Personal Care Services (PCS)

Information Session

December 2025

Agenda

- Overview of Clinical Coverage Policy 3L- Personal Care Services
- Requesting PCS for CCH Members Initial & Reauthorization
- Electronic Visit Verification (EVV)
- Provider Portal
- Billing & Payment
- Key Contacts & Provider Resources
- Questions

Overview of Clinical Coverage Policy 3L- Personal Care Services

What is PCS?

Personal care services (PCS) is a benefit for the elderly, people with disabilities, and people with chronic or temporary conditions.

It assists them with Activities of Daily Living (ADLs) and helps members remain in their homes and communities.

NC DHHS policies:

3L - State Plan Personal Care Services (PCS)

3L-1 - State Plan Personal Care Services (PCS) Provided in Congregate Settings

Care Locations for PCS

Personal Care Services (PCS) provides direct care services to individuals residing in several settings:

- Private living arrangement (Beneficiaries under 18 years of age approved for PCS under EPSDT may receive services in the home, school, or other approved community settings)
- Residential facility licensed by North Carolina as an adult care home
- Combination home as defined in G.S. 131E-101(1a)
- Group home licensed under Chapter 122C of the General Statutes and under 10A NCAC 27G.5601 as a supervised living facility for two or more adults whose primary diagnosis is mental illness, a developmental disability or substance abuse dependency

PCS Prior Approval Requirements

Prior approval is required before rendering Personal Care Services

- **The amount of prior approved service is based on an independent assessment** conducted by a Care Manager, to determine the members' ability to perform Activities of Daily Living (ADLs).
- The five qualifying ADLs for the purposes of this program are **bathing, dressing, mobility, toileting, and eating**.
- Member performance is rated as:
  - **totally independent;**
  - **requiring cueing or supervision;**
  - **requiring limited hands-on assistance;**
  - **requiring extensive hands-on assistance; or**
  - **totally dependent**

PCS Prior Approval Requirements cont.

Members must:

- Meet minimum PCS eligibility requirements;
- Obtain a Physician Referral, and attestation, prior to start of service;
- Receive an independent assessment from a CCH LTSS care manager
- Obtain a service authorization for a specified number of PCS hours per month; and
- Obtain an approved service plan from the provider

Qualifying for PCS

To qualify for PCS, a member must have a medical condition, disability or cognitive impairment, and demonstrate unmet needs for:

- Three of the five ADLs with limited hands-on assistance; or
- Two ADLs, one of which requires extensive assistance; or
- Two ADLs, one of which requires assistance at the full dependence level

PCS program eligibility is determined by an independent assessment conducted by a Care Manager and is provided according to an individualized service plan, based on medical necessity.

Requirement for Physician Referral for PCS

- The member must be referred to PCS by his or her primary care practitioner or attending physician utilizing the Physician Referral form.
- The Physician Referral approved by NC Medicaid is the DHB-3051 PCS Request Form, for Independent Assessment for Personal Care Services Attestation for Medical Need.
- Members, family, or legally responsible person are responsible for contacting their primary care or attending physician and requesting a referral for Medicaid PCS.
- Members must be seen by their physician/practitioner during the 90 calendar days preceding the referral. If not, they must schedule an office visit to request a referral for a Medicaid PCS eligibility assessment.
- Once a referral is made by the member's physician/practitioner, the PCS assessment must be performed and is required prior to approval/authorization of services.

PCS Assessments

1. PCS assessments, expedited assessments, reassessments, and change of status reviews for determining eligibility and authorizing services must be conducted by a CCH Care Manager.
   - PCS provider organizations are not authorized to perform PCS assessments for the purposes of authorizing Medicaid services.
2. The assessment shall determine the effective date and issue prior authorization for a member approved for services.
3. The assessment determines the qualifying ADLs, the level of assistance required for each, and the amount and scope of PCS to be provided.
4. The assessment determines the end date for approval of services and the date of the next reassessment, which shall be no later than 365 calendar days from the previous assessment.
5. Provide the basis for service plan development.

Requirements for PCS Initial Assessments

All PCS assessments must be performed by Independent Assessors.

All assessments for new admissions to PCS shall be face-to-face and conducted in the beneficiary's primary residence.

In-home assessments must contain an assessment of the beneficiary's home environment to identify any health or safety risks to the beneficiary or to the PCS aides who will provide the services.

Requirements for PCS Reassessments

- Reassessment that shall occur no later than 365 calendar days from the previous assessment.
- PCS providers shall report discharges within seven business days of the member's discharge from PCS.
- Reassessments must be conducted face-to-face.
- Determine and authorize hours of service and level of care for continuation of PCS for each subsequent authorization period.
- Determine and authorize hours of services and level of care resulting from significant changes in the member’s ability to perform their ADLs.
- Provide the basis for service plan continuation and/or adjustments.

PCS Monthly Service Hour Limits

The following hour limits apply to a beneficiary who meets PCS eligibility requirements and coverage criteria in this policy unless warranted by a doctor's order (signed attestation on the 3051 form) or utilization of EPSDT.

- A member **under 18 years** of age may be authorized to receive up to **60** hours of service **per month**
- A member **age 18 years and older** may be authorized to receive up to **80** hours of service **per month**

NOTE: Providers can use the secure provider portal to view authorizations and approved monthly units Secure Provider Portal Guide Viewing Assessments and Authorizations Provider Guide

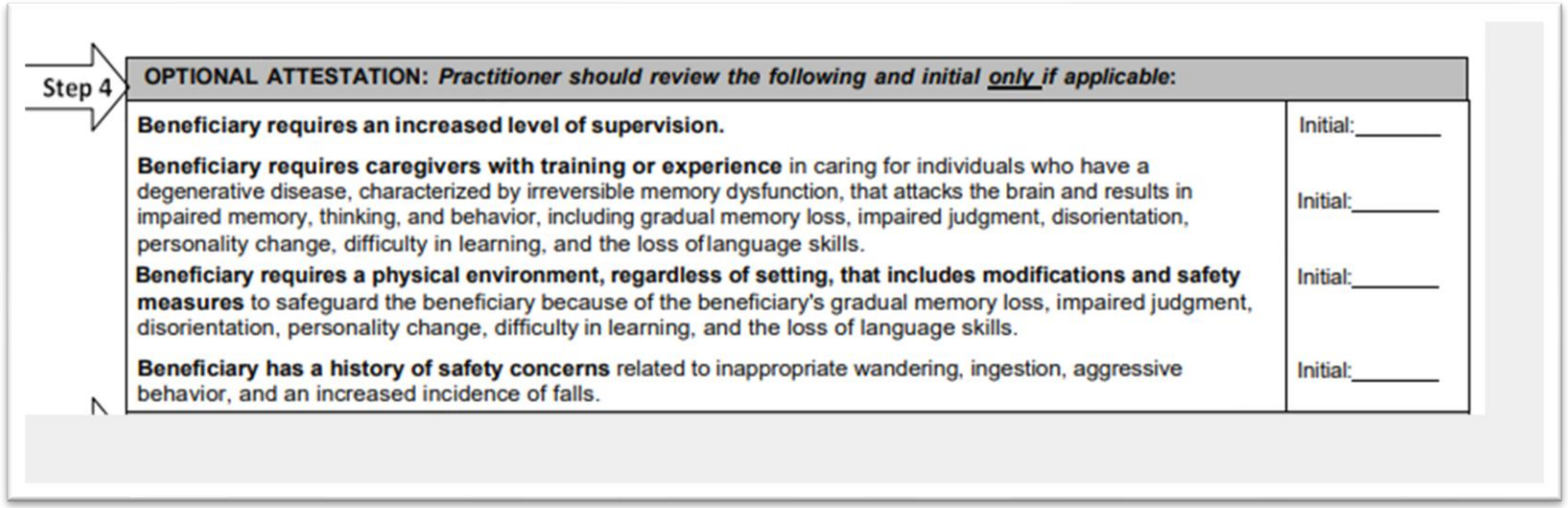
Additional PCS Service Hours

Additional hours (up to 50 per month) may be approved for members 18+ years of age who meet **ALL the criteria provided below:**

1. Requires an increased level of supervision, based on the in-home assessment.
2. Requires caregivers with training or experience in caring for individuals who have a degenerative disease characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty learning, and the loss of language skills.
3. Regardless of setting, requires a physical environment that addresses safety and safeguards the beneficiary because of the beneficiary's gradual memory loss, impaired judgment, disorientation, personality change, difficulty learning, and loss of language skill; and
4. Health record documentation or verifiable information provided by a caregiver obtained during the independent assessment reflects a history of escalating safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.

Additional PCS Service Hours , cont.

Physician attestation that the member meets all criteria to receive the additional hours is **REQUIRED** on the DHB-3051 (Section B Optional Attestation)



Step 4	OPTIONAL ATTESTATION: *Practitioner should review the following and initial only if applicable*:	
	Beneficiary requires an increased level of supervision.	Initial:_____
	Beneficiary requires caregivers with training or experience in caring for individuals who have a degenerative disease, characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss oflanguage skills.	Initial:_____
	Beneficiary requires a physical environment, regardless of setting, that includes modifications and safety measures to safeguard the beneficiary because of the beneficiary's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.	Initial:_____
	Beneficiary has a history of safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.	Initial:_____

Additional PCS Service Hours - EPSDT

Medicaid may authorize services that exceed the PCS service limitations if determined to be medically necessary under EPSDT based on some or all of the following documents submitted by the provider before PCS is rendered:

- Work and School verification, where applicable, for the beneficiary's caregiver, legal guardian, or power of attorney. PCS may not cover all time requested by caregiver for work and school that exceed full-time hours;
- Verification from the Exceptional Children's program per county if PCS is being requested in school setting;
- Health record documentation from the beneficiary's physician, therapist, or other licensed practitioner;
- Physician documentation of primary caregiver's limitation that would prevent the caregiver from caring for the beneficiary, if applicable; or
- Any other independent records that address ADL abilities and need for PCS.

Service Plan Requirements

- PCS providers shall create a PCS service plan which addresses each unmet ADL, IADL, & special assistance or delegated medical monitoring task need identified in the independent assessment, considering other pertinent information available to the providers.

- The provider organization shall ensure the PCS service need frequencies documented in the independent assessment are accurately reflected in the PCS service plan schedule as well as any special scheduling provisions such as weekend days documented in the assessment.

- The provider organization shall ensure that the beneficiary or their legally responsible person understands and, to the fullest extent possible participates in the development of the PCS service plan.

When is PCS Not Covered according to CCP-3L?

Per CCP-3L PCS IS NOT COVERED when:

- The initial independent assessment has not been completed;
- The service is not documented as completed in accordance with this clinical coverage policy;
- A reassessment has not been completed within 30 calendar days of the end date of the previous prior authorization period because the beneficiary refused assessment, could not be reached to schedule the assessment, or did not attend the scheduled assessment;
- The service is provided at a location other than the beneficiary's primary congregate or private residence, except when EPSDT requirements are met as listed in Subsection 2.2;
- The service exceeds the amount approved by the Independent Assessment

When is PCS Not Covered according to CCP-3L?, cont.

Per CCP-3L PCS IS NOT COVERED when:

- The service is not completed on the date the service billed;
- The service is provided prior to the effective date or after the end date of the prior authorized service period;
- The service is provided by an individual whose primary private residence is the same as the beneficiary's primary private residence;
- The service is performed by an individual who is the beneficiary's legally responsible person, spouse, child, parent, sibling, grandparent, grandchild, or equivalent step or in-law relationship to the beneficiary;
  - **Note:** Spouses are expected to provide care for each other unless medical documentation, work verification, or other information indicates otherwise.

When is PCS Not Covered according to CCP-3L?, cont.

In addition to the specific criteria not covered in Subsection 4.2.1 of CCP-3L:

- PCS is not covered when rendered concurrently with another substantially equivalent Federal or State funded service. Services equivalent to PCS:
  - When home health aide services and in-home aide services in the Community Alternatives Programs (CAP/Children, CAP/Choice, CAP/Disabled Adults) are rendered;
  - Member is receiving Private Duty Nursing (PDN)
- PCS is not intended as a substitute for childcare, daycare, or afterschool care. PCS is not covered for infants or children when the personal care needs do not meet the medical necessity criteria, or the **needs are a parental responsibility or are age-appropriate needs**.

Process for Requesting PCS Services

Requesting PCS for CCH Members- Initial PCS

1. The CCH Personal Care Services Request "3051" Form is to be completed by member's primary care provider or attending physician.
   - This can be found on the Manuals, Forms, and Guides page.
2. Fax the completed & signed 3051 form to CCH Care Management: **1-833-706-0238**
3. A face-to-face assessment by CCH Care Manager will be scheduled within 30 days of receipt of completed 3051 form.
4. An authorization will be created and reviewed for medical necessity by CCH after assessment is completed and start of care date is determined
   - PCS Agencies will receive the authorization determination via fax, and can also view on the CCH Secure Provider Portal.
   - Person Centered Service Plan will also be faxed to PCS agency.

Reauthorization of PCS

Providers do not need to request reauthorization of PCS.

- CCH LTSS Care Managers are responsible for reauthorizing personal care services through comprehensive face-to-face visits and assessments.
- Providers can access member health records, assessments and authorization status through the Secure Provider Portal.
  - For support in navigating the Secure Provider Portal, reach out to your Provider Engagement Administrator.

Please contact our customer service department at 1-833-552-3876. If the member is in active care management for PCS, you may request to speak to the assigned Care Manager or LTSS Manager.

Expedited Assessment

Qualifications for the expedited process:

- Medically stable
- Being discharged from the hospital
- Being discharged from a skilled nursing facility
- Under adult protective services
- To prevent harm, institutionalization, or loss of function

Expedited process can only be requested by:

- Hospital discharge planner
- Skilled nursing facility discharge planner
- APS worker
- LME-MCO Transition Coordinator

If requirements met, member may receive a provisional authorization for up to 60 hours for 60 days, and the CCH Care Manager will schedule an expedited assessment.

Change of Provider

- **Providers are responsible for notifying CCH of any discharges**
- Submit DHB-3051 with Change of Provider section completed, or member may request provider change via their CCH Care Manager
- New PCS provider has 7 days to submit a service plan to CCH

NON-MEDICAL CHANGE OF STATUS OR CHANGE OF PROVIDER REQUESTS, COMPLETE PAGE 3 ONLY

REQUEST TYPE: (select one)	**DATE OF REQUEST:**
☐ **Change of Status: Non-Medical** ☒ **Change of Provider**	____/____/____
Form Submission: Fax Carolina Complete Health at 1-833-706-0238 **Questions:** Call Carolina Complete Health at 1-833-552-3876	

SECTION F: CHANGE OF PCS PROVIDER

Requested by (Select One): ☐ Care Facility ☐ Beneficiary ☐ Other (Relationship): _____

Requestor's Contact Name: _____ Phone: (___) _____

Reason for Provider Change (Select One):	☐ Beneficiary or legal representative's choice	☐ Current provider unable to continue providing services	☐ Other: _____

Status of PCS Services (Select One):

☐ Discharged/Transferred Date: ___/___/____

☐ Scheduled Discharge/Transfer Date: ___/___/____

☐ No Discharge/Transfer Planned. Continue receiving services until established with a new provider.

Change of Status/Condition

Change of Status/Condition

- Submit DHB-3051 with Change of Status section completed and supporting clinical information from the member's physician regarding the change in medical status
- CCH LTSS leadership will review the information submitted and determine if a reassessment is warranted

Gaps in PCS services

- A new DHB-3051 form is required when there is a gap in PCS service delivery of more than 60 days.

Electronic Visit Verification (EVV)

What is EVV?

- 21st Century Cures Act mandate for In-Home Personal Care Services (PCS)
- Electronic Visit Verification is used to track and monitor timely service delivery
- EVV technology records the following:
  - Type of service performed
  - Person receiving the service
  - Date
  - Location
  - Person providing the services
  - Service begin and end times
- NC DHHS EVV webpage

- **Carolina Complete Health partners with HHAeXchange as its EVV solution.**

EVV In Scope PCS Services

Personal Care Services (PCS)

- 99509 HA or HB only
- Provider taxonomy 253Z00000X
- Adult care homes, congregate living, etc are excluded from EVV

All PCS In-Home claims **must** come from our vendor HHAX or they will deny for missing EVV requirements.

Not yet connected with HHAeXchange?

Option 1 – Agencies currently without an EVV Solution: use the free EVV tools provided by HHAeXchange & Carolina Complete Health

Option 2 – Agencies currently using another 3rd Party EVV Solution: use your existing EVV system and import visit data into HHAeXchange – HHA will route claims to Carolina Complete Health

The HHAeXchange Provider Info Center outlines necessary requirements to set up access to the HHAeXchange system.

1st step – Complete Provider Enrollment Form

Important Note: NC DHHS requires completion of a registration form for EVV providers who choose to use any EVV vendor except Sandata.

Registration link here

More information here

EVV Compliance

Providers must use electronic means to capture visits (mobile app or IVR/telephony).

- Manual entry should only be used in rare circumstances and should account for less than 15% of visits.

- HHAX Provider Job Aids
  - Record EVV on the Mobile App, FOB, or Patient Phone
  - Mobile App Get Started
  - Mobile App Offline Mode
  - Track Location Where EVV is Performed

- Providers should monitor their EVV compliance using the HHAX Compliance reports

HHAeXchange Resources

Visit the HHAeXchange Knowledge Base

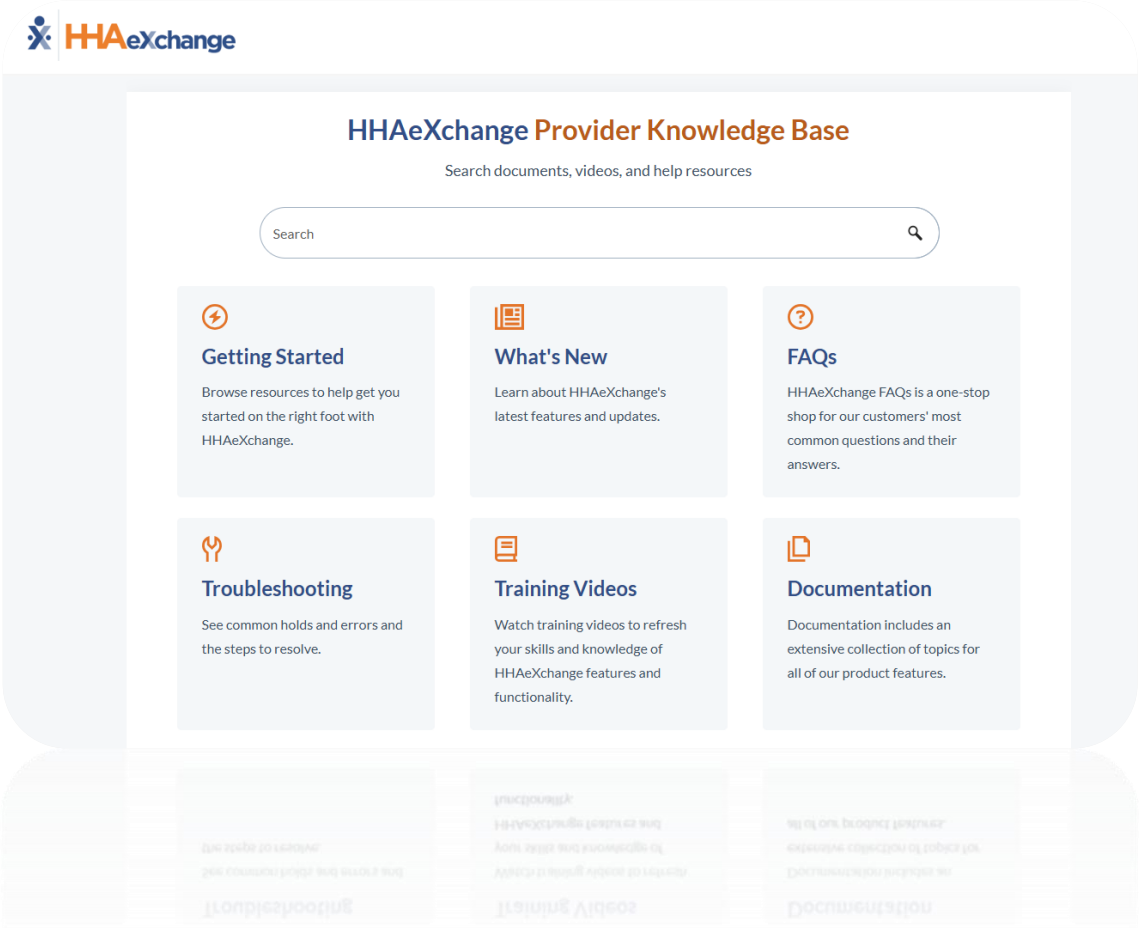
- No login required
- Access training videos, FAQs, job aids, and more
  - Providers using HHAX as your EVV vendor
  - 3rd party vendor (EDI) providers

3rd party vendor/EDI Resources

- Visit Import Guide v5
- EDI Export Interface Guide v5
- EDI Code Table Guide

Support from HHAeXchange

- Client Support Portal
- Client Support Training Video



CCH Provider Portal

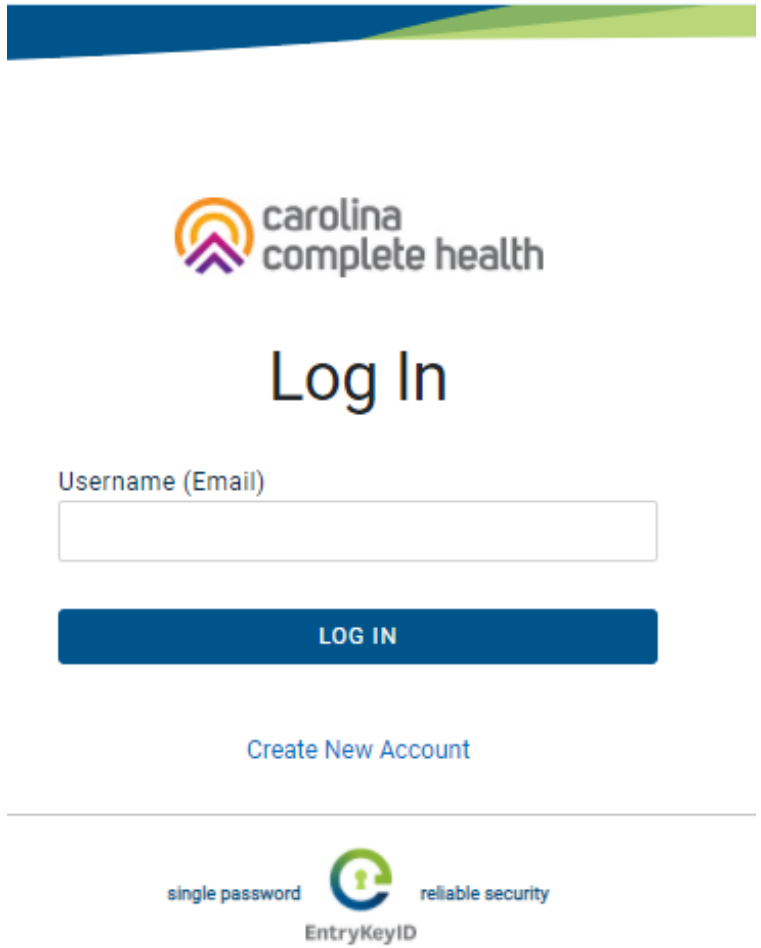
CCH Standard Secure Portal

CCH Standard Plan Secure Provider Portal:

http://provider.carolinacompletehealth.com/

Secure Provider Portal Functions for PCS:

- Beneficiary eligibility & patient listings
- Health records
- Prior Authorization
- Health Assessments
- Submit PCS claims not subject to EVV requirements
- View payment history



Viewing Assessments and Authorizations

Look Up a Member Using the Eligibility Check with Quick Actions

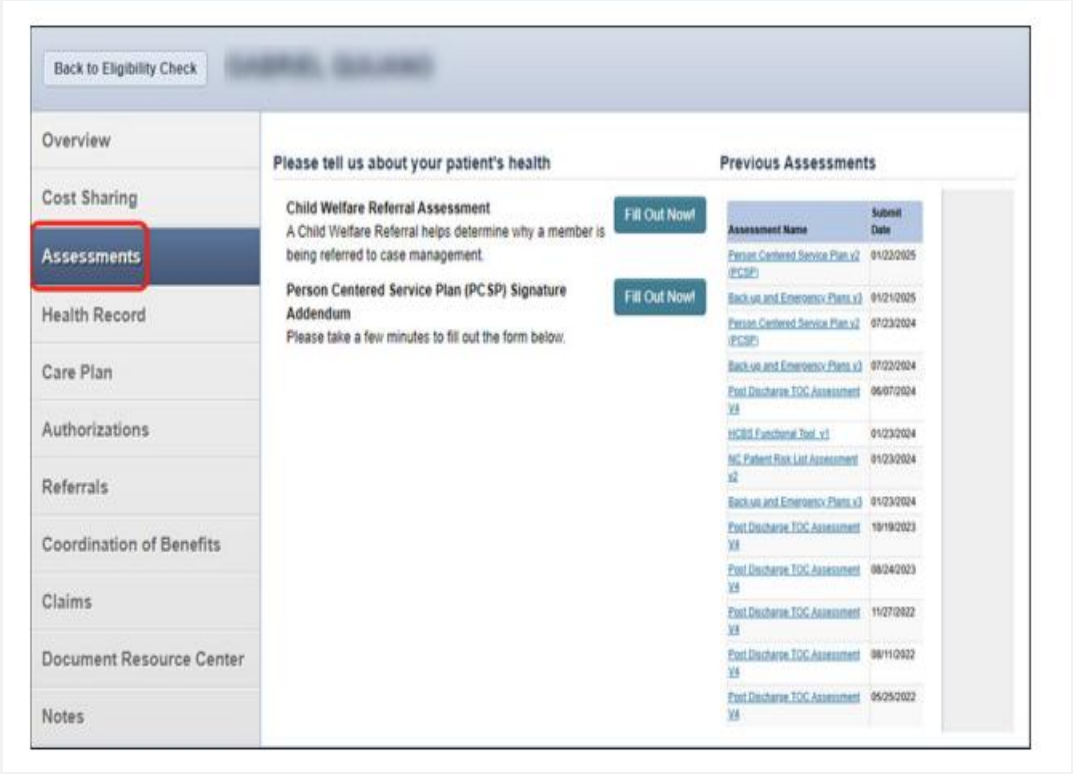
To find a member, navigate to the "Quick Actions" section located on the home page.

- Enter the required member details: Member ID or Last name.
- Enter the Member's Date of Birth.
- Select "View Eligibility & Patient Information", then click "Submit."

Viewing Assessments and Authorizations

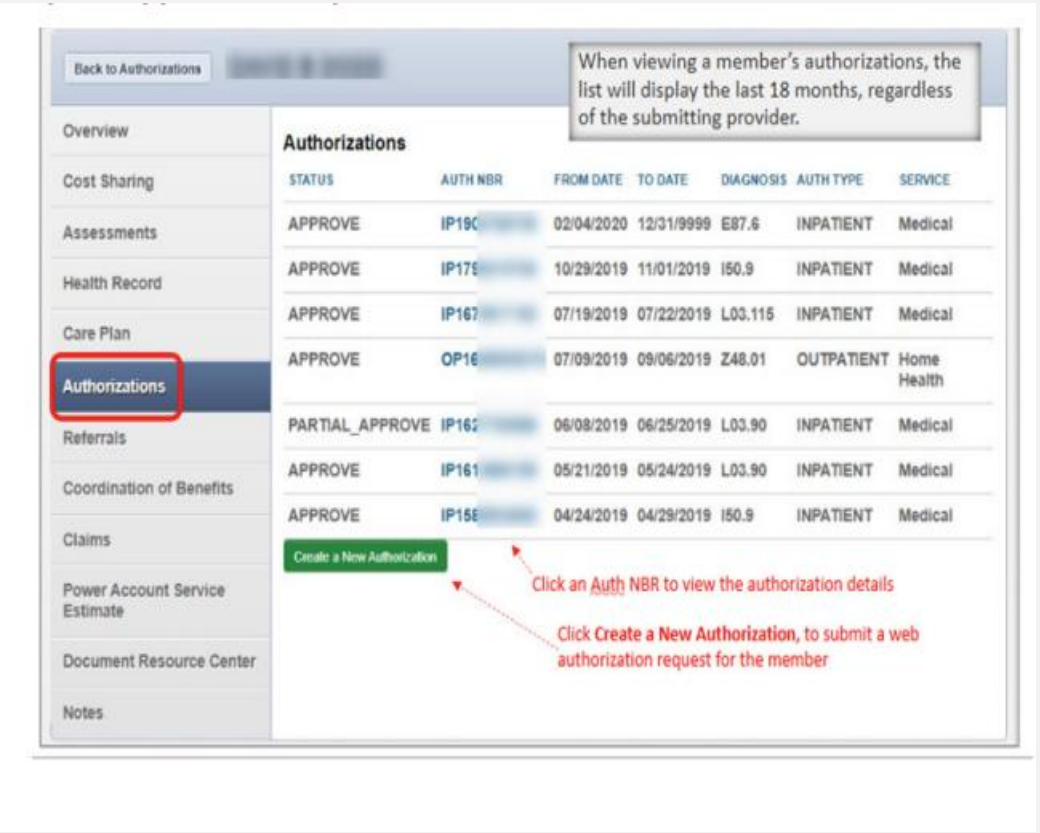
If the member is eligible, click their name to access their health record. From there, click on the “Assessments” tab.

NOTE: Under the "Assessments" tab, you will be able to view the needed assessments as well as the "Previous Assessments".



Viewing Assessments and Authorizations

To View authorizations, select the "Authorizations" tab. You can view the status and create a new authorization by selecting green tab that says “Create a New Authorization.”



Provider Portal Resources

Provider Engagement Adminstrator

Portal Administrator Guide (PDF)

Registering and Logging In (PDF)

Checking Member Eligibility and Health Record (PDF)

Viewing Assessments and Authorizations (PDF)

Submitting a Claim (PDF)

Secure Portal Slide Guide (PDF)

Billing and Payment

Billing

Billing for Personal Care Services

EVV:

- In-Home PCS services (taxonomy 253Z00000X, HA or HB modifier)
- **Claims must be submitted through HHAeXchange**.
- Claims submitted via any other source will be denied for EVV.

Non-EVV:

- Other PCS services (i.e Congregate Care settings) can be billed through the CCH Secure Provider Portal.
- Claims can be submitted through the portal: http://provider.carolinacompletehealth.com/

PCS Modifiers

Provider Type	Definition	Modifier	List of Facilities
In Home Care Agencies	Beneficiary under 21 Years regardless of setting	HA	n/a
In Home Care Agencies	In-Home Care Agencies, Beneficiary 21 Years and Older	HB	n/a
Adult Care Homes	ACH/assisted living facilities serving 7 beds or more.	HC	https://info.ncdhhs.gov/dhsr/data/ahlist.pdf?ver=2.5 *could have Special Care Unit – see that link below
Combination Homes	Nursing home offering one or more levels of care, including any combination of skilled nursing, intermediate care, and adult care home.	TT	https://info.ncdhhs.gov/dhsr/data/Nhlist_co.pdf?ver=2.4 Look for 'Adult Care Home Beds'
Special Care Units	For persons with Alzheimer's disease and related disorders.	SC	https://info.ncdhhs.gov/dhsr/acls/pdf/sculist.pdf?ver=3.4
Family Care Homes	Capacity of two to six residents	HQ	https://info.ncdhhs.gov/dhsr/data/fchlist.pdf?ver=2.4
Supervised living Facilities for adults with MI/SA	Serving adults whose primary diagnosis is mental illness but may have other diagnoses.	HH	https://info.ncdhhs.gov/dhsr/data/mhlist.pdf?ver=2.9 – Look for 'Supervised Living for Adults with Mental Illness' or 'Supervised Living for Adults with Substance Abuse Dependency'
Supervised living Facilities for adults with I/DD	Serving adults whose primary diagnosis is a developmental disability but may have other diagnoses.	HI	https://info.ncdhhs.gov/dhsr/data/mhlist.pdf?ver=2.9 - Look for ': Supervised Living for Adults with Developmental Disabilities'
Multi-unit Assisted Housing with Services	Registered as MUAHS but not licensed adult care homes or licensed assisted living facilities and are not inspected or monitored by DHHS	HA/HB	https://info.ncdhhs.gov/dhsr/acls/multiunitfac.html *considered private residence and PCS services would be provided by a licensed In-Home PCS provider, not the MUAHS

PCS Congregate Care Billing Changes for 2025

New Per Diem Reimbursement Methodology:

- Applies to codes 99509 HC, HH, HI, HQ, SC and TT only
- Providers will be reimbursed a daily rate based on the total approved units within the authorization, not the actual time spent delivering the service on a specific day.
- Impacts claims for dates of service **4/1/2025+**

PCS Congregate Care Billing Changes for 2025

Billing Tips:

- Submit one line per date of service with 1 unit per service.
  - A claim line that spans multiple dates or includes a unit greater than one will deny.
- Providers should bill their usual and customary charge. No calculations are required by providers.
- Claims submitted will hit a pend code for pricing (DF: Pend: Manual Pricing Required)

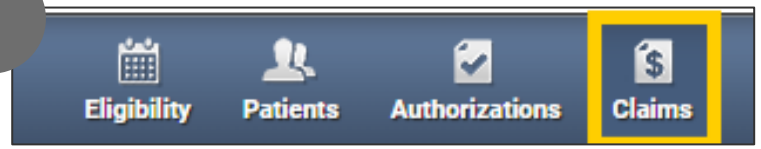
Payment

Provider Payments

- Clean claims will be resolved (finalized paid or denied) 95% within 15 calendar days and 99% within 30 calendar days following receipt of the claim.
- Carolina Complete Health Standard Plan check run is weekly on Monday, Wednesday and Friday, with payment issued to providers the following business day.
- Remittance Advice, also referred to as an 835 or Explanation of Payment (EOP), are issued with payment and can be accessed several ways:
  - Portal: **http://provider.carolinacompletehealth.com/**
  - Payspan: **https://www.payspanhealth.com/**
  - Physical copy if you receive paper check
  - PCS EVV claims: **Review Claim Status** in HHAeXchange

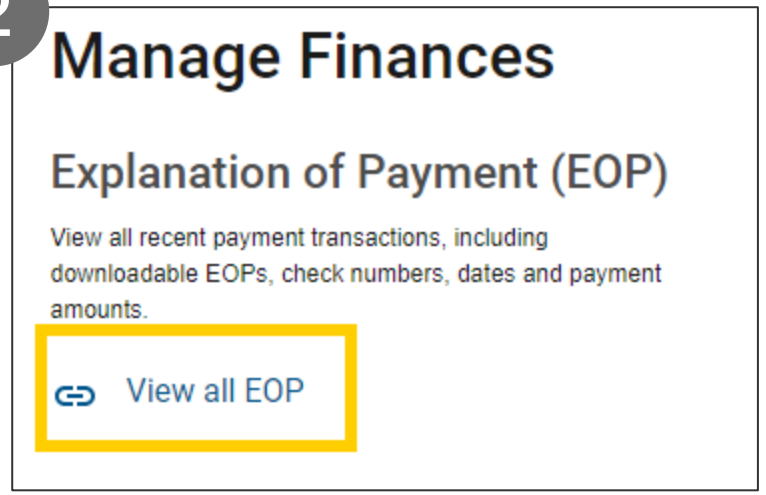
Access EOPs in the Secure Provider Portal

1



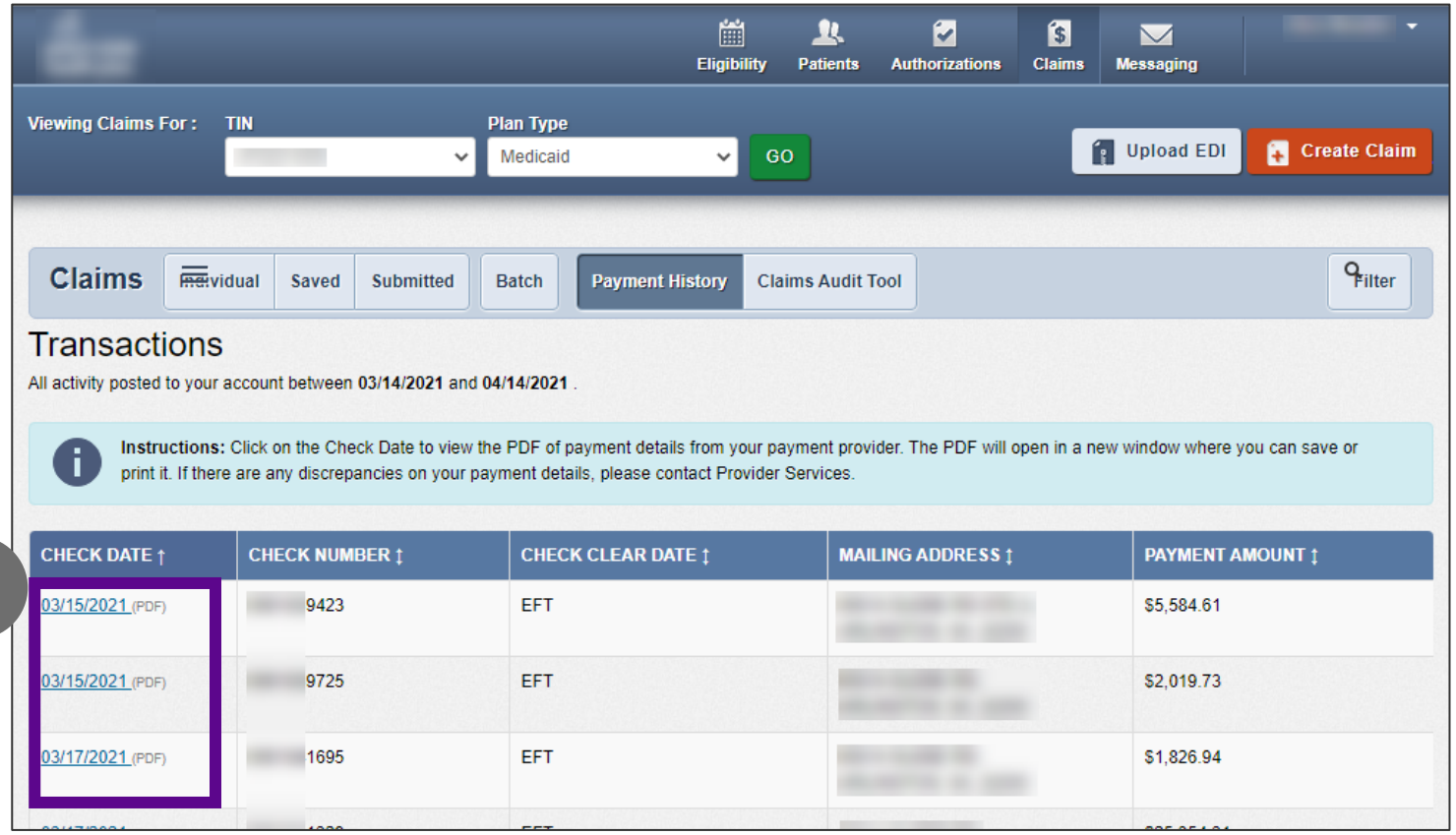
Click ‘Claims’ in the header menu

2



Scroll down and click ‘View all EOP’

3



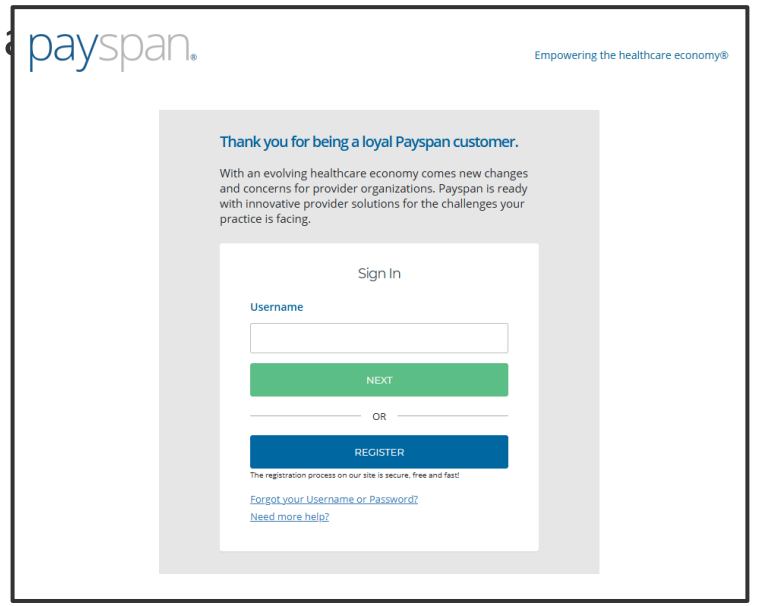
Click the Check Date links which will download a PDF of the EOP

Electronic Funds Transfer: Payspan

To contact Payspan: Call 1-877-331-7154, Option 1 – Monday thru Friday 8:00 am to 8:00 pm est.or by email providersupport@payspanhealth.com.

Payspan offers monthly training sessions for providers covering the following topics:

- How to register with Payspan (New User)
- How to add additional registration codes to an existing Payspan a
- How to navigate through the Payspan web portal
- How to view a payment
- How to find a remit
- How to change bank account information
- How to add new users



For training links visit our website under Education and Training

Access ERA in Payspan

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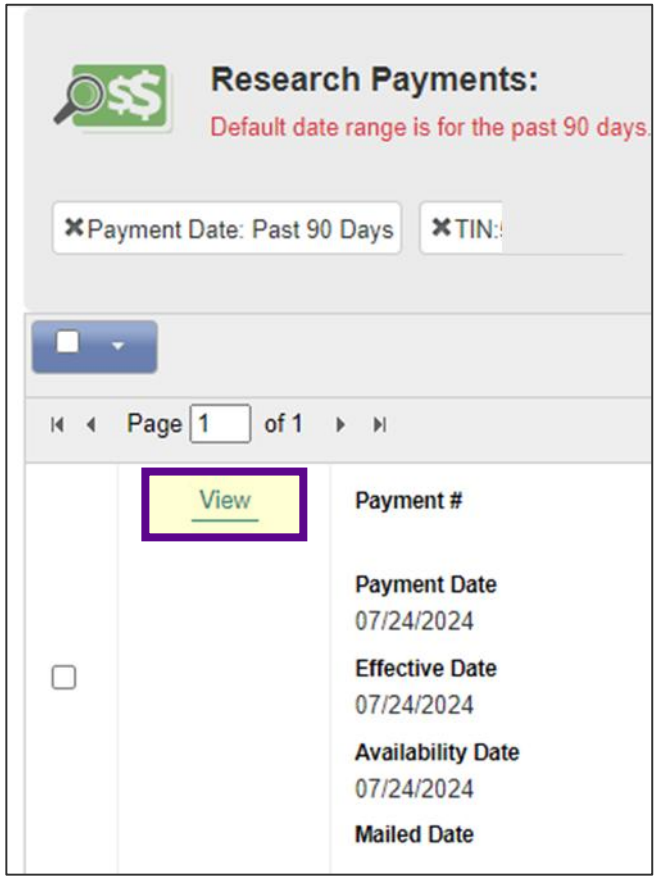

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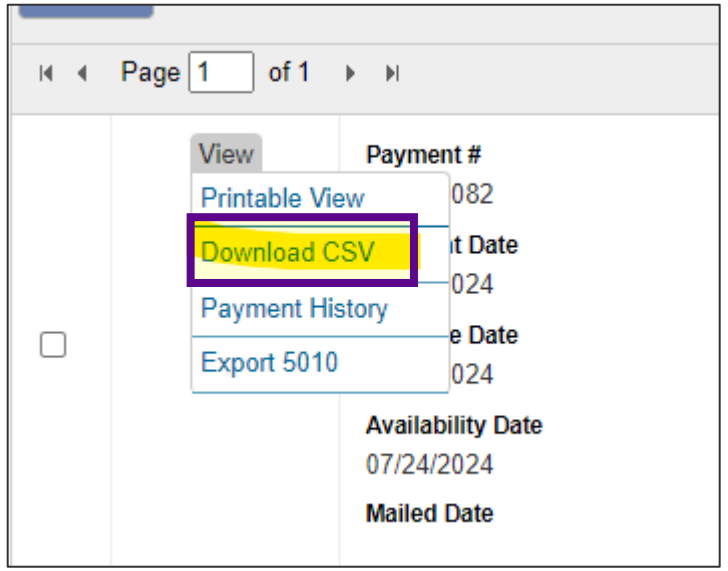

Download CSV

Contacts & Provider Resources

Key Contacts

- Provider Services at 1-833-552-3876
- Provider Engagement Administrator
- Email Provider Relations at NetworkRelations@cch-network.com

Provider Resources

- Personal Care Service Provider Guide (PDF)
- CCH Personal Care Services Request 3051 Form
- Secure Provider Portal Guide Viewing Assessments and Authoriations Provider Guide
- CCH Home Health and Personal Care Services Webpage
- Clinical Coverage Policy 3L
- NC DHHS Personal Care Services
- CCH Home Health and Personal Care Services Webpage

Please help us shape future webinars and fill out our brief survey: https://www.surveymonkey.com/r/2B8SQGG

carolina complete health network

carolina complete health

Thank You!

Questions?