Provider Training (May 2015) Questions and Responses

The following questions were posted during the May 2015 Provider Trainings that covered the following topics:

- Clinical Coverage Policy 3L
- The Provider Manual
- PASRR
- The Service Plan
- Program Integrity

All questions with responses are provided in this document.

Clinical Coverage Policy 3L

- **Section 6.1.3, 'Requirements for State Plan PCS On-line Service Plan', when does this go into effect**?
  June 10, 2015.

- **Section 6.1.3, 'Requirements for State Plan PCS Plan of Care On-line Service Plan', signing off on the service plan by recipient? Do we need to add this to our consents/or add to POC?**
  For the PCS Service Plan, either the beneficiary's signature or that of their legal representative will be required. The Service Plan does not follow the POC regulations, they are separate.

- **Will the Internal Quality Improvement Program replace the Quality Assurance Reports that are done quarterly within the agency?**
  No. The Internal Quality Improvement Program has been in the policy since the start of the program. The attestation requirement is ensuring that providers attest to DMA that they have a Quality Improvement Program in place.

- **For the required survey for the Quality Improvement Program, is this to be for all beneficiaries which service was provided? What if they choose not to participate? Will the results be made available for audit?**
  If the beneficiary chooses not to complete the survey, so long as it is documented that you have issued the survey to the beneficiary, that is all that will be required.

- **Does PCS need its own satisfaction survey?**
  Questions to be asked are not specified, it will be up to providers to draft their own questions to receive feedback on customer satisfaction related to PCS.

- **Will DMA provide an example of a Continual Quality Improvement Plan for reference?**
  As of now, DMA has not developed an example. The requirement has not changed; it has been in policy since the inception of the program. DMA is only requiring that you attest to what you are currently doing. The new requirement is that you attest to all of the things you are currently doing, such as completing the PCS surveys of your beneficiaries and that you submit the attestation. DMA will consider if they need to provide any other interpretive guidance; if so, it will be posted.

- **What is the consequence to not completing the 3136 attestation by Dec. 31 of each year?**
  Please complete the attestation by December 31. The requirement that provider organizations are to have an Internal Quality Improvement Program is not new, the requirement that provider organizations attest that they are following the requirements as outlined in Clinical Policy 3L is new. Providers who do not submit attestations will be subject to audit by DMA Program Integrity.

- **Can your sibling, child, or any relative provide PCS?**
  Per Clinical Coverage Policy 3L, section 4.2.2, the following persons cannot provide PCS and be reimbursed by Medicaid: any legally responsible person, spouse, parent, child, sibling, grandparent, grandchild, or any equivalent step- or in-law relative. In addition, any person whose primary residence is the same as the beneficiary's cannot provide PCS.

- **Are there any circumstances where a relative could be a person's aide? Can they live with the client under any circumstance?**
  The answer is no to both questions. Refer to Section 4.2.2 which lists all of the individuals who cannot be the PCS aide. Under no circumstances can the aide live with the beneficiary.

- **If an employee's grandparent lives at the facility where they work, does this mean the employee cannot provide PCS for the resident?**
  Yes, they may not be an aide providing PCS.

- **Policy used to be that a spouse could say they were not willing to care for their spouse, is this still the case with the new policy change or is documentation required?**
  Under the new policy, section 4.2.2, documentation is required for medical limitation and/or work verification. When assessors are in the field and the spouse is there, they use nursing judgement and document the need. If they feel the spouse is fully capable and able, this will be documented as well.

- **Are providers required to look at current patients and discontinue services if a spouse is in the home, able, and willing?**
  If they have been approved for PCS, then PCS should continue as is. Liberty assesses these situations when reassessment time comes and the consideration for that will happen at that time, but if they have a current PA and have been approved for PCS, things should continue as normal.

- **Section 4.2.3, 'Medicaid Additional Criteria Not Covered', will PCS not be covered if the beneficiary is receiving other services like Hospice or Home Health?**
  Hospice and PCS are only allowed concurrently when services are provided in an Adult Care Home Setting~~,~~ Home Health aide services and PCS are not allowed.

- **Can PCS be provided with Private Duty Nursing?**
  No, they may not.

- **Discharges must be submitted within 7 days; what if the beneficiary is in the hospital/rehab and will be returning?**
  If they will be returning and you plan to continue PCS when they return, you do not need to discharge them.

- **Last session we were told that we had to discharge if someone was without services for more than 30 days, now I am being told we can place someone on hold for up to a year; which is correct?**
  An individual is granted PA's for a year and will then be reassessed at that time to see if they are still eligible for PCS. If you have a beneficiary that you have started to provide services for and you know they will be coming back and you will continue to provide their PCS, you should not discharge them.

- **If a beneficiary does not want services to start right away or puts services on hold for an undetermined time, must a discharge be done within 7 days?**
  If services are put on hold for an undetermined time, the guideline is 30 days. If it has been more than 30 days, discharge the beneficiary and start the process over.

- **Can you provide a confirmation number after each discharge is submitted since it is being tracked?**
  Liberty does track it manually. There is not an automated process that generates a confirmation number, so that not something we can provide at this time.

- **What happens if the provider does not discharge in time? What does DMA do with the list of providers who do not discharge in time?**
  Liberty sends a report to DMA and the PCS Provider could be subject to an audit.

- **Is it mandatory to have in place for In-Home Aides to clock in and out when reporting to work and leaving the client's home? I read about the Telephony System, but if you don't have that system, is it mandatory to have something in place for the aides?**
  Telephony is an optional service and is not required. You do not have to have a system that would require an aide to clock in and out, but their times of service should be documented.

- **Accepting or rejecting a referral for PCS, is this business days? Does it include weekends?**
  This is business days; weekends are excluded.

- **Which felonies are not permitted in a group home setting?**
  See section 6.0 of Clinical Coverage Policy 3L.

<u>The Provider Manual</u>

- **If a medical COS is signed by a physician, can the PCS Provider fax it in or must the MD fax it in?**
  The providers can assist with getting the requests into Liberty.

- **What was the purpose of separating a COS into medical and non-medical, both result in an assessment?**
  They both result in an assessment, but one results in the beneficiary connecting with their doctor and remaining under their care. We are focusing on improving the health outcome for beneficiaries, so if something has changed since the last time they saw their physician, we want them to go back to their physician to be sure increased PCS is the best treatment plan or to see if other options should be explored based on the change in their condition. This change ensures that we are keeping physicians involved in their care.

- **The 3051 form does not provide an area that signifies a change in status is due to session law 2013-306 only, how will Liberty know to review for that criteria only and not effect current hours?**
  There is an optional attestation section where physicians can initial that the beneficiary meets the criteria of session law 2013-306. However, assessments overall are based on demonstrated need and not medical need. Information provided by the physician or PCS provider is considered, but the calculation of hours is always based on demonstrated need.

- **A COS submitted via QI reflects a status of 'suspended', what does this mean?**
  That means it is under review and no decision has been made as to whether it will be accepted or rejected.

- **For the new 3051, is there a timeframe the doctor must complete the request in? What is the appeal process if the doctor denies the request or fails to fill out the request?**
  Per policy, it is the responsibility of the beneficiary to work with their doctor to get a request for an independent assessment. There is no appeal process or timeframe for completion of that form.

- **What PCS Provider input do you have regarding forms, program operations, and changes in policy?**
  In the Provider Manual there is a section on our Stakeholder Group for those who want to be involved. The group meets once a month and DMA brings any changes they are proposing to make or policies they are looking to roll out for their input. Check out the contact information in the Provider Manual.

- **On page 12 of the new PCS Provider Manual it is stated that an agency RN "shall" request a change of status review, is this possible for an agency RN to do if the reason for the COS is medical?**
  A Medical COS must come from a physician, nurse practitioner, or physician's assistant. RN's may request a non-medical COS only.

- **If a client has been diagnosed with a deteriorating condition, who can request a COS, the MD/NP/PA or can the agency request a non-medical COS?**
  A deteriorating condition constitutes as a change in medical condition, so the request must come from the MD/NP/PA.

- **'Seen by a physician' does that include a NP or PA?**
  Yes, it does. The qualifying credentials are MD/NP/PA.

- **If the client requests a change in number of days, how does the provider request the change?**
  If the reason for a change in frequency is due to a change in caregiver status or the beneficiary simply does not wish to receive PCS all days indicated, that is a non-medical COS. It is important that an assessment be completed and the change indicated since the assessment and the service plan have to match.

- **What happens if an ACH doesn't accept a referral within 2 days?**
  Liberty will attempt to contact the facility and request a timely response. If the facility is unresponsive to the request, Liberty will hold the referral for 30 days. If no response is received, the PA's will be voided and a new request will need to be sent to Liberty for another assessment.

- **Why does the system not send an email to indicate a response is needed on a referral?**
  This suggestion has been made before and Viebridge is currently reviewing it to see if this is something they can implement.

- **Two letters of approval are issued with new beneficiaries that have two different start dates; can there be only one letter?**
  When providers accept a beneficiary, the notification letter posts immediately. Liberty may not print the letter until the next day, which would have a different effective date on it. The beneficiary's letter is the official letter of record; always refer to the dates on the beneficiary letter.

- **Completion of the 3051 form, can the agency or beneficiary fill out the demographics on the form before submitting to the physician for attestation?**
  Only the physician may complete Pages 1 and 2 of the 3051 form.

- **Do we still submit new resident information/requests for assessments via paper fax to Liberty?**
  Yes. Liberty is looking into making this an electronic process, but for now the 3051 must be faxed.

PASRR

- **Is there a list of PASRR providers who are able to issue PASRR numbers?**
  There is not a list of providers; PASRR is a process. PASRR's may be completed by the following independent screeners:
  - Physicians
  - Physician assistants
  - Family Nurse Practitioners
  - RNs and LPNs
  - Medical/Clinical and non- licensed Social Workers
  - Qualified Mental Health Professionals
  - Psychologists
  - Pharmacists
  - Hospital discharge planners and case managers
  - Case managers from regional, local, and community organizations who make referrals to long term care services and supports.
  - Staff of Aging Disability Resource Centers (ADRCs)

- **I have been unable to acquire a PASRR, no one is issuing them. Do you have a contact for assistance?**
  You can contact any of the following persons for assistance in location a registered screener:
  - Barbara Flood – EAST- 919-218-3872, barbara.flood@dhhs.nc.gov
  - Patricia McNear – CENTRAL – 919-218-3272, patricia.mcnear@dhhs.nc.gov
  - Bill Joyce – WEST – 336-312-0212, bill.joyce@dhhs.nc.gov

- **What is the definition of 'affiliated' in regards to a person who cannot complete a screening for a PASRR?**
  This is language per the DOJ; what they are looking for is a conflict of interest. Any person who is a legal representative for the individual requesting admission to an ACH or any person employed, paid by or works with any licensed adult care home cannot complete a PASRR screen.

- **Time limited PASRR numbers, will the provider need to request a new PASRR or will they receive a reminder notice that it is expiring?**
  No reminder notifications will be sent out, but the initial notification will indicate the expiration date. Providers should take note of the expiration date and consult with the beneficiary, as they will need to be screened again.

- **Are PASRR determinations of SMI/SPMI the same used to make IMD determinations or attestation by the ACH?**
  No, the primary concern in a PASRR determination is if the person is psychiatrically and medically stable enough to enter into an ACH.

- **Will Liberty come out to assess the resident even if PASRR screening number is not indicated on DMA-3051 form?**
  Yes, Liberty will process the request and do the assessment, but we will not complete the assessment or provide a PA. Since the PASRR number is a requirement, we will hold it and give the facility 30 days to get the PASRR number and provide it to Liberty. If Liberty does not receive the PASRR, we will remove the workflow and deny the request.

- **Individuals with a 'U' or 'R' PASRR authorization code cannot be admitted to an ACH?**
  That is correct. The 'U' or 'R' means that they are psychiatrically or medically unstable. When they are stabilized, they can be screened again in order to obtain a different code if appropriate.

- **Do private pay residents need to be screened for a PASRR at all?**
  Not unless they become a Medicaid recipient at some point. If that happens, they will need to be screened.

- **What if the PASRR number is not reflecting in NCMust?**
  You will want to contact NCMust to verify the beneficiary has been issued a PASRR number. If you have received a letter with confirmation of a PASRR number, you will want to contact NCMust to make sure their system reflects properly.

- **If a resident was admitted prior to 1/1/2013, had Medicaid, but not PCS, do they need a PASRR to receive PCS?**
  If they were admitted prior to 1/1/13 and had Medicaid, they do not need to have a PASRR number unless there is a significant change in psychiatric or medical status. However, if they were admitted prior to 1/1/13 and did not have Medicaid but after that date became a Medicaid recipient, then they will need a PASRR.

- **What code is given for a LVL I PASRR that identifies no signs of SMI/SPMI?**
  This would be an "O" code.

- **Is a new PASRR needed to be obtained for current ACH residents who require a COS for additional hours?**
  No, a new PASRR is not required.

- **Does a level II PASRR screen have to go through an LME or does it come directly from DHHS?**
  When a person is determined to be SMI/SPMI, a state employee is independently contracted to go to their location and conduct a face-to-face assessment. This comes back to DHHS and they make the final determination. If the person is psychiatrically and medically stable, the information is downloaded to LME's MCO that same day and the letter generated same day.

<u>The Service Plan</u>

- **When do the revisions to the service plan need to be submitted by? Will there be a field for change date**?
  Revisions can be made at any time it is deemed appropriate. You can go in the portal at any time and revise the service plan, as long as it stays in line with the assessment and the frequency that was indicated. There will be a field for change date.

- **Does an ACH have to identify the days of the week a service will be provided in the service plan? Can variations in tasks be performed and documented? What about changes in resident preference, are those to be reported?**
  Knowing that ACH facilities typically provide 24-hour care, the time is allotted across 7 days and tasks performed do not need to be indicated at set times.

- **Will the service plan be accepted in place of 3050R? Does the ACH still have to do both?**
  Yes, both still need to be completed as they are separate requirements, one is for licensure and one is for PCS.

- **If the beneficiary switches a task to a new day, does the agency have to submit a new service plan or just a deviation?**
  If the change is a long term change, a revision in the service plan is required. If the change is for one day, then a deviation for that day needs to be documented.

- **If there is an increase in caregiver availability, decreasing the need for PCS, is a new assessment needed? A new service plan?**
  Yes, this constitutes a non-medical Change of Status and both a new assessment and a new service plan would be required.

- **If service is provided before a service plan is approved, will the services that were provided be paid?**
  The effective period for PA's will not change, but there will not be an active PA in NCTracks for approval to bill until the service plan is completed.

- **Can the service plan be used against an agency in an audit if the POC is used for aide task sheet?**
  There are two different documents to print, a service plan and an aide task sheet. The Qi Reportaide task sheet is not required, but it is a mirror of the service plan itself. If using your own aide task sheet, there will not be a problem as long as it matches the service plan.

- **Is the level of care provided an optional item? Do you have to document it?**
  You do not have to document the level of care for the service plan.

- **If a beneficiary is incompetent, how can they confirm they received services?**
  If a beneficiary has a responsible person, they should be made aware of the service plan that is developed and a signature is required.

- **Will a blank service plan be able to be printed to use for other patients?**
  The service plan is assessment specific. An assessment has to be completed in order to generate a service plan so unfortunately blank service plans cannot be provided for other patients.

- **The timeliness submission requirements for the service plan, is that from the effective date or the acceptance date?**
  The service plan must be submitted within 7 days of referral acceptance.

- **How long will it take the system to validate the service plan once submitted by the provider?**
  Validation is immediate; it will either be accepted or not. If it is rejected, you will be prompted to make necessary changes.

- **When does a PA become effective, from date of assessment or date of service plan submitted?**
  Neither. New requests are effective from the date of request and reassessments are effective from the date of acceptance. Providers should be sure to accept all referrals within 2 days so it does not affect the PA effective date.

- **If the IAE does not identify a task on assessment that the beneficiary does need assistance with, does the beneficiary appeal and the provider complete service plan as is until mediation or can corrections be requested by provider on behalf of the beneficiary?**
  Only tasks indicated on the service plan will be paid for by Medicaid. If a beneficiary disagrees and feels that they need assistance with other tasks, they will need to go through the appeal process. If it is concluded at settlement that they do need additional assistance, a new service plan can be completed at that time.

- **Does a service plan have to be completed on all clients or just new clients going forward?**
  Everyone who has an assessment after 6/10/2015 will need to have a service plan completed.

- **Aide task sheet have only one signature line; how will this work for the ACH facilities that have more than one aide providing services? Is a task sheet needed for each aide or can multiple sign?**
  This is something that DMA is currently looking at, and this will be updated in the FAQ's and the Webinar for the service plan that will be posted on the provider portal on May 19.

- **Is there any plan to make any of the 'optional' features be required in the future for the service plan?**
  There is no intention of that at this time.

- **What happens if the service plan is not completed within the timeliness standards indicated in policy?**
  Prior approval for PCS hours or units is not granted until the on-line PCS service plan is entered into and validated by the Provider Interface. Providers who are not compliant with the time frames indicated in policy 3L will be subject to DMA Program Integrity audit.

- **Can an administrator complete the service plan or must it be an RN?**
  The proposed policy has not defined who can complete service plan and who cannot. It would be in your judgement as to who is qualified to complete the service plan and who is not.

- **Will adults with IDD living in a group home require the new service plan?**
  Yes, everybody receiving PCS will require a service plan.

- **Is the service plan good for a whole year?**
  The service plan is good until the next assessment, which could be earlier than a year or possibly a little more than a year.

- **Are there restrictions to the type of service plan that is used? Does the service plan have to be signed by the beneficiary or RP prior to submitting?**
  The service plan in the provider portal is the one that must be used. You can have your own service plan, but you must complete the service plan that is in the provider portal and it must be submitted and validated. It does not have to be signed prior to submitting; it can be completed and sent for validation and then signed. The signed copy should be uploaded into 'Supporting Documents' in the portal.

- **What part of the service planning functionality will be needed for state compliance to be kept at the ACH?**
  The entire service plan is required, with the exception of optional features.

- **We are currently seeing a few mistakes with days of the week and service numbers indicated on the assessment; how is this going to affect the online service plan?**
  The service plan must mirror the assessment and a change in the days of the week will require a non-medical COS. Liberty has heard consistently in feedback from providers that this is an issue, so we are highlighting in our training that Assessors ask the beneficiaries if they want service on the weekends. We will be documenting that in Section R of the assessment in order to provide insight to the PCS Provider of the beneficiary's request.

- **What if Liberty marks an ADL at 7 days when it was stated in the assessment that weekend hours are not needed? How does the agency complete the service plan correctly?**
  Call Liberty; they can pull the assessment back and correct it and then it will reflect properly on the service plan.

- **Can we do a service plan for beneficiaries who have old plans prior to June 10 if we would want them all with the same plan?**
  We do not have that functionality built to take the old assessment and provide a new service plan so it will only be for the new assessments.

- **Will providers be able to change NPI's between sister agencies or correct NPI's? How will this affect the PA after it has been accepted? Is a new service plan needed?**
  No, a new service plan will not be needed. If you need to change the NPI's between sister agencies or if you selected the wrong agency, you will be able to update that in the provider portal. We will update the PA's in order to reflect the new NPI assignment.

- **If we use our own weekly task sheets, is the beneficiary's attestation required on those sheets?**
  Only the aide's signature is required on task sheets at this time.

- **Will the author identification that is auto populated on the service plan be audited? Is there another way to ID the preparer?**
  Viebridge will explore making this a fillable field for accurate documentation.

- **Will the system compute the hours for each month? For longer months, how does the system compute weekly hours?**
  The number of monthly hours is the same for every month, regardless of the number of days. The service plan is based on the formula of dividing the monthly hours by 4.35 to get weekly hours. Billing is still based off of the monthly authorization.

- **Do we have to enter the frequency or assistance level in the service plan?**
  That auto populates from the assessment, so there is no need to fill that in.

- **The service plan options, are they another tool to initiate an audit?**
  No.

- **Will units be pre-entered or do we enter them?**
  The units will be pre-entered and will be listed. As you enter the scheduled days and times in which you plan to provide service, it will deduct the appropriate amount of units until you have used all approved units.

- **Would the beneficiary lose hours if the service plan identifies a task is not needed as often as the assessment indicates?**
  The service plan and assessment will always be the same. You will get a warning if the frequency does not match when you submit your service plan for validation. If the beneficiary does not agree with the frequency, they could always appeal the assessment or submit a non-medical COS.

- **Once a client is discharged in QiReport, will there be a notice to stop the service plan and will it be noted? Will we still be able to generate the service plan as a report?**
  As long as the person is on your portal, you will be able to access their service plan. If you plan on discharging someone, Viebridge recommends printing out the service plan so that you have it for your files.

- **In the audit process, do we need to have a QiReport generated service plan?**
  During an audit, the provider will be required to provide QiReport generated on-line service plans for referrals completed 6/10/2015 and after. There are few exceptions when providers will be required to complete manual service plans outside of QiReport, in those cases, auditors will review manual service plans. For questions on cases where a manual service plan is allowed, contact Liberty Healthcare Corporation.

- **Will QiReport generate a printable service plan to give to the client so they may have a copy?**
  Yes, you will need to print out the service plan so you can get it signed and then you can make a copy and provide it to the beneficiary.

- **Should we use a particular browser i.e. Firefox for the new QiReport? Is there an app?**
  All major browsers may be used, but there is no app. There is no requirement for which browser you use. Keep in mind that some reports will not generate if you are using Internet Explorer.

- **Is the service plan to be completed prior to the RN's in the home assessment?**
  The RN requirement is separate and is under licensure requirements. Please see licensure requirements for timeliness expectations on home assessments.

- **Are electronic signatures or digital signature stamps sufficient for aide, RN, and client approvals?**
  No, all signatures must be written.

- **If a client wants to have their BP checked two times per week, the new rule would require a medical COS so the task would be put on the service plan, correct?**
  If a beneficiary wants to have a task added for medical reasons, that will require a medical COS submitted by the physician so that it will then be indicated on the service plan.

- **What do you do if the comments state that laundry should be done once a week but it is not marked on the actual IA?**
  It has to be marked in the IA for it to transfer to the service plan. If you are seeing a conflict that a task should be conducted but it was missed in the assessment, please call Liberty.

- **Do you need to take time away if a task was not completed for a day (i.e. The aide did not wash dishes)?**
  A change to the service plan is not required if a task was not done on a particular day, the PCS Provider simply cannot bill for that task.

- **What is the timeframe between completing the service plan and getting an active PA? Is it immediate or do we need to wait 24 hours?**
  It is 24 hours.

- **Can hours be made up? For example, the client went to the doctor on Monday, can staff work extra time on Tuesday to make up time?**
  The focus is on the ADL tasks and not the time. If an ADL task is missed due to a doctor's appointment and it needs to be made up, it can be made up on the same day. If the task missed is task required daily, then the provider cannot make that task up on a different day. This should be documented as a deviation.

- **If ADL documentation is done electronically by a provider, are electronic aide task sheets expected to be printed and signed?**
  Yes.

- **If the annual assessment isn't effective for 10 days after notification, is the service plan still due in the time indicated in policy?**
  Yes, because different assessment types have different effective dates. The expectation is that the service plan be completed within the timeliness standards set in Clinical Coverage Policy 3L, section 6.1.3.

- **Will a service plan be required as a result of an appeal resolution settled at mediation? How will the qualifying ADL tasks populate in the service plan?**
  Liberty is currently looking at creating a derivative assessment. All new information will be entered at settlement and a new service plan will be generated. Until then, notification requires providers to write their own service plan until another assessment is completed. The PA's will generate as normal.

- **Can the aide task schedule be assigned to different aides during the course of the week?**
  Yes, you may use one than one aide within the same week.

- **After the service plan is validated, does the PA change the NPI associated for the new NPI?**
  Any changes in the service plan would not affect the NPI at all, that comes directly from the assessment. If there are changes that need to be made to the NPI, you can either do them in the portal or you can call Liberty.

- **Since the service plan can be completed by anyone, does it have to be signed by a RN?**
  The service plan is not your Plan of Care, which requires a specific staff member to complete it. As a provider, you determine who will complete the service plan and whoever does that will be the author who signs it.

- **Will ACHs be given a phase-in or hold harmless period for all new implementations/changes as all other providers are given?**
  As far as the service plan or implementation of policy goes, there is no "phase-in" time period. The policy will be effective on June 1 and the service plan will be effective on June 10.

- **Whose service plan takes precedence, QiReport or the 3rd party biller?**
  For Medicaid, your service plan through QiReport/DMA is required within 7 business days of accepting the referral.

- **With the service plan being completed on-line, what should be done if an ACH recipient must begin Home Health or Hospice services on the same day of another approved task?**
  If you have accepted a beneficiary and find that they have a Home Health aide service or Hospice, contact Liberty to do a COS. Home Health aide services are not allowed while receiving PCS. Liberty will complete another assessment based on certain ADL tasks that will be met on those particular days. When a Hospice aide comes in, they will complete certain tasks that your aide will not be required to do.

- **Will the beneficiary notice load into QiReport before we complete the service plan or does the service plan have to be completed first?**
  You will continue receiving the notice immediately after acceptance. You do not need to complete your service plan before you get a notice.

Program Integrity

- **Can we get a 'Top 10 List' of suspicious claim activity?**
  There is no set "Top 10" list; data analysis is required based on what is being measured. Claim issues that have been received, such as a physician billing variably over time, variations in the number of units billed per day, changes in the number of days of the week or weekends, a pattern of several denials in billing for people who are deceased or in the hospital, etc. would trigger an audit.

- **Will Program Integrity/DMA publish detailed explanations of what training is provided to auditors?**
  It is required for internal PI positions to be licensed in the state of NC. Credentialing during the hiring process ensures that employees are licensed if required. If specific training requirements are in place for contractors, that training must be provided. There is information on the DHHS website that describes reviewer training.

- **Will PI do a webinar on how to respond to an audit request?**
  If providers would find this to be beneficial, a recommendation will be made to PI's training coordinator.

- **How may Providers obtain a copy of the audit tool used by PI for the PCS services?**
  PI is currently working on the audit tool; there are a couple of items that need to be tweaked and then PI should be able to release it. The questions in the Power Point from today's presentation are the questions on the review tool, so you already have access to that. The interpretive steps are all program specific and are policy pointers to guide the reviewers through the process.

- **If materials are requested by mail, when will the agency hear back? What does it mean if the agency does not hear anything?**
  PI will notify the agency on the outcome of the review, but that can take varying lengths of time.

- **Why are facilities receiving notice of an audit when prompted by a complaint?**
  If a facility receives a "records request," per 108C, Program Integrity is required to explain or give some general information as to what they are going to look at when they do an audit. There is not a process in place to notify an agency or facility every time there is a complaint. If PI is looking for records, they will send out a records request.

- **Are there cross agency checks for staff working for different agencies?**
  No, there are not.

- **When will ACH PI Audits begin?**
  The Division of Medicaid Program Integrity has already done some reviews based on last year's state auditor's samples. They also do reviews based on complaints and referrals, as well as anything identified through their Problem Abuse Detection software. Some audits or special types of projects are scheduled, but there is no way to know when a complaint or a referral will be received or what the software will identify.

- **Has the record request for an ACH audit been modified to fit requests made of ACH providers? What are vendors looking for in an ACH audit?**
  PI has recommended a revision in the medical records requests. Everything used is template-driven and all of the templates have been attorney approved. Vendors will be looking for records of whatever documentation fits the questions based on the program coverage requirements. For example: IA authorizations and assessments, employee records to be sure they are properly trained and credential qualified, copies of providers' DHSR licenses, in-home aide logs for private residences, and service logs for ACH home facilities. For supervision for private residents, they may request copies of the supervisory visit notes, and copies of supervisory schedules at facilities.

- **How far do the PI reviews back to? What if the records have met the timeline for removal?**
  In general, PI will only look back a maximum of 5 years. In some instances, they will look further back if the licensing or practice rules are different for that particular program. However, they do not go back further than Medicaid and/or the licensing entity would say that the provider needs to maintain records.

- **What should the sample size be when we do our internal quality audit/assessment?**
  In regard to the internal quality program requirements, there has been no sample size indicated. It is up to providers to determine that based on the number of staff and how big your facility is, but there has been no requirement for that.

- **As it relates to program integrity, if the agency realizes they have made errors or have been out of compliance, do you all take into consideration that the errors/compliance issues have been noted and changes have been made to correct them to make sure it doesn't happen again?**
  If PI sees overpayments over specific thresholds, they are required to address them. They are also required to pay back the federal government on any overpayment determination that makes it through the appeal process. PI may request that a provider complete a corrected action plan after a limited scale audit to make sure the errors don't occur again, but if they see evidence that they took steps to identify and correct those errors, that is something they would review. Overpayment determination is based on a recovery threshold of $150 or more.

- **Will DMA PI licensure accept the service plan and time sheet from Liberty during audit?**
  Yes. The DMA PI auditors will be looking at the service plans that were completed during the particular time period they are auditing.

- **Does DMA conduct audits for Homecare? If so, how often?**
  We would need to look at tracking systems to say how many are conducted per month or per year. For routine audits, the state auditor sample is conducted every year. If tasked with a targeted audit or project, sometimes that will have a frequency identified. There aren't any audits being conducted right now, targeted or regularly scheduled. Most referrals and complaints result in some type of level of records review. If looking at data analysis, sometimes contractors work with us to look at claims data and are given instructions to come up with a certain number of reports to complete in a certain period of time, but not all of these reports result in an audit.

- **Can you ask for a voluntary review of PI?**
  Frequently providers do their own self-audits and send their information into the third-party sections. Those audits are assigned to someone in PI to look at. If there are any problems or any more information is needed, they will contact the providers and talk about the audit results and what more may be needed.

- **For Program Integrity, do the aide task sheets have to exactly match the ADL's and frequency of the tasks?**
  Yes, they must match.

General

- **Is there anyway the denials can come up on the referral page like MOS so they are not missed?**
  At this time, denials are posted on a separate tab that you must go into and check consistently. Viebridge will note this as a suggestion for the future.

- **When bathing is evaluated, the recipient has on shoes and the tub is not wet, this will have a different outcome then the reality of the situation; is this not considered?**
  The beneficiary being able to demonstrate tub transfer safely is taken into consideration. It is appropriate for the assessors to ask for physical demonstration of applying and removing shoes & socks, which is part of the dressing task.

- **Is pulling up from the toilet by way of the towel rack or sink considered 'normal', there are safety issues that are of concern?**
  Transfers and demonstrations are done both with and without assisted devices. Just because beneficiaries pull or hold onto something does not necessarily mean that they have a bath or transfer issue. The assessor would take that into consideration in its entirety, as it may be a habit.

- **Are hours/units billed to be based on the approved service plan or aide documentation hours?**
  Hours are to billed based on your service plan. If there was a deviation from the service plan and the aide did not provide a particular task, you should document this and bill only for the service that was provided.

- **If we discharge a beneficiary in QiReport before the final bill, how come it doesn't pay for a valid bill?**
  If you are having this issue, please contact Liberty. The PA's end with the discharge date that you enter, so it shouldn't affect billing for any days prior to that.

- **Why do we have to call Liberty to get PAs every month?**
  You should not have to call Liberty every month as this is an automated process. If you are experiencing that, please contact Liberty.

- **What things are most critical in determining to assign a CNA vs. PCA?**
  You will need to check your licensure rules regarding this inquiry; this is completely separate from PCS.

- **I am finding that the PCPs do not know about the program and how to refer; is there any plan to educate?**
  DMA has partnered with CCNC to be sure all providers in their network have been educated on the form, how to complete the form, when it is required, and on PCS; we will continue providing information to the physicians. In addition, training is provided for physicians on the websites of Liberty, DMA and CCNC.

- **Is there any rule on how many clients plus staff one nurse can manage in a particular agency?**
  You will need to refer to licensure requirements on this as this would not be a PCS requirement.

- **Should the providers call the DSS caseworker rather than check NCTracks for CAP status since NCTracks is not reliable?**
  We have noticed times where NCTracks has been delayed in their updates. Unfortunately, Liberty cannot process a PCS request if NCTracks is still displaying that CAP status on the beneficiary's account. DMA is working with them on trying to get their system updated in a timely manner. We suggest retaining the original request and calling the caseworker to try to get NCTracks updated.

- **What is the process to file a complaint on a Liberty RN that will result in follow-up?**
  There is a formalized complaint process at Liberty. When a complaint is made through the Customer Support Center it is escalated to a manager. There is a 2 day resolution standard, so you can expect to be contacted within 2 days. If you are not seeing that happen, escalate the complaint to either Lyneka Judkins or Lacey Barnes at Liberty. In addition, each month a report detailing every complaint is submitted to DMA for additional review.

- **Why is the diagnosis and medications disregarded when doing an assessment?**
  Medications are considered, but when it comes to overall calculations, the PCS assessment is not one of medical need but is based on demonstrated need. There can be two individuals who have the same diagnosis, but based on their progress will demonstrate the ADL's at different levels and their outcome of award may differ.

- **Sometimes the aide cares for a client and later the same day the client enters the hospital; is the timeline taken into consideration whether the agency should be paid for services rendered on the day a client is admitted in the hospital?**
  DMA is currently reviewing this policy, but no changes have been made to date. If a beneficiary is admitted to the hospital, that claim will process and the agency will not be able to bill for PCS on the same day of admission.

- **Has Liberty changed their policy or procedure when they cannot get in touch with a Medicaid recipient to perform their annual reassessment? We have received three denials for UTC and were never called to assist in contact.**
  The process has not changed – we will always try to call the PCS provider, any alternate contacts, or the referring physician to try to get a contact number for the beneficiary. There is no particular order in which we call, the goal is to get the contact information confirmed and we stop our outreach once this is achieved. We are reviewing a new process which will get PCS providers involved in the annual assessment. The proposed process will include Liberty alerting the PCS provider that the annual is coming up and ask for their assistance in contacting the beneficiaries. We are hoping for approval and implementation by the end of the year.

- **How are you addressing situations where the ADL assistance is not performed on one task, can the provider still bill for it in the ACH setting?**
  A beneficiary is awarded a particular amount of time for tasks per day, which is required depending on the assistance level. If a task is not conducted then the time should be deducted. Refer to the back of your policy and document the time. Submit the claim for the units of service that you delivered on any given day.

- **We have begun to see reassessments triggered by Community Care of the Sandhills, why is this happening?**
  Community Care of North Carolina (CCNC) provides beneficiaries with a medical home and a primary care provider (PCP) who will coordinate medical care. Assessments may be requested at any time by partners of Community Care of NC**.**

- **Who owns the information entered into the provider portal? Will any documents uploaded be provided to the new provider if there is a change in provider?**
  DMA owns this information. If there is a COP, the new provider will be required to complete their own service plan, but they will see the previous template.

- **I am hearing from potential clients that the evaluator tells them that they can use their PCS hours any way they want, is this correct?**
  This is incorrect; the new service plan must mirror the frequency. The Assessor will indicate the frequency of need and the service plan must mirror that.

- **CAP Innovations doesn't show through NCTracks, how does documentation of Innovations get verified?**
  Innovations is indicated in NCTracks as special coverage. There have been some delays with updates in NCTracks, so we recommend contacting the caseworker as well to double check.

- **Will Liberty nurses be up to date on coding ICD-10 prior to 10/1/15 when it goes live?**
  Liberty nurses are not coders; they include the diagnosis on the assessment what was provided by the practitioner.

- **We have several clients whom Liberty told them that 'Liberty does not indicate CNA or IHA required' on the assessment, but they do that by the scores they give them, correct?**
  Liberty does not indicate if a CNA is required or what level aide is required. You will want to refer to your licensure rules for that. When you review the assessment in your referral page, you will need to determine if you have the staffing to provide the level of care needed.

- **Liberty's fax numbers are very difficult to get through, is there any change anticipated to address this issue?**
  Liberty has invested in two additional fax lines, so there are now three lines for regular fax requests and one for expedited requests; all lines are set to roll over to another line when the original line faxed to is busy. Please contact Lyneka Judkins if you are still having difficulties getting a fax to go through.

- **Discharges still show up in QiReport, why doesn't it update to reflect they are no longer active?**
  There is an "Accepted within the Last Year" page, where you can access discharged beneficiaries in case you need to reference their accounts for billing or documentation purposes. They will not show up when you "Search Recipients", this is only for active beneficiaries.

- **Do hospice patients have to be evaluated every 6 months by Liberty instead of yearly?**
  Reassessments may vary in type and frequency depending on the beneficiary's level of functional disability and his or her prognosis for improvement or rehabilitation, as determined by the IAE, but not less frequently than once every 365 calendar days.

- **Will ICD-10 effect PCS billing?**
  Changes in ICD-10 will not affect PCS billing. There are multiple diagnoses relating to beneficiaries receiving PCS and DMA uses a code that will work for all beneficiaries.

- **Why are we seeing such long wait times for Liberty to assess, which results in the client waiting weeks to receive services?**
  We do a lot of data analysis at Liberty and have concluded that for those in the IHC setting, it typically takes 10 days to contact the beneficiary, schedule and complete the assessment. The time for ACH facilities is typically 9 days; per policy, Liberty has 14 days. If you are seeing longer times than what has been indicated, please contact Lyneka Judkins directly.

- **After an annual assessment, does the RN need to do another complete assessment or can they update the original assessment done when the beneficiary was admitted?**
  DMA does not require that the RN do another complete assessment. If you are already doing that for your licensure requirements, you may continue with that but for PCS the beneficiary will need an updated service plan.

- **Does the provider need to discharge the patients who switched to another agency**?
  No. When Liberty processes a Change of Provider (COP) request, the beneficiary is automatically removed from the old provider portal and they no longer have access to the account to submit a discharge. The COP request takes the place of a required discharge.

- **Is the weekly aide schedule in QiReport required or can the provider use their own aide schedule?**
  The schedule is a part of the service plan and will need to be completed. You may use your own aide task documentation sheet.

- **Providers will call beneficiaries that currently have a PCS provider and offer gifts in order to change companies; this is against DMA policy, why does this continue?**
  When this is reported to DMA or Liberty from either the beneficiaries or PCS providers, it is passed on to Program Integrity.

- **If Liberty does not do the assessment within a year, how do we put in our annual assessment request for the client in QiReport?**
  A PCS provider cannot enter an annual assessment request in QiReport. If you have not seen Liberty contact the beneficiary or facility within 30 days after the annual due date please call Liberty.

- **Why are we still required to print out, fill out, and fax the QiReport registration form for new users? Are authors assigned by user who is signed in or is the user signed in always going to reflect as the author for the service plan?**
  There is no electronic process for signing up for QiReport registration. The form is on the home page, but it is not automated. The system always considers the author to be the individual who is signed in. However, if the individual who is signed in is not the author, Viebridge will be adding a field so you can indicate who the author is.

- **When Liberty issues a TD in writing and it's reversed, why do you not send an updated letter?**
  A new letter was launched last week, which will document this change in writing. Anytime there is a change to a PA or a reversal on a TD, you will get a letter uploaded into the provider portal.

- **If the beneficiary refuses bathing assistance, can the aide do the IADL's only?**
  No.