Clinical Policy: Personal Assistant Services (PAS) - 1915 (j) Program Services

Reference Number: NH.CP.MP.603
Last Review Date: 08/25
Effective Date: 10/15/2025

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Statement
This clinical policy is to define the criteria needed to be reviewed in order to approve Personal Assistant Services (PAS) – 1915(j) Program Services.

Purpose

To ensure consistency in the application of medical necessity criteria for members who require Personal Assistant Services (PAS) – 1915(j) Program Services.

Scope

This policy applies to the Utilization Management team at NH Healthy Families for HCPS code T1019.

Definitions
T1019: Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)
**Note: These will be billed with a specific modifier to denote the difference between Personal Care Attendant (PCA) and Personal Assistant Services (PAS) – 1915(j) Program Services.*

Personal Assistant Services (PAS) – 1915(j) Program Services are defined as supportive services intended to step down individuals from other services they may be receiving, such as G0156 Licensed Nursing Assistant (LNA) services, or S1923 or S9124 Private Duty Nursing (PDN) services. These services may be provided by legally responsible individuals and/or family members to provide personal care services. PAS are self-directed. Hours allowed are subject to all eligibility requirements, required documentation, and in support of existing services (e.g. unfilled hours, replacement, or step down of existing services included in an authorized plan of care).

Policy/Criteria
POLICY:
1. Personal Assistant Services (PAS) – 1915(j) Program Services are covered in instances where:
    a. The member has a documented initial assessment, completed by a Registered Nurse (RN)

b. Services must be re-certified every 6 months for ongoing services, assessment to be completed by RN
c. There is documentation of an every 60 day Face-to-Face assessment by the servicing or ordering provider
d. Plan of care is signed by the Primary Care Provider or Attending Physician
e. The member has self directed and hired a specific person to provide PAS care, which may be a family member
f. The provider must be in compliance with all Electronic Visit Verification requirements

2. Upon receipt of the prior authorization completed documentation from the ordering provider, the Plan shall review the request. If the Plan approves the entire request as ordered by the ordering provider, the Plan shall notify the Member and the rendering provider of the approval of service coverage. If the Plan is unable to approve the entire request, as signed by the ordering provider, the Plan shall deny or partially deny the request, sending notification to the Member, the ordering provider and the rendering provider. The Plan shall afford the ordering provider the opportunity to have a peer-to-peer consultation after a denial or partial denial has been issued. The ordering provider may request a peer-to-peer consultation with the authorizer at any time during the utilization management determination process including prior to an approval, denial, or partial denial of service is issued.

3. The Plan shall comply with all contract provisions regarding continuing coverage of services which the beneficiary is already receiving to allow for care transitions and time periods for notifications to beneficiaries, ordering providers and rendering providers throughout the utilization review process.

PROCEDURE:
All Personal Assistant Services (PAS) – 1915(j) Program Services require Plan prior authorization, including the initial evaluation. The Plan uses the clinical criteria included in this policy and/or EPSDT guidelines, when applicable, to determine medical necessity of Personal Assistant Services (PAS) – 1915(j) Program Services.

Once all criteria is met as per this policy, Personal Assistant Services (PAS) – 1915(j) Program Services will be authorized in no less than 3 months for initial services, and must be re-certified every six months in six month authorization spans.

Criteria that must be met includes:

1. Prior authorization must be requested for all Personal Assistant Services (PAS) – 1915(j) Program Services.
2. The member must meet all of the eligibility requirements for Personal Assistant Services (PAS) – 1915(j) Program Services.
3. The provider must submit the assessment, documentation, and other plan of care documents, which must include:
    a. Initial assessment completed by an Registered Nurse (RN)

   b. Documentation of an every 60 day Face-to-Face assessment by the servicing or ordering provider
   c. Plan of care signed by the Primary Care Provider or Attending Physician
   d. Documentation of the member's ability to self-direct
4. In the event of services being stepped down or filling unfilled hours from another type of service (e.g. LNA, PDN), the Utilization Management (UM) designee will adjust the authorization to reflect the stepping down or unfilled services as follows:
   a. This may include end dating of a prior authorization to begin a new one with Personal Assistant Services (PAS) – 1915(j) Program Services.
   b. If more than one agency is supplying services, the authorization may be adjusted to reflect this change (e.g. 20 hours in total have been approved, but now must be split to 10 hours with Home Health Agency A, and 10 hours with Home Health Agency B).
   c. All updates to authorizations will be communicated via notice to both the member and provider.
   d. In the event that the previously unfilled hours become available, these can be reinstated and the authorizations can be adjusted to reflect the new plan of care (e.g. unfilled hours reinstated will replace new authorizations to prevent duplication).

Personal Assistant Services (PAS) – 1915(j) Program Services are considered non-covered and not payable for any one of the following a. through m.:

a. Any service whose primary purpose is the care or supervision that would be required by any individual of the member's chronological age;
b. Any service whose primary purpose is providing emotional support;
c. Any service whose purpose is to implement follow-through on a behavioral treatment plan;
d. Home care services provided in a hospital, nursing facility, intermediate care facility, or any other institutional facility providing medical, nursing, rehabilitative, or related care including a licensed/certified day care center;
e. Home care services that are provided through other state-funded department programs;
f. Home delivery of meals;
g. Homemaker services considered to be general household activities, day care, or recreational services;
h. Nutritional services, including those services provided by a nutritionist, registered dietician, nutrition therapy, and/or diet expert;
i. Physician services;
j. Services rendered without a signed order by a physician or not included in the physician's signed plan of care for the member;
k. Services provided by a home health aide (home-based LNA services) when the Plan's medical necessity criteria are not met in the Clinical Criteria section of this policy; AND/OR
l. Social worker services.
m. Duplicative services are not considered medically necessary.

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed.	08/25	08/25

References

1. New Hampshire Medicaid 1915(j) Self-Directed Personal Assistant Services Document – May 4, 2023

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/Enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.