Provider Training (Oct. 2014) Questions and Responses

The following questions were posted during the October 2014 Provider Trainings that covered the following topics:

- The Provider Manual
- The Provider Portal (QiReport)
- The PCS Beneficiary Participation Guidelines
- The 3085 Training Requirement
- The Service Plan

All questions with responses are provided in this document.

BILLING

- **Can we bill for the initial agency RN assessment, subsequent assessments and/or supervisory visits?**
  No. Medicaid will only reimburse for services provided up to the max hours awarded, limited to the ADL's approved through the independent assessment.

- **Is there a faster way to put client's information in for those who have many clients?**
  DMA and Liberty Healthcare of NC are not aware of any steps that make this process more efficient. NCTracks may be able to provide additional assistance.

- **There is no limit on plan hours anywhere in Policy 3L-only a limit on billing. When did that happen?**
  There is no limit to the total number of PCS hours a PCS provider may choose to provide. Medicaid will only reimburse for the total number of hours approved through the independent assessment.

- **In the first couple of trainings we received regarding PCS back in 2013 it was said that providers could still bill for services if a resident refused that task as that is the Resident's right to refuse care. However, we cannot bill for services if the resident was not in the building to receive them. Is this correct?**
  Correct. You can only bill for services that were provided, on the day they were provided.

- **If you discharge a resident before completing all billing, will you be denied? Example: Discharged in September, still need to bill February-September.**
  No. The PA will remain in the system and effective for the period approved.

- **If a resident passes before an assessment can happen, what can a Provider do so they can still get paid?**
  An independent assessment is required for a Prior Approval for PCS. If an independent assessment is not conducted and a PA is not awarded, PCS cannot be reimbursed.

- **In the past, if a resident was admitted to the hospital for some period of time, whether that is half a day or all day, we lost that entire day of payment to the hospital. On the chance that a resident comes back during the day from the hospital, and care services are provided, will we be able to bill those services or lose the entire day of payment to the hospital?**
  Medicaid will not pay for services on the same day that the beneficiary was hospitalized.

- **Is MOS allowed when the actual PCS assessment results in zero-approved hours. Can we bill MOS?**
  If the beneficiary had approved PCS hours prior to the assessment that resulted in zero hours, then MOS would remain at the previous level of hours if the appeal is filed within 30 days. If the beneficiary was not receiving PCS, then MOS is not applicable.

- **Can the same taxonomy code be used for PCS and CAP? (Both programs under one umbrella)**
  CAP providers may use the same taxonomy code for PCS In-Home Services (In-Home Supportive Care 253Z00000X) when the CAP provider is licensed by DHHS as a CAP provider who also provides Home Care Services.

- **Do we need ICD.10 for PCS billing?**
  ICD.10 will go into effect October 2015. Providers will be asked to use the ICD.10 codes at that time.

<u>Chang of Providers/Change of Status</u>

- **Are you working on a better way to prevent other agencies from invading recipients' homes, getting information and changing to another agency? Some clients don't realize what is going on.**
  Liberty has a strict process in place for the processing of a change of provider request. The process includes limitation on who can request a change of provider and required information to approve the request.

- **Can a client be served in 2 locations? I have an Alzheimer's dialysis client that the primary residence is at the niece's home. The niece's husband also takes care of a CAP/DA client, niece's father that also lives with them. On occasion they want to take off 1-2 days and leave client with client's son Charles and his wife that live 4 miles away. Charles and his wife refuse**

to give client a bath and personal care and request that our C.N.A. go there to provide care when the client goes to their house as she is in poor health. Is this allowed?
PCS must be provided in the beneficiary's primary residence only.

- **40% of your calls are verifying receipt of requests. Why can't those requests be scanned in like Change of Status requests so that providers can verify receipt without calling every time a new request is faxed?**
  Liberty Healthcare of NC, DMA, and Viebridge are always exploring ways to improve our processes and enhance systems for the convenience of all stakeholders. This suggestion will definitely be considered.

- **When we do a change of status and there is not a new diagnosis, do we have to enter one to perform the change of status?**
  A diagnosis is required on all change of status requests.

PCS BENEFICIARY PARTICIPATION GUIDELINES; FORMERLY KNOWN AS THE BENEFICIARY RIGHTS & RESPONSIBILITIES FORM

- **If a person has a guardian, are they the one that signs the form?**
  If the beneficiary is unable to sign the form, a legal guardian, power of attorney, or witness may sign the form.

- **Will the beneficiary be required to sign Beneficiary Rights and Responsibilities during EACH assessment or only the initial one?**
  The PCS Beneficiary Participation Guidelines will be provided at each assessment.

- **In regard to the beneficiary rights and responsibilities form, is this the sole responsibility of Liberty assessors to obtain?**
  Yes. PCS providers will not be required to provide this form and obtain acknowledgement from the beneficiary.

PLAN OF CARE/SERVICE PLAN

- **Is there a date set for the Plan of Care workgroup to reconvene?**
  The Plan of Care workgroup will not reconvene. DMA will pilot and begin training on the PCS Service Plan Provider Interface functionality. DMA Clinical Coverage Policy 3L Personal Care Services will require a PCS Service Plan not a Plan of Care.

- **Will the Service Plan replace the required DMA 3050 for the ACHs?**
  No. Providers shall adhere to their DHSR licensure requirements and requirements of the PCS Clinical Coverage Policy 3L.

- **Will the ACH be allowed to use the Service Plan form for their private pay residents if they choose to do so?**
  At this time the service plan functionality is for Medicaid PCS beneficiaries only. The Service Plan functionality is based on an Independent Assessment conducted by the Independent Assessment Entity (IAE). Private Pay residents do not receive Independent Assessments from the (IAE).

- **What happens in the ACH setting – since the Service Plan is not designed to capture 2417 Care Plan schedules – care is not provided in the "from – to" timeframe from a Program Integrity standpoint at audit? You simply cannot pinpoint the exact bath hour or toileting or dressing hour, etc. in the 2417 setting.**
  The Service Plan functionality for the ACH setting has been updated to remove the "from-to" requirement. Updated functionality will allow ACH providers to identify services provided during shifts.

- **When a mistake is made on the independent assessment, i.e., assessment shows 5 days/week service, but one task shows 7 days, will the agency be able to correct this when doing the electronic service plan?**
  The agency will not be able to correct this on their own in the service plan. If there is a discrepancy then the Provider may contact Liberty in regards to the assessment.

DISCHARGES

- **Why is it that after discharging a client, the name still remains on the portal?**
  The providers are able to see previously accepted beney's for up to one year after discharging in the case they need to reference historical information. If a beneficiary changes providers, then this information will not be accessible.

- **If a client refuses service (waiting on particular aide), declines fill-in after several days – when should client be discharged?**
  Provider has the right to discharge the beneficiary at any time. In accordance to 10A NCAC 13J .1101, advance notification of at least 48 hours to the client or responsible party when service provision is to be reduced or terminated, except in cases where the client is in agreement with changes, there is a danger to a client or staff member, or the physician terminates services; and referral to and coordination with other appropriate agencies when the agency is unable to respond to a request for service promptly, or to continue to provide service.

- **Do you have to discharge a deceased person?**
  Yes. PCS providers are required to discharge all persons whom they are no longer providing PCS to and the system allows for proper indication of such.

HOURS

- **Is it mandatory to schedule staff for all 7 days if that is what is on the assessment? What if the family decides that they want all the hours during the week?**
  If the days of need for PCS change then a change of status request is required for a new assessment.

- **Can an agency elect not to use the total hours in the month for a client on months that there is an overage from the weekly average?**
  Yes. An agency should only bill for service provided.

- **If a physician allots a recipient's need for service and/or additional hours, can a nurse override the physician's request?**
  The completion of the 3051 form by a physician is a request for an independent assessment to determine PCS eligibility. The nurse documents demonstrations by the beneficiary and then the system calculates hours. Liberty is unable to 'override' hour determination.

- **If PCS has been in place and needs are being met, patient has remained stable/improved or ameliorated, why a decrease or deny services?**
  Hours are awarded based off of demonstrated need. The system will calculate the appropriate amount of hours approved for PCS based off the demonstrations of the beneficiary.

ACH RELATED

- **How is an ACH provider expected to determine at what time of each shift a beneficiary will need to be toileted, dressed or undressed, or pushed down the hall in their wheelchair?**
  The ACH service plan functionality has been updated to remove the requirement for a specific time frame. ACH providers will identify the shift the task was completed.

- **Does QiRePort have a 'Counties Served' section for ACHs?**
  No. This information is only used for the In-Home setting in order to provide the beneficiary with a list of PCS Providers who service their county. In the ACH setting, there is no need to select a PCS beneficiary because the beneficiary already resides in the facility.

- **Why are ACH communities not contacted when assessment request has an issue and assessment cannot be done? Doctors are being notified, not ACH?**
  According to Clinical Coverage Policy 3L, section 5.4.2, it is the responsibility of the beneficiary or legal guardian to see their physician in regards to the completion of the 3051. Since the request is supposed to come from a physician, all communication will occur between Liberty and the physician a/or the beneficiary.

- **What if the ACHs do not accept a beneficiary referral within 2 days on QiRePort?**
  If a PCS Provider fails to respond to the 'Request for Service' in QiReport within 2 days, Liberty will conduct a courtesy call on day 3 to provide assistance if needed. Liberty will continue to follow up with the provider for a total of 3 attempts. If the provider does not respond to the request or to the call attempts made by Liberty, Liberty will reject the 'Request for Service' on behalf of the provider and reach out to the next provider of choice.

PASRR

- **Approval for PCS is based on PASRR approval date, why is it not approved when Liberty receives the referral?**
  A PASRR is required to be PCS eligible and is obtained through a screening that should occur prior to the submission of a PCS request. Liberty does not handle these screenings. They are handled through DHHS.

- **How long does it take to get a PASRR number?**
  ACH Level I – 1 business day or less
  Level 2 - 5-7 business days

LIBERTY/ASSESSOR RELATED

- **What can an agency do when the nurses from Liberty are showing favoritism towards other agencies?**
  This is not Liberty's practice. If you have experienced this, please contact Liberty immediately at 919-322-5944 and ask to speak with a supervisor.

- **When Liberty calls to schedule an assessment, we are given a 1-2 hour timeframe - then the day before, the Assessor calls and tries to reschedule. Can they stay with scheduled time with no window?**
  There are times when the Assessor will need to make rearrangements in her schedule to accommodate other immediate requests that may have been unplanned. If you are unable to reschedule your assessment, please communicate that and the nurse will work to stick to the original scheduled appointment time if possible.

- **Why can't a PCS provider schedule an assessment for the beneficiary? What is the rationalization for not being able to contact even if we are not listed as alternate contact?**
  For purposes of HIPAA, Liberty can only schedule an assessment with the beneficiary, legal guardian, power of attorney, or indicated alternate contact.

- **In a recent experience, a client was assigned to wrong provider that had a similar name. What is the most expeditious way to correct the error?**
  Please have the beneficiary call Liberty and we will expedite the correction.

MISCELLANEOUS

- **Would it be possible to have a message system (like email) to receive a message when the notification comes in? The letter that gives us a date when we can start. At this time, there is no way of knowing.**
  This is a good suggestion and has been noted to take into consideration.

- **How does the PCS manual reconcile with the aide rules in DHSR licensure?**
  The Provider Manual is a guide. You should always refer to policy for all requirements.

- **Is it lawful for a client's family to get "aide and attendance money from Veterans Administration," while the client is also receiving Medicaid PCS?**
  Yes, it is lawful for a client's family to receive the Aid and Attendance Pension. This is a benefit provided to a qualifying veteran and surviving spouses.

- **Is CPR required for workers with PCS and CAP/DA programs?**
  You will want to refer to your licensure rules and regulations for all aide requirements.

- **After you make your decision on accepting or rejecting the client, why can't you explain this in the Comment box?**
  In response to previous suggestions made, PCS Providers now have the capability to enter a comment when they accept or reject a referral. Once the decision has been submitted, the comments cannot be edited. Liberty is able to view these comments on their end.

- **Clients cannot have CAP & PCS services at the same time, correct?**
  Correct.

- **When I change the NPI# for a beneficiary in QiReport, does this generate a new letter?**
  No, a letter is not generated at this time when this change is made in the provider portal.

- **Can the Alzheimer's Association come in with a speaker and would that be sufficient for DMA 3085?**
  The DMA 3085 training attestation requires that the provider submit to DMA an outline of the structure and training methodology including goals, core competencies, and skills validation. DMA does not mandate how the training is delivered.

- **How may the service definition change to include a greater emphasis and respect for the NON hands-on prompting and guiding for PCS that is required by IDD residents in adult care group homes? The Providers need this funding that was lost when the service definition devalued this type of assistance.**
  The service definition for State Plan PCS will not change.

- **If the home is not safe, what is the reporting responsibility of the IA/contractor to APS?**
  Liberty has a formalized process setup for the submission of APS reports if concerns of safety are identified during the independent assessment.

- **Will medications ever be added as one of the ADLs?**

No. Activities of Daily Living consist of Bathing, Dressing, Mobility, Toileting, and Eating

- **Are the aide task worksheets optional or mandatory?**
  Provider Interface generated task sheets are not required; provider organizations may use their own aide task worksheets. If a provider organization elects to use their own aide task worksheets, the worksheets must accurately reflect all aide tasks and schedule documented in the online PCS service plan, task by task.

- **Once a provider completes the training attestation for providing additional hours (over 80), once DMA sends an auto-reply of accepting the submission will there be another email sent with DMA approval of attestation?**
  No. At this time, once the training attestation has been submitted to DMA, the provider may move forward with providing services. They will want to be sure to keep a copy of the attestation for any future audits.

- **My client is moving to another county that is not on my list of counties but wants to stay with my company. How do I add the county to my list?**
  You can update the list of counties you serve through the 'Counties Served' link in QiReport.