_ Contact Position: \_\_\_\_\_  
 Facility Fax Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Facility Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ County: \_\_\_\_\_

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|     | Medicaid ID# | First Name | Last Name | Date of Birth<br>(mm/dd/yyyy) | Admission Date<br>(mm/dd/yyyy) |
|-----|--------------|------------|-----------|-------------------------------|--------------------------------|
| 1.  | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 2.  | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 3.  | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 4.  | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 5.  | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 6.  | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 7.  | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 8.  | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 9.  | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
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| 11. | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 12. | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 13. | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 14. | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
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| 17. | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
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| 19. | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |
| 20. | _____        | _____      | _____     | ___/___/___                   | ___/___/___                    |

*Attach additional sheet to report more than 20 New Admissions.*

**IMPORTANT:**

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DMA-3066  
09/18/2012

FORM NOT VALID FOR USE AFTER NOVEMBER 30, 2012

# TRANSITION REQUESTS

## Change of Status

**N.C. Department of Health and Human Services – Division of Medical Assistance  
REQUEST FOR INDEPENDENT ASSESSMENT FOR CONSOLIDATED PERSONAL CARE SERVICES (PCS)  
CHANGE OF STATUS**

Complete this form and send to The Carolinas Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail: CCME, ATTN: Consolidated PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598. For questions, contact CCME at 800-228-3365 or IHCAssessment@thecarolinascenter.org.

Requested By: \_\_\_ PCP \_\_\_ Attending MD \_\_\_ PCS Agency/Facility \_\_\_ Recipient/Responsible Party

Date of Referral: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy)

**Section A. Recipient Demographics**

Medicaid ID#: \_\_\_\_\_  
 Recipient Name (as shown on Medicaid Card) First: \_\_\_\_\_ MI: \_\_\_ Last: \_\_\_\_\_  
 Date of Birth: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy) Gender: \_\_\_ Male \_\_\_ Female Primary Language: \_\_\_ English \_\_\_ Spanish \_\_\_ Other  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Alternate Contact/Parent/Guardian (required if recipient under 18): First: \_\_\_\_\_ Last: \_\_\_\_\_  
 Relationship to Recipient: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Section B. Recipient Medical History**

| Current Medical Diagnoses – Related to need for hands-on assistance with Activities of Daily Living (ADL) needs (ICD-9 codes) | Onset or Exacerbation (Enter O or E) | Date (mm/yyyy) |
|---|--------------------------------------|----------------|
|   |                                      |                |
|   |                                      |                |
|   |                                      |                |
|   |                                      |                |
|   |                                      |                |

Medically Stable: \_\_\_ Yes \_\_\_ No Check if Active Adult Protective Services

Reason for Change in Condition Requiring Reassessment for Services:

- Change in medical condition  Change in caregiver status  
 Change in recipient location affecting ability to perform ADLs  
 Hospitalization Discharge Date: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy)  Other

Briefly describe the change in condition and its impact on recipient's need for assistance (required for all reasons):

\_\_\_\_\_

\_\_\_\_\_

**Section C. Referral Source if not Recipient or Recipient's Responsible Party:**

NPI# \_\_\_\_\_ First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Facility Contact Name: \_\_\_\_\_ Contact Position: \_\_\_\_\_  
 Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_

**Section D. Primary Care Physician Demographics**

Same As Referring Practitioner: \_\_\_ Y \_\_\_ N; If yes, request is complete; submit to CCME

NPI# \_\_\_\_\_ Practitioner First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Facility Contact Name: \_\_\_\_\_ Contact Position: \_\_\_\_\_  
 Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_



**What Can I  
Expect as a  
Provider Once I  
Receive  
Authorization to  
Begin PCS?**

# Plan of Care Development



# A Person-Centered Plan of Care

The development of the plan of care should focus on person-centered planning. Support beneficiary's:

- ❖ Unique needs
- ❖ Expressed preferences
- ❖ Decisions



# A Person-Centered Plan of Care

The Independent Assessment aims to obtain comprehensive information concerning each beneficiary's :

- ❖ Preferences
- ❖ Needs and abilities
- ❖ Health status; and
- ❖ Support systems



# Case Study



- Ms. Evelyn Lyons
- Resident in the ***Above All Others*** residential facility

# Medical Attestation Form

## MAILING:

CCME  
ATTN: PCS Independent Assessment  
100 Regency Forest Drive, Suite 200  
Cary, NC 27518-8598

## FAX:

CCME  
1- 877-272-1942

N.C. Department of Health and Human Services – Division of Medical Assistance  
**PERSONAL CARE SERVICES (PCS) MEDICAL ATTESTATION FOR LICENSED CARE HOME RESIDENTS**  
Completed attestation form serves as authorization to conduct PCS eligibility assessment of current licensed care home residents.

**Licensed Home Provider:** Present completed form to The Carolinas Center for Medical Excellence (CCME) RN Assessor at time of resident assessment. If form is completed after resident's assessment, send completed form to CCME via fax at 877-272-1942, or mail to: **CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598.** (Forms for more than one resident may be bundled and sent together. Certified mail with delivery confirmation is recommended.)  
Receipt may be confirmed with CCME at 800-228-3365. E-mail questions to [PCSAssessment@thecarolinascenter.org](mailto:PCSAssessment@thecarolinascenter.org).

### PLEASE COMPLETE ALL FIELDS.

**Section A. Resident Demographics—TO BE COMPLETED BY LICENSED CARE HOME PROVIDER**

Medicaid ID#: 927454321K Most Recent FL-2/IR-2 Date: 02/21/2012 (mm/dd/yyyy)  
Resident Name (as shown on Medicaid Card) Last: Lyons First: Evelyn MI: S  
Gender:  Male  Female Date of Birth: 7/26/1939 (mm/dd/yyyy) Primary Language:  English  Spanish  Other  
Resident Phone: (919) 555-1212  
Current Residence (Facility Name): Above All Others  
Facility License Number: MHL-999-999 License Date: 01/01/2012 (mm/dd/yyyy)  
Facility Fax Number: (919) - - - - -  
Facility Type:  Family Care Home  Adult Care Home  SLF-5600a  SLF-5600c  Adult Care bed in Nursing Facility  
Does Resident Have a Legal Guardian?  Yes  No  
If Yes, Guardian Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**Section B. Resident Information—TO BE COMPLETED OR VERIFIED BY ATTESTING PRACTITIONER**  
*List conditions that currently limit resident's ability to independently perform Activities of Daily Living (bathing, dressing, mobility, toileting, eating), prepare meals, and manage medications:*

Primary Diagnosis: Rheumatoid Arthritis  
Secondary: Congestive Heart Failure Secondary: Dementia Secondary: Diabetes  
Secondary: Hypertension Secondary: Urinary Incontinence Secondary: \_\_\_\_\_  
Secondary: \_\_\_\_\_ Secondary: \_\_\_\_\_ Secondary: \_\_\_\_\_  
Conditions listed are:  Chronic Medical  Physical Disability  Mental Illness  MR/Developmental  Dementia  
(check all that apply)  
In the absence of caregivers, is resident at risk of any of the following? (check all that apply):  
 Falls  Malnutrition  Skin Breakdown  Adverse Consequences of Medication Non-Compliance  
Is 24-hour caregiver availability required to ensure resident safety?  Yes  No  
(e.g., Does resident have unscheduled ADL needs or require safety supervision or structured living, or is resident unsafe if alone for extended periods?)

**Section C. Attesting Practitioner Information—TO BE COMPLETED BY ATTESTING PRACTITIONER—RETURN SIGNED FORM TO LICENSED HOME PROVIDER**

Practitioner Last Name: James First Name: Michael NPI#: 123456789  
Attesting Practitioner:  FCP/Attending MD  NP  PA  
Date of Resident's Last Visit with Attesting Practitioner: 07/30/2012 (mm/dd/yyyy)  
Practice Name: Jones Medical Associates  
(if applicable)  
Office Contact Last Name: Jones First: Kimberly Position: Manager  
Phone: (919) 566-3880 Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ E-mail: manager@jonesmedical.net  
Practitioner Signature: Michael James Date: 05/06/2012 (mm/dd/yyyy)  
*Dated signature is verification that information in Section B is accurate for this patient and authorization to conduct PCS eligibility assessment.*



# Transition Notice



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October 15, 2012

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456 Production Drive  
Anywhere, NC 28822

Maryam Burnette  
123456789M  
Above All Others  
456 Production Drive  
Anywhere, NC 28822

RE: Evelyn Lyons  
MID: 987654321K  
Service Requested: Personal Care Services

Dear Ms. Evelyn Lyons:

Effective January 1, 2013, N. C. Medicaid will no longer offer services under the In-Home Care (IHC) and Adult Care Home Personal Care Services (ACH-PCS) programs. Personal care services for beneficiaries residing in private living arrangements and licensed ACH facilities will instead be provided under a new, consolidated Personal Care Services (PCS) benefit. Licensed ACH facilities include Adult Care Homes, Family Care Homes, Supervised Living Group Homes, and Combination Homes with ACH beds.

Pursuant to N.C. Session Law 2012-142, Sections 10.9F.(b) and 10.9F.(c); North Carolina State Plan for Medical Assistance; and Division of Medical Assistance (DMA) Clinical Coverage Policy 3L, PCS covers hands-on assistance with Activities of Daily Living (ADLs), including bathing, dressing, mobility, toileting, and eating. PCS may also include assistance with related home management tasks, medications, adaptive or assistive devices, and durable medical equipment. **PCS does not cover transportation or errands.** The full list of covered and non-covered services can be found in Division of Medical Assistance (DMA) Clinical Coverage Policy 3L, which is available at: <http://www.dhhs.state.nc.us/dma/mp/index.htm>.

As required by the North Carolina State Plan for Medical Assistance; N.C. Session Law 2012-142, Sections 10.9F.(b) and 10.9F.(c); and Division of Medical Assistance (DMA) Clinical Coverage Policy 3L, all Medicaid beneficiaries receiving Personal Care Services must be referred by their primary or attending physician and receive an independent assessment by a registered nurse or social worker affiliated with DMA or the Independent Assessment Entity (IAE) designated by DMA. The Carolinas Center for Medical Excellence (CCME) is the IAE designated by DMA to conduct independent assessments.

**Usted tiene treinta (30) días para apelar esta decisión. Tiene que enviar su solicitud dentro de diez (10) días para continuar los servicios sin interrupción. Si necesitas ayuda para leer y entender la carta, por favor contáctese con el 1-800-662-7030. DIGA AL OPERADOR QUE LA NOTIFICACION DMA 2002PCS-Transition.**

DMA 2002PCS Transition [Select One: HB HC HH HI HA SC TT]



# Transition Notice



## The Carolinas Center *for* Medical Excellence

100 Regency Forest Drive, Suite 200, Cary, NC 27518-8598 • 919.461.5600 • 800.228.3365

CCME completed your assessment on **November 7, 2012**. After reviewing the assessment results, Medicaid **approved 61 hours** of PCS per month until the earlier of **November 7, 2013** or the next assessment completed by DMA or the IAE designated by DMA. This is **no change** to the service hours you currently receive.

Your approved service level is based on your assessed self-performance levels and days of unmet need for assistance with the five qualifying Activities of Daily Living (ADLs). Your assessed self-performance levels and days of unmet need for assistance with the five qualifying ADLs are as follows:

| ADL       | Self-Performance Level | Days of Unmet Need per Week |
|-----------|------------------------|-----------------------------|
| Bathing   | Limited                | 7                           |
| Dressing  | Limited                | 7                           |
| Mobility  | Supervision            | 0                           |
| Toileting | Limited                | 7                           |
| Eating    | Limited                | 0                           |

This approval of services is effective **January 1, 2013**. The above named provider was selected by you and will be providing these services. If you wish to select a different provider, please contact CCME at 1-800-228-3365.

Sincerely,

Independent Assessment Department  
The Carolinas Center for Medical Excellence  
1-800-228-3365

C: Provider

**Si necesitas ayuda para leer y entender la carta, por favor contáctese con el 1-800-662-7030.  
DIGA AL OPERADOR QUE LA NOTIFICACION DMA 3504PCS-Transition.**

DMA 3504PCS-Transition- HC  
10/23/2012

**NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE (DMA)**  
**Independent Assessment for Personal Care Services In Licensed Homes**

| <b>Section A. Assessment Identification</b>                    |                              |       |  |   |                          |                              |                           |                       |                             |                  |
|--|------------------------------|-------|--|---|--------------------------|------------------------------|---------------------------|-----------------------|-----------------------------|------------------|
| Assessment Type  | ACH Transition               |       | Assessment Date  | 11/07/2012                                    |                          | Travel Mileage (RT)          | 25                        |                       |                             |                  |
| Assessment Start Time  | 8:00 am                      |       | Assessment Completion Time   | 9:00 am                                       |                          | Travel Time (In minutes)     | 30                        |                       |                             |                  |
| Assessment Completed In (Location)                             | Residence (ACH/SLF Facility) |       | Assessor Name  | Capocasona, AchAssessor                       |                          |                              |                           |                       |                             |                  |
| Others Present During Assessment:                              |                              |       |  |   |                          |                              |                           |                       |                             |                  |
| Name of Person Attending                                       | Relationship to Recipient    |       | If Other, Specify  |   | Name of Person Attending |                              | Relationship to Recipient |                       | If Other, Specify           |                  |
| John Doe   | Home/facility admin          |       |  |   |                          |                              | -- select --              |                       |                             |                  |
| Cynthia Lamb   | Daughter (in-law)            |       |  |   |                          |                              | -- select --              |                       |                             |                  |
|  | -- select --                 |       |  |   |                          |                              | -- select --              |                       |                             |                  |
| <b>Section B. Recipient Identification</b>                     |                              |       |  |   |                          |                              |                           |                       |                             |                  |
| Manual Assessment ID   | 20121107-222160-221492       |       |  | Medicaid ID                                   | 987654321K               |                              | Last FL-2/MR-2 Date       | 10/15/2012            |                             |                  |
| Recipient Last Name  | LYONS                        |       | First Name   | EVELYN  |                          | MI                           | T                         | Recipient Telephone   | 919-555-1212                |                  |
| Gender   | F                            | DOB   | 07/28/1939   | Primary Lang.                                 | English                  |                              | Interpreter Required      | Interpreter Last Name | Telephone                   |                  |
| Recipient's Cognitive Capacities To Participate in Assessment? | Requires limited assistance  |       |  | Recipient Consent For Release of PHI On File? |                          | Yes                          |                           |                       |                             |                  |
| Recipient Facility Information:                                |                              |       |  |   |                          |                              |                           |                       |                             |                  |
| Facility Name  | ABOVE ALL OTHERS             |       |  |   |                          |                              | Facility Type             | SLF 5600c             |                             |                  |
| Facility License Number  | MHL-999-999                  |       | Facility License Date  | 01/01/2012                                    |                          | License Verified By Assessor | Yes                       |                       |                             |                  |
| Legal Guardianship:  |                              |       |  |   |                          |                              |                           |                       |                             |                  |
| Does Recipient Have Legal Guardian?                            | Yes                          |       | If yes, Assessor Verified Legal Guardian Status ?                                  |   |                          |                              | Yes                       |                       |                             |                  |
| Guardian Last Name   | Lamb                         |       | Guardian First Name  | Cynthia                                       |                          | Contact Telephone            | 919-555-2222              |                       |                             |                  |
| <b>Section C. Attestation Summary</b>                          |                              |       |  |   |                          |                              |                           |                       |                             |                  |
| Attestation Date   | 11/01/2012                   |       |  |   |                          |                              |                           |                       |                             |                  |
| Attesting Physician/Practitioner Last Name                     | James                        |       | First Name   | Michael                                       |                          | Attesting Practitioner NPI   | 123456789                 |                       | Attesting Practitioner Type | PCP/Attending MD |
| Date of Recipient's Last Visit With Attesting Practitioner     | 10/08/2012                   |       |  |   |                          |                              |                           |                       |                             |                  |
| Attesting Practitioner Contact Information:                    |                              |       |  |   |                          |                              |                           |                       |                             |                  |
| Practice Name, if applicable                                   | Jones Medical Associates     |       |  |   |                          |                              |                           |                       |                             |                  |
| Practice/Office Contact Information:                           | Last Name                    | Jones |  | First Name                                    | Kimberly                 |                              | Position/Title            | Manager               |                             |                  |
| Telephone  | 919-566-3800                 |       | Fax  | 919-566-3880                                  |                          | Email                        | manager@jonesmedical.net  |                       |                             |                  |

097694321K

LYONS

EVELYN

**Section C. Attestation (Continued)**

|           | Diagnosis Description (Enter description) | Comments/Explanation |
|-----------|---|----------------------|
| Primary   | Rheumatoid Arthritis                      |                      |
| Secondary | Congestive Heart Failure                  |                      |
| Secondary | Dementia                                  |                      |
| Secondary | Diabetes                                  |                      |
| Secondary | Hypertension                              |                      |
| Secondary | Urinary Incontinence                      |                      |
| Secondary |   |                      |

Check box if no Diagnoses are present

Conditions Listed Are: Chronic Medical  Yes Physical Disability  Yes Mental Illness  No MR/Developmental  No Dementia  Yes

In The Absence Of Caregivers, Is Patient At Risk of Any Of The Following:

Falls  Yes Malnutrition  No Skin Breakdown  No Adverse Consequences of Medications Non-Compliance  Yes

Is 24-hour Caregiver Availability Required To Ensure Patient Safety?  Yes

**Section D. Medications**

| Medication Name | Prescription or OTC | Routing | Scheduled or PRN | Frequency If Scheduled | # of Dosages in 24 Hour Period | Medications Admin Complex? |
|-----------------|---------------------|---------|------------------|------------------------|--------------------------------|----------------------------|
| Lasix           | Prescription        | Oral    | Scheduled        | Daily                  | 1                              | No                         |
| Lopressor       | Prescription        | Oral    | Scheduled        | BID                    | 2                              | No                         |
| Plaquenil       | Prescription        | Oral    | Scheduled        | Daily                  | 1                              | No                         |
| Glucophage      | Prescription        | Oral    | Scheduled        | Daily                  | 1                              | No                         |
| Multivitamin    | OTC                 | Oral    | Scheduled        | Daily                  | 1                              | No                         |
| Aricept         | Prescription        | Oral    | Scheduled        | Daily                  | 1                              | No                         |
| Calcium         | OTC                 | Oral    | Scheduled        | Daily                  | 1                              | No                         |
|                 |                     |         |                  |                        |                                |                            |
|                 |                     |         |                  |                        |                                |                            |
|                 |                     |         |                  |                        |                                |                            |

| <b>Beneficiary's Overall Self-Performance Capacity</b> |   |                                    |                                   |
|--|---|------------------------------------|-----------------------------------|
|  | Limited Assistance                            | Extensive Assistance               | Full Dependence                   |
| ADL  |   |                                    |                                   |
| Bathing  | 35  | 50                                 | 60                                |
| Dressing   | 20  | 35                                 | 40                                |
| Mobility   | 10  | 20                                 | 20                                |
| Toileting  | 25  | 30                                 | 35                                |
| Eating   | 30  | 45                                 | 50                                |
| <b>Medication Assistance</b>                           |   |                                    |                                   |
| Reminders/<br>Set-Up                                   | <b>Routine Administration,<br/>8 or Fewer</b> | Routine Administration<br>Plus PRN | Polypharmacy<br>and/or<br>Complex |
| 10   | 20  | 40                                 | 60                                |

**Section G. Recipient Declaration and Assessor Observation of ADL and Related IADL Self-Performance Capacities – Bathing and Personal Hygiene**

**Assistive Devices Used (check all that apply)**

|                            |                                     |
|----------------------------|-------------------------------------|
| 1. Shower chair            | <input checked="" type="checkbox"/> |
| 2. Long handle scrub brush | <input type="checkbox"/>            |
| 3. Grab bars               | <input checked="" type="checkbox"/> |
| 4. Handheld shower         | <input type="checkbox"/>            |
| 5. Tub bench               | <input type="checkbox"/>            |
| 6. Transfer bench          | <input type="checkbox"/>            |
| 7. Other, Specify below:   | <input type="checkbox"/>            |

Comments

Beneficiary requests shampoo twice a week. Daughter does shampoo on Saturday during visit. Aide will do shampoo on Wednesday as requested. Beneficiary able to step into shower with no difficulty, steady and balanced, used grab bars for support, required limited assistance for upper and lower body could do 50% but needed assistance to complete. Did not require assistance with hygiene tasks. Staff provides all IADL care.

**Bathing & Personal Hygiene Tasks**

|  | Demonstrated Ability? | Check if Required                   | Assistance Level | Frequency (days/wk) | Need Fully Met (days/wk) | PCS Need Frequency (days/wk) | Weekend (Y/N) |
|--|-----------------------|-------------------------------------|------------------|---------------------|--------------------------|------------------------------|---------------|
| <b>ADL Task Needs</b>  |                       |                                     |                  |                     |                          |                              |               |
| 1. Tub bath or shower  | Yes                   | <input checked="" type="checkbox"/> | 1 - limited      | 4                   | 0                        | 4                            | Yes           |
| 1.a. Upper body  | Yes                   | <input checked="" type="checkbox"/> | 1 - limited      | 4                   | 0                        | 4                            | Yes           |
| 1.b. Lower body  | Yes                   | <input checked="" type="checkbox"/> | 1 - limited      | 4                   | 0                        | 4                            | Yes           |
| 2. Tub/shower transfer/position                                      | -- select --          |                                     |                  |                     |                          |                              |               |
| 3. Bed bath  | -- select --          |                                     |                  |                     |                          |                              |               |
| 4. Sponge bath   | Yes                   | <input checked="" type="checkbox"/> | 1 - limited      | 3                   | 0                        | 3                            | Yes           |
| 5. Additional transfer, i.e., reposition in bed, change occupied bed | -- select --          |                                     |                  |                     |                          |                              |               |
| 6. Shampoo/hair care   | Yes                   | <input checked="" type="checkbox"/> | 1 - limited      | 2                   | 1                        | 1                            | No            |
| 7. Skin care (includes wash face/hands, foot care)                   | Yes                   |                                     |                  |                     |                          |                              |               |
| 8. Nail care   | Yes                   |                                     |                  |                     |                          |                              |               |
| 9. Mouth/oral/denture care   | Yes                   |                                     |                  |                     |                          |                              |               |
| 10. Shave  | Yes                   |                                     |                  |                     |                          |                              |               |
| <b>IADL Task Needs</b>   |                       |                                     |                  |                     |                          |                              |               |
| 1. Change linens   | N / A                 | <input checked="" type="checkbox"/> | 1 - limited      | 1                   | 0                        | 1                            | No            |
| 2. Make bed  | N / A                 | <input checked="" type="checkbox"/> | 1 - limited      | 7                   | 0                        | 7                            | Yes           |
| 3. Tidy/clean bathroom   | N / A                 | <input checked="" type="checkbox"/> | 1 - limited      | 7                   | 0                        | 7                            | Yes           |
| 4. On-site laundry tasks   | N / A                 | <input checked="" type="checkbox"/> | 1 - limited      | 1                   | 0                        | 1                            | No            |

Assessor's Overall Self-Performance Capacity Rating: Can do with limited hands-on assistance

**Section H. Recipient Declaration and Assessor Observation of ADL and Related IADL Self-Performance Capacities – Dressing**

Assistive Devices Used (check all that apply)

|                         |   |
|-------------------------|---|
| 1. Sock aide            |   |
| 2. Reacher              | ✓ |
| 3. Button hook device   |   |
| 4. Velcro shoes         |   |
| 5. Other, Specify below |   |

Comments

Beneficiary able to remove shirt but couldnt get back on, able to start with sleeves but couldnt completed due to pain. Could remove pants to knee level but unable to remove past that and could put on pants once aide had put feet in and to knee height

| <b>Dressing Tasks</b>          | Demonstrated Ability | Check if Required | Assistance Level | Frequency (days/wk) | Need Fully Met (days/wk) | PCS Need Frequency (days/wk) | Weekend (Y/N) |
|--------------------------------|----------------------|-------------------|------------------|---------------------|--------------------------|------------------------------|---------------|
| <b>ADL Task Needs</b>          |                      |                   |                  |                     |                          |                              |               |
| 1. Don clothing/socks/shoes    | Yes                  | ✓                 | 1 - limited      | 7                   | 0                        | 7                            | Yes           |
| 2. Remove clothing/socks/shoes | Yes                  | ✓                 | 1 - limited      | 7                   | 0                        | 7                            | Yes           |
| 3. Clothing and shoe fasteners | Yes                  | ✓                 | 1 - limited      | 7                   | 0                        | 7                            | Yes           |
| 4. Assist with TEDS            | -- select --         |                   |                  |                     |                          |                              |               |
| 5. Assist with braces/splints  | -- select --         |                   |                  |                     |                          |                              |               |
| 6. Assist with binders         |                      |                   |                  |                     |                          |                              |               |
| 7. Assist with prosthetics     | -- select --         |                   |                  |                     |                          |                              |               |
| <b>IADL Task Needs</b>         |                      |                   |                  |                     |                          |                              |               |
| 1. Hang/retrieve clothing      | N / A                | ✓                 | 1 - limited      | 7                   | 0                        | 7                            | Yes           |
| 2. On-site laundry tasks       | N / A                | ✓                 | 1 - limited      | 1                   | 0                        | 1                            | No            |

|  |   |
|--|---|
| Assessor's Overall Self-Performance Capacity Rating: | Can do with limited hands-on assistance |
|--|---|

**Section I. Recipient Declaration and Assessor Observation of ADL and Related IADL Self-Performance Capacities – Mobility**

**Assistive Devices Used (check all that apply)**

|                               |   |
|-------------------------------|---|
| 1. Braces and crutches        |   |
| 2. Wedges/Positioning devices |   |
| 3. Trapeze                    |   |
| 4. Bed cane                   |   |
| 5. Walker/stroller            | ✓ |
| 6. Rollator                   |   |
| 7. SP cane/Quad cane          | ✓ |
| 8. Manual or electric scooter |   |
| 9. Hoyer lift                 |   |
| 10. Transfer board            |   |
| 11. Stander                   |   |
| 12. Wheelchair                |   |
| 13. Pressure relief device    |   |
| 14. Gait belt                 |   |
| 15. Protective helmet         |   |
| 16. Other, Specify below      |   |

Comments

Beneficiary able to get up from chair/couch/bed with no assistance; one standing used s/p cane to balance and ambulate. No pain, no abnormal gait noted. Staff reports 2 falls over last 30 days.

| <b>Mobility Tasks</b>                 | Demonstrated Ability | Check if Required | Assistance Level | Frequency (days/wk) | Need Fully Met (days/wk) | PCS Need Frequency (days/wk) | Weekend (Y/N) |
|---------------------------------------|----------------------|-------------------|------------------|---------------------|--------------------------|------------------------------|---------------|
| <b>ADL Task Needs</b>                 |                      |                   |                  |                     |                          |                              |               |
| 1. Transfer to/from bed               | Yes                  | ✓                 | Set up/Sup       | 7                   | 0                        | 7                            | Yes           |
| 2. Transfer to/from chair             | Yes                  | ✓                 | Set up/Sup       | 7                   | 0                        | 7                            | Yes           |
| 3. Ambulation room to room            | Yes                  | ✓                 | Set up/Sup       | 7                   | 0                        | 7                            | Yes           |
| 4. Assist with stairs inside the home | -- select --         |                   |                  |                     |                          |                              |               |
| 5. ROM                                | -- select --         |                   |                  |                     |                          |                              |               |
| 6. Turn/reposition                    | -- select --         |                   |                  |                     |                          |                              |               |
| <b>IADL Task Needs</b>                |                      |                   |                  |                     |                          |                              |               |
| 1. Clear pathways/minimize clutter    | N / A                | ✓                 | Set up/Sup       | 7                   | 0                        | 7                            | Yes           |
| 2. Retrieve/return equipment          | N / A                | ✓                 | Set up/Sup       | 7                   | 0                        | 7                            | Yes           |

Assessor's Overall Self-Performance Capacity Rating:

Needs verbal cueing or supervision only

**Section J. Recipient Declaration and Assessor Observation of ADL and Related IADL Self-Performance Capacities – Toileting**

Assistive Devices Used (check all that apply)

|                         |                                     |
|-------------------------|-------------------------------------|
| 1. BSC                  | <input checked="" type="checkbox"/> |
| 2. Elevated toilet seat | <input type="checkbox"/>            |
| 3. Urinal               | <input type="checkbox"/>            |
| 4. Bed pan              | <input type="checkbox"/>            |
| 5. Transfer board       | <input type="checkbox"/>            |
| 6. Other, Specify below | <input type="checkbox"/>            |

Comments

Observed beneficiary walk into bathroom, sit on toilet without assist but demonstrated need for assist to remove clothing. Pantomimed actions of hygiene, needed hands-on assist to complete task, confirmed with staff.

| Toileting/Incontinence Mgt Tasks                 | Demonstrated Ability | Check if Required                   | Assistance Level | Frequency (days/wk) | Need Fully Met (days/wk) | PCS Need Frequency (days/wk) | Weekend (Y/N) |
|--|----------------------|-------------------------------------|------------------|---------------------|--------------------------|------------------------------|---------------|
| <b>ADL Task Needs</b>                            |                      |                                     |                  |                     |                          |                              |               |
| 1. Remove/pull up/fasten garments                | Yes                  | <input checked="" type="checkbox"/> | 1 - limited      | 7                   | 0                        | 7                            | Yes           |
| 2. Hygiene after toileting/incontinence          | Yes                  | <input checked="" type="checkbox"/> | 1 - limited      | 7                   | 0                        | 7                            | Yes           |
| 3. Transfer to/from BSC or toilet                | Yes                  | <input type="checkbox"/>            |                  |                     |                          |                              |               |
| <b>IADL Task Needs</b>                           |                      |                                     |                  |                     |                          |                              |               |
| 1. Clean BSC/urinal/bedpan/toileting area        | N / A                | <input checked="" type="checkbox"/> | 1 - limited      | 7                   | 0                        | 7                            | Yes           |
| 2. Empty trash, dispose of incontinence supplies | N / A                | <input checked="" type="checkbox"/> | 1 - limited      | 7                   | 0                        | 7                            | Yes           |
| 3. On-site laundry tasks                         | N / A                | <input checked="" type="checkbox"/> | 1 - limited      | 1                   | 0                        | 1                            | No            |

|  |   |
|--|---|
| Assessor's Overall Self-Performance Capacity Rating: | Can do with limited hands-on assistance |
|--|---|

**Section K. Recipient Declaration and Assessor Observation of ADL and Related IADL Self-Performance Capacities – Eating and Meal Preparation**

**Assistive Devices Used** (check all that apply)

|                          |  |
|--------------------------|--|
| 1. Adaptive utensils     |  |
| 2. Adaptive dishes       |  |
| 3. Tube feeding supplies |  |
| 4. Pump                  |  |
| 5. IV pole               |  |
| 6. Bag/tubing, etc.      |  |
| 7. Other, Specify below  |  |

Comments

Facility staff prepares, serves and cleans for all meals 7 days per week. Beneficiary otherwise independent.

**Eating Tasks**

|   | Demonstrated Ability? | Check if Required | Assistance Level | Frequency (days/wk) | Need Fully Met (days/wk) | PCS Need Frequency (days/wk) | Weekend (Y/N) |
|---|-----------------------|-------------------|------------------|---------------------|--------------------------|------------------------------|---------------|
| <b>ADL Task Needs</b>                   |                       |                   |                  |                     |                          |                              |               |
| 1. Assist with cutting food             | -- select --          |                   |                  |                     |                          |                              |               |
| 2. Assist with feeding                  | -- select --          |                   |                  |                     |                          |                              |               |
| 3. Assist with utensil usage            | -- select --          |                   |                  |                     |                          |                              |               |
| 4. Lift limb to mouth                   | Yes                   |                   |                  |                     |                          |                              |               |
| 5. Tube feeding                         | -- select --          |                   |                  |                     |                          |                              |               |
| 6. Equipment setup                      | -- select --          |                   |                  |                     |                          |                              |               |
| 7. Chop/grind/puree/thicken             | -- select --          |                   |                  |                     |                          |                              |               |
| 8. Meal Preparation: Open packages      | N / A                 | ✓                 | 1 - limited      | 7                   | 0                        | 7                            | Yes           |
| 9. Meal Preparation: Heat/assemble food | N / A                 | ✓                 | 1 - limited      | 7                   | 0                        | 7                            | Yes           |
| <b>IADL Task Needs</b>                  |                       |                   |                  |                     |                          |                              |               |
| 1. Clean meal service area              | N / A                 | ✓                 | 1 - limited      | 7                   | 0                        | 7                            | Yes           |
| 2. Clean utensils/dishes, empty trash   | N / A                 | ✓                 | 1 - limited      | 7                   | 0                        | 7                            | Yes           |

Assessor's Overall Self-Performance Capacity Rating: Can do with limited hands-on assistance

**Section M. Conditions Affecting Recipient's ADL Self-Performance/Assistance Time**

| (Assess if Recipient symptoms/conditions affect time required to self-perform/assist with ADLs.) |                  |  | ADLs Affected |     |         |          |          |           |        |
|--|------------------|--|---------------|-----|---------|----------|----------|-----------|--------|
| Conditions Potentially Affecting ADL Self-Performance  | Check if Present | Evaluation of Condition Severity (Where Indicated by non-shaded boxes) | None          | All | Bathing | Dressing | Mobility | Toileting | Eating |
| <b>Respiratory</b>   |                  |  |               |     |         |          |          |           |        |
| Dyspnea/Shortness of Breath  | ✓                | Moderate exertion - dressing, commode use, walking les                 |               |     | ✓       | ✓        |          | ✓         |        |
| Use of Oxygen  |                  |  |               |     |         |          |          |           |        |
| <b>Cardiovascular</b>  |                  |  |               |     |         |          |          |           |        |
| Impaired endurance   |                  |  |               |     |         |          |          |           |        |
| Symptoms of Heart Disease  |                  |  |               |     |         |          |          |           |        |
| <i>Orthopnea</i>   |                  |  |               |     |         |          |          |           |        |
| <i>Edema or self-reported weight gain</i>  |                  |  |               |     |         |          |          |           |        |
| <i>Dyspnea</i>   |                  |  |               |     |         |          |          |           |        |
| <b>Gastrointestinal/GU</b>   |                  |  |               |     |         |          |          |           |        |
| Incontinence - Urine   | ✓                | Incontinent day and night  |               |     | ✓       | ✓        |          | ✓         |        |
| Urinary Ostomy   |                  |  |               |     |         |          |          |           |        |
| Incontinence - Bowel   |                  |  |               |     |         |          |          |           |        |
| Bowel Ostomy   |                  |  |               |     |         |          |          |           |        |
| <b>Neurological</b>  |                  |  |               |     |         |          |          |           |        |
| General Neurological Symptoms  |                  |  |               |     |         |          |          |           |        |
| <i>Adult Seizure Disorder</i>  |                  |  |               |     |         |          |          |           |        |
| <i>Child Seizure Disorder</i>  |                  |  |               |     |         |          |          |           |        |
| <i>Tremors/Parkinsonism</i>  |                  |  |               |     |         |          |          |           |        |
| <i>Muscle Dystonia</i>   |                  |  |               |     |         |          |          |           |        |
| <i>Late Effects of CVA, Hemiparesis, Aphasia</i>   |                  |  |               |     |         |          |          |           |        |
| Lack of Balance  |                  |  |               |     |         |          |          |           |        |
| Cognitive Impairment   | ✓                | Requires prompting in unfamiliar situations only                       |               |     | ✓       | ✓        |          | ✓         |        |



# Plan of Care

| Bathing and Personal Hygiene                | Assistance Level | PCS Need Frequency | Show aide task schedule by placing (x) in each day that aide service is needed. |         |           |          |        |          |        |
|---|------------------|--------------------|---|---------|-----------|----------|--------|----------|--------|
|   |                  |                    | Monday  | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| <b>ADL Tasks</b>                            |                  |                    |   |         |           |          |        |          |        |
| 1. Tub bath or shower                       | 1-limited        | 4                  | X   |         | X         |          | X      | X        |        |
| 1.a. Upper body                             | 1-limited        | 4                  | X   |         | X         |          | X      | X        |        |
| 1.b. Lower body                             | 1-limited        | 4                  | X   |         | X         |          | X      | X        |        |
| 2. Help w. getting in tub/shower            | 1-limited        | 4                  | X   |         | X         |          | X      | X        |        |
| 3. Bed bath                                 | n/a              | 0                  |   |         |           |          |        |          |        |
| 4. Sponge bath                              | 1-limited        | 3                  |   | X       |           | X        |        |          | X      |
| 5. Additional transfer                      | n/a              | 0                  |   |         |           |          |        |          |        |
| 6. Shampoo/Hair care                        | 1-limited        | 2                  |   |         |           |          | X      |          |        |
| 7. Skin care (inc. wash face/hands& foot ca | n/a              | 0                  | X   | X       | X         | X        | X      | X        | X      |
| 8. Nail care                                | n/a              | 0                  | X   | X       | X         | X        | X      | X        | X      |
| 9. Mouth/oral/denture care                  | n/a              | 0                  | X   | X       | X         | X        | X      | X        | X      |
| 10. Shave                                   | n/a              | n/a                |   |         |           |          |        |          |        |



# Plan of Care

| Dressing                             | Assistance Level | PCS Need Frequency | Show aide task schedule by placing (x) in each day that aide service is needed |         |           |          |        |          |        |
|--------------------------------------|------------------|--------------------|--|---------|-----------|----------|--------|----------|--------|
|                                      |                  |                    | Monday   | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| <b>ADL Tasks</b>                     |                  |                    |  |         |           |          |        |          |        |
| 1. Don clothing/socks/shoes          | 1-limited        | 7                  | X  | X       | X         | X        | X      | X        | X      |
| 2. Remove clothing/socks/shoes       | 1-limited        | 7                  | X  | X       | X         | X        | X      | X        | X      |
| 3. Help with clothing/shoe fasteners | 1-limited        | 7                  | X  | X       | X         | X        | X      | X        | X      |
| 4. Assist with TEDS                  | n/a              | 0                  |  |         |           |          |        |          |        |
| 5. Assist with braces/splints        | n/a              | 0                  |  |         |           |          |        |          |        |
| 6. Assist with binders               | n/a              | 0                  |  |         |           |          |        |          |        |
| 7. Assist with prosthetics           | n/a              | 0                  |  |         |           |          |        |          |        |



# Plan of Care

| Mobility                          | Assistance Level | PCS Need Frequency | Show aide task schedule by placing (x) in each day that aide service is needed. |         |           |          |        |          |        |
|-----------------------------------|------------------|--------------------|---|---------|-----------|----------|--------|----------|--------|
|                                   |                  |                    | Monday  | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| <b>ADL Tasks</b>                  |                  |                    |   |         |           |          |        |          |        |
| 1. Transfer to/from bed           | Cue/Super        | 7                  |   |         |           |          |        |          |        |
| 2. Transfer to/from chair         | Cue/Super        | 7                  |   |         |           |          |        |          |        |
| 3. Ambulation room to room        | Cue/Super        | 7                  |   |         |           |          |        |          |        |
| 4. Assist with stairs             | n/a              | 0                  |   |         |           |          |        |          |        |
| 5. Passive/active range of motion | Cue/Super        | 7                  |   |         |           |          |        |          |        |
| 6. Turn/reposition                | n/a              | 0                  |   |         |           |          |        |          |        |
| <b>Related IADL Tasks</b>         |                  |                    |   |         |           |          |        |          |        |
| 1. Clear pathway/minimize clutter | n/a              | 7                  |   |         |           |          |        |          |        |
| 2. Retrieve/return equipment      | n/a              | 7                  |   |         |           |          |        |          |        |



# Plan of Care

| Eating                                | Assistance Level | PCS Need Frequency | Show aide task schedule by placing (x) in each day that aide service is needed. |         |           |          |        |          |        |
|---------------------------------------|------------------|--------------------|---|---------|-----------|----------|--------|----------|--------|
|                                       |                  |                    | Monday  | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| <b>ADL Tasks</b>                      |                  |                    |   |         |           |          |        |          |        |
| 1. Assist with cutting food           |                  |                    |   |         |           |          |        |          |        |
| 2. Assist with feeding                |                  |                    |   |         |           |          |        |          |        |
| 3. Assist with utensil usage          |                  |                    |   |         |           |          |        |          |        |
| 4. Lift limb to mouth                 |                  |                    |   |         |           |          |        |          |        |
| 5. Tube feeding                       |                  |                    |   |         |           |          |        |          |        |
| 6. Equipment setup                    |                  |                    |   |         |           |          |        |          |        |
| 7. Chop/grind/puree/thicken           |                  |                    |   |         |           |          |        |          |        |
| 8. Open packages                      | limited          | 7                  |   |         |           |          |        |          |        |
| 9. Heat/assemble food                 | limited          | 7                  |   |         |           |          |        |          |        |
| <b>Related IADL Tasks</b>             |                  |                    |   |         |           |          |        |          |        |
| 1. Clean meal service area            | limited          | 7                  |   |         |           |          |        |          |        |
| 2. Clean utensils/dishes, empty trash | limited          | 7                  |   |         |           |          |        |          |        |



# Plan of Care

| Toileting                                     | Assistance Level | PCS Need Frequency | Show aide task schedule by placing (x) in each day that aide service is needed. |         |           |          |        |          |        |   |
|---|------------------|--------------------|---|---------|-----------|----------|--------|----------|--------|---|
|   |                  |                    | Monday  | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |   |
| <b>ADL Tasks</b>                              |                  |                    |   |         |           |          |        |          |        |   |
| 1. Remove/pull up/fasten garments             |                  |                    |   |         |           |          |        |          |        |   |
| 2. Hygiene after toileting                    | 1-limited        | 7                  | X   | X       | X         | X        | X      | X        | X      | X |
| 3. Transfer to/from BSC or toilet             | 1-extensive      | 7                  | X   | X       | X         | X        | X      | X        | X      | X |
| <b>Related IADL Tasks</b>                     |                  |                    |   |         |           |          |        |          |        |   |
| 1. Clean BSC/urinal/bedpan/toileting area     | 1-limited        | 7                  | X   | X       | X         | X        | X      | X        | X      | X |
| 2. Empty trash/dispose incontinence supplies  | 1-limited        | 7                  | X   | X       | X         | X        | X      | X        | X      | X |
| 3. Laundry tasks (Assign time for max 2 ADLs) | 1-extensive      | 1                  |   |         |           |          | X      |          |        |   |

# Calculating A Monthly Authorization for Services

| 1. Activities of Daily Living    |                         |                 |                 |                                  |
|----------------------------------|-------------------------|-----------------|-----------------|----------------------------------|
| ADL                              | Level of Assistance     | Qualifying ADL? | Minutes per day | Minutes per week                 |
| Bathing                          | Limited                 | Yes             | 35              | 245                              |
| Dressing                         | Limited                 | Yes             | 20              | 140                              |
| Mobility                         | Supervision             | No              | 0               | 0                                |
| Toileting                        | Limited                 | Yes             | 25              | 175                              |
| Eating                           | Limited                 | Yes             | 0*              | 0                                |
| * Because basic meal prep only   |                         |                 | Total           | 80                               |
| 560                              |                         |                 |                 |                                  |
| 2. Medication Assistance         |                         |                 |                 |                                  |
| Number of meds                   | Any PRN?                | Any complex?    | Minutes per day | Minutes per week                 |
| 7                                | No                      | No              | 20              | 140                              |
| 3. Base Time                     |                         |                 |                 |                                  |
| ADLs                             | Meds                    | Min/Week        | Min/Month       |                                  |
| 560                              | 140                     | 700             | 3045            |                                  |
| 4. Exacerbating conditions       |                         |                 |                 |                                  |
| Number                           | Additional percentage   | Min/Month       |                 |                                  |
| 3                                | 20%                     | 609             |                 |                                  |
| 5. Monthly Service Authorization |                         |                 |                 |                                  |
| ADLs/Meds                        | Exacerbating Conditions | Total minutes   | Hours (Min/60)  | Authorized monthly service level |
| 3045                             | 609                     | 3654            | 60.9            | <b>61 hours</b>                  |

# How to Write A Care Plan

| Monthly Hours | Divide by 4.35= | Round down to next ¼ hour to obtain weekly POC hours |
|---------------|-----------------|--|
| <b>61</b>     | <b>14.02</b>    | <b>14.00</b>   |
| <b>59</b>     | 13.56           | 13.50  |
| <b>38</b>     | 8.74            | 8.50   |
| <b>26</b>     | 5.97            | 5.75   |





# What Are the Requirements for Aide Documentation?

# Aide Documentation Requirements

- Document performance of ADL tasks
- Frequency of performance
- Date of services and tasks were provided
- Name of the aide



# Example of ACH Aide Documentation

**PERSONAL CARE RECORD** Page 1 of 2

Month: \_\_\_\_\_ Date: \_\_\_\_\_ **CHARTED DAILY**

**BATHING**  
*(Record when provided)*

**EVENT CODES:**  
S = Shower  
ST = Shower/Tub  
BB = Bed Bath  
SB = Sponge Bath

**ASSISTANCE CODES:**  
See below

| DAY OF THE MONTH |            | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |  |  |  |
|------------------|------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|--|--|--|
| 1st SHIFT        | Event      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                  | Assistance |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                  | Initials   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
| 2nd SHIFT        | Event      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                  | Assistance |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                  | Initials   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
| 3rd SHIFT        | Event      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                  | Assistance |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                  | Initials   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |

**SKIN/HAIR/FEET**  
*(Provide Daily)*

**EVENT CODES:**  
SH = Shampoo/Hair Care  
SC = Skin Care (wash face/hands/foot care)  
NC = Nail Care

**ASSISTANCE CODES:**  
See below

| DAY OF THE MONTH |            | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |  |  |  |
|------------------|------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|--|--|--|
| 1st SHIFT        | Event      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                  | Assistance |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                  | Initials   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
| 2nd SHIFT        | Event      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                  | Assistance |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                  | Initials   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
| 3rd SHIFT        | Event      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                  | Assistance |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                  | Initials   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |

**ASSISTANCE CODES**

|  |  |
|--|--|
| <p><b>I = Independent</b> – The resident can perform the activity without help or with only occasional help.</p> <p><b>P = Prompt</b> – The resident needs to be reminded to perform the activity.</p> <p><b>S = Supervision</b> – The resident can perform the activity when another person provides oversight, encouragement and prompting.</p> <p><b>LA = Limited Assistance</b> – The resident is highly involved in performing the activity for him/herself, i.e., the resident requires assistance with dressing or walking less than 3 times a week.</p> <p><b>EA = Extensive Assistance</b> – The resident can perform part of the activity him/herself. the resident requires assistance with dressing or walking more than 3 times a week.</p> | <p><b>TD = Totally Dependent</b> – Someone must complete the task for the resident at all times</p> <p><b>TL = Therapeutic Leave</b> – Initial by date when resident is on therapeutic leave.</p> <p><b>OOF = Out of Facility</b> – Initial by date when resident is out of facility.</p> <p><b>R = Refused</b></p> <p><b>H = Hospital</b> – Initial by date when resident is in the hospital.</p> <p><b>O = Other Instructions:</b> _____</p> |
|--|--|

|                          |               |           |            |
|--------------------------|---------------|-----------|------------|
| Physician/Alt. Physician | Telephone No. | Diagnosis | Store Name |
|                          |               |           |            |

|                         |      |     |              |             |     |               |           |                      |          |
|-------------------------|------|-----|--------------|-------------|-----|---------------|-----------|----------------------|----------|
| Resident/Patient/Client | Room | Bed | Patient Code | Admin. Date | Sex | Date Of Birth | Allergies | Charting For/Through | Page No. |
|                         |      |     |              |             |     |               |           |                      |          |

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# Example of ACH Aide Documentation

## PERSONAL CARE RECORD

Month: \_\_\_\_\_

Date: \_\_\_\_\_

CHARTED DAILY

| PERSONAL HYGIENE<br><i>(Provided Daily)</i>              |           | DAY OF THE MONTH | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |  |
|--|-----------|------------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|--|
| EVENT CODES:<br>M = Mouth/Oral/Denture Care<br>S = Shave | 1st SHIFT | Event            |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
|  |           | Assistance       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
|  |           | Initials         |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
| ASSISTANCE CODES:<br>See below                           | 2nd SHIFT | Event            |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
|  |           | Assistance       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
|  |           | Initials         |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
|  | 3rd SHIFT | Event            |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
|  |           | Assistance       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
|  |           | Initials         |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |

### ASSISTANCE CODES

**I = Independent** – The resident can perform the activity without help or with only occasional help.  
**P = Prompt** – The resident needs to be reminded to perform the activity.  
**S = Supervision** – The resident can perform the activity when another person provides oversight, encouragement and prompting.  
**LA = Limited Assistance** – The resident is highly involved in performing the activity for him/herself, i.e., the resident requires assistance with dressing or walking less than 3 times a week.  
**EA = Extensive Assistance** – The resident can perform part of the activity him/herself, the resident requires assistance with dressing or walking more than 3 times a week.

**TD = Totally Dependent** – Someone must complete the task for the resident at all times  
**TL = Therapeutic Leave** – Initial by date when resident is on therapeutic leave.  
**OOF = Out of Facility** – Initial by date when resident is out of facility.  
**R = Refused**  
**H = Hospital** – Initial by date when resident is in the hospital.  
**O = Other Instructions:** \_\_\_\_\_

### COMMENTS

### Special Instructions/Findings:

**Patient Uses:**  Shower Bench/Chair  Grab Bars  Handheld Shower  Reacher  Walker  Rollator  Cane/Quad Cane  Scooter  
 Hoyer  Transfer Board  Wheelchair  Pressure Relief Device  BSC  Elevated Toilet Seat  Urinal  Bed Pan  Pad/Diapers

**CERTIFICATION:** I certify that the record of personal care services shown here is true and accurate, and the personal care aide identified below performed personal care tasks in a satisfactory manner

Signature of Administrator or Designated Supervisor \_\_\_\_\_

| INIT. | NAME OF PC AIDE |
|-------|-----------------|-------|-----------------|-------|-----------------|-------|-----------------|
|       |                 |       |                 |       |                 |       |                 |
|       |                 |       |                 |       |                 |       |                 |
|       |                 |       |                 |       |                 |       |                 |
|       |                 |       |                 |       |                 |       |                 |
|       |                 |       |                 |       |                 |       |                 |
|       |                 |       |                 |       |                 |       |                 |
|       |                 |       |                 |       |                 |       |                 |



# Example of ACH Aide Documentation

PERSONAL CARE RECORD  
Page 2 of 2

Month: \_\_\_\_\_ Date: \_\_\_\_\_ CHARTED BY EXCEPTION ONLY: NOTE OCCURRENCE

**TOILETING/INCONTINENCE (Chart daily)**

**EVENT CODES:**

- D = Diarrhea
- R = Routine Toileting
- I = Incontinence of Bowel and/or bladder
- C = Change linen/clothing due to incontinence
- B = Bath due to incontinence
- RF = Remove/Fasten Garments
- HT = Hygiene after Toileting/Incontinence
- TT = To/From BSC or Toilet
- CB = Clean BSC/Urinal/Bedpan
- OC = Ostomy Care
- CC = Catheter Care

**ASSISTANCE CODES:**

- I = **Independent** – The resident can perform the activity without help or with only occasional help.
- P = **Prompt** – The resident needs to be reminded to perform the activity.
- S = **Supervision** – The resident can perform the activity when another person provides oversight, encouragement and prompting.
- LA = **Limited Assistance** – The resident is highly involved in performing the activity for him/herself, i.e., the resident requires assistance with dressing or walking less than 3 times a week.
- EA = **Extensive Assistance** – The resident can perform part of the activity him/herself, the resident requires assistance with dressing or walking more than 3 times a week.
- TD = **Totally Dependent** – Someone must complete the task for the resident at all times
- TL = **Therapeutic Leave** – Initial by date when resident is on therapeutic leave
- OOF = **Out of Facility** – Initial by date when resident is out of facility.
- R = **Refused**
- H = **Hospital** – Initial by date when resident is in the hospital.
- O = **Other Instructions:** \_\_\_\_\_

|                             | DAY OF THE MONTH | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |  |
|-----------------------------|------------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|--|
| <b>1st SHIFT OCCURRENCE</b> | Event Code       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
|                             | Total # events   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
|                             | Asst. Code       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
|                             | Initials         |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
|                             | Event Code       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
|                             | Total # events   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
| <b>2nd SHIFT OCCURRENCE</b> | Asst. Code       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
|                             | Initials         |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
|                             | Event Code       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
|                             | Total # events   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
|                             | Asst. Code       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
|                             | Initials         |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |

PROPOSED

Physician/Ait. Physician

Telephone No.

Diagnosis

Store Name

Resident/Patient/Client

Room

Bed

Patient Code

Admin. Date

Sex

Date Of Birth

Allergies

Charting For/Through

Page No.

46

# Example of ACH Aide Documentation

**PERSONAL CARE RECORD**

Month: \_\_\_\_\_ Date: \_\_\_\_\_ **CHARTED BY EXCEPTION ONLY: NOTE OCCURRENCE**

|                      |                | DAY OF THE MONTH |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|----------------------|----------------|------------------|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|--|--|--|
|                      |                | 1                | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |  |  |  |
| 3rd SHIFT OCCURRENCE | Event Code     |                  |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                      | Total # events |                  |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                      | Asst. Code     |                  |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                      | Initials       |                  |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                      | Event Code     |                  |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                      | Total # events |                  |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                      | Asst. Code     |                  |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                      | Initials       |                  |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                      | Event Code     |                  |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                      | Total # events |                  |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                      | Asst. Code     |                  |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |
|                      | Initials       |                  |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |

**TOILETING/INCONTINENCE (Chart daily)**

**EVENT CODES:**

- D = Diarrhea
- R = Routine Toileting
- I = Incontinence of Bowel and/or bladder
- C = Change linen/clothing due to incontinence
- B = Bath due to incontinence
- RF = Remove/Fasten Garments
- HT = Hygiene after Toileting/Incontinence
- TT = To/From BSC or Toilet
- CB = Clean BSC/Urinal/Bedpan
- OC = Ostomy Care
- CC = Catheter Care

**ASSISTANCE CODES:**  
See Below

**ASSISTANCE CODES**

|  |   |
|--|---|
| <p><b>I = Independent</b> – The resident can perform the activity without help or with only occasional help.</p> <p><b>P = Prompt</b> – The resident needs to be reminded to perform the activity.</p> <p><b>S = Supervision</b> – The resident can perform the activity when another person provides oversight, encouragement and prompting.</p> <p><b>LA = Limited Assistance</b> – The resident is highly involved in performing the activity for him/herself, i.e., the resident requires assistance with dressing or walking less than 3 times a week.</p> <p><b>EA = Extensive Assistance</b> – The resident can perform part of the activity him/herself, the resident requires assistance with dressing or walking more than 3 times a week.</p> | <p><b>TD = Totally Dependent</b> – Someone must complete the task for the resident at all times.</p> <p><b>TL = Therapeutic Leave</b> – Initial by date when resident is on therapeutic leave.</p> <p><b>OOF = Out of Facility</b> – Initial by date when resident is out of facility.</p> <p><b>R = Refused</b></p> <p><b>H = Hospital</b> – Initial by date when resident is in the hospital.</p> <p><b>O = Other Instructions:</b> _____</p> |
|--|---|

**COMMENTS**

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**CERTIFICATION:** I certify that the record of personal care services shown here is true and accurate, and the personal care aide identified below performed personal care tasks in a satisfactory manner

Signature of Administrator or Designated Supervisor: \_\_\_\_\_

| INIT. | NAME OF PC AIDE |
|-------|-----------------|-------|-----------------|-------|-----------------|-------|-----------------|
|       |                 |       |                 |       |                 |       |                 |
|       |                 |       |                 |       |                 |       |                 |
|       |                 |       |                 |       |                 |       |                 |
|       |                 |       |                 |       |                 |       |                 |
|       |                 |       |                 |       |                 |       |                 |
|       |                 |       |                 |       |                 |       |                 |

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Reorder Form: **MED-PASS** 800-438-8884
IHNoe1012

# Example of ACH Aide Documentation

Month: November 2012 Date: \_\_\_\_\_

CHARTED DAILY

PERSONAL CARE RE

| DAY OF THE MONTH  |           | 1          | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |  |  |
|---|-----------|------------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|--|--|
| DRESSING<br><i>(Record when provided)</i>   | 1st SHIFT | Event      | AC | AL |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
|   | 1st SHIFT | Assistance | LA |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
|   | 1st SHIFT | Initials   | KV | KY | KY | KV | KV | KY | KV |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
| EVENT CODES:<br>DR = Don/Remove<br>Clothes/Socks/Shoes<br>AC = Assist with<br>Clothing/Shoes/Fasteners<br>TB = Don/Remove<br>TEDS/Braces/<br>Prothesis/Splints<br>HR = Hang/Retrieve Clothing | 2nd SHIFT | Event      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
|   | 2nd SHIFT | Assistance |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
|   | 2nd SHIFT | Initials   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
| ASSISTANCE CODES:<br>See below  | 3rd SHIFT | Event      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
|   | 3rd SHIFT | Assistance |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
|   | 3rd SHIFT | Initials   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
| TRANSFER/MOBILITY<br><i>(Chart Daily)</i>   | PRN       | Event      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
|   | PRN       | Assistance |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
|   | PRN       | Initials   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
| EVENT CODES:<br>BC = To/From Bed/Chair<br>TS = To/From Tub/Shower<br>TR = Turn/Reposition<br>AR = Ambulate Room to Room<br>AS = Assist with Stairs<br>RO = ROM                                | 1st SHIFT | Event      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
|   | 1st SHIFT | Assistance |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
|   | 1st SHIFT | Initials   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
| ASSISTANCE CODES:<br>See below  | 2nd SHIFT | Event      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
|   | 2nd SHIFT | Assistance |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
|   | 2nd SHIFT | Initials   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
| ASSISTANCE CODES:<br>See below  | 3rd SHIFT | Event      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
|   | 3rd SHIFT | Assistance |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |
|   | 3rd SHIFT | Initials   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |

DRAFT

- ASSISTANCE CODES**
- I = **Independent** – The resident can perform life activity without help or with only occasional help.
  - P = **Prompt** – The resident needs to be reminded to perform the activity.
  - S = **Supervision** – The resident can perform the activity when another person provides oversight, encouragement and prompting.
  - LA = **Limited Assistance** – The resident is highly involved in performing the activity for him/herself. I.e., the resident requires assistance with dressing or walking less than 3 times a week.
  - EA = **Extensive Assistance** – The resident can perform part of the activity him/herself, the resident requires assistance with dressing or walking more than 3 times a week.
  - TD = **Totally Dependent** – Someone must complete the task for the resident.
  - TL = **Therapeutic Leave** – Initial by date when resident is on therapeutic leave.
  - OOF = **Out of Facility** – Initial by date when resident is out of facility.
  - R = **Refused**
  - H = **Hospital** – Initial by date when resident is in the hospital.
  - O = **Other Instructions:** \_\_\_\_\_

Form # M012LPCR2 (0/012) MED-PASS® (01)-415181M

Bubba Smith Home Care

REC'D DEC 08 2010

Deviation Report

Date: 3-2-10

Patient name: Goofy Dog

Aide name: Minnie Mouse

Classification:  CAP  PCS  Private  Other:

Missed 2 hours of care today due to MD appointment. Patient's daughter is taking and will be gone most of the day. No PCS is needed. Resume tomorrow at regularly scheduled time.

Signature of Agency Staff: *Suzy Staffer*

## Sample deviation documentation

# How Do I Submit My Claims?



# CPT CODE and MODIFIERS

| CPT CODE | DESCRIPTION          |
|----------|----------------------|
| 99509    | Assistance with ADLs |

| MODIFIER(S) | PROVIDERS   |
|-------------|---|
| HA          | In-Home Care Agencies, Beneficiary Under 21 Years     |
| HB          | In-Home Care Agencies, Beneficiary 21 Years and Older |
| HC          | Adult Care Homes                                      |
| TT          | Combination Homes                                     |
| SC          | Special Care Units                                    |
| HQ          | Family Care Homes                                     |
| HH          | Supervised Living Facilities for adults with MI/SA    |
| HI          | Supervised Living Facilities for adults with I/DD     |



# The Carolinas Center *for* Medical Excellence

100 Regency Forest Drive, Suite 200, Cary, NC 27518-8598 • 919.461.5500 • 800.682.2650 • www.thecarolinascenter.org

## NOTICE OF DECISION ON A CONTINUING REQUEST FOR MEDICAID SERVICES

October 15, 2012

Ms. Evelyn Lyons  
456 Production Drive  
Anywhere, NC 28822

Maryam Burnette  
123456789M  
Above All Others  
456 Production Drive  
Anywhere, NC 28822

RE: Evelyn Lyons  
MID: 987654321K  
Service Requested: Personal Care Services

Dear Ms. Evelyn Lyons:

Effective January 1, 2013, N. C. Medicaid will no longer offer services under the In-Home Care (IHC) and Adult Care Home Personal Care Services (ACH-PCS) programs. Personal care services for beneficiaries residing in private living arrangements and licensed ACH facilities will instead be provided under a new, consolidated Personal Care Services (PCS) benefit. Licensed ACH facilities include Adult Care Homes, Family Care Homes, Supervised Living Group Homes, and Combination Homes with ACH beds.

Pursuant to N.C. Session Law 2012-142, Sections 10.9F.(b) and 10.9F.(c); North Carolina State Plan for Medical Assistance; and Division of Medical Assistance (DMA) Clinical Coverage Policy 3L, PCS covers hands-on assistance with Activities of Daily Living (ADLs), including bathing, dressing, mobility, toileting, and eating. PCS may also include assistance with related home management tasks, medications, adaptive or assistive devices, and durable medical equipment. **PCS does not cover transportation or errands.** The full list of covered and non-covered services can be found in Division of Medical Assistance (DMA) Clinical Coverage Policy 3L, which is available at: <http://www.dhhs.state.nc.us/dma/mp/index.htm>.

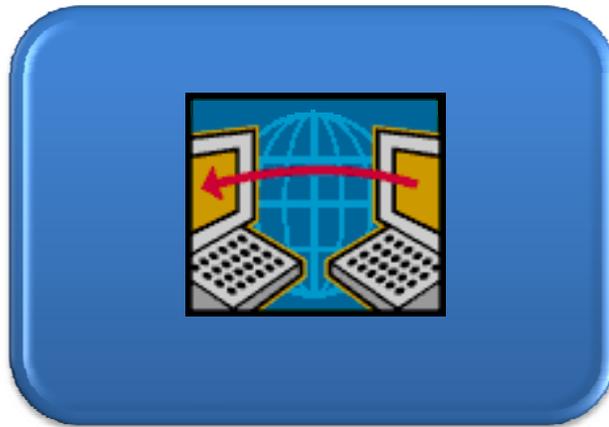
As required by the North Carolina State Plan for Medical Assistance; N.C. Session Law 2012-142, Sections 10.9F.(b) and 10.9F.(c); and Division of Medical Assistance (DMA) Clinical Coverage Policy 3L, all Medicaid beneficiaries receiving Personal Care Services must be referred by their primary or attending physician and receive an independent assessment by a registered nurse or social worker affiliated with DMA or the Independent Assessment Entity (IAE) designated by DMA. The Carolinas Center for Medical Excellence (CCME) is the IAE designated by DMA to conduct independent assessments.

**Usted tiene treinta (30) días para apelar esta decisión. Tiene que enviar su solicitud dentro de diez (10) días para continuar los servicios sin interrupción. Si necesitas ayuda para leer y entender la carta, por favor contáctese con el 800.662.7030. DIGA AL OPERADOR QUE LA NOTIFICACION DMA 2002PCS-Transition.**

DMA 2002PCS Transition [Select One: HB HC HH HI HA SC TT]

# Transition Notifications

# Billing: How to Submit Claims Electronically



Web tool



Hire a Vendor

North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool <https://webclaims.ncmedicaid.com/ncecs>

1500

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

|   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> <input type="checkbox"/> PICA  |  | <input type="checkbox"/> <input type="checkbox"/> PICA  |  |
| <b>1.</b> MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/> |  | <b>1a.</b> INSURED'S I.D. NUMBER (For Program in Item 1)<br><b>MID</b>  |  |
| <b>2.</b> PATIENT'S NAME (Last Name, First Name, Middle Initial)  |  | <b>3.</b> PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>   |  |
| <b>5.</b> PATIENT'S ADDRESS (No., Street)   |  | <b>6.</b> PATIENT RELATIONSHIP TO INSURED<br>Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> |  |
| CITY STATE  |  | <b>4.</b> INSURED'S NAME (Last Name, First Name, Middle Initial)  |  |
| ZIP CODE TELEPHONE (Include Area Code) ( )  |  | <b>7.</b> INSURED'S ADDRESS (No., Street)   |  |
| <b>8.</b> PATIENT STATUS<br>Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/><br>Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>  |  | CITY STATE  |  |
| ZIP CODE TELEPHONE (Include Area Code) ( )  |  | <b>11.</b> INSURED'S POLICY GROUP OR FECA NUMBER  |  |
| <b>9.</b> OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)  |  | <b>10.</b> IS PATIENT'S CONDITION RELATED TO:   |  |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER   |  | a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>   |  | b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)  |  |
| c. EMPLOYER'S NAME OR SCHOOL NAME   |  | c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| d. INSURANCE PLAN NAME OR PROGRAM NAME  |  | <b>10d.</b> RESERVED FOR LOCAL USE  |  |
| <b>12.</b> PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.   |  | <b>13.</b> INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.                |  |
| SIGNED _____ DATE _____   |  | SIGNED _____  |  |

CARRIER  
PATIENT AND INSURED INFORMATION

|   |    |      |  |          |  |  |  |                           |   |          |  |   |  |    |                         |                  |  |               |                 |  |                 |                 |  |                      |  |  |              |  |  |                             |  |  |
|---|----|------|--|----------|--|--|--|---------------------------|---|----------|--|---|--|----|-------------------------|------------------|--|---------------|-----------------|--|-----------------|-----------------|--|----------------------|--|--|--------------|--|--|-----------------------------|--|--|
| 14. DATE OF CURRENT:<br>MM DD YY  |    |      | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) |          |  | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.<br>GIVE FIRST DATE MM DD YY  |  |                           | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION<br>FROM MM DD YY TO MM DD YY |          |  |   |  |    |                         |                  |  |               |                 |  |                 |                 |  |                      |  |  |              |  |  |                             |  |  |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE  |    |      |  |          |  | 17a. NPI   |  |                           | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES.<br>FROM MM DD YY TO MM DD YY |          |  |   |  |    |                         |                  |  |               |                 |  |                 |                 |  |                      |  |  |              |  |  |                             |  |  |
| 19. RESERVED FOR LOCAL USE  |    |      |  |          |  | 20. OUTSIDE LAB?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |                           |   |          |  | \$ CHARGES  |  |    |                         |                  |  |               |                 |  |                 |                 |  |                      |  |  |              |  |  |                             |  |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)  |    |      |  |          |  | 22. MEDICAID RESUBMISSION<br>CODE ORIGINAL REF. NO.                          |  |                           |   |          |  | 23. PRIOR AUTHORIZATION NUMBER  |  |    |                         |                  |  |               |                 |  |                 |                 |  |                      |  |  |              |  |  |                             |  |  |
| 24. A. DATE(S) OF SERVICE   |    |      |  |          |  | B. PLACE OF SERVICE  |  |                           | C. EMG  |          |  | D. PROCEDURES, SERVICES, OR SUPPLIES<br>(Explain Unusual Circumstances) |  |    | E. DIAGNOSIS<br>POINTER |                  |  | F. \$ CHARGES |                 |  | G. NYS OR UNITS |                 |  | H. EPSDT Family Plan |  |  | I. ID. QUAL. |  |  | J. RENDERING PROVIDER ID. # |  |  |
| From  |    | To   |  | MM DD YY |  | MM DD YY   |  | CPT/HCPCS                 |   | MODIFIER |  |   |  |    |                         |                  |  |               |                 |  |                 |                 |  |                      |  |  |              |  |  |                             |  |  |
| 1   | 03 | 03   | 12   |          |  |  |  |                           | 99509   |          |  |   |  |    |                         |                  |  | 8.0           |                 |  |                 |                 |  |                      |  |  |              |  |  |                             |  |  |
| 2   | 03 | 04   | 12   |          |  |  |  |                           | 99509   |          |  |   |  |    |                         |                  |  | 9.0           |                 |  |                 |                 |  |                      |  |  |              |  |  |                             |  |  |
| 3   |    |      |  |          |  |  |  |                           |   |          |  |   |  |    |                         |                  |  |               |                 |  |                 |                 |  |                      |  |  |              |  |  |                             |  |  |
| 4   |    |      |  |          |  |  |  |                           |   |          |  |   |  |    |                         |                  |  |               |                 |  |                 |                 |  |                      |  |  |              |  |  |                             |  |  |
| 5   |    |      |  |          |  |  |  |                           |   |          |  |   |  |    |                         |                  |  |               |                 |  |                 |                 |  |                      |  |  |              |  |  |                             |  |  |
| 6   |    |      |  |          |  |  |  |                           |   |          |  |   |  |    |                         |                  |  |               |                 |  |                 |                 |  |                      |  |  |              |  |  |                             |  |  |
| 25. FEDERAL TAX I.D. NUMBER   |    |      |  | SSN      |  | EIN  |  | 26. PATIENT'S ACCOUNT NO. |   |          |  | 27. ACCEPT ASSIGNMENT?<br>(For govt. claims, see back)                  |  |    |                         | 28. TOTAL CHARGE |  |               | 29. AMOUNT PAID |  |                 | 30. BALANCE DUE |  |                      |  |  |              |  |  |                             |  |  |
|   |    |      |  |          |  | <input checked="" type="checkbox"/>  |  |                           |   |          |  | <input type="checkbox"/> YES <input type="checkbox"/> NO                |  |    |                         | \$               |  |               | \$              |  |                 | \$              |  |                      |  |  |              |  |  |                             |  |  |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER<br>INCLUDING DEGREES OR CREDENTIALS<br>(I certify that the statements on the reverse<br>apply to this bill and are made a part thereof.) |    |      |  |          |  | 32. SERVICE FACILITY LOCATION INFORMATION                                    |  |                           |   |          |  | 33. BILLING PROVIDER INFO & PH # ( )                                    |  |    |                         |                  |  |               |                 |  |                 |                 |  |                      |  |  |              |  |  |                             |  |  |
| SIGNED  |    | DATE |  | a.       |  | NPI  |  | b.                        |   | a.       |  | NPI   |  | b. |                         |                  |  |               |                 |  |                 |                 |  |                      |  |  |              |  |  |                             |  |  |

PHYSICIAN OR SUPPLIER INFORMATION

# What billing topics can be addressed by the CCME Billing Department?

## Inquires about Personal Care Services error codes

- 2222 – no documentation on file
- 0023 – services requires prior approval
- 5129/5111 - provider number on claims doesn't match provider number on record
- 5308 - authorized units are exceeded
- 5130/5112 – procedure coded billed doesn't match procedure code on record



# When Should Billing Questions be Directed to HP?

- Denials
- Wrong Carolina Access Number
- Wrong CPT code
- Assistance with the web tool
- Request for an on-site visits



# Billing Resources

**DMA Website - <http://www.ncdhhs.gov/dma/index.htm>**

**Medicaid and Health Choice Providers:**

<http://www.ncdhhs.gov/dma/provider>

**Basic N.C. Medicaid and N.C. Health Choice Seminars**

<http://www.ncdhhs.gov/dma/provider/seminars.htm>

**Basic Medicaid Billing Guide Slide:**

<http://www.ncdhhs.gov/dma/basicmed/index.htm>



PCS Provider Use of QiRePort

# What is QiReport?

- Web-based information system to support PCS independent assessments
  - Helps collect, store and communicate assessment results
    - Secure site to protect the privacy and confidentiality of recipient data

# QiRePort: Getting Started

IHC providers will continue to utilize the same form and registration process.

**The Carolinas Center for Medical Excellence**  
**Provider Registration For PCS Agency Use of QiRePort**

Complete this form and send to The Carolinas Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail: CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598. For questions, contact CCME at 800-228-3365 or PCSAssessment@thecarolinasceneter.org.

**Agency Identification and Primary Contact Information**

|  |            |            |           |                |    |
|--|------------|------------|-----------|----------------|----|
| Owner/Corporate Identity (Full name)   |            | Main Phone |           | Main Fax       |    |
| Agency Name If Different Than Corporate Identity (dba):  |            | NPI        |           | DHSR License # |    |
| Agency Mailing Address   |            |            |           |                |    |
| Street Address or PO Box   |            | City       |           | State          | NC |
|  |            |            |           | Zip            |    |
| Agency Staff Contact Information For QiRePort Support and Communications (For the agency as a whole) |            |            |           |                |    |
| Last Name  | First Name | Position   | Telephone | E-Mail         |    |
|  |            |            |           |                |    |
| Last Name  | First Name | Position   | Telephone | E-Mail         |    |
|  |            |            |           |                |    |

**List Agency Medicaid Provider Numbers Used For PCS Billing** (List up to 15 agency Medicaid provider numbers below)

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**List Staff Requiring Access To Recipient Information For All Agency Medicaid Provider Numbers Listed Above** (Up to 5 agency staff)

| Agency Staff or Designated Representatives |            |                              |                |           |
|--|------------|------------------------------|----------------|-----------|
| Last Name                                  | First Name | Type of Access To QiRePort * | E-Mail Address | Telephone |
|  |            |                              |                |           |
|  |            |                              |                |           |
|  |            |                              |                |           |
|  |            |                              |                |           |
|  |            |                              |                |           |

\* Type of Access: Select either Add/Edit or View Only

# QiRePort: Getting Started

REGISTER  
NOW

The screenshot shows the NC Division of Medical Assistance website. The top navigation bar includes links for 'DHHS Home', 'A-Z Site Map', 'Divisions', 'About Us', 'Contacts', and 'En Español'. There are search boxes for 'Search DHHS' and 'Search DMA'. The main header features the 'dhhs' logo and the text 'NC Department of Health and Human Services' on the left, and 'NC Division of Medical Assistance' on the right. Below the header is a navigation menu with four tabs: 'FOR BENEFICIARIES', 'FOR COUNTY STAFF', 'For Providers', and 'STATISTICS AND REPORTS'. The 'For Providers' tab is selected. The left sidebar contains a list of links under 'DMA HOME', including 'Medicaid Providers', 'A-Z Provider Topics', 'Calendars', 'Claims and Billing', 'Community Care (CCNC/CA)', 'Contacts for Providers', 'Enrollment', 'EPSDT and Health Check', 'Fee Schedules/Cost Reports', 'Forms', 'Fraud and Abuse', 'HIPAA', 'Library (bulletins, policies)', 'National Provider Identifier', 'Programs and Services', and 'Seminars'. Below this are sections for 'ABOUT DMA', 'CONTACT DMA', and 'Quick Links' with links to 'Archived 1915 b/c Waiver Content', 'Basic Medicaid Billing Guide', 'Clinical Coverage Policies and Provider Manuals', and 'DMA Contract Standardized'. The main content area displays the title 'Consolidated Personal Care Services (PCS)' and the 'EFFECTIVE DATE: January 1, 2013'. The text describes the PCS program as a Medicaid State Plan benefit for individuals in private living arrangements, residential facilities, or group homes. It lists qualifying activities of daily living (ADLs) and states that PCS program eligibility is determined by an independent assessment. At the bottom, there are links for 'DMA Clinical Policy & Programs', 'Frequently Asked Questions', and 'What's New Information'.

DMA Website:

<http://www.ncdhhs.gov/dma/pcs/pas.html>

# QiRePort: Getting Started

## ACH QiRePort registration form

— Fax completed form to CCME  
1-877-272-1942

**The Carolinas Center for Medical Excellence**  
**Provider Registration For Licensed Facility PCS Provider Use of QiRePort**

Complete this form and send to The Carolinas Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail: CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598. For questions, contact CCME at 800-228-3365 or PCSAssessment@thecarolinascenter.org.

**Facility Identification and Primary Contact Information**

|  |            |                |           |          |  |
|--|------------|----------------|-----------|----------|--|
| Owner/Corporate Identity (Full name)   |            | Main Phone     |           | Main Fax |  |
| Facility Name If Different Than Corporate Identity (dba)   | NPI        | DHSR License # |           |          |  |
| Facility Mailing Address   |            |                |           |          |  |
| Street Address or PO Box   | City       | State          | NC        | Zip      |  |
| Facility Staff Contact Information For QiRePort Support and Communications (For the organization as a whole) |            |                |           |          |  |
| Last Name  | First Name | Position       | Telephone | E-Mail   |  |
| Last Name  | First Name | Position       | Telephone | E-Mail   |  |

**List Facility Medicaid Provider Numbers Used For PCS Billing** (List up to 15 agency Medicaid provider numbers below)

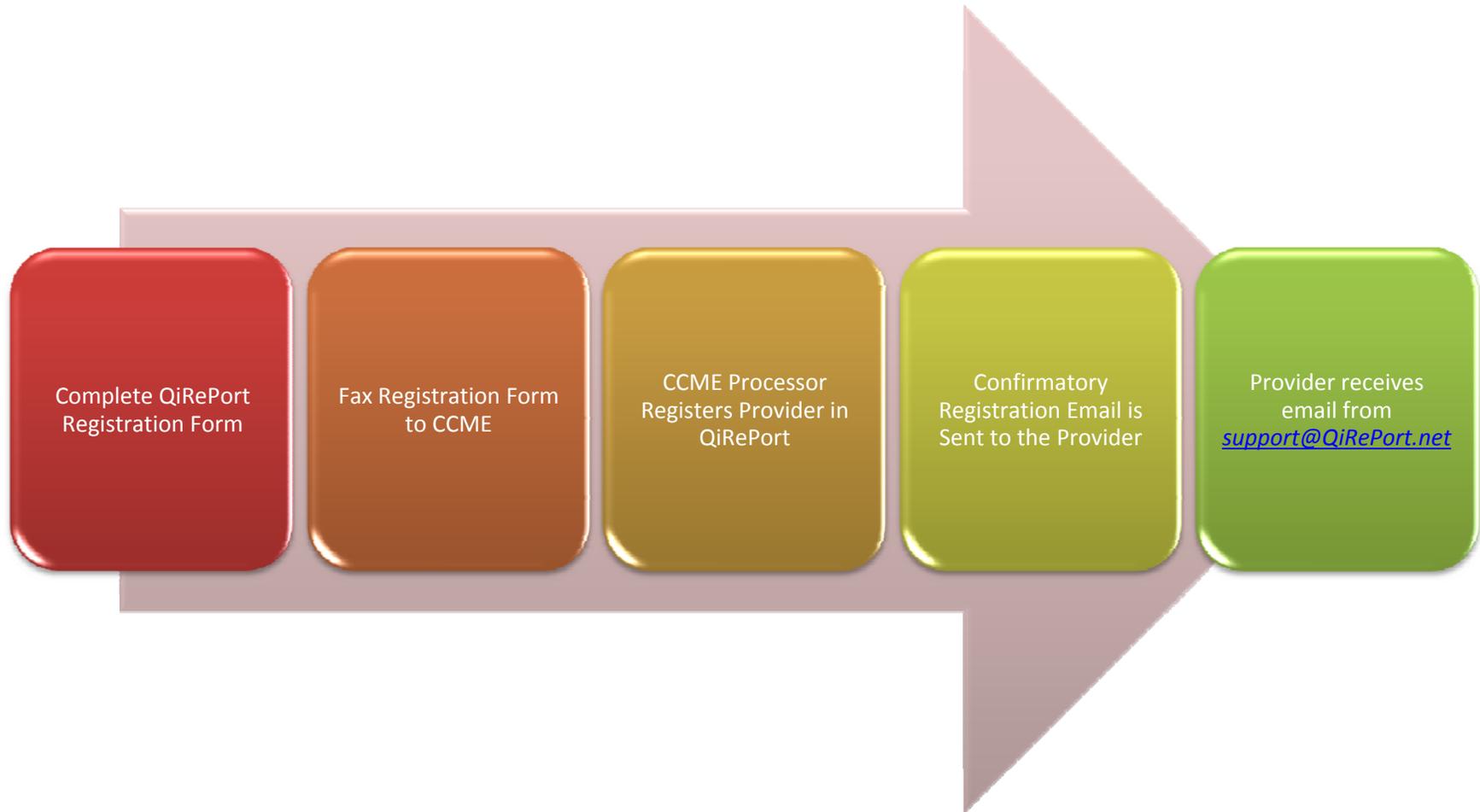
|  |  |  |  |  |
|--|--|--|--|--|
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**List Staff Requiring Access To Beneficiary Information For All Facility Medicaid Provider Numbers Listed Above** (Up to 5 staff)

| Agency Staff or Designated Representatives |            |                              |                |           |
|--|------------|------------------------------|----------------|-----------|
| Last Name                                  | First Name | Type of Access To QiRePort * | E-Mail Address | Telephone |
|  |            |                              |                |           |
|  |            |                              |                |           |
|  |            |                              |                |           |
|  |            |                              |                |           |
|  |            |                              |                |           |

\* Type of Access: Select either Add/Edit or View Only

# QiRePort Registration Process



# How does QiReport work?

- Providers have a unique version of QiRePort (different from CCME version)
- Recipient referral and assessment information organized around provider numbers
- PCS agency or residential facility staff users linked to provider numbers

# Usage Requirements

- Internet access required
- Use Internet Explorer or Firefox web browser
- Log-in username and password
  - You must register to receive these
  - All agency staff members listed on the registration form will receive these by e-mail
- No special computers or software required

## Welcome

### User Login

User Name:

Password:

Log In

[Forgot password?](#)

### Information

[Terms of Use](#)

[Safety and Usage Requirements](#)

### Contact Us

Your Email:

Enter Question:

Send

Call Center Phone Number:

1-800-228-3365



**Learn more about PCS Independent Assessments and PACT Reviews:** The DHHS, Division of Medical Assistance is implementing new policies and procedures for personal care services. Agencies and organizations interested in knowing more about this new initiative should [click here to learn more](#). You do NOT need to log-in with a user name and password to see this information.

**QiReport** is a new web service developed to support quality improvement and utilization management initiatives sponsored by the NC Department of Health and Human Services, Division of Medical Assistance. The Carolinas Center For Medical Excellence administers QiReport on behalf of the Division Medical Assistance.



Visit [www.qireport.net](http://www.qireport.net)



# Features of the Provider Interface For QiReport

## Electronic Referral Process

- Receipt from CCME
- Agency accept or decline

## Access to CCME generated PCS documents for your agency's clients/referrals only

- IA documents
- Accept or decline letters
- Notification letters

# Features of the Provider Interface For QiReport

Beginning in mid-December 2012, registered licensed facility PCS providers will be able to log into QiRePort to view and download beneficiary assessments for beneficiaries assessed during the transition assessment period including:

- Beneficiaries authorized for services effective January 1, 2013;
- Beneficiaries denied transition effective January 1, 2013; and
- Beneficiaries who appeal adverse decisions and are authorized for maintenance of service.

# Features of the Provider Interface For QiReport

## Online submission of information

- Change of Status
- Beneficiary discharges
- (IHC) Provider billing number changes
- (IHC) Provider service area

## Notification of beneficiary appeals

# Provider Interface For QiReport

Features of the upcoming version of the provider interface:

- Automated tool for plans of care
- Quality measures

# Security Provisions: Privacy Protection Requirements

- HIPAA and HITECH compliance basics for personal health information
  - QiRePort hosting security
  - Data transmittal security
  - Data origination security
- Provider security responsibilities
  - Staff/designated representative access management
  - Agency computer security provisions
  - Control and security of recipient paperwork
  - Staff training and agency policy and procedures on data privacy and security

# Security Provisions: Computer Usage

- Protect your username and password
- Lock your workstation every time you leave your desk
  - CTRL + ALT+ delete, “Lock computer”
- Use timeouts for screen displays
  - Require computer passwords to clear screensavers
- Log out from QiReport when you finish your session
- Control use of data backup devices

# Viewing Recipient Information: Referrals

*Log in to QiReport daily to check for referrals!*

- QiReport tracks the date of the referral and when a referral decision (accept or deny) is due from the provider (**2 business days**)
  - Referrals without a provider response move to the beneficiary's next choice of provider after 2 days

# User Support

1. Frequently asked questions
2. On-Line help: guides and instructions
3. Ask a question via QiRePort
  - E-mail support system
4. Call center

# User Support: Common Questions To Be Answered By FAQs

- Online FAQs
  - Are posted and available for review
  - Accessible through the provider interfaces
- Categories included in the FAQs
  - QiRePort access
  - How to use QiRePort features
  - How to respond to an error message
  - How to add and delete users

# CCME Call Center Support

- If the on-line information doesn't answer your question...

**Email:**

[PCSAssessment@thecarolinascenter.org](mailto:PCSAssessment@thecarolinascenter.org)

**Telephone:**

1-800-228-3365

# Resources

**Division of Medical Assistance (DMA)** - <http://www.ncdhhs.gov/dma/index.htm>

Basic Medicaid and NC Health Choice Billing Guide -

<http://www.ncdhhs.gov/dma/basicmed>

**The Carolina Center for Medical Excellence (CCME)** - [www.thecarolinascenter.org](http://www.thecarolinascenter.org)

CCME's Call Center is available Monday through Friday from 8:00 a.m. – 5:00 p.m.

Toll Free Number: 800-228-3365

**HP Enterprise Services (HPES)** – Provider Services

Toll Free Number: 800-688-6696



**Thank you for participating!**