# Meeting Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00-9:00 am</td>
<td>Registration</td>
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<tr>
<td>9:00-9:15 am</td>
<td>Welcome and Introductions</td>
<td>Lyneka Judkins-Executive Director; Liberty Healthcare</td>
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<tr>
<td>9:15-9:45 am</td>
<td>PCS Updates</td>
<td>Jill Elliott – Director of Operations; Liberty Healthcare</td>
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<tr>
<td>9:45 - 10:15 am</td>
<td>OCPI</td>
<td>Kay Cox-East Region, Tina Huffman-West Region; Office of Compliance and Program Integrity</td>
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<tr>
<td>10:15 -10:45 am</td>
<td>Medicaid Investigation</td>
<td>Freeman Kirby–Medicaid Investigations</td>
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<tr>
<td>10:45 – 11:15 am</td>
<td>Q &amp; A Session</td>
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<tr>
<td>11:15 – 11:30 am</td>
<td>Break</td>
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## Meeting Agenda Continued

<table>
<thead>
<tr>
<th>Time</th>
<th>Break Out Sessions I</th>
<th>Presenters</th>
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<tbody>
<tr>
<td>11:30 – 12:00 pm</td>
<td>Room A – Building a Quality Improvement Program</td>
<td>Jill Elliott – Director of Operations; Liberty Healthcare</td>
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<td>Room B – Internal Audits</td>
<td>Denise Hobson – Director of Clinical Services; Liberty Healthcare</td>
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<tr>
<th>Time</th>
<th>Break Out Sessions II</th>
<th>Presenters</th>
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<tr>
<td>12:00-1:00 pm</td>
<td>Room A – Mediations &amp; Appeal Overview</td>
<td>Denise Hobson – Director of Clinical Services; Liberty Healthcare</td>
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<tr>
<td></td>
<td>Room B – PCS 101 &amp; QiReport Overview</td>
<td>Jill Elliott – Director of Operations; Liberty Healthcare</td>
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PCS UPDATES

Presented by: Jill Elliott, Liberty Healthcare
DMA to NC Medicaid Transition

• Beginning August 1, 2018, Division of Medical Assistance (DMA) is now NC Medicaid.
• Website is updated to reflect this change.
  • NC Medicaid site is now https://medicaid.ncdhhs.gov/
• Old links will redirect to the new web pages.
• Forms and notifications are currently being updated.
• Forms referenced in today’s presentation will be referred to using new titles. i.e. current DMA-3085 will be referred to as the NC Medicaid-3085 Form.
Electronic Visit Verification (EVV)

- Estimated implementation date is January 1, 2020.
- EVV requirements do not apply to licensed residential settings (ACHs/FCHs).
- NC Medicaid will be issuing a RFI (Request for Information) for potential EVV vendors.
- Prior to issuing the RFP (Request for Proposal), NC Medicaid will host stakeholder workgroup sessions to include representation from in-home care providers, associations, and key Medicaid and State staff.
Electronic Visit Verification (EVV)

• Additional information on EVV can be found at https://medicaid.ncdhhs.gov/electronic-visit-verification

• Questions may be emailed to Medicaid.EVV@dhhs.nc.gov
Clinical Coverage 3L Policy Updates

What is new?

• Updated policy effective November 1, 2018
• Introduction of RSVP
• Requirement of a RS ID on the NC Medicaid-3051 Form for Adult Care Homes
• New email addresses
Goodbye PASRR, Hello RSVP

The Referral Screening Verification Process (RSVP) will replace the Pre-Admission Screening and Resident Review (PASRR) for Adult Care Homes, providing a more streamlined and effective process to screen Transition to Community Living Initiative (TCLI) target populations.
Clinical Coverage 3L Policy Updates

• Under Medicaid Clinical Coverage Policy 3L, section 3.2.3 (b), any Medicaid beneficiary who are referred to or seeking admission to Adult Care Homes licensed under NC General Statute (G.S.) 131D-2.4 must be referred to a LME-MCO for the Referral Screening Verification Process (RSVP).

• Adult Care Home providers licensed under G.S. 131D-2.4 will not receive a PCS assessment or prior approval without verification of a Referral Screening ID.
Clinical Coverage 3L Policy Updates

• RSVP implementation date is 11/1/2018.

• Who should be referred?
  ▪ All Medicaid-eligible individuals who are being considered for admission to an ACH licensed under G.S. 131D-2.4, with the exception of group homes.
  ▪ All Medicaid-eligible individuals requesting Personal Care Services (PCS), who reside in ACH licensed facilities under G.S. 131D-2.4, with exception of group homes.

NOTE: Beneficiaries will not be assessed for Personal Care Services (PCS) without a Referral Screening ID.
Clinical Coverage 3L Policy Updates

- RSVP Requirements
  - Effective November 1, 2018, Medicaid beneficiaries requesting an independent assessment for PCS, who reside in an Adult Care Home, are required to go through the Referral Screening Verification Process (RSVP).
  - Beneficiaries will receive a Referral Screening ID (RS ID) when the RSVP has been initiated.
  - The Referral Screening ID (RS ID) must be presented at time of submission of the NC Medicaid-3051 Form or the request will be denied.
  - Beneficiaries will not be assessed for PCS without a Referral Screening ID.
Clinical Coverage 3L Policy Updates

• Who should NOT be referred?
  ▪ Individuals who have a previous ACH PASRR prior to 11/1/18 for an ACH and enter a medical or psychiatric hospital, an acute or sub-acute rehabilitation facility, or a long-term acute care hospital for medical or psychiatric treatment and return to the ACH after treatment. They do not need an additional screen through the RSVP unless there has been a significant change in psychiatric or medical status (for those with SMI/SPMI).

  ▪ Individuals who requested to transfer from one ACH to another AND already have an ACH PASRR prior to 11/1/18. They can transfer if they are medically and psychiatrically stable.
Referral Screening Verification Process

Referral Submitted

Option #1: URL
https://www.socialserve.com/nc/rsvp
(not accessible until Nov. 1, 2018)
Option #2: Paper version can be mailed or faxed to the following locations:
Mailing Address:
Attention Mental Health Section -RSVP
Mail Service Center 3001 Raleigh, NC 27699-3001
FAX#: 919-508-0953

Liberty will review new request and if valid, will verify if a Referral Screening ID (RS ID) exists for the beneficiary.

If RS ID is present, the valid new request will be processed. If no RS ID is present, a technical denial will be issued.
Referral Screening Verification Process

Who can make a referral?
Anyone (i.e., individual consumers, guardians, family members, advocates, providers, hospitals and LME/MCO staff) may submit a referral using RSVP.

When should the referral be completed?
During hospital admission discharge planning and prior to the admission of a Medicaid-eligible individual into an ACH or prior to assessment for PCS.
Referral Screening Verification Process

• For additional training, FAQ’s, and forms, visit the NC Medicaid, TCLI website at:
  https://www.ncdhhs.gov/about/department-initiatives/transitions-community-living-initiative

• For additional questions, please contact:
  ▪ Stacey Lee, BS TCLI Diversion Lead at stacey.lee@dhhs.nc.gov or 919-715-2056; or
  ▪ Tamara Smith, PhD TCLI In-Reach Lead/RSVP Project Manager at tamara.smith@dhhs.nc.gov or 919-715-2228
Clinical Coverage 3L Policy Updates

- Beginning September 1, 2018, DMA.PCSQualityImprovement@lists.ncmail.net and DMA.PCSTraining@lists.ncmail.net will no longer be valid email addresses.

- Providers must submit Internal Quality Improvement Program Attestation (NC Medicaid-3136) Form to Medicaid.PCSQualityImprovement@lists.ncmail.net
  - Reminder : NC Medicaid-3136 Form (DMA Form 3136) is due by 12/31/2018.

- Providers must submit Session Law 2013-306 PCS Training Attestation (NC Medicaid-3085) Forms to Medicaid.PCSTraining@lists.ncmail.net
Outstanding Service Plan

Delinquent Service Plans continue to be an issue.

### Service Plan Aging

<table>
<thead>
<tr>
<th>Days Past Due</th>
<th># of Beneficiaries</th>
<th>%</th>
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<tbody>
<tr>
<td>1-30</td>
<td>237</td>
<td>43%</td>
</tr>
<tr>
<td>31-90</td>
<td>118</td>
<td>21%</td>
</tr>
<tr>
<td>91+</td>
<td>200</td>
<td>36%</td>
</tr>
</tbody>
</table>
Outstanding Service Plan Updates

- Prior Approvals (PAs) will not be made retroactive for service plans not completed timely.
- PAs are only continued with the completion of an assessment, acceptance of the referral, and completion of the Service Plan.

D O N’ T
F O R G E T
Outstanding Service Plans - Requirements

- Required each time an assessment is completed or referral accepted.
- Required any time there is a change in hours (annual, MCOS, COS, mediation, court settlement).
- Required when providing PCS under Maintenance of Service (MOS).
- Must be completed within 7 business days of acceptance.
- Must be signed and uploaded to ‘Supporting Docs’ within 14 business days from completion of Service Plan.
- PAs will not be generated until the on-line service plan is entered into the portal and validated.
- Not a Plan of Care.
- Requirement details can be found in Clinical Coverage Policy 3L, section 6.1.4.
Outstanding Service Plans

- Office of Compliance and Program Integrity (OCPI) will send a letter to providers identified as non-compliant, notifying them that they are at risk for further action identified by OCPI if non-compliance continues.
- Providers will be given 5 business days from the date the letter is received to complete the Service Plan in QiRePort.
- Providers who remain non-compliant are subject to further action identified by OCPI.
Forms, Forms, and more Forms

Important Forms

- NC Medicaid-3085: Session Law 2013-306 PCS Training Attestation Form
- NC Medicaid-3136: Internal Quality Improvement Program Attestation Form
- NC Medicaid-3137: ICD-10 Transition Form
NC Medicaid-3085: Session Law 2013-306 PCS Training Attestation Form

Who is required to submit this form?

Any provider servicing or who plans to service a beneficiary that receives additional hours mandated by N.C. Session Law 2013-306.

NOTE: Providers who are non-compliant with submission of the NC Medicaid-3085 Form are subject to audit by OCPI.
NC Medicaid-3136: Internal Quality Improvement Program Attestation Form

- Required to be submitted to NC Medicaid by December 31st each year;
- There is no standard regarding the format of the required documents;
- All documents are not required to be submitted to NC Medicaid, just the NC Medicaid-3136 Form.
- Providers who are non-compliant with submission of the NC Medicaid-3136 Form are subject to audit by OCPI.
Outstanding NC Medicaid 3137: ICD-10 Transition Forms

- Beneficiaries who began receiving PCS services prior to October 1, 2015 were required to submit a NC Medicaid-3137 Form to Liberty Healthcare of N.C. no later than the date of their next scheduled annual assessment.

- The NC Medicaid-3137 Form must be completed by the beneficiary’s primary care physician or the practitioner providing care for the medical, physical, or cognitive condition causing the functional limitation.

- If a New Request or Medical COS was received after 10/1/2015 with valid ICD-10 codes, that fulfills the requirement for a transition form.

- As of June 1, 2018, QiReport no longer provides a blank NC Medicaid-3137 Form with the annual reminder notification.
Outstanding NC Medicaid 3137: ICD-10 Transition Forms

If the provider accepts a new beneficiary, it is their responsibility to confirm that the NC Medicaid 3137: ICD-10 Transition Form has been completed and provided to Liberty.

To confirm this requirement has been met, the provider should refer to their ‘Caseload’ report in QiReport.
Outstanding NC Medicaid 3137: ICD-10 Transition Form

- Completed NC Medicaid-3137 Forms can be uploaded to Supporting Documents or faxed to 919-307-8307 or 855-740-1600 (new fax numbers).
- If unable to obtain form after 3 documented outreach attempts, provider may contact Liberty for assistance.
- When contacting Liberty, the provider must provide the following:
  - Physician Name
  - Practice Name
  - Practice Phone and Fax Number
  - Beneficiary DOB or MID
  - Dates of all contact attempts
Outstanding NC Medicaid 3137: ICD-10 Transition Form

Outstanding ICD-10 Transition Forms

IHC: 892
ACH: 728

Total Outstanding: 1620

45%
55%
Location of Forms

All forms with instructions can be found in the following locations:

1. Liberty website: http://nc pcs.com/Medicaid-PCS-forms/

2. NC Medicaid PCS webpage under “Forms.”
   http://www2.ncdhhs.gov/NC Medicaid/pcs/pas.html
Office of Compliance and Program Integrity Updates

Presented by: Office of Compliance and Program Integrity
Office of Compliance and Program Integrity

Kay Cox, RN, CPIP
Nurse Consultant
East Team Investigations

Tina Huffman, RN, BSN, CPIP
Nurse Consultant
West Team Investigations

October, 2018
Objectives

• Participant will gain an understanding of the Office of Compliance and Program Integrity’s (OCPI’s) role and responsibilities with the Division of Health Benefits (DHB)

• Participant will have a better understanding of fraud/waste/abuse

• Participant will obtain an overview of the review process
VISION

MISSION

VALUES
**Vision**

Ensuring North Carolina’s Medicaid Program delivers intended results

**Mission**

Protect the resources of DHB by reducing or eliminating fraud, waste and abuse through the NC Medicaid program

**Values**

✓ Accountability
✓ Integrity
✓ Collaboration
✓ Innovation
✓ Communication
Office of Compliance and Program Integrity

• Federally mandated
• Protect the resources of DHB by reducing or eliminating fraud, waste and abuse through the NC Medicaid program
• Ensures North Carolina’s Medicaid Program funds are utilized appropriately
• Protects the “Integrity” of the Medicaid Program
OCPI Responsibilities

Include (but are not limited to):

• Receiving complaints and referrals of possible provider or beneficiary fraud, waste or program abuse

• Detecting/identifying potential provider fraud, waste and program abuse

• Conducting investigations of suspected provider fraud, waste, program abuse or noncompliance
Program Integrity Authority

- North Carolina General Statutes
  N.C.G.S. 108A and 108C

- Medicaid State Plan

- North Carolina Administrative Code (NCAC)
  10A NCAC 22F

- State Clinical Policies and Bulletin Articles
What is Fraud?

**Intentional** deception or misrepresentation made by a person with the **knowledge** that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
What is Waste?

Cost that could have been avoided without a negative impact on quality
Examples of Waste

Beneficiary has a small cut that the aide is qualified to perform a dry dressing change daily for 5 days. The aide takes out an entire box of gloves when 10-12 pair would be sufficient for this to heal in 7-10 days.
What is Abuse?

Provider abuse includes any incident, services or practices that are inconsistent with acceptable fiscal or medical practice and result in an unnecessary cost to the Medicaid program or its beneficiaries, or which are not reasonable or necessary.
Examples of Fraud/Abuse

• Providers who deliberately submit claims for services not actually rendered

• Providers submitting claims for payment for which there is no supporting documentation available.

• Billing for care and services that are provided by an unauthorized or unlicensed person
Public Concern

• It is an important mission of OCPI to identify, investigate, prevent and recover money billed improperly to Medicaid.

• Fraud and Abuse cost taxpayers millions of dollars each year. Whether you are a Medicaid provider, beneficiary or simply a taxpayer, fraud and abuse cost YOU.
As of 7/1/18, there were 2,037,412 individuals enrolled in the Medicaid/Children’s Health Insurance Program (CHIP) program.

Sources
Medicaid in Terms of Spending

**Enrollment**
- Other: 20%
- ABD: 25%
- Children: 55%

**Spending**
- Other: 13%
- ABD: 63%
- Children: 24%

Aged, Blind and Disabled (ABD)
Referral Sources

Complaints are sent to OCPI from several resources:

• Beneficiaries
• General public
• Providers
• Employees
Other Sources of Referrals

• Referrals from State and Federal Agencies
• Division of Social Services (DSS)
• Department of Health and Human Services (DHHS)
• Division of Health Benefits (DHB) Program Consultants
• Center for Medicare and Medicaid Services (CMS)
• Office of State Auditors (OSA)
Types of Reviews

- Desk Review
- On Site Review-Announced
- On Site Review-Unannounced
- Self Audits
OCPI Desk Review

• Currently most common type of review is a Post Pay Review
• Provider is notified of review via written request for records by certified mail
• Time frame and instructions for submission will be included within the request
• Contact information is listed for provider questions
• The written request for records includes description of items requested and required for the review

OCPI uses **correspondence address** listed in NCTRACKS
Onsite Review Announced

Provider is given advance notification of OCPI or Post Pay contractor site visit via:

- fax
- telephone call
- email

(# days advance notice may vary per scope of review)
Onsite Review Unannounced

- OCPI or Post Pay Contractor arrives on day of review to provider site (no prior fax, letter, phone call or email)
- Introductory discussion with Provider Management and staff
- Medical Records Request provided
- Intro to Provider Files & Setup for OCPI Staff
- Exit Discussion per Scope of Review
- OCPI’s Goal - As Minimally Disruptive as Possible
For every date of service (DOS) being reviewed, each category below is addressed:

• Services Authorized/Approved in Accordance with Program Requirements.
• Documentation Supports Billed Codes/Modifiers/Claim Details.
• Licensing/Training/Credentialing Requirements Met.
• Required and/or Covered Components of Service Completed/Provided in accordance with Clinical Coverage Policy #3L.
• Documentation supports clinical appropriateness in accordance with clinical coverage policy requirements.
Common Errors Found in Reviews

✓ Licensing Requirements
✓ Staff Credentials
✓ Staff Training
✓ Background Verification
✓ Competency Verification
Self Audits

Medicaid and Health Choice providers are encouraged to:

• implement necessary policies, processes and procedures to ensure compliance with federal and state laws, regulations, and policies relating to the Medicaid and Health Choice Programs

• voluntarily disclose any overpayments or inappropriate payments of Medicaid and Health Choice funds

Call the Business Intake Center (BIC) at 919-814-0181 if you need a Self Audit Packet
Other Types of Review

Prepayment Review

- The contractor for the Prepayment Review is currently the Carolina Center for Medical Excellence (CCME)
Prepayment Review

Provider claims may be subject to prepayment review due to:

• Credible allegation of fraud

• Identification of aberrant billing practices as a result of data analysis or investigations

• Other grounds as listed by the Department
Prepayment Review Process

- Provider receives written notification
- Claims temporarily pend in NCTRACKS
- Provider submits documentation to DHB contractor (CCME)
- Documentation is reviewed
- Provider must obtain 70% accuracy rate with no less than 50% of the average billing for 3 consecutive months
Most Common Prepayment Review Findings for PCS

• Billing units in excess of what was provided per documentation

• Revisions made to timesheets, plans of care (POC), supervisory visits, etc. that do not meet regulatory requirements

• Staff not certified or trained when needed to perform certain procedures

• Supervisory visits not completed per policy

• Aide not following POC and no deviation notes present in the record

• Signature and date issues on time sheets
Most Common Error

Not following Clinical Policy

https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies
Tips for Providers

• Always check billing before it is submitted
• Assure you have the documentation to support your billing
• Update NCTRACKS with any changes
• Do background checks, know the staff you are hiring
• Make sure your staff are trained
• Read and understand the Clinical Coverage Policy
• Ask questions
Tips for Providers

• Know your beneficiaries
• Maintain good record keeping
• When records are requested, send them
• Cooperate with all announced or unannounced site visits, audits, investigations, post payment reviews or other program integrity activities. Failing to grant prompt and reasonable access or failing to timely provide documentation may result in termination from the NC Medicaid or NC Health Choice program (N.C.G.S.108C-11)
DHB-OCPI Vendors

- Health Management Services (HMS)
- Public Consulting Group (PCG)
- Carolina Centers for Medical Excellence (CCME)
Reporting Fraud/Waste/Abuse

Website:
https://www.ncdhhs.gov/contact/report-fraud

Medicaid Fraud, Waste and Program Abuse Tip Line: 1-877-362-8471
Contact Information

Kay Cox, RN, Nurse Consultant
East Team Investigations
Kay.cox@dhhs.nc.gov  Phone #: 919-980-2070

Tina Huffman, RN, BSN, Nurse Consultant
West Team Investigations
Tina.huffman@dhhs.nc.gov  Phone #: 336-932-2115
Medicaid Investigations

Presented by: Freeman Kirby, Medicaid Investigations
N.C. Medicaid Investigations Division (MID)
What is MID?

➢ A Division of the North Carolina Attorney General’s Office

➢ We are the **Medicaid Fraud Control Unit** ("MFCU") for N.C.
What is MID?

➢ Created in 1979 pursuant to federal legislation

➢ 50 MFCUs across the United States

➢ Oversight by U.S. DHHS-OIG

➢ 75% federally funded
What is MID’s Jurisdiction?

1. Fraud in the administration of the Medicaid Program
2. Fraud perpetrated by Medicaid Providers
3. Patient physical abuse in Medicaid facilities
4. Misappropriation of Patient funds in Medicaid facilities

* NOT recipient fraud*
Who Works for MID?

➢ When fully staffed – 59 employees
➢ Prosecutors and civil attorneys
➢ Sworn and non-sworn investigators
MID’s recent results

- Fiscal year 2018 total recoveries of $15,191,215.18
- Twenty-one criminal convictions in 2018
MID’s Interest in PCS?

- We exercise oversight
- Examples of MID’s areas of concern:
  - Services not provided
  - Upcoding units of service
  - False records
  - Kickbacks
Example of Recent Case – Rosa Powell

➢ Rosa Powell was a Registered Nurse
➢ Owner of Designing the Future Home Care
➢ Business based in Pitt County
➢ Participated in Medicaid Program
➢ Referred to MID by DHHS-DMA-OCPI
Rosa Powell

➢ Referral alleged:

➢ billing Medicaid for in-home services that were not provided

➢ falsification of service documents

➢ paying kickbacks to recipients for referrals
Rosa Powell

➢ MID investigation found:
  ➢ Powell instructed in-home aides to sign time sheets even though the aides had not provided any services to the clients
  ➢ Powell billed Medicaid for PCS services that were not provided
Rosa Powell

➢ Powell also paid kickbacks to recipients:
STATE OF NORTH CAROLINA
COUNTY OF PITT

STATE OF NORTH CAROLINA

vs.

ROSA MARIE POWELL,
Defendant.

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
ILE NO: 16 CRS 58050

INDICTMENT
I. ACCESSING A GOVERNMENT COMPUTER
TO DEFRAUD OR OBTAIN PROPERTY
II. SCHEME OR ARTIFICE TO DEFRAUD BY
MEDICAL ASSISTANCE PROVIDER
III. OFFERING OR PAYING REMUNERATION
Rosa Powell Guilty Plea – 10/30/17

- One count of felony scheme to defraud by a medical assistance provider
- One count of felony anti-kickback violation
Rosa Powell’s sentence:

- Powell placed on supervised probation for 60 months
- Will face two consecutive prison sentences of 6 to 17 months if she violates her probation
- Powell must pay Medicaid restitution of $49,438.48
Rosa Powell’s sentence (cont.):

- Powell must pay cost of court and attorney’s fees.
- Powell was ordered not to own or manage any business that submits billing claims to the government while on probation.
- Powell must fully cooperate with the government in any further investigation.
Questions for the Audience:

➢ Why should such conduct be punished?

➢ Who is harmed by it?
Thank You!

To report suspected Medicaid Provider fraud:

Medicaid Investigations Division
919-881-2320
5505 Creedmoor Road
Raleigh, NC 27612
Question and Answer Session
BREAK

Leading Today, Empowering Tomorrow
Building A Quality Improvement Program

Presented by: Jill Elliott, Liberty Healthcare
What is Quality Improvement?

“Quality improvement (QI) is a systematic, formal approach to the analysis of practice performance and efforts to improve performance”. – American Academy of Family Physicians

Understanding and properly implementing QI is essential to a well-functioning agency or facility, and is necessary for any agency or facility interested in improving efficiency, beneficiary safety and satisfaction, and clinical outcomes.
Why is a Quality Improvement Program Important?

- Builds a culture of excellence
- Defines your priority focus areas
- Validates program compliance
- Tells your story as a provider
- Customer service-centric
Where Do I Start? Program Requirements

In accordance with Clinical Coverage Policy 3L Section 7.7, The PCS Provider Organization shall:

a. Develop and update at least quarterly, an organizational Quality Improvement Plan or set of quality improvement policies and procedures that describe the PCS Continuous Quality Improvement (CQI) program and activities;

b. Implement an organizational CQI program designed to identify and correct quality of care and quality of service problems;

c. Conduct at least annually a written beneficiary PCS satisfaction survey for beneficiaries and their legally responsible person; and

d. Maintain complete records of all CQI activities and results.
Where Do I Start?  Program Requirements

e. PCS Providers **shall submit by December 31st of each year** an attestation to NC Medicaid that they are in compliance with “a through d” of this subsection. (see NC Medicaid-3136 Form)

f. Provide these documents to NC Medicaid or a DHHS designated contractor upon request in conjunction with any on-site or desktop quality improvement review
NC Medicaid-3136: Internal Quality Improvement Program Attestation Form
How Do I Develop a Quality Improvement Plan?

1. Consider developing a quality improvement team.
   - Agency Director
   - RN Supervisor
   - Resident Care Coordinator
   - Direct care staff member
   - Office staff member (billing or customer relations staff)
   - Staff development /trainer
How Do I Develop a Quality Improvement Plan?

2. Define QI Team responsibilities:
   - Who will facilitate meetings?
   - How often will the team meet?
   - Mission and vision defined.
   - Who and how will meetings be recorded?
   - What QI methodology will be adopted?
How Do I Develop a Quality Improvement Plan?

3. Define your QI plan

- Start by asking questions that support customer service and program requirements.
- What do we want to know?
- What is important for our customer?
- How do we know we are providing great service?
- How can we validate compliance with program requirements/regulations?
- How will we measure our performance?
- What do we consider an acceptable target of performance to be?
- How will we communicate our results?
Possible Key Performance Measures for a Successful QI Plan

Think about what you are already collecting data for:

1. Customer Satisfaction Survey
2. Monthly chart reviews
3. 90 day RN Supervisory visits
4. Complaint Log/Tracker
5. Training and orientation validation (competency)

*These are intended to be examples only and are not endorsed by NC Medicaid or Liberty Healthcare Corporation of NC.*
Customer Satisfaction Surveys

- Decide who is responsible to deliver/mail/track;
- Develop what questions to include;
- Decide what scoring will look like (i.e., Ranking 1-5, agree/disagree, etc.);
- Will it include a comment section;
- Will it require a signature or be anonymous;
- Who will review and compile results;
- What will be the process for follow up; and/or
- Will we recognize staff for their accomplishments?
*This sample survey serves as an example of a Customer Satisfaction Survey and is not endorsed by NC Medicaid or Liberty Healthcare Corporation of NC.*
Monthly Chart Reviews

- Develop a chart review tool/checklist
- Establish appropriate sample sizes
- Assign review responsibilities and timeline of completion
- Include regulatory requirements as a guide for record review and compliance validation, such as PCS Clinical Coverage Policy 3L Section 7.10.b.8 (a-g)
- Include review of required Supervisory visits and documentation in accordance with PCS Clinical Coverage Policy 3L Section 7.10.(a-c)
- Consider other external regulatory requirements and include as an all inclusive review
Complaint Tracking

- Maintain detailed complaint logs
- View as opportunity to improve customer service
- Develop log or tracker to facilitate recording and efficiency with identifying trends
- Review regularly, as defined by your QI Team, to determine performance improvement actions needed
- Share with staff to foster a culture of customer-centric service provision
Maintaining QI Activities & Results

• QI Team determines record keeping practices
• Determine who is responsible for maintenance
• Assign/decide who has access
• Critical to share results regularly with staff
• Presentation method can be storyboarding, Quality Improvement Manual, or combination
• Most importantly, use the data to improve quality of services provided
• Let it tell your story
### Sample: Complaint Log Tracker

<table>
<thead>
<tr>
<th>MID</th>
<th>COMPLAINTANTS NAME</th>
<th>PHONE</th>
<th>CALLER</th>
<th>COMP_DATE</th>
<th>Number of Business Days to Resolution</th>
<th>Complaint Overview</th>
<th>Supervisor follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td>L2345678 9K</td>
<td>Jan Doe</td>
<td>111-222-3333</td>
<td>Beneficiary</td>
<td>10/1/2018</td>
<td>1</td>
<td>Beneficiary called to report aide Susie Que did not report to work and did not call.</td>
<td></td>
</tr>
</tbody>
</table>

*This sample Complaint Log Tracker serves as an example only and is not endorsed by NC Medicaid or Liberty Healthcare Corporation of NC.*
Resources for Successful QI Plan Development

- [https://nc-pcs.com/Medicaid-PCS-forms/](https://nc-pcs.com/Medicaid-PCS-forms/)
  PCS Forms: 3136 form with instructions
  PCS Clinical Coverage Policy 3L
- [http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx](http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx)
  Quality Improvement tools, methodologies, charts
  PCS Provider Manual, Chapter 7 (coming soon)
Questions

[Image of clouds in the shape of question marks]
PCS Internal Audit

• In spring of 2015, PCS underwent an internal audit conducted by Office of the Internal Auditor (OIA). This audit concluded in July of 2015.

• Two areas of concern identified by OIA were Supervisory Visits and Aide Training requirements.

• As a result of the PCS program internal audit, NC Medicaid began conducting audits of PCS providers in January 2016.
PCS Internal Audit

• NC Medicaid conducts the PCS internal audits by randomly selecting between a total of 30-50 beneficiaries for review of Supervisory visits and/or Aide Training Requirements.

• NC Medicaid requests specific documents from Provider via certified mail for RN Supervisory Visits and PCS Aide Training.

• Providers have ten business days from the date of the letter to submit documentation via fax to NC Medicaid.

• NC Medicaid also reviews their internal databases for provider submission of the NC Medicaid-3085 and NC Medicaid-3136.

• Providers may request the results of their audit three weeks after submission of their documentation.
PCS Internal Audit Process Flow

1. PM Receives random sample of Beneficiaries for identified Month
2. Forwarded to NC Medicaid Staff
3. NC Medicaid verifies Provider Contact Information
4. NC Medicaid Requests via certified mail specific documents from Provider for RN Supervisory Visits and PCS Aide Training
5. Faxed to NC Medicaid within 10 Business Days by Provider
6. NC Medicaid Completes QI Parameter Review Tool for each Beneficiary in sample
7. Results will be documented internally by NC Medicaid
8. NC Medicaid Review of Provider Compliance
9. Providers deemed non-compliant are submitted to PI
10. Providers may request the results of their audit three weeks after submission of documentation
PCS Internal Audit

- The PCS internal audit is an independent audit conducted by NC Medicaid PCS Nurse Consultants.
- The most recent audit was conducted in June of 2018.
- A randomized selection process was used to select 30 providers for the PCS Internal Audit.
- 15 Supervisory Visit Audit Letters were mailed to providers and 15 Aide Training Documentation Letters were mailed to providers.
- Findings of non-compliance with Clinical Coverage Policy 3L and the associated PCS Internal Audit are reported to the Office of Compliance and Program Integrity (OCPI).
PCS Internal Audit: Aide Training

• Documentation on Aide Training Requirements is audited based on PCS Clinical Coverage Policy 3L Section 6.1.2 (a – g).

• Personnel records of aides providing PCS must provide documentation of training in, at minimum, each of the following content areas:
PCS Internal Audit: Aide Training

A. Beneficiary Rights;

B. Confidentiality and privacy practices;

C. Personal care skills, such as assistance with the following ADLs:
   1. Bathing
   2. Dressing
   3. Mobility
   4. Toileting; and
   5. Eating
D. In-home and Residential Care Aides providing services to beneficiaries receiving hours in accordance with Session Law 2013-306, have 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 of language skills. Providers shall submit an attestation to NC Medicaid that they are in compliance with this requirement. The attestation form (NC Medicaid-3085) and instructions are located on the NC Medicaid PCS webpage.
E. Documentation and reporting of beneficiary accidents and incidents;
F. Recognizing and reporting signs of abuse and neglect; and
G. Infection control.
Dear Provider,

As part of our DMA quarterly internal quality improvement program for Personal Care Services (PCS), we are requesting documentation of mandatory competency training records. The records requirement is documented in NC DMA, State Plan PCS Clinical Coverage Policy 3E, Section 6.1.2, “PCS Paraprofessional Aide Minimal Training Requirements.” Please provide documentation of aide training in the following areas:

- a. Beneficiary rights;
- b. Confidentiality and privacy practices;
- c. Personal care skills, such as assistance with bathing, dressing, mobility, toileting, and eating;
- d. Requirements of Session Law 2013-306 including submission of the DMA-3082;
- e. Documentation and reporting of beneficiary accidents and incidents;
- f. Recognizing and reporting signs of abuse and neglect; and,
- g. Infection control.

Submit documentation of the training credentials listed above, including corresponding aide task sheets for August 18, 2017 for all aides caring for the following beneficiary:

Name: 

Medicaid ID:

*For adult care home providers, include all the requested documentation for aides on first shift only.*
PCS Internal Audit: Supervisory Visits

- Documentation on Supervisory visits is audited based on PCS Clinical Coverage Policy 3L Section 7.10 b. (1-9).
- The in-home PCS provider shall ensure that a qualified RN Nurse Supervisor conducts a RN Supervisory visit to each beneficiary’s primary private residence location every 90 calendar days (Note: a seven calendar day grace period is allowed). Two visits within 365 calendar days must be conducted when the in-home aide is scheduled to be in the primary private residence. The RN Supervisor shall:
PCS Internal Audit: Supervisory Visits

1. Confirm that the in-home aide is present or has been present as scheduled during the preceding 90 calendar days;
2. Validate that the information documented on the aide’s service log accurately reflects his or her attendance and the services provided;
3. Evaluate the in-home aide’s performance;
4. Identify any changes in the beneficiary’s condition and need for PCS that may require a change of status review;
5. Request a change of status review if the beneficiary’s service plan exceeds or no longer meets the beneficiary’s needs for ADL assistance;
6. Identify any new health or safety risks that may be present in the primary private residence;
7. Evaluate the beneficiary’s satisfaction with services provided by the in-home aide and the services performed by the home care agency;
8. Review and validate the in-home aide’s service records to ensure that:
   
   A. Documentation of services provided is accurate and complete;
   
   B. Services listed in the service plan have been implemented;
   
   C. Deviations from the service plan are documented;
   
   D. Dates, times of service, and services provided are documented on a daily basis;
   
   E. Separate logs are maintained for each beneficiary;
   
   F. All occasions when the beneficiary is not available to receive services or refused services for any reason are documented in the service record along with the reason the beneficiary was not available or refused services;
   
   G. Logs are signed by the in-home aide and the beneficiary after services are provided on a weekly basis.

9. Document all components of the supervisory visits: the date, arrival and departure time, purpose of visit, findings and supervisor’s signature.
PCS Internal Audit: Supervisory Visits

As part of our DMA quarterly internal quality improvement program for Personal Care Services (PCS), we are requesting documentation of in-home PCS supervisory visits performed by a qualified RN Nurse Supervisor.

Supervisory visits should be conducted per State Plan PCS Clinical Coverage Policy 3L, Section 7.10 (b), “Supervisory Visits in Beneficiary Private Residences.” Submit documentation of all RN Supervisory Visits within the last two years from the date of this letter for the following beneficiary:

Name: ___________________________ Medicaid ID: ___________________________

Documents should be faxed to 919-715-0102 within ten business days of the date on this letter.

For any questions regarding this process, please contact DMA at 919-855-4360.
PCS Internal Audit: NC Medicaid-3085 and NC Medicaid-3136

- Auditing of the NC Medicaid-3085 and NC Medicaid-3136 is included with review of Aide Training Documentation and Supervisory Visits.

- Providers who have provided services to beneficiaries receiving additional safeguard hours through Session Law 2013-306 without submitting their NC Medicaid-3085 will be referred to OCPI and at risk for recoupment.

- Providers who have not submitted their NC Medicaid-3136 will be referred to OCPI for additional education and potential investigation.
Aide Training

- 3 providers were referred to OCPI for non-compliance with Section 6.1.2 of Clinical Coverage Policy 3L

Supervisory Visits

- 1 provider was referred to OCPI for non-compliance with Section 7.10 of Clinical Coverage Policy 3L

Non-Responsiveness

- 7 providers referred to OCPI for non-responsiveness

Total Referrals to OCPI: 11
Aide Training

- 3 providers were referred to OCPI for non-compliance with Section 6.1.2 of Clinical Coverage Policy 3L

Supervisory Visits

- 4 providers were referred to OCPI for non-compliance with Section 7.10 of Clinical Coverage Policy 3L

DMA-3085 & DMA-3136

- 10 providers were referred to OCPI for non-compliance with submission of forms

Non-Responsiveness

- 5 providers were referred to OCPI for non-responsiveness

**Total Referrals to OCPI: 22**
PCS Internal Audit: Things To Remember

• Providers should ensure that contact information in NCTracks is current and updated so that they receive all mail and requests from NC Medicaid as well as other regulatory agencies.

• Providers must remember to submit corresponding aide task sheet documentation when responding to the audit request pertaining to Aide Training Documentation.

• For Adult Care Home Providers, information regarding PCS Aide Training Documentation should be submitted for first shift aides only.
Questions
Mediations & Appeals

Presented by: Denise Hobson, Liberty Healthcare
Reconsideration Process – A Review
Beneficiaries 21 and older who receive an initial approval for less than 80 hours per month may submit a NC Medicaid-3114: Request for Reconsideration of PCS Authorization form to the IAE (Liberty Healthcare) if they do not agree with the initial level of service determined.

*Section 5.6 Reconsideration Request for Initial Authorization for PCS*
Reconsideration Process – A Review

When is reconsideration appropriate?

✓ Request for increase in hours are not based on a Change of Status; and

✓ The beneficiary is able to provide supporting documentation that supports why additional authorized hours of PCS is needed.
The Process:

1. Beneficiary sends request between day 31 and 60.
2. RP processes the request. UTP letter sent on all incomplete requests.
3. Nurse assessor reviews request and makes determination if face to face is needed.
4. If assessment is needed, this follows the normal scheduling process. If not, then a derivative assessment is completed.
5. Assessment results are sent to the beneficiary.
## Process Timeframe:

<table>
<thead>
<tr>
<th>Action</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>RP processes request</td>
<td>2 business days</td>
</tr>
<tr>
<td>Nurse Assessor reviews request</td>
<td>3 business days</td>
</tr>
<tr>
<td>Re-assessment completed (if required)</td>
<td>14 business days</td>
</tr>
<tr>
<td>Results sent to beneficiary</td>
<td>5 business days</td>
</tr>
</tbody>
</table>
### Appeal Rights?

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Appeal Rights?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours stay the same</td>
<td>Yes</td>
</tr>
<tr>
<td>Hours increase</td>
<td>No</td>
</tr>
<tr>
<td>Initial request had a completed attestation but did not get an award over 80</td>
<td>Yes</td>
</tr>
</tbody>
</table>
A look into the appeals process
Beneficiary Right to Due Process

- PCS beneficiaries have the legal right to due process.
- Beneficiaries who have received a denial, reduction, termination, or suspension of PCS must receive written notice of the adverse decision and have the opportunity for a fair hearing.
- Liberty sends all adverse decision notifications via USPS Priority Mail; this mail is tracked for delivery, but does not require a signature.
Beneficiary Right to Due Process

Filing the Appeal

- If the beneficiary decides to appeal, the beneficiary or their legal representative must sign and date the appeal request form and send it to the Office of Administrative Hearings (OAH) within 30 days of the date the notice was mailed.

NOTE: Providers may not file appeals on the behalf of the beneficiary. Providers may be listed as the representative on the appeal request form and may assist in filing the appeal. In addition, The Hearing Request form must be received by the OAH within 30 days from the date of the adverse notice for the beneficiary to receive Maintenance of Service (No exceptions).

- The OAH may be contacted to validate that the appeal request has been received and the date it was received.
Due Process: Mediation

- Mediation is an informal hearing process for appeals and occurs prior to a court hearing.
- The purpose of mediation is to understand why the decision was made and to attempt to reach a resolution to the appeal that is mutually acceptable to the beneficiary and to NC Medicaid, through a confidential and legally binding proceeding facilitated by a mediator.
- Most of the mediation discussions occur over the telephone, but the beneficiary does have the option to participate in person at the local mediation center if they so choose.
Due Process: Mediation

- A mediation is conducted with the beneficiary/legally responsible party and/or identified authorized representative, third-party mediator, and Liberty Mediation Nurse.
- EPSDT mediations are conducted with the legally responsible person and/or identified authorized representative, third-party mediator, and a NC Medicaid Nurse Consultant.
- During the scheduling of the mediation, the third-party mediator should notify the beneficiary that they may provide supporting medical documentation to Liberty Healthcare, prior to the mediation.
- Supporting medical information that supports the need for PCS will be reviewed and considered.
Due Process: Mediation

- If the mediation results in a resolution that is satisfactory to both parties, the appeal will be dismissed.
- If an offer of settlement hours is made and the beneficiary accepts, both the beneficiary and the beneficiary’s provider of choice will receive a notification letter that lists the new number of authorized hours. This authorization will remain valid until the beneficiary’s next independent assessment.
- If the beneficiary withdraws his or her appeal, the original decision (reduction in hours or denial of services) will remain valid.
- If it is determined that the beneficiary may be eligible for a 20 hour or more increase in awarded hours, or when necessary, a new assessment will be offered.
Due Process: Mediation

- Beneficiaries are not required to participate in mediation. The beneficiary may choose instead to request that the case go straight to hearing before an Administrative Law Judge.

- If the beneficiary does wish to participate in mediation in an effort to resolve the appeal, the mediation session must be completed within 25 calendar days of the date that OAH received the beneficiary’s Request for Hearing form.

- For example, if OAH received the beneficiary’s Request for Hearing form on June 1, the mediation process should be completed by June 26.
Due Process: Mediation

- If the beneficiary does not accept the outcome of mediation, the mediator will file an “impasse” decision with OAH. The case will then proceed to the next stage, which is a hearing before an Administrative Law Judge.
- If the beneficiary or designated representative accepts an offer of mediation and then fails to attend mediation without good cause, OAH is required to dismiss the appeal.
- If the beneficiary declines to participate in mediation, the mediator will report this outcome to OAH, and the case will proceed to hearing.
- A successful resolution to the appeal at mediation is legally binding, so the beneficiary does not have the option to re-open the case once it is settled through mediation.
Due Process: Court Hearing and Final Decision

- If the beneficiary declines the offer of mediation and desires his/her case to go straight to hearing, an OAH court hearing will be scheduled in lieu of mediation.

- A hearing will be scheduled following mediation for beneficiaries who do not accept a settlement offer during mediation or for unsuccessful mediations.

- Notices of hearing are sent via certified mail to the address(es) listed on the appeal form. This notice contains important information about the appeal process.
Due Process: Court Hearing and Final Decision

- An administrative law judge presides over the OAH hearing.

- The beneficiary may participate in the hearing over the phone, by teleconference, or may come in person to Raleigh.

- Prior to the hearing date, the beneficiary may request the hearing to be in person at a location within or near the beneficiary’s county of residence.

- The beneficiary may represent him/herself or appoint an attorney or someone else (friend, family member, etc.) to speak for him/her during the hearing.
Due Process: Court Hearing and Final Decision

- NC Medicaid will be represented by an attorney from the Attorney General’s Office. That attorney will send the documents related to the appeal, including the independent assessment if applicable, to the beneficiary or his/her designated representative prior to the hearing.

- In turn, it is expected for the beneficiary or the designated representative to send documents related to the appeal, including past independent assessments, to the attorney from the Attorney General’s Office prior to the hearing.

- The administrative law judge requires all documents to be exchanged 5 business days prior to the hearing.

- A registered nurse from NC Medicaid will be present during the hearing.

- Additionally, the registered nurse who completed the assessment may participate in the hearing.
Due Process: Court Hearing and Final Decision

- All information is presented anew, during the hearing.
- As necessary, the beneficiary may also present new information that was not shared during the mediation discussion.
- Following the hearing, the administrative law judge will enter his/her decision in the case which will be rendered as the final agency decision, with information on how to appeal further.
- The beneficiary will receive written notification of the judge’s decision.
Due Process: Providing Services during the Appeal Process

- Services may be provided during the pendency of the appeal under maintenance of service (MOS) when the request is for a continuing service.

- MOS will be provided as long as the beneficiary remains Medicaid eligible, unless they give up this right.

  - If the beneficiary appeals within **10 days of the date the notice was mailed**, payment authorization for services will continue without a break in service. Authorization for payment must be at the level required to be authorized on the day immediately preceding the adverse determination or the level requested by the provider, whichever is less.

  - If the beneficiary appeals **more than 10 calendar days but within 30 calendar days** of the date the notice is mailed, authorization for payment must be reinstated, retroactive to the date the completed appeal request form is received by the OAH. Authorization for payment must be at the level required to be authorized on the day immediately preceding the adverse determination or the level requested by the provider, whichever is less.
Due Process: Providing Services during the Appeal Process

MOS will not be authorized if:

- The beneficiary appeals more than 30 days after the date the notice was mailed, regardless of whether OAH accepts the appeal, or,

- The beneficiary’s provider submitted a continuing request for service after the current authorization for services expired. Medicaid will treat this request as an initial rather than a reauthorization or continuing request.

NOTE: MOS ends upon the issuance resolution of the appeal at OAH.
Due Process: Change of Status Requests during an Appeal

- Non-Medical/Medical Change of Status requests can be made at any time, including during the appeal process.

**NOTE:** The results of the COS assessment will be considered during the appeal process and therefore not released until the appeal is resolved.

- New Requests for services cannot be processed during an appeal and if submitted will be held until the appeal is closed before being processed.
Questions about Mediation/Appeals

Beneficiaries and/or providers may reach out to Liberty, NC Medicaid, or the Office of Administrative Hearings (OAH) at any time during the pendency of an Appeal with questions.

**Liberty Contact** – 1-855-740-1400 or 919-322-5944

**NC Medicaid Contact** – 919-855-4360 or PCS_Program_Questions@dhhs.nc.gov

**OAH** – 919-431-3000
Provider Manual

Check out Chapter 5 of the PCS Provider Manual for more details and use as a reference –

Chapter 5: The Appeal Process

In accordance with federal law, the beneficiary has the right to appeal a decision when a beneficiary’s service is denied, reduced, suspended, or terminated. Liberty Healthcare sends a notice to the beneficiary, with a copy to the provider of record that includes the following:

- An explanation of why the service was reduced, denied, suspended or terminated;
- A citation of the state law that supports the decision; and
- The effective date of the denial or reduction.

Beneficiary Only:

- A list of steps the beneficiary should follow in order to appeal the decision;
- Contact information for someone who can answer questions about the case; and
- A Request for Hearing form.

Beneficiaries who have entered a timely appeal (within 30 days of the date on the notice) are entitled to Maintenance of Service until the appeal is resolved (see “Maintenance of Service”, section 5.5 of this manual).

Questions
PCS 101 & QiReport Overview

Presented by: Jill Elliott, Liberty Healthcare
PCS 101

To provide a broad overview of Personal Care Services and Provider Requirements.
Medicaid Personal Care Services

What is it?

- Personal Care Services (PCS) is state provided assistance with Activities of Daily Living (ADLs).
- Services are provided in the Medicaid beneficiary’s primary private residence.
- Services are provided by paraprofessional aides employed by licensed home care agencies, licensed adult care homes, or home staff in supervised living homes.
- The amount of prior-approved service is based on an assessment conducted by an independent entity (Liberty Healthcare) to determine the beneficiary’s ability to perform ADLs.
Activities of Daily Living (ADLs)

- Bathing
- Dressing
- Mobility
- Toileting
- Eating
Covered Services Include:

- Assistance to help with qualifying ADL;
- Assistance with medications that treat medical conditions that effect the qualifying ADL; and
- Assistance with devices directly linked to the qualifying ADL.
Tasks Not Covered

- Skilled nursing by LPN or RN
- Respite care
- Care for pets or animals
- Yard work
- Medical or non-medical transportation
- Financial Management
- Errands
- Companion sitting
PCS Eligibility Criteria

✓ Have active Medicaid;
✓ Have a medical condition, cognitive impairment or disability that limits them from performing their activities of daily living;
✓ Be considered medically stable;
✓ Be under the care of their primary care physician or attending physician for the condition causing limitations;
✓ Have seen their treating physician within the last 90 days;
✓ Reside in a private living arrangement, or in a residential facility licensed by the State of North Carolina as an adult care home, a combination home, or a group home as a supervised living facility; and
✓ Not have a family member or caregiver who is willing and able to provide care.
How Does The Beneficiary Qualify For Services?

*The beneficiary must have at a minimum:*

- ✓ 3 of the 5 qualifying ADLs with limited assistance;
- ✓ 2 ADLs, one of which requires extensive assistance; or
- ✓ 2 ADLs, one of which requires assistance at the full dependence level.
How Many Hours Can A Beneficiary Receive?

80 Hours
- For a beneficiary who does not meet the criteria for Session Law 2013-306.

60 Hours
- EPSDT on the initial assessment hour generation.
- All EPSDT assessments go to NC Medicaid for final hour calculation/evaluation.

Up to 130 Hours
- For a beneficiary who meets the criteria for Session Law 2013-306.
PCS Requirements for Physician Referral

- A beneficiary, family or legally responsible person must contact his/her primary care or attending physician and request they complete the ‘Request for Independent Assessment for PCS Form (NC Medicaid-3051 form) in order to have an assessment for PCS.
- The form can only be completed by a MD, NP, or PA.
- The beneficiary will be required to have seen the referring physician within the last 90 days from the date on the form.
The Assessment

Once the doctor completes a NC Medicaid-3051 Form and sends it to the IAE (Liberty Healthcare), the PCS assessment will be performed by a Nurse Assessor at the beneficiary’s home or residential facility.

The Nurse Assessor will capture the following in their assessment:

- Demonstrations of a beneficiary’s ability to perform their activities of daily living (ADLS)
- Available caregivers
- Daily medicine regimen
- Diagnosis information
- Paid supports/Non Paid supports
- Special assistive tasks
- Exacerbating conditions that impact their ability to perform their ADLS
- Environmental conditions and home safety evaluation
- Beneficiary preferred providers
- Return frequency

Once the doctor completes a NC Medicaid-3051 Form and sends it to the IAE (Liberty Healthcare), the PCS assessment will be performed by a Nurse Assessor at the beneficiary’s home or residential facility.

The Nurse Assessor will capture the following in their assessment:

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- Paid supports/Non Paid supports
- Special assistive tasks
- Exacerbating conditions that impact their ability to perform their ADLS
- Environmental conditions and home safety evaluation
- Beneficiary preferred providers
- Return frequency
<table>
<thead>
<tr>
<th>Assistance Levels</th>
<th>Defined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totally Able</td>
<td>Self-perform 100% of the activity with or without assistance of aid or assistive devices and without supervision or assistance to set up supplies and environment for task.</td>
</tr>
<tr>
<td>Verbal Cueing or Supervision</td>
<td>Self-perform 100% of the activity with or without assistance of aid or assistive devices and requires supervision, monitoring or assistance to retrieve or set or supplies or equipment.</td>
</tr>
<tr>
<td>Limited Hands On Assist</td>
<td>Self-perform 50% of the activity and requires hands on assistance to complete remainder of the task.</td>
</tr>
<tr>
<td>Extensive Hands On Assist:</td>
<td>Able to self-perform less than 50% of the activity and requires hands on assist to complete remainder of activity.</td>
</tr>
<tr>
<td>Cannot Do At All:</td>
<td>Unable to perform any of the activity and is totally dependent on another person to perform the activity.</td>
</tr>
</tbody>
</table>
PCS Independent Assessment Process

Referral Request is Received

Scheduling Coordinator Schedules Appointment with Beneficiary for Assessment

Assessor visits Beneficiary Home to Complete Independent Assessment

The Selected Provider Accepts Care for the Beneficiary and Initiates Care

The Assessor Submits the Assessment for Review

If necessary, at the time of the assessment, Assessor Provides the Beneficiary with a List of Providers, the Beneficiary Can Select up to 3
Overview of the NC Medicaid-3051 Form

Personal Care Services (PCS) Request for Services forms have been consolidated into one form as of 10/1/13 and updated with ICD-10 Codes as of 10/1/15.

**NC Medicaid-3051:**
Request for Independent Assessment for Personal Care Services Attestation of Medical Need

- All PCS providers, regardless of setting, will use the NC Medicaid-3051 form.
- NC Medicaid-3051 is the only form that will allow physicians to provide written attestation to the medical necessity for up to 50 additional PCS hours per NC Session Law 2013-306.
- Download the current form at:

Completing the NC Medicaid-3051 Form

Key Information

- The NC Medicaid-3051 Form has 6 sections – A through F. You are not required to complete all of the sections of the NC Medicaid-3051 Form each time you submit the form, just those specific to type of request.

- Sections A through D must be completed by the Primary Care Physician or Attending Physician Only (page 1 & 2).

- Section E and F must be completed by the Beneficiary, Caregiver, or PCS Provider Only (page 3).

- Completion of ALL fields ensures timely processing of the submitted requests. **NOTE:** Forms received with info. fields left blank will be returned to the referring physician. If not completed timely, the request will be denied.

- Refer to the Request for Independent Assessment for Personal Care Services (PCS) Form – NC Medicaid-3051 with Instructions available at:

  http://nc-pcs.com/Medicaid-PCS-forms/DMA-3051-Request-for-Services-Instructions-and-Form.pdf
Completing PCS NC Medicaid 3051 – Change of Status Medical

Things to remember:

- The Change of Status Medical should be submitted when there is a change in the beneficiary’s medical condition; and
- 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.
Completing PCS NC Medicaid-3051 – Change of Status Medical

For Medical Change of Status Requests, Complete The Following Sections

<table>
<thead>
<tr>
<th>Section</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section A</strong></td>
<td>• Beneficiary Demographics</td>
</tr>
<tr>
<td><strong>Section B</strong></td>
<td>• Beneficiary’s Conditions That Result in Need for Assistance with ADLs</td>
</tr>
<tr>
<td><strong>Section C</strong></td>
<td>• Practitioner Information</td>
</tr>
<tr>
<td><strong>Section D</strong></td>
<td>• Change of Status: Medical</td>
</tr>
</tbody>
</table>
Completing PCS NC Medicaid-3051 – Change of Status Medical

Change of Status Medical Requests, Section D Required Fields

- Describe in detail the change in medical condition which results in a need for decreased or increased hours of PCS.

For clarification when completing the NC Medicaid-3051 form, “Medical” is defined as any change in a person’s health condition.

<table>
<thead>
<tr>
<th>SECTION D. CHANGE OF STATUS: MEDICAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete for medical change of status request only.</td>
</tr>
<tr>
<td>Describe the specific medical change in condition and its impact on the beneficiary’s need for hands on assistance (required for all reasons):</td>
</tr>
</tbody>
</table>
Completing PCS NC Medicaid-3051 – Change of Status Non-Medical

Things to remember:

- Should be submitted when –
  - Change in beneficiary’s location
  - Change in caregiver status
  - Change in days of need

- Can be submitted by the beneficiary, caregiver, legal guardian, or PCS Provider
Completing PCS NC Medicaid-3051 – Change of Status Non-Medical

Non-Medical Change of Status Request, Complete The Following Sections of Page 3 only:

**Top Section**

**Beneficiary Demographics**
(all fields required to be completed)

**Section E**

**Change of Status: Non-Medical**

---

**FOR NON-MEDICAL CHANGE OF STATUS OR CHANGE OF PROVIDER REQUESTS, COMPLETE THIS PAGE ONLY.**

**Step 1**
- Please select one: □ Change of Status: Non-Medical □ Change of PCS Provider □ Date of Request: ___/___/___
- Beneficiary’s Name: First: ___________ MI: ___________ Last: ___________ DOB: ___/___/___
- Medicaid ID: ___________ Gender: □ M □ F Language: □ English □ Spanish □ Other: ___________
- Address: __________________________________________________________________________
- City: ___________ State: ___________ Zip: ___________ Phone: ___________
- County: ___________ Alternate Contact (Non-PCS Provider)/Parent/Guardian (required if beneficiary < 18): Name: ___________
- Relationship to Beneficiary: ___________ Phone: ___________
- Beneficiary currently resides: □ At home □ Adult Care Home □ Hospitalized/medical facility □ Skilled Nursing Facility □ Group Home □ Special Care Unit (SCU) □ Other: ___________ □ C date (Hospital/SNF): ___/___/___

**SECTION E, CHANGE OF STATUS: NON-MEDICAL**

Requested By (select one): □ PCS Provider □ Beneficiary
- Responsible Party: □ Guardian □ Legal Power Of Attorney (POA) □ Family (Relationship): ___________

Requestor Name: _______________________________________________________________________

PCS Provider NPI: ___________ PCS Provider Locator Code#: ___________ (three digit code)

Facility License #: (if applicable) ___________ License Date (if applicable) ___________ (mm/dd/yyyy)

Provider Contact Name: ___________________________________________________________________

Contact’s Position: ___________________________________________________________________

Provider Phone: ___________ Provider Fax: ___________ Email: ___________________________________________________________________

Reason for Change in Condition Requiring Reassessment:
- □ Change in beneficiary’s location affecting ability to perform ADLs □ Change in caregiver status
- □ Change in days of mood □ Other: ___________

Describe the specific change in condition and its impact on the beneficiary’s need for hands on assistance (required for all reasons):

__________________________________________________________

__________________________________________________________
Completing PCS NC Medicaid-3051 – Change of Provider

For Change of Provider Requests, Complete The Following Sections of Page 3 Only:

- Top Section
  - Beneficiary Demographics (All fields are required to be completed)

- Section F
  - Change of Provider Request
Completing PCS NC Medicaid-3051 – Change of Provider

Things to remember:

- Change of Provider requests can be made by completing the NC Medicaid-3051 form or by calling Liberty Healthcare. *Form completion 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.
## Completing PCS NC Medicaid-3051 – Change of Provider

### New Request vs. Change of Provider?

<table>
<thead>
<tr>
<th>Beneficiary moves from:</th>
<th>Required Request Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACH to ACH</td>
<td>COP request – Effective in 1 day</td>
</tr>
<tr>
<td>IHC to IHC</td>
<td>COP request – Effective in 10 days</td>
</tr>
<tr>
<td>IHC to ACH</td>
<td>New Request</td>
</tr>
<tr>
<td>ACH to IHC</td>
<td>New Request</td>
</tr>
</tbody>
</table>
## Completing PCS NC Medicaid-3051

### Form Completion Recap

<table>
<thead>
<tr>
<th>REQUEST TYPE</th>
<th>COMPLETED BY</th>
<th>REQUIRED PAGES</th>
<th>REQUIRED SECTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEW REQUEST</td>
<td>PRACTITIONER</td>
<td>1 &amp; 2</td>
<td>SECTION A, B, C</td>
</tr>
<tr>
<td>CHANGE OF STATUS: MEDICAL</td>
<td>PRACTITIONER</td>
<td>1 &amp; 2</td>
<td>SECTION A, B, C, D</td>
</tr>
<tr>
<td>CHANGE OF STATUS: NON-MEDICAL</td>
<td>BENEFICIARY, CAREGIVER, PCS PROVIDER</td>
<td>3</td>
<td>TOP SECTION AND E</td>
</tr>
<tr>
<td>CHANGE OF PROVIDER</td>
<td>BENEFICIARY, CAREGIVER, ACH FACILITY</td>
<td>3</td>
<td>TOP SECTION AND F</td>
</tr>
</tbody>
</table>
Completing PCS NC Medicaid-3051

Submitting the Completed Form

- Complete all appropriate sections
- Fax the completed form to: 919-307-8307 or 855-740-1600 (toll free)
- If preferred, forms can be mailed to:
  Liberty Healthcare Corporation of NC
  Attn: Referral Processing Department
  5540 Centerview Drive, Suite 114
  Raleigh, NC 27606

Reminder: Practitioners must submit pages 1&2, Non-Practitioners should submit page 3.

- For questions regarding the form, email: NC-IASupport@libertyhealth.com or call 919-322-5944.
- Keep copies of all forms and fax confirmations for your records.
PCS Expedited Process - Eligibility

Requirements:

• There is an active Adult Protective Services (APS) case; or
• The beneficiary is currently hospitalized in a medical facility or in a Skilled Nursing Facility (SNF); or
• Is under the Transition to Community Living Initiative.
• For those being admitted to an Adult Care Home (excluding 5600 facilities), the beneficiary must have a Referral Screening ID.
  • To learn more of this form and process, please go to https://files.nc.gov/ncdhhs/documents/RSVP-Fact-Sheet.pdf
• The beneficiary is medically stable.
• The beneficiary has active or pending Medicaid.
Expedited Process – Submitting the Form

• Form should be completed and submitted by one of the following –
  • Hospital Discharge Planner
  • Skilled Nursing Facility Discharge Planner
  • Adult Protective (APS) Worker
  • An approved LME-MCO Transition Coordinator*

• Persons submitting the NC Medicaid-3051 will need to have the beneficiary select a provider of services PRIOR to calling Liberty and completing the expedited process.

• Completed forms should be sent to Liberty via fax at 919-322-5942 followed by a call to Liberty Healthcare at 919-322-5944.

*LME-MCO Transition Coordinators, who are approved through DMA, are able to execute the expedited process.
Expedited Process – Next Steps

1. Once connected with Liberty, the request will be reviewed and immediately approved or denied based on eligibility only, by a Customer Service Team Member.

2. If eligibility is approved, the caller will be transferred to a Liberty Healthcare nurse who will conduct a brief phone assessment.

3. If a need for PCS is identified, the beneficiary will be immediately awarded temporary hours for personal care services, up to 60 hours, and the referral is sent to the selected PCS Provider.

4. Liberty Healthcare will then contact the beneficiary within 14 days to schedule a complete assessment in person.
What is QiRePort?

QiRePort is an integrated web service designed to support the operation of the PCS program. QiRePort was developed and is hosted by VieBridge, Inc.

Important: Registration is required for all PCS Providers. A registration form and instructions can be obtained by visiting https://www.qireport.net
What can I do with QiReport?

Provider Agencies utilize QiRePort to do the following:

➢ Receive service referrals and accept/reject them electronically
➢ Manage servicing beneficiaries' accounts, including access to historical assessments and PAs
➢ Submit Discharges
➢ Submit Service Plans
➢ Submit Change of Status Requests
➢ Upload the Beneficiary Consent Form
➢ Manage Servicing Territories
➢ Update/Correct Modifiers
➢ Update NPI association
Providers are able to
- View training resources
- Ask Viebridge questions
- Ask NC Medicaid questions
Referrals and Provider Acceptance

• Referrals are located in QiReport on the ‘Referrals’ page.
• If a PCS Provider does not respond in two days, LHC will reject the referral and submit the referral to the next provider choice.
• PAs are made effective based off of the provider acceptance date, with exception of initial assessments.

NOTE: PAs will not be made retroactive for failure to respond to a referral timely.
Referrals

Access to all beneficiary information and account management can be found under the ‘Referrals’ tab.

Access links are located in the left side toolbar.

Click the ‘Referrals’ tab to access beneficiary information.
Referrals for Review

Referrals for Review

Referral for Acceptance Review

Recipient Data

Recipient Name
Address 1
City, State Zip
Phone
Gender

Medicaid ID
Address 2
County
DOB
Status

Requests for Independent Assessment

Recipient Name
MID
Phone Number
Request Date
Request Type

Independent Assessments on file for Recipient

Assessment Data
Assessment Type
Hours
4/25/2014
Change of Status
39
5/7/2013
Admission
39

Referral Decision *

Provider should select a response to request by selecting the appropriate response decision

Hours awarded is displayed here

Click here to access a copy of the assessment
## Referral Info – Accepted (last 1 year)

### QiRePort

#### Referrals

**Referrals Accepted/Reviewed Last 1 Year**

<table>
<thead>
<tr>
<th>Beneficiary Name</th>
<th>MID</th>
<th>Accept Date</th>
<th>Notification Type</th>
<th>Action Date</th>
<th>Provider No.</th>
<th>Notification Letter</th>
<th>Beneficiary Notice</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>03/17/2015</td>
<td>Annual Assessment</td>
<td>03/09/2015</td>
<td>[letter]</td>
<td>[letter]</td>
<td>[letter]</td>
<td>71</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12/01/2014</td>
<td>Annual Assessment</td>
<td>12/01/2014</td>
<td>[letter]</td>
<td>[letter]</td>
<td>[letter]</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11/13/2014</td>
<td>Annual Assessment</td>
<td>11/12/2014</td>
<td>[letter]</td>
<td>[letter]</td>
<td>[letter]</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td></td>
<td>06/13/2015</td>
<td>Change of Provider</td>
<td>10/02/2014</td>
<td>[letter]</td>
<td>[letter]</td>
<td>[letter]</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01/21/2015</td>
<td>Annual Assessment</td>
<td>01/20/2015</td>
<td>[letter]</td>
<td>[letter]</td>
<td>[letter]</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td></td>
<td>07/09/2015</td>
<td>Annual Assessment</td>
<td>07/07/2015</td>
<td>[letter]</td>
<td>[letter]</td>
<td>[letter]</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td></td>
<td>03/12/2015</td>
<td>Annual Assessment</td>
<td>02/26/2015</td>
<td>[letter]</td>
<td>[letter]</td>
<td>[letter]</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td></td>
<td>05/04/2015</td>
<td>New Request</td>
<td>05/04/2015</td>
<td>[letter]</td>
<td>[letter]</td>
<td>[letter]</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td></td>
<td>07/02/2015</td>
<td>MOS</td>
<td>06/08/2015</td>
<td>[letter]</td>
<td>[letter]</td>
<td>[letter]</td>
<td>174</td>
</tr>
<tr>
<td></td>
<td></td>
<td>07/31/2014</td>
<td>New Request</td>
<td>07/31/2014</td>
<td>[letter]</td>
<td>[letter]</td>
<td>[letter]</td>
<td>80</td>
</tr>
</tbody>
</table>

**Display:** notification type

**Click active link:** to access notifications

**See total hrs**
Referral Info – Accepted (last 1 year)

Select a beneficiary to access the Beneficiary Summary page

Click date to access assessment  Displays assessment type  Displays total hours
Referral Info – Denials (last 6 months)

- This page displays almost identical to the ‘Accepted (last 1 year)’ page. The ‘Denials’ page provides a list of beneficiaries who have been accepted by the provider agency but since denied PCS. From this page you can:
  - Access notifications regarding the denial of PCS for a beneficiary
  - Review current approved hour totals
  - Access historical assessments
  - Review demographic information
Accepted and Active Recipients

Search Recipients/Recipient Summary:

The ‘Search Recipients’ link allows you to search for a particular beneficiary and access the following:

- Review demographic information
- Review the request entry entered by the IAE
- Review current approved hour totals
- Access historical assessments
# Accepted and Active Recipients

Recipient Summary, continued

## QiRePort

### Referrals

#### Recipient Summary

<table>
<thead>
<tr>
<th>Recipient Name</th>
<th>Address 1</th>
<th>Address 2</th>
<th>City, State Zip</th>
<th>Phone</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid ID</th>
<th>Address 2</th>
<th>County</th>
<th>DOS</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Requests for Independent Assessment

<table>
<thead>
<tr>
<th>Recipient Name</th>
<th>MID</th>
<th>Phone Number</th>
<th>Request Date</th>
<th>Request Type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>11/12/2013</td>
<td>Change of Status</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>12/10/2010</td>
<td>Change of Provider</td>
</tr>
</tbody>
</table>

### Independent Assessments on file for Recipient

<table>
<thead>
<tr>
<th>Assessment Date</th>
<th>Comments</th>
<th>Assessment Type</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/3/2013</td>
<td>[comments]</td>
<td>Change of Status</td>
<td>80</td>
</tr>
<tr>
<td>1/8/2013</td>
<td>[comments]</td>
<td>Annual Review</td>
<td>92</td>
</tr>
<tr>
<td>1/10/2012</td>
<td>[comments]</td>
<td>Annual Review</td>
<td>80</td>
</tr>
<tr>
<td>1/26/2011</td>
<td>[comments]</td>
<td>Change of Provider</td>
<td>51</td>
</tr>
</tbody>
</table>

Can review request entries entered by the IAE.
Beneficiary Profile

What is the Beneficiary Profile?

• The beneficiary profile is used to store and maintain key information about a beneficiary in a single location.

• The profile uses information collected from the assessment and NC Tracks.

• Providers may update and add information to the profile record including current contact information and current diagnosis codes.

• Liberty Coordinators may reference the information in the profile in order to obtain the most up to date information.
Beneficiary Profile

How to access the Beneficiary Profile

Once you have searched for a beneficiary, you will want to click ‘Beneficiary Profile’ from the left index bar in order to access their profile.

[Image of Beneficiary Profile form]

* = Required

Beneficiary Identification

- Medicaid Number
- Case ID
- First Name
- Middle Name
- Last Name
- Preferred Name
- Medicaid X-Ref ID
- Alternate MID1
- Alternate ID - 1
- Medicaid County
- Birth Date
- Gender
- Race
- Ethnicity
- Date of Signed Facility Contract
- Date of Signed Resident Register
- PASRR Number
- PASRR Date
- Advance Directives Documentation Complete?
- Does Beneficiary Have Legal Guardian?
- If Yes: Guardian Name
- Guardian Agency Affiliation (if applicable)
- Guardian Contact Telephone
## Beneficiary Profile

### Beneficiary Contact Information

<table>
<thead>
<tr>
<th>Physical Address (if living in a private residence)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address 1 *</td>
</tr>
<tr>
<td>Address 2</td>
</tr>
<tr>
<td>Apt #</td>
</tr>
<tr>
<td>City *</td>
</tr>
<tr>
<td>State *</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mailing Address/Facility Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing Address 1</td>
</tr>
<tr>
<td>Mailing Address 2</td>
</tr>
<tr>
<td>Mailing City</td>
</tr>
<tr>
<td>Mailing State</td>
</tr>
<tr>
<td>Zip</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternate Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternate Address 1</td>
</tr>
<tr>
<td>Alternate Address 2</td>
</tr>
<tr>
<td>Alternate Apt #</td>
</tr>
<tr>
<td>Alternate City</td>
</tr>
<tr>
<td>Alternate State</td>
</tr>
<tr>
<td>Zip</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>336-567-6437</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cell Phone</th>
<th>Work Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Assigned Aide/History

<table>
<thead>
<tr>
<th>Assigned Aide Entry</th>
<th>Qualifications</th>
<th>Effective Date</th>
<th>Reason</th>
</tr>
</thead>
</table>

### Informal Caregivers/Contacts

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Relationship</th>
<th>Emerg</th>
<th>Prim?</th>
</tr>
</thead>
</table>

### Medical Professional Providers

<table>
<thead>
<tr>
<th>Name</th>
<th>Practice</th>
<th>Provider Type</th>
<th>Office Phone</th>
</tr>
</thead>
</table>
Once you have searched for a beneficiary, you will want to click ‘Supporting Docs’ from the left index bar in order to access documents that have been uploaded to the beneficiary’s account or to upload a new document.

To upload a new document, you will click ‘Add’, locate the document from your computer, and upload.
Supporting Docs

• Providers are required to upload all signed service plans to Supporting Docs.
• If a provider is unable to complete a service plan in QiReport- they must upload a copy of the manually generated service plan to Supporting Docs.
• Providers may upload any other medical or personal information pertaining to the beneficiary to supporting docs.
• Liberty can view all information uploaded to supporting docs.

*Supporting documents do not transfer with a beneficiary when they request a change of provider.
Service Plan

- The service plan requirement became effective June 10, 2015.
- 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
Completing the Service Plan

- A Service Plan is required in order for the PA approval to be sent to NCTracks.
- PCS Providers who do not complete their service plans will be referred to Office of Compliance and Program Integrity.

**NOTE:** PAs will not be made retro active for beneficiaries in which a service plan was not completed and the beneficiary is no longer under the care of the PCS Provider.
Completing a Service Plan

To access a beneficiary’s service plan a provider will...

- Select the ‘Plan’ tab at the top of their screen
- Next they will select ‘In Process Plans’ from the left index bar to view all service plans awaiting completion

Note: Providers have 7 business days after acceptance to complete and submit the service plan.
Completing a Service Plan

This is where provider enters the shifts to calculate the daily hours.

Weekly hours are already divided by 4.35
Completing a Service Plan

Providers must ensure the frequency listed matches the number of days selected for each task.
Completing a Service Plan

Before submitting service plan provider needs to select if the service plan is completed.

Once complete, select save to submit the service plan.
Service Plan revision

Accessing a completed Service Plan

- Go to the “Plan” tab and perform a search for the beneficiary.
- Click on the beneficiary’s name to display their Beneficiary Summary
- IHC- select “Beneficiary Service Plan List” found on left index of the QiReport
- ACH- select “Plan List” found on the left index of the QiReport

Click here to access completed service plans for a beneficiary

Select ‘Plan’ to access service plans
Service Plan revision

Once you select ‘Beneficiary Service Plan List’, a list of completed service plans will populate, click the date of the service plan you wish to access.

Providers will click on the plan start date to access the service plan.
Revising a Completed Service Plan

Click on ‘Revise Service Plan’ to make changes to the Service Plan. A revision date will need to be entered to indicate when the changes will be effective.

NOTE: Changes in days of service can be made and which days a task will be completed, but frequency must still match what has been indicated in the assessment. These changes must be documented as deviations. Not applicable to EPSDT.
Completing a Manual Service Plan

The PCS Provider should complete a manual service plan when the amount of approved hours does not match the hours reflected in the assessment, upload into QiReport, and call Liberty. **NOTE:** All manually drafted service plans must be uploaded to supporting docs. in the provider portal.

**Scenario**

EPSDT Temporary Summer Hours Change

Settlements

Expedited Assessments

COP with Active Appeal

COP and Bene had Settlement for More Hours than Reflected on Assessment
Change of Status Requests

The ‘Change of Status (COS) Request’ link allows the provider to submit an electronic COS non-medical request form directly to the IAE as well as access historical requests submitted and review the status of approval.

**NOTE:** Physician attestation cannot be submitted through the provider portal.

Review historical requests and the approval status

Click the ‘Add’ button to submit a new request. Complete the request form and hit ‘save’.
Discharges

- Discharges for a PCS beneficiary are completed through QiReport.
- If the PCS Provider continues to provide services, but they are not reimbursed by Medicaid, they must discharge the beneficiary in QiReport.
- Discharges must be completed in 7 business days.
Discharges

The PCS Provider is required to discharge a beneficiary from QiReport if they are no longer providing PCS that is reimbursed through Medicaid.

1. Select the ‘Referrals’ tab.

2. Select ‘Discharge’ to discharge beneficiary.
Additional Questions?

For any additional questions regarding the use of QiRePort, please contact Viebridge at 888-705-0970.
Support
Top PCS Provider Resources

➢ Websites
  www.nc-pcs.com
  www.qireport.net
  https://medicaid.ncdhhs.gov
  https://www.nctracks.nc.gov

➢ Clinical Coverage Policy 3L

➢ Provider Manual

➢ Trainings/Webinars

➢ Stakeholder and Focus Group Meetings
MEDICAID PERSONAL CARE SERVICES

CONTACTS

NC Medicaid

Phone: 919-855-4360
Fax: 919-715-0102
Email: PCS_Program_Questions@dhhs.nc.gov

Liberty Healthcare Corporation of North Carolina

Request forms and general inquiries should be addressed to:
Liberty Healthcare Corporation-NC PCS Program
5540 Centerview Dr., Suite 114
Raleigh, NC 27606

Call Center Phone:
   919-322-5944
or 855-740-1400 (toll free)
Fax: 919-307-8307
or 855-740-1600 (toll free)
Email: NC-IAsupport@libertyhealth.com
Website: www.nc-pcs.com
Questions
Leading Today, Empowering Tomorrow

Liberty Healthcare PCS Provider Training

October 2018