PCS 101 Provider Training Questions and Answers- August 16, 2022

Who should be contacted if the Liberty assessment does not match the care plan of the resident at the community?

Each time a provider accepts a referral for new or existing beneficiary, a service plan must be completed. A service plan will need to be completed after each of the following:

- New admission assessments
- Annual assessments
- COS assessments
- COP requests
- MOS notifications

Service plan updates can be made in QiRePort. Please refer to slides 71-80 for instructions.

If the tasks or frequency do not align with the service plan or if the provider thinks there is an error on the frequency noted in the assessment, please contact the Liberty and the issue can be escalated to a manager for review.

If a client changes providers will Liberty do another assessment? Or is it based upon previous assessment?

Change of Provider requests can be made by completing the DHB-3051 form or by calling Liberty Healthcare. Completing the form is not required. Request can be made by a call to Liberty by the beneficiary or legal guardian.

For an IHC Change of Provider, a request may only be submitted by the beneficiary, Power of Attorney, or Legal Guardian.

An ACH facility may submit a Change of Provider request if a current PCS beneficiary is admitted.

If a beneficiary needs assistance in selecting an 'Alternate Preferred Provider', a Liberty Healthcare Customer Support Representative can assist. Liberty Healthcare will confirm all Change of Provider requests with the beneficiary or legal guardian.

If there is no change in the Beneficiary's medical condition or service location, an assessment is not typically conducted when a beneficiary changes provider. However, if it has been more than 365 days since the last conducted assessment a reassessment would be needed.

What do you consider an appropriate time frame to get the form completed by the physician's office?

The Beneficiary must have seen their treating physician's visit within 90 days of the when the referral is received by Liberty Healthcare.

Could you email us a copy of the PowerPoint?

The presentation is posted on at www.nc-pcs.com in the Training tab.

During an assessment in a Supervised Living (.5600c) and when reviewing Diagnosis, are there considerations for preventative care measures? Ever granting Limited Assistance PCS hours?

Diagnosis information is captured in the assessment however regardless of diagnosis a beneficiary must have hands on assist needs in 3 of the ADLs or at least 1 extensive or greater and 1 other limited assist or greater need to qualify.

Vitals are covered under the PCS requirements, correct?

Vitals are not a part of the Liberty Healthcare PCS assessment process.

Can you clarify again how a client may be in need of increasing hours?

If a Beneficiary has a medical change of status, Section A-D on the DHB-3051 need to be completed and sent to Liberty Healthcare. Section D should describe in detail the change in medical condition which results in a need for decreased or increased hours of PCS. The Change of Status: Medical must be completed and submitted by the beneficiary's Primary Care Physician or Attending Physician.

Note: "Medical" is defined as any change in a person's health condition that results in improved or decreased ability to perform their Activities of Daily Living

After we get the referral from Liberty, we have 2 business days to accept the referral

The provider has two business days to accept the Beneficiary once the assessment is presented to the provider for review and acceptance.