

**Policy terminated. Coverage will be provided under new policy
3L, Personal Care Services
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1.0 Description of the Procedure, Product, or Service

1.1 General Description

In-Home Care for Adults (IHCA) provided under this benefit includes a range of hands-on human assistance provided to qualified NC Medicaid (Medicaid) recipients age 21 or older who, because of a physical disability, cognitive impairment, or chronic medical condition, are unable to accomplish tasks that they would ordinarily do for themselves if they were not disabled. Covered services under this program include hands-on supplemental assistance by a paraprofessional aide with activities of daily living (ADLs) that, for this program, are eating, dressing, bathing, toileting, and mobility.

1.2 Program Parameters

Services provided under this Medicaid Program are based on the assessed level of the recipient's functional limitations and unmet needs for assistance in performing the ADLs listed above. Services are provided on a scheduled and intermittent basis to supplement other community services; including services available through other public and private agencies; and the care, assistance, and support provided by the recipient's family and other informal caregivers. These services and supports are meant to supplement, not replace, family roles and responsibilities. Services are provided in the recipient's home.

1.3 Alternative to Institutionalization

Recipients who qualify for this service are not required to meet Medicaid nursing facility level of care requirements to participate in this program and this program is not intended to provide services as an alternative to Medicaid facility or home and community-based services that do require the recipient to meet this level of care criteria. Further, this Medicaid program is not intended to address unmet needs of individuals in this age group who are not medically stable or who require ongoing care, supervision, or monitoring by a nurse or other health care professional. This program is appropriate for recipients whose unmet needs for assistance can be safely met in the home and community by family members and other informal caregivers supported by scheduled home visits by paraprofessional aides trained to provide personal assistance services.

1.4 IHCA Policy Definitions and Acronyms

For the purposes of this Clinical Coverage Policy the following terms have the following meanings:

Activities of Daily Living (ADLs) means the physical functions that an individual performs each day and, as used in this Clinical Coverage Policy, are bathing, dressing, toileting mobility, and eating.

Change of Status Review means a reassessment required because of a significant change in the recipient's unmet need for assistance with activities of daily living (ADLs).

Continuous Quality Improvement (CQI) means the process of designing program monitoring and evaluation activities, identifying program problems and deficiencies, correcting or remediating those problems and deficiencies, and continually improving the quality of care and services provided to Medicaid recipients under this program.

Division of Health Services Regulation (DHSR) means the state agency responsible for licensing and regulating home care agencies.

Division of Medical Assistance (DMA) means the state Medicaid agency.

Functional Limitation means a limitation in the individual's capacity to perform ADLs independently because of a physical, cognitive, or health-related impairment.

HIPAA means Health Insurance Portability and Accountability Act of 1996 that provides federal regulations for the protection and security of confidential health information.

In-Home Aide Services means hands-on assistance provided by a paraprofessional aide to assist individuals to perform activities of daily living and related activities, as defined in this Clinical Coverage Policy.

Independent Assessment Entity (IAE) means an organization under contract to DMA to perform IHCA assessments and related activities that is not a provider of in-home aide services, or affiliated in any way with any home health or home care provider organization.

Instrumental Activities of Daily Living (IADLs) means light housekeeping tasks directly related to the approved ADL assistance specified on the recipient's plan of care, such as cleaning up after a bath or meal.

Medically Stable means that the recipient has reached a point in his or her medical treatment where a life-threatening or serious injury, disease, medical condition, or cognitive impairment has been brought under control and the recipient no longer needs medical care, services, supervision, or monitoring from a licensed health care professional and can live safely at home under his or her current living conditions.

Nursing Services means professional services provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of a registered nurse.

Personal Care Aide or In-Home Aide means an individual who is a paraprofessional and who provides hands-on assistance to recipients receiving personal assistance under this Clinical Coverage Policy.

Private Residence means a home or apartment privately owned or privately rented by the recipient, his or her family, or unrelated individual who is providing a home for the recipient.

Program Reassessment or **Continuation Review** means the reassessment of the IHCA program participant conducted prior to the end of his or her current authorization period to determine if he or she continues to qualify for services and to determine the amount of care to be provided.

Provider Organization or **Home Care Provider** means a public or private entity that is licensed as a home care agency by the North Carolina Division of Health Services Regulation and enrolled with Medicaid to furnish in-home personal care to Medicaid recipients.

Recipient means an individual qualified for Medicaid who is receiving services under this Medicaid program.

2.0 Eligible Recipients

2.1 General Provisions

NC Medicaid (Medicaid) recipients shall be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

NC Health Choice (NCHC) shall not cover In-Home Care for Adults.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

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

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid and NC Health Choice Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid and NC Health Choice Billing Guide:

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

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

2.3 Health Choice Special Provision: Exceptions to Policy Limitations for Health Choice Recipients ages 6 through 18 years of age

EPSDT does not apply to NCHC recipients. If a NCHC recipient does not meet the clinical coverage criteria within **Section 3.0** of the clinical coverage policy, the NCHC recipient shall be denied services. Only services included under the Health Choice State Plan and the DMA clinical coverage policies, service definitions, or billing codes shall be covered for NCHC recipients.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.

3.1 General Criteria

Procedures, products, and services related to this policy are covered when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

Medicaid covers IHCA for eligible recipients when all of the following are met:

- a. The home environment is safe and free of health hazards for the recipient and IHCA provider(s), as determined by an in-home environmental assessment conducted by DMA or its designee.
- b. The home is adequately equipped to implement needed services.
- c. There is no other third-party payer responsible for covering IHCA Services or similar in-home aide services.
- d. There is no available, willing, and able family member or other informal caregiver **household** to provide the authorized services during those periods of time when the services are provided.
- e. The required IHCA Services are directly linked to a documented medical condition or physical or cognitive impairment causing the functional limitations requiring the IHCA, and are medically necessary, appropriate, and provided in amounts directly related to the recipient's documented unmet need for IHCA services.
- f. The recipient is under the ongoing direct care of a physician for the medical condition, or physical or cognitive impairment causing the functional limitations.
- g. The recipient is medically stable and does not require continuous care, monitoring, or supervision by a licensed nurse or other licensed health care professional.

3.3 Covered Tasks Under IHCA

If the recipient meets minimum program requirements for IHCA and the recipient has documented unmet needs for assistance provided under this Clinical Coverage Policy, he or she may be authorized to receive services that include:

- a. Up to 80 hours per month of hands-on assistance to address unmet needs for limited assistance in three of the five qualifying ADLs, or unmet needs for limited assistance in one qualifying ADL and extensive assistance or full dependence in one of the other four qualifying ADLs;
- b. Instrumental Activities of Daily Living directly related to the ADL;
- c. Assistance with adaptive or assistive devices;
- d. Assistance with the use of durable medical equipment; and
- e. Assistance with Nurse Aide II tasks.

3.4 Essential Errands

Essential errands that are critical to maintaining the health and welfare of the recipient may be approved on a case-by-case basis when there is no willing or able family member, other individual, program, or service available to meet this need.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Non-Covered Criteria

Medicaid shall not cover IHCA when any of the following are true:

- a. The IHCA is provided at a location other than the recipient's private residence;
- b. The recipient's primary need is housekeeping or homemaking;
- c. The IHCA provided in the month exceeds the amount approved by the IAE;
- d. The assigned ADL assistance is not completed on the date billed;
- e. The IHCA is provided by a live-in aide;
- f. The IHCA is performed by an individual who is the recipient's spouse, child, parent, sibling, grandparent, grandchild, or equivalent step or in-law relationship to the recipient; and
- g. There are willing and able family members or other informal caregivers available on a regular basis adequate to meet the recipient's need for personal assistance.

4.2.1 Non-Covered Tasks

Medicaid shall not cover certain services and tasks under this program, including, but not limited to:

- a. Skilled nursing services provided by a LPN or RN;
- b. Services provided by other licensed health care professionals;
- c. Respite care;
- d. Care of non-service-related pets and animals;
- e. Yard or home maintenance work;
- f. Medical and non-medical transportation;
- g. Money management;
- h. Non-essential errands and shopping;
- i. Companion sitting or leisure activities;
- j. Continuous monitoring or ongoing recipient supervision;
- k. Personal care or home management tasks for other residents of the household; and
- l. Other tasks and services not specified in the recipient's approved plan of care.

4.2.2 Cueing, Prompting, Guiding, or Coaching

Cueing, prompting, guiding, or coaching may be provided as part of the hands-on assistance to recipients for the qualified ADLs, but do not constitute a covered service in and of themselves.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.

5.1 Prior Approval

The provider shall obtain approval before rendering In-Home Care Services for Adult Medicaid recipients.

5.2 Prior Approval Requirements

The provider(s) shall submit to DMA's designee the following:

- a. the prior approval request;
- b. all health records and any other records that support the recipient has met the specific criteria in **Subsection 3.2** of this policy; and
- c. if the Medicaid recipient is under 21 years of age, information supporting that all EPSDT criteria are met and evidence-based literature supporting the request, if available.

To be prior approved for IHCA, the recipient shall receive an independent assessment from DMA or the IAE, meet minimum program admission requirements, receive a service authorization for a specified number of IHCA hours per month, and have a plan of care submitted by the provider and approved by the IAE.

When these requirements have been completed, the service authorization and the approved number of hours are entered into the Medicaid Management Information System and the provider organization may bill for services.

5.3 Authority to Conduct IHCA Assessments, Reassessments, Change of Status Reviews, Service Authorizations, and Related Administrative Tasks

- a. IHCA assessments, reassessments, and change of status reviews for the purpose of authorizing services shall be conducted by DMA, or the IAE designated by DMA.
- b. In-Home Care Provider Organizations are not authorized to perform IHCA assessments for the purpose of authorizing Medicaid services. Such assessments include initial assessments of recipients referred to IHCA, continuing need reviews or reassessments for IHCA services, and change of status reviews for IHCA services. All recipients requiring IHCA assessments for the purpose of authorizing services shall be referred to DMA or the designated IAE.
- c. In-Home Care Providers shall not initiate IHCA Services until the service authorization is received from DMA or the designated IAE and the plan of care is approved by DMA or the designated IAE.

- d. DMA or the designated IAE shall determine the qualifying ADLs, the level of assistance required for each, and the amount and scope of IHCA services to be provided, according to the criteria provided in **Subsections 5.6, 5.7, and 5.8** of this Clinical Coverage Policy.
- e. DMA, or the designated IAE, shall determine the end date for approval of services and the date of the next reassessment that shall be no later than 365 calendar days from the approval date or a shorter period of time based on the recipient's chronic or continuing acute condition and expectation for improvement in the recipient's medical condition causing the need for IHCA.
- f. DMA, at its sole discretion, shall conduct a review of a recipient's IHCA services or order a re-assessment of the unmet need for IHCA services at any time.

5.4 Requirement for Qualifying Activities of Daily Living (ADLs)

IHCA services are provided to Medicaid recipients who qualify for coverage and have documented unmet needs for hands-on assistance with:

- a. Bathing,
- b. Dressing,
- c. Toileting,
- d. Mobility, and
- e. Eating.

5.5 Requirement for Physician Referral

- a. The recipient shall be referred to IHCA by his or her primary care or attending physician.
- b. The recipient or the recipient's family, or legally responsible person, is responsible for contacting his or her primary care or attending physician and requesting a referral for Medicaid IHCA services.
- c. If the recipient has not been seen by his or her physician during the preceding 90 calendar days, he or she shall schedule an office visit to request Medicaid IHCA Services.
- d. A recipient participating in Community Care of North Carolina (CCNC) shall be referred for IHCA by his or her designated primary care physician, except as described in **Subsection 5.6.f** below.
- e. If a recipient does not have a primary care physician, he or she shall obtain a referral from the physician who is providing the care and treatment for the medical, physical, or cognitive condition causing the functional limitations requiring IHCA.
- f. Once ordered by the recipient's physician, the IHCA assessment shall be performed by an IAE RN Assessor at the recipient's home, except as noted in **Subsection 5.6.g** below. An environmental risk assessment of the recipient's home shall also be performed at this time.

5.6 Requirements for IHCA Assessments

- a. All IHCA assessments shall be conducted by DMA or RNs affiliated with the IAE using a standardized process and assessment tool provided or approved by DMA.
- b. All IHCA assessments shall be performed by individual RN Assessors.
- c. All assessments for new admissions to the IHCA Program shall be face to face and conducted in the recipient's home or at the inpatient medical facility if the recipient is being evaluated for IHCA as part of the discharge planning process.
- d. In-home assessments shall include an assessment of the recipient's home environment to identify any health or safety risks to the recipient or to the IHCA aides who will provide the services.
- e. Physician attestation that the approved IHCA is medically necessary.
- f. If the recipient is an inpatient in a medical facility such as a hospital, rehabilitation center, or nursing facility, his or her attending physician may order the IHCA assessment through the facility's discharge planning office. A written copy of the order shall be placed in the recipient's medical record and, if requested, shall be provided to the DMA or the IAE.
- g. The recipient may receive an IHCA assessment in the inpatient medical facility by an IAE RN Assessor, if allowed by the facility. If the recipient qualifies for IHCA, the RN Assessor shall complete a home risk evaluation before he or she is authorized for services.
- h. Primary care and attending physicians referring patients for IHCA shall complete the IHCA on-line referral and medical necessity attestation form and submit the form to the IAE via the Internet. The referral form shall be complete and provide:
 1. Physician authorization for the IAE to perform an IHCA assessment;
 2. The medical diagnosis or diagnoses causing the need for IHCA and related medical information; and
 3. An attestation to the medical necessity of the service.
- i. Referring physicians may access a summary of the assessment via the Internet by registering with the IAE, or by requesting this information be provided via facsimile. The home care agency's plan of care may also be requested via the Internet or facsimile.
- j. Referring physicians who do not agree with the results of the assessment may assist the recipient to appeal the results and provide additional documentation to support the need for additional amounts of IHCA.

5.7 Requirements for IHCA Reassessments

- a. All reassessments for continuing authorization of IHCA shall be conducted by DMA or the designated IAE.
- b. IHCA Providers are responsible for submitting requests for reassessments to the IAE no later than 30 calendar days before the end of the current services authorization date.
- c. Reassessments may vary in type and frequency depending on the recipient's level of functional disability and his or her prognosis for improvement or rehabilitation, as determined by the IAE, but no less frequently than once every 365 calendar days.
- d. Reassessment frequency shall be determined by the IAE as part of the new referral admission and assessment process.
- e. Reassessments shall be conducted on a face-to-face basis.

5.8 Requirements for IHCA Change of Status Reviews

- a. All Change of Status Reviews shall be conducted by DMA or the designated IAE.
- b. Change of status reviews may be requested at any time by the recipient, recipient's family, or legally responsible person; home care provider; or recipient's physician.
- c. Requests for Change of Status Reviews shall include documentation that supports the need to conduct the reassessment.
- d. Change of status reviews shall be conducted by DMA or the designated IAE on a face-to face basis by RN Assessors.

5.9 Requirements for IHCA Assessment and Reassessment Tools

IHCA assessment and reassessment tools shall be provided or approved by DMA and shall be designed to accomplish the following in a valid and consistent manner:

- a. Determine the recipient's eligibility for IHCA;
- b. Determine and authorize hours of service and level of care for new IHCA referrals;
- c. Determine and authorize hours of service and level of care for continuation of IHCA for each subsequent authorization period;
- d. Determine and authorize hours of services and level of care resulting from significant changes in the recipient's ability to conduct their ADLs;
- e. Identify existing or potential recipient risks or conditions that require interventions or services in addition to, or as an alternative to IHCA;
- f. Provide the basis for plan of care development;
- g. Support IHCA program utilization and compliance reviews; and
- h. Support IHCA program quality assessment and continuous quality improvement activities.

5.10 Timelines for Assessment and Recipient Notification

The IAE shall:

- a. Notify the recipient within 15 business days of the result of his/her initial request for IHCA or change of status review;
- b. Conduct a reassessment and notify the recipient of the results within 15 business days of the end date of the completed authorization period; and
- c. Conduct priority assessments within five business days of the request to include:
 1. Recipients who are being discharged from an inpatient facility and who are being referred for IHCA;
 2. Recipients who are under a Department of Social Services protective order; and
 3. Change of status reviews.

5.11 Determination of the Recipient's ADL Self-Performance Capacities

The assessment tool shall be a standardized ADL assessment that shall include the following components:

- a. Definition and tasks for each of the qualifying ADLs;
- b. The medical diagnosis or diagnoses causing the need for the IHCA and any exacerbating medical conditions or symptoms that may affect the ability of the recipient to perform the ADLs;
- c. A review with family members or other caregivers present at the time of assessment of the recipient's ability to perform ADLs, the amount of assistance required, and any physical or cognitive limitations or symptoms that may affect his or her ability to complete each ADL and associated IADL tasks.

- d. A rating of the recipient's overall self-performance capacity for each ADL, as summarized in the table below.

Recipient's Self-Performance Rating	Description
0 – Totally able	Recipient 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	Recipient 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	Recipient 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	Recipient 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)	Recipient is unable to perform any of the activity and is totally dependent on another to perform all of the activity

- e. The IHCA assessment shall evaluate and document the following factors for each qualifying ADL:
1. Recipient capacities to self perform specific ADL tasks organized into Nurse Aide I and Nurse Aide II categories;
 2. Recipient capacities to self-perform selected IADL tasks directly related to each ADL;
 3. Use of assistive devices;
 4. Availability, willingness, and capacities of family members and other informal caregivers to provide assistance to the recipient to perform ADLs;
 5. Availability of other home and community-based services and supports;
 6. Medical conditions and symptoms that affect ADL self-performance and assistance time; and
 7. Environmental conditions and circumstances that affect ADL self performance and assistance time.

5.12 Minimum Requirement for Admission to and Continuation of IHCA

To qualify for admission to IHCA services and continuation of IHCA services, the recipient shall meet all the requirements of this Clinical Coverage Policy and shall demonstrate unmet needs for:

- a. Hands-on assistance with three of the five qualifying activities of daily living (ADLs) at the limited assistance level; or
- b. Hands-on assistance with two ADLs, one of which is at the extensive assistance of full dependence level.

5.13 Requirements for Selecting and Changing IHCA Providers

RN Nurse Assessors shall provide options and assist the recipient to select a home care agency to provide the IHCA services. This process shall include the following steps:

- a. Each recipient shall select at least three providers from a randomized list of available providers that are licensed to provide home care services in the county where he or she resides.
- b. The IAE shall make a referral to the recipient's first choice of IHCA Service Provider. If the provider does not accept the referral, the IAE shall make a referral to the second provider on the recipient's list and, if necessary the third provider on the list.
- c. If the recipient requires Nurse Aide II tasks, the home care agency selected to provide the services shall have this level of expertise available.
- d. The recipient may change his or her IHCA Provider during the course of the authorized service period by notifying the IAE of the desired change. A new assessment shall not be required unless a change of status review is required.
- e. The IAE shall furnish the new provider with a copy of the assessment and service authorization.
- f. The new IHCA Provider shall be required to conduct a home visit, develop a new plan of care, and submit the plan of care to the IAE for approval.
- g. The new IHCA Provider shall not initiate services until the plan of care is approved by the IAE.
- h. Providers shall notify the IAE of any discharges as they occur via an on-line reporting mechanism.
- i. Recipients or their representative shall certify, in a manner prescribed by DMA, that they have exercised their right to choice of provider and have not been offered any gifts or service-related inducements to choose any specific provider organization.

5.14 Requirements for IHCA Plan of Care

The home care agency accepting the referral to provide services shall:

- a. Conduct a home visit to develop a person-centered plan of care with full participation by the recipient, legally responsible person, and other family members as appropriate.
- b. Ensure that the Plan of Care is based on the independent IHCA assessment, home risk evaluation, and other pertinent information available to the provider.
- c. If the provider agency determines a discrepancy in the IHCA assessment and the recipient condition when developing the Plan of Care (POC), the provider agency shall submit a Change of Status Report to DMA or their designated IAE.

- d. Report any recipient unmet needs for personal assistance not identified in the assessment.
- e. Request a change of status review if there has been a significant change in the recipient's health status since the assessment.
- f. Submit the plan to the IAE for review and approval via the Internet.
- g. Not initiate services until the Plan of Care is approved by the IAE. Once the plan of care is approved, the service start date shall be the date of the provider agency's initial RN home visit.
- h. Furnish only those services specified in the approved Plan of Care in the amount specified in the service authorization.

5.15 Nurse Aide Tasks

In-home aides may provide Nurse Aide I and Nurse Aide II tasks under this Clinical Coverage Policy when they meet the training, competency evaluation, and other professional qualifications specified in 21 NCAC 36.0403 (a) and 21 NCACE 36.0403 (b) respectively and such tasks are specified on the recipient's Plan of Care.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet Medicaid or NCHC qualifications for participation;
- b. be currently Medicaid - enrolled; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications

Providers shall be licensed by the North Carolina Division of Health Services Regulation (DHSR) as a home care agency in the county or counties where the IHCA Services are being provided.

7.0 Additional Requirements

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.

7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

Providers also shall:

- a. Comply with all requirements and guidelines pertaining to IHCA contained in Medicaid program manuals, memoranda, and bulletins; and
- b. Maintain all home care service records as specified in 10A NCAC 13J.1402.

7.2 Assessment Tools, Plans of Care, and Forms

Providers shall utilize only those assessment tools, plan of care formats, report formats, surveys, and related documents provided or approved by DMA.

7.3 Automated Reporting

Providers shall utilize all available Internet-based assessments plans of care, forms, reports, surveys, and other documents provided by DMA to submit information to DMA, the IHCA Independent Assessment Entity, the recipient's physician, and other individuals or organizations designated by DMA.

7.4 Telephony

Providers may utilize telephony and other automated systems to document the provision of IHCA. Guidelines for the use of telephony are provided in the January 2009 general Medicaid bulletin (<http://www.ncdhhs.gov/dma/bulletin/0109bulletin.htm#tele>).

7.5 Marketing Prohibition

Agencies providing IHCA under this Medicaid Program are prohibited from offering gifts or service related inducements of any kind to entice recipients to choose it as their IHCA Provider or to entice recipients to change from their current provider.

7.6 DMA Compliance Reviews

The IHCA Provider Organization shall:

- a. Cooperate with and participate fully in all desktop and on-site quality, compliance, prepayment, and post-payment audits that may be conducted by DMA or its designee;
- b. Meet DMA requirements for addressing identified program deficiencies, discrepancies, and quality issues through the DMA corrective action process and any overpayment recovery or sanctioning process imposed by DMA's Program Integrity Section; and
- c. Maintain all clinical records and billing documentation in an accessible location in a manner that will facilitate regulatory reviews and post payment audits.

7.7 Internal Quality Improvement Program

The IHCA Provider Organization shall:

- a. Develop, and update at least quarterly, an organizational Quality Improvement Plan or set of quality improvement policies and procedures that describe the home care agency's Continuous Quality Improvement (CQI) Program and activities;
- b. Implement an organizational CQI Program designed to identify and correct quality of care and quality of service problems;
- c. Maintain complete records of all CQI activities and results; and
- d. Provide these documents to DMA or its designee upon request in conjunction with any on-site or desktop quality improvement review.

7.8 Quality Improvement, Utilization Review, Pre- and Post-Payment Audits

The IHCA Provider Organization shall cooperate with and participate fully with DMA's quality improvement, utilization review, and pre- and post-payment audits, including, but not limited to:

- a. Provider on-site reviews, evaluations, and audits;
- b. Desktop reviews;
- c. Targeted record reviews;
- d. Recipient in-home reviews;
- e. Recipient satisfaction surveys;
- f. Retroactive utilization and medical necessity reviews;
- g. Quality of care and quality of service reviews and evaluations;
- h. Program Integrity prepayment and post-payment reviews;
- i. Reviews of recipient complaints; and
- j. Reviews of critical incident reports.

7.9 Recipient Health, Welfare, and Safety

The IHCA Provider Organization shall:

- a. Implement and demonstrate compliance with all Client Rights and Responsibilities, as specified in 10A NCAC 13J.1007;
- b. Report to the IAE and DMA any home safety risks identified during the 90-day RN Supervisor visits;
- c. Maintain an internal recipient complaint log and utilize the DMA uniform complaint form to forward all complaints by IHCA recipients to DMA;
- d. Utilize the DMA Internet-based uniform critical incident reporting form to report all incidents involving recipients that have, or appear to have, implications for the health, welfare, and safety of the recipient and forward all such reports to DMA; and
- e. Ensure that all incidents involving alleged, suspected, or observed recipient abuse, neglect, or exploitation are reported immediately to DMA, the county Department of Social Services, and the Division of Health Services Regulation as required in GS 131E-256(g).

7.10 Provider Supervision and Staffing Requirements

a. RN Supervision

The IHCA Provider shall provide a qualified and experienced RN to supervise IHCA, who shall be responsible for:

1. Supervising and ensuring that all services provided by the In-Home Aides under his or her supervision are conducted in accordance with this Clinical Coverage Policy, other applicable federal and state statutes, rules, regulations, policies and guidelines and the provider agency's policies and procedures.
2. Supervising the Provider Organization's CQI program;
3. Completing or approving all plans of care for assigned recipients submitted to IAE;
4. Implementing the approved plan of care; and
5. Maintaining service records and complaint logs in accordance with state requirements.

b. RN Supervisory Visits

The IHCA Provider shall ensure that a qualified RN Nurse Supervisor conducts a RN Supervisor visit to each recipient's home every 90 calendar days (Note: a seven day grace period is allowed). Two visits each year shall be conducted when the In-Home Aide is scheduled to be in the home. The RN Supervisor shall:

1. Confirm that the In-Home Aide is present or has been present as scheduled during the preceding 90 days.
2. Validate that the information documented on the aide's service log accurately reflects his or her attendance and the services provided.
3. Evaluate the In-Home Aide's performance.
4. Identify any changes in the recipient's condition and need for IHCA that may require a change of status review.
5. Request a change of status review if the recipient's plan of care exceeds or no longer meets the recipient's needs for ADL assistance.
6. Identify any new health or safety risks that may be present in the home.
7. Evaluate the recipient's satisfaction with services provided by the In-Home Aide and the services performed by the home care agency.
8. Review and validate the in-home aide's service records to ensure that:
 - a. Documentation of services provided is accurate and complete;
 - b. Services listed in the plan of care have been implemented;
 - c. Deviations from the plan of care are documented;
 - d. Dates, times of service, and services provided are documented on a daily basis;
 - e. Separate logs are maintained for all recipients;
 - f. All occasions when the recipient was not available to receive services or refused services for any reason are documented in the service record, including the reason the recipient was not available or refused services; and
 - g. Logs are signed by the In-Home Aide and the recipient after services are provided on a weekly basis.
9. Document all components of the supervisory visits to include the date, arrival and departure time, purpose of visit, findings and supervisor's signature.

c. In-Home Aides

The IHCA Provider shall ensure that:

1. Criminal background checks are conducted on all In-Home Aides before they are hired.
2. In-Home Aides hired are not listed on the North Carolina Health Care Registry as being under investigation or as having a substantiated finding of previous client abuse or neglect, misappropriation of client property, diversion of client or facility/program drugs, or fraud as an employee of one of the reporting health facility types.
3. In-Home aides under investigation for those reasons listed in **Subsection 7.10.c.2** above do not work with recipients until the investigation is completed and the individual is cleared of any crime or misconduct.
4. All In-Home Aides meet the qualifications contained in the North Carolina Home Care Licensure Rules (10A NCAC 13J.1107); and
5. An individual file is maintained on all In-Home Aides that documents aide training and competency evaluations and provides evidence that the aide is supervised in accordance with the requirements specified in 10A NCAC 13J.

d. Staff Development and Training

The IHCA Provider Organization shall:

1. Provide a new employee orientation for all new In-Home Aides and other agency employees that includes information on state rules pertaining to home care agencies and the requirements of this Clinical Coverage Policy;
2. Develop, implement, and manage an ongoing staff development and training program appropriate to the job responsibilities of agency staff;
3. Provide competency training and evaluate the required competencies for In-Home Aides at least annually;
4. Maintain comprehensive records of all staff orientation and training activities; and
5. Ensure that agency directors, administrative personnel, RN nurse supervisors, and other agency personnel with management responsibilities attend regional and on-line training programs conducted by DMA or its designee.

8.0 Policy Implementation/Revision Information

Original Effective Date: June 1, 2011

Revision Information:

Date	Section Revised	Change
06/01/2011	All sections and attachment(s)	Initial promulgation of new program
03/12/2012	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
12/31/2012	All sections and attachment(s)	Policy terminated due to SL 2012-142 House Bill 950. Coverage will be provided under new policy, 3L, Personal Care Services

Appendix A: Assessment Design and Service Level Determinations

Assessment Tool Design

All IHCA assessments shall be conducted using a standardized ADL assessment tool provided or approved by DMA. The assessment shall include documentation and evaluation of the following:

1. Assessment identification information, including date, completion time, and names and relationships of others attending.
2. Recipient identification information, including name and Medicaid ID, gender, date of birth, primary language, contact information, and alternate contacts.
3. Referral summary, including date and practitioner name and contact information.
4. Diagnoses related to the need for services.
5. Prescription medications.
6. Special diet types.
7. Availability of other supports, including names and relationships of informal caregivers and their capacity and availability to provide ADL assistance, and provider names and types of other formal supports and services.
8. Assistive devices the recipient uses to perform each ADL.
9. Tasks needs for each ADL, including required assistance level and number of days per week of unmet need for assistance.
10. Assessor's overall rating of the recipient's capacity to self-perform each ADL.
11. The recipient's needs for assistance with NA-II and delegated medical monitoring tasks.
12. Essential off-site laundry, grocery shopping, and medication pick-up errands that are critical to the recipient's health and welfare and that no family member, other individual, program, or other service is willing and able to perform.
13. Conditions and symptoms that affect the time for the recipient to perform and an aide to assist with the completion of the recipient's qualifying ADLs.
14. Environmental conditions and circumstances that affect the time for the recipient to perform and an aide to assist with the completion of the recipient's qualifying ADLs.
15. Functional status of home structures and utilities, and the assessor's evaluation of the safety and adequacy of the recipient's home for providing IHCA.
16. Assessor comments about essential information not captured elsewhere on the assessment.
17. The recipient's preferred in-home care provider agencies.

Service Level Determinations

Authorized monthly service levels for qualifying recipients are determined as follows:

1. Time is assigned for each day of unmet need for hands-on assistance, as summarized in the table below.

Daily Minutes for Qualifying ADLs and Associated IADLs

ADL	Recipient's Overall Self-Performance Capacity		
	Limited Assistance	Extensive Assistance	Full Dependence
Bathing	35	50	60
Dressing	20	35	40
Mobility	10	20	20
Toileting	25	30	35
Eating	30	45	50

2. If the total time assigned for all qualifying ADLs is less than 60 minutes per day, total time is increased to 60 minutes per day of unmet need for hands-on assistance with qualifying ADLs.
3. Additional time up to 25 percent may be authorized for assistance with special assistance (Nurse Aide II) tasks required daily, delegated medical monitoring tasks that require more than five minutes per visit, and exacerbating conditions and symptoms that affect the recipient's qualifying ADLs.
4. Additional time up to 25 percent may be authorized for environmental conditions and circumstances that affect the recipient's qualifying ADLs.
5. When critical to maintaining the recipient's health and welfare; and when there is no willing or able family member, other individual, program, or service available to assist; additional time may be approved on a case-by-case basis with essential errands as follows: off-site laundry, 4 hours per month; grocery shopping, 4 hours per month; and medication pick-up, 1 hour per month.
6. The total authorized service hours per month may not exceed 80.

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid or NCHC guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid and NCHC managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)

B. Diagnosis Codes

Providers shall bill the ICD-9-CM diagnosis code(s) to the highest level of specificity that supports medical necessity.

C. Billing Code(s)

Providers are required to select the most specific billing code that accurately describes the service(s) provided.

Code	Modifier	Description	Notes
S5125	HB	Attendant Care Services; Per 15 Minutes	Effective 06/01/2011

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

1 unit of service = 15 minutes.

IHCA follows wage and hour requirements for rounding billing units (7/8 rule).

F. Place of Service

IHCA is provided in the recipient's private residence and cannot be provided in a nursing facility, group home, assisted living facility, or other health care facility.

G. Co-payments

Co-payment(s) may apply to covered services, procedures, prescription drugs and over-the-counter drugs.

Co-payment(s) are not required for IHCA.

H. Reimbursement

Providers shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>