Liberty Healthcare Corporation of North Carolina

Provider Training (May 2016) Questions and Responses

The following questions were posted during the May 2016 Provider Trainings that covered the following topics:

- Internal DMA Audit
- Understanding the Beneficiary's Assessment
- Policy 3L Requirements and Updates
- Miscellaneous PCS Questions

All questions with responses are provided in this document.

Internal DMA Audit

- **Are RN Supervisory visits required for in-home PCS only and not ACH facilities?**
  That is correct; when DMA compiles a sample for supervisory visits, they only pull from in-home beneficiaries.

- **What timeframe is included in DMA's request for the last two years of supervisory visits?**
  DMA will indicate what dates they are looking for and this will include two years back from that date.

- **When it comes to the DMA Internal Audit, can DMA or LHC provide a chart audit tool?**
  There is not a tool for this audit. DMA wants to ensure that you are meeting the requirements outlined in policy. Refer to Section 6.1.2 for Aide Training Requirements and 7.10b for Supervisory visit requirements.

- **When it comes to the audit, is there specific training in the service material that is required or is your own sufficient?**
  Your own is sufficient; you just need to make sure that you provide it when requested.

- **Who does DMA ask to speak with when they call providers to request records?**
  When DMA calls, they will confirm that you are still providing services to the beneficiary, and will ask who will be responsible for getting us the medical records.

Understanding the Beneficiary's Assessment

- **If caregivers are available to be at the assessment, are they allowed to speak up and tell the nurse that it's not the client's norm?**
  Caregivers are certainly encouraged to be present at assessments and may speak to the needs of the beneficiaries. Liberty invites any information regarding their care. If there is a specific situation that you are concerned about, please contact Denise Hobson at Liberty to discuss.

- **What is the process to remove weekends when an assessment says weekend services are needed but the agency RN visits to do the Plan of Care and the client says they do not want services on the weekend?**
  A non-medical Change of Status will need to be submitted. If the beneficiary is approved for 7-day care but the agency does not provide care on weekends, the beneficiary must confirm approval for receiving services on weekdays only.

- **What is the process to add a task that is omitted on the service plan but is on the Liberty assessment?**
  This should never happen. If you experience this, contact Liberty to be directed to the IT contractor.

- **If there is an extensive hands on task like Clean Meal Service Area only, the other tasks on assessment are 'limited' hands on; can this patient be staffed with a PCA?**
  The overall ADL assistance level is identified in the assessor's overall self-performance capacity rating of the independent assessment. Utilizing the scoring provided in the overall self-performance capacity rating you will refer to DHSR Licensure Requirements, 13J, before assigning the appropriate aide.

- **Can we request a different nurse to come out and do an assessment?**
  It is not protocol to allow assessors be requested. If you have concerns or feel there is a conflict of interest, please contact Denise Hobson. All assessors are trained in the same manner and should be evaluating in the same way.

- **Approximately how many beneficiaries are seen daily?**
  Assessors are scheduled to see 4 beneficiaries per day and are blocked for two hours to complete each assessment.

- **If the beneficiary is accepted by the PCS provider in December, the agency's RN does the initial assessment, and now the state's annual assessment is being done in May, is the PCS provider's RN required to do another assessment or continue with 90-day reviews from the initial assessment in December?**
  The provider is responsible for adhering the criteria outlined in Section 7.10b of the PCS policy in reference to Supervisor visits and should also comply with requirements

outlined in their DHSR Licensure rule. The PCS Policy and Licensure regulations are not worded the same and the PCS Policy requires additional steps. Providers should contact DMA and DHSR if they have questions.

- **Do assessors consider ACH staff available caregivers?**
  We include the ACH staff in the assessment, and ask that someone who is familiar with their care be present in support of the beneficiary. We do not count them as being a caregiver on the assessment.

- **When or why would approved hours not match assessment hours?**
  There are different scenarios. If the beneficiary goes to mediation and is awarded more hours, the awarded hours will not match the assessment hours. If they change providers, the provider will be approved for the higher number of hours but the assessment will still indicate the lower number. If DMA awards EPSDT beneficiaries a higher number of hours, this will not match the assessment. In each of these cases, if the hours do not match, a manual Service Plan must be completed.

- **How do you assure "Mr. Jones" knows he can/should have all available caregivers/family/provider RN/etc. present at assessment? Is it part of the 24 hour advance call?**
  This originates when the scheduler calls to make the appointment through the script read to the beneficiary as well as the assessing nurses reminding the beneficiaries when they call 24 hours prior to the assessment. In addition, when the nurse arrives and is preparing to begin the assessment, if the beneficiary wants to wait until a family member or caregiver is available, the nurse may recommend that they reschedule.

- **Additional hours according to Session Law 2013-306: Do we have to appeal to be considered for the extra hours or do we submit the 3051 form for the extra hours?**
  To request additional hours, the beneficiary's physician must complete the DMA 3051 attestation form. If the beneficiary is new to the program, they will complete the new request. If the beneficiary is currently receiving PCS but is requesting additional hours, the physician will complete the Medical Change of Status. If a 3051 form with a completed attestation was submitted and the beneficiary was not approved for additional hours, the beneficiary may file an appeal.

- **We have had 3 residents in SCU (special care unit) to receive 80 hrs, why did they not receive 130 hrs from their annual assessment?**
  This is a scenario where the assessment would need to be reviewed – please call Liberty with any questions. In addition, it is important to note that not all beneficiaries residing in SCU's are eligible for additional hours; beneficiaries must meet the criteria outlined in N.C. Session Law 2013-306.

- **How long does the assessment process take for a new beneficiary?**
  Assessment processes are approached the same, whether they are new or existing beneficiaries and should take anywhere between 60 minutes to two hours.

- **During the annual assessment, is it acceptable for the assessor to document that the beneficiary has demonstrated a task they were never asked to do?**
  This would never be an acceptable scenario. The assessors must document exactly what they see or did not see. If there are any concerns about a specific beneficiary or case, please contact Denise Hobson at Liberty.

- **What if the areas are left blank, such as who lives with the client? Do we assume nobody lives with them?**
  We certainly would not recommend making such an assumption. Assessor's document information that is provided at the time of the assessment and are unable to document information that is not provided.

- **Does Liberty give beneficiaries a list of licensed facilities, rest homes, family care home, etc. during the assessment?**
  Yes. Liberty provides a randomized list of providers that are registered through NCTracks.

- **If a task is not checked, does the aide need to do/ help do it (medical monitoring tasks)?**
  No, if a task was not indicated as needing assistance, it is not approved as being a billable task for PCS.

- **What is average time from assessment performance to being loaded in QiReport?**
  Assessments must be completed and loaded into QiReport within 24 hours. The assessment will then go through Liberty's QC process and then be sent to the provider of choice within 3 business days from the day it was uploaded.

- **What if the nurse completing the assessment did not welcome ACH staff to be present?**
  During assessments, Liberty always encourages anyone to be present, irrespective of residential setting. If there is a specific isolated incident, please let Liberty know.

- **What if the patient is only washing their hair every two weeks but needs it more frequently? What will the assessment reflect?**
  All tasks, including shampooing must occur at least one time a week for scoring. If it is only needed every two weeks, that will not be scored but a note would be made in the narrative.

- **How can we notify Liberty of an error on an assessment?**
  If there was clearly an error on the assessment, call Liberty. They will have a nurse review it, pull it off of the portal, correct it, and send it back to your portal so you can do a new Service Plan for that assessment; please allow 72 hours for that process.

- **If the assessment is done after the annual due date and is only paying from the date the assessment was put into the system, how do we rectify that?**
  If there is a lapse in billing, call Liberty's Call Center so that we can update those PA's.

- **Under conditions affecting ADL performance time, where do you allow for "chronic pain" as a condition affecting time? How is it measured or rated as it relates to time?**
  Throughout the assessment, nurses are observing for any conditions that are impacting or interfering with the beneficiary's ability to perform ADL's. They will document whether the pain is chronic or acute, and if it impacts ability to perform or complete that task.

- **Beneficiary with dementia is assessed and gets zero hours. Doctor has signed attestation, recipient failed to perform a task due to cognitive impairment. Why would she not qualify?**
  Assessments are based on what our observations are at that time and the beneficiary's ability to complete tasks with or without assistance. Assessors will observe for cognitive impairment. Dementia patients may be highly functioning; the issue is their ability to complete tasks with or without assistance.

- **Statements about medical monitoring tasks make sense for IHC but in ACH med techs monitor this. How do we document this on the task sheets for ACH?**
  Document what the needs are for that beneficiary on the Service Plan and task sheet, and note that the aides do not complete that task.

- **Patients say that Liberty must cut hour for patients at annual assessment. Is this true?**
  This is not true. Liberty's role is to conduct an independent assessment on behalf of the PCS program. They conduct each assessment separately and are focused only on the patient's needs.

- **Have there been changes made to the algorithm that providers were not made aware of resulting if fewer hours?**
  There have not been any changes to the algorithm. Questions regarding policy/scoring of assessments may be directed to the Division of Medical Assistance at 919-855-4360.

- **What is the time frame for corrections to be made by Independent Assessor?**
  Liberty's process is to do a very thorough review. New assessors are on 100% review, and our overall process is 72 hours, or 3 business days from the time the assessment is completed and submitted to the review process. If assessments are returned for

clarification, and we see that the narrative does not support something and have questions requiring additional information, they will have 24 hours to respond back.

- **When medications change on facility nurses assessment, do we need to notify Liberty of that change?**
  You don't need to notify us, but when we go to do the annual assessment we will review the history of medications on file and confirm that they are still current. If there is a new medication or condition that impacts PCS, providers should consider submitting a medical COS.

- **If a client declines a bath on a particular day, the aide documented that the client refused, and our agency does not bill Medicaid for that day, is that the rule or the agency's best practice?**
  If a client refuses all bathing tasks, document this and do not bill. However, if the client refuses just one part of it and you are performing all other tasks that are assigned; you may continue to bill but document that as a deviation.

- **Why do Liberty assessors not take into consideration time of day that the assessments are being done?**
  We do try to take that into consideration. When the scheduler calls to schedule the assessment, beneficiaries are encouraged to tell them when they prefer to schedule the appointment.

- **Should the nurse assessor "push" a resident to perform a task if the resident is showing distress during the assessment?**
  No, this is not our desire nor our expectation. We are there to observe the demonstration based on our clinical judgement. The assessors have been trained to have the clinical judgement to stop the beneficiary from pushing themselves so that their health is compromised.

- **What is the difference between the term "extensive" as used in DHSR rules and what Liberty does or are they the same?**
  The PCS Clinical Coverage Policy describes "Extensive hands-on assistance" as the beneficiary is able to self-perform less than 50 percent of the activity and requires hands-on assistance to complete the remainder of activity. Liberty assesses beneficiaries based on PCS policy.

- **Is it the position of DMA/Liberty that any beneficiary with S.A. has their food prep need "met" in an ACH facility?**
  In reference to changes per the settlement, meal prep and clean-up tasks are included in room and board at facilities. The beneficiary is not physically performing tasks 6-9 on the assessment tool, so therefore they will not be scored as needing assistance.

- **What is assistance level of someone who is physically capable of bathing but because of dementia, believes they have already had a bath and will NOT shower on their own?**
  For someone who has dementia or is cognitively impaired, we are observing for that. PCS requires the need for hand-on assistance, but we also understand the conditions of beneficiaries with Alzheimer's/Dementia therefore the assessor will review medical records, speak with staff/caregivers, and ask specific questions to determine the level of hands-on assistance needed to assist the beneficiary with completing tasks.

- **Is an assessor required to consider all available medical documentation or other data in conducting an assessment?**
  We do look at and ask to see all medical records, documentation of diagnoses, medications, etc., that are available.

- **Are the assessors trained on residents with dementia? Do they understand that they might be able to perform the task one day but no other days or even right after the assessment? Does the assessor take into account how long it takes for the beneficiary to do the task independently without help in determining assistance level?**
  All assessors receive training for beneficiaries who have dementia or are cognitively impaired. We certainly do understand that a day may be atypical, which is why we ask their caregivers or staff for input to see if this is a typical day. We will also look at documentation to see how often it is consistently documented that they have to provide that assistance.

- **Assessments indicate that if a client can operate a microwave they do not get any time for meal prep. Are clients expected to cook all their meals, even meat, in a microwave?**
  The assessor will ask how the beneficiary typically prepares or gets their meals. If beneficiaries state that they do prepare their own meals, we will ask them to simulate that for us.

- **If a provider feels that the assessment does not reflect the needs of the beneficiary, could we request a new assessment since the one we have is wrong in many areas or do we just appeal?**
  If you feel that the assessment is incorrect, call Liberty and we will look at it to see if we missed something. We may recommend a reassessment or to go through the appeals process.

- **Does the Liberty assessor review prior Liberty/CCME assessments?**
  We train assessors to have each assessment be independent of itself for that time period. Therefore, we don't recommend that they look at former assessments before conducting the current assessment. We do look at prior assessments for diagnoses to be sure they were appropriately converted to ICD-10's.

- **How would you assess a beneficiary who keeps a box of sugar cubes by their bed and does not follow their PCPs order for nutritional diet and low sugar meals?**
  When doing their assessment, we ask what their typical diet is. It does not affect their scoring, but that's how we address and assess their nutritional needs and diet regimen.

- **Why is the assessment process different than it was 2 years ago in ACH communities?**
  The process is not different; there have been no changes in policy, procedures, or requirements as far as the assessment is concerned. Liberty has been retrained on having beneficiaries demonstrate tasks to ensure compliance with PCS Policy. Beneficiaries are encouraged to appeal and submit medical documentation if they receive an adverse decision.

- **Why are some assessments held up for weeks in review before showing up in QiReport? We have heard that assessors are sometimes asked to change things. Why is that? Is this an attempt to approve less hours for the residents?**
  There has recently been a backlog in assessments going through the quality review process, which requires 100% review for new assessors and on all EPSDT assessments. This backlog has been reduced down to normal levels. We do not ask for anything to be changed to result in any number of hours. On review we are looking to see that their narrative documentation supports what is scored on the assistance level. If we ask about a change it's because we've seen a discrepancy in the narratives and the score.

- **How would the assessor evaluate the level of need if a beneficiary is able to do a task, but due to cognitive impairments they are unwilling to do it without assistance and will not, for example, bathe or shave?**
  The assessor would identify and look for the hands-on assistance needed with completing the task through medical documentation, speaking with the staff/caregiver, and asking additional questions.

- **Even if a resident demonstrates adequate range of motion, we know they are not capable of toileting and maintaining proper hygiene. How should we handle this?**
  We would look to the staff, caregiver, or the beneficiaries themselves and medical records to support the need for hands-on assistance and the reason(s) why.

- **What percentage of assessments is set at 52 weeks for the next reassessment?**
  The average requirement is at a minimum of once a year. However, if a reassessment is determined to be necessary, that can be added at any time needed.

- **Please explain how an exacerbating condition, say for a neurological condition, would need to be demonstrated, would it require clinical documentation?**
  Exacerbating conditions and assessment scoring consists of the observation, clinical judgement and what is seen during the demonstration. If there are neurological conditions present that affect their ability to complete task, we would see that. The neurological diagnosis must affect the ability/inability to complete the ADL's.

- **Why aren't IADLs reported for those ADLs that are scored Totally Able or Set up/Supervision?**
  IADL's are only scored if there is a need for hands-on assistance with the ADL's.

- **If a beneficiary needs only assistance in opening packages, prep food and clean up, how will the eating ADL be scored?**
  Currently, we will score that as whatever their needs are. With the new change going into effect in July, that will be different within the ACH settings.

- **What if the provider's assessment does not match Liberty's assessment?**
  There are many different reasons why they would not match - reconsideration, appeals, change of status. Contact LHC with any questions determining how to proceed.

- **If a resident does everything asked on the day of the assessment but this is not an everyday task and the next day they can't remember to do the task, how is that scored?**
  Liberty must score the assessment based on what they see during the time they spend with the beneficiary. However, the IA's do ask if this is a typical day and encourage others to be there who can speak on their behalf.

- **What if the IA diagnosis does not match diagnosis given at time of the ICD 10 conversion?**
  With any new assessment, the beneficiary receives a "Beneficiary Profile," and every diagnosis from every assessment will go into that profile. After that, all diagnoses will populate on the assessment. The IA's will go to the home or facility and confirm that those diagnoses are still valid. The ICD-9's are still being converted to ICD-10's and most codes did not have a one-on-one conversion which is why the ICD-10 Transition Forms are so important. The deadline for submitting required ICD-10 forms is January 31, 2017.

- **What is the meaning of the check if required box and give examples?**
  That box is checked if it is required that the beneficiary will need hands-on assistance with that task.

- **How is verbal cueing or supervision not limited once the aide has to perform action of retrieving or set up for the beneficiary?**
  If it moves from verbal cueing & supervision to require hands-on assistance to complete that task, it would be considered limited.

Policy 3L Updates

- **Will changes to the Eating ADL take effect on July 1 for all current beneficiaries or will this take effect on their next assessments?**
  Eating ADL changes per the settlement will not be automatically applied July 1. The changes will apply in beneficiaries upcoming assessment.

- **Is there anything in Policy 3L that mandates a nurse do a home visit after a hospitalization or is it at the discretion of the agency and their policy manual?**
  There is no policy that mandates that the RN do an assessment post-hospitalization for PCS. However, keep in mind that if they have been in the hospital, they may not be medically stable and could potentially require a home visit.

- **Can a Change of Status be requested within the 30 days with supporting documentation, instead of using the formal Reconsideration Request on day 31?**
  A COS can be submitted at any time and does not require documentation. A Reconsideration request should not be submitted if there has been a change of status.

- **Are section 5.6 updates regarding the reconsideration process for initial assessments only? Do all others still have to go through the appeal process?**
  That is correct. Reconsideration is only for initial assessments.

- **Do you still need to submit ICD-10 codes after Oct 1, 2015 for new beneficiaries?**
  No, those ICD-10's will be indicated on the new 3051 form after 10/1.

- **If a client dies, what process do we go through in QiR?**
  There is a drop down for "Deceased" on the discharge page; select that as you do the discharge in QiR.

- **Could you please explain how to fill out and upload a manual plan of care in order to capture the missing hours?**
  When hours are completely different in cases such as EPSDT, Appeals, MOS, a manual service plan is required. Use your desired format that captures all tasks, assistance levels, frequencies, etc. (i.e. Plan of Care template), complete, upload it to supporting documents and then call Liberty.

- **What do you do when the primary doctor refuses to complete the ICD-10 form on a patient?**
  If you run into this situation, call Liberty for assistance**.**

- **Do you discharge if client is admitted to rehab?**
  It is not required that you discharge if they are still in their approved period for PCS. If they are outside of the approved period and due for their annual, the beneficiary can stay for 30 days before they must be discharged.

- **When it comes to Policy 3L changes, when should provider start receiving reinstatement letters?**
  The letters should go out between July and August.

- **If the Reconsideration increases hours, does it go back for reimbursement purposes?**
  The hours become effective the date of the new letter, they will not retro back.

- **How is it that eligibility of a client can be determined by an assessor when they are only with the client for an hour and this is not a typical day?**
  Since assessors are only there for a snapshot of the day, if you feel that the assessment is not really reflective of what the beneficiary can or cannot do, there is now a reconsideration process for initial requests and an appeal process, where more documentation can be provided.

- **When it comes to Pettigrew vs Brajer, how many hours will the beneficiaries in ACH's lose based on the policy change relating to the Eating ADL?**
  The Settlement requires the PCS criteria to be comparable irrespective of setting. If ACH's are currently reimbursed for meal prep and clean up through Sate/County Special Assistance, the beneficiary's needs are being met the assessment will be marked as "needs met", as it is with any other ADL's that have needs met. You may refer to the PCS Policy Service Level Determinations to review the daily minutes for Qualifying ADLs.

- **Bene moves from one home to another; the receiving provider submits the 3051 form on 1/1/17 when will the provider begin receiving benefits?**
  If the beneficiary has already been approved for PCS and moves from one ACH home to another that will be processed within one day. Based on when it is accepted, you may be reimbursed starting the next day. If the beneficiary is moving from IHC to an ACH facility, you can start providing services on the date of request, as long as they are approved for PCS. This is outlined in the Provider Manual.

- **How should the PCS Provider proceed if after acceptance, the client cannot or will not schedule a visit for the service plan within 7 days?**
  You can complete the Service Plan, and then you have 14 days to meet with the beneficiary to see if they agree with the plan. If you are still unable to meet with beneficiary, be sure to document all attempts to schedule so DMA can see your efforts.

- **Is the state eliminating or changing the eating ADL?**
  No, this is not being eliminated. This is a service that is already paid for in ACH facilities, so the eating ADL's are being marked as "needs met."

- **Does the provider have to apply for hours up to 130?**
  Beneficiaries must have their physician complete the DMA 3051 attestation to be considered for additional hours. Providers may assist the beneficiary with getting the request to the physician.

- **Why do "special diets" not qualify for time in eating b/c it is extra and specific to that resident's care?**
  Special diets are prepared in the kitchen and are therefore not a task for the personal care aide, CNA, or staffer to provide. *Effective December 1, 2016, beneficiaries with a mechanically altered diet may receive assistance with the eating ADL. Refer to the December 2016 PCS Special Medicaid Bulletin.

- **If an Alzheimer's/dementia beneficiary is cognitively unable to do meal prep but is not on a textured modified diet, would they not qualify for eating?**
  If a beneficiary resides in an Adult Care Home regardless of their cognitive abilities, beneficiaries do not perform tasks #6-9, meal prep & clean up. If this is an IHC beneficiary who is cognitively unable to do a task and there is not a caregiver available, then that task will be scored accordingly.

- **Is the reconsideration request going to be a form?**
  Yes, there will be a form, along with a separate instructions sheet. The form will be out on July 1 but cannot be submitted until August 1.

- **Can reconsideration requests be done on hours less than 130?**
  Reconsideration requests are for beneficiaries who did not receive up to 80 hours. Individuals who requested and were denied additional hours receive appeal rights. There are some exceptions to the rules, so please call Liberty for further clarification.

- **Can the documentation for Policy 3L be the aide's task sheets that actually show what is being provided?**
  If this is for DMA's internal audit, DMA will be looking for supervisory visits and the required aide trainings. The request will identify specifically what documents to be submitted to DMA.

- **If a caregiver's schedule needs to be changed from the time that was originally specified in the Service Plan, does the provider have to generate a new Service Plan and have it re-signed by the client?**
  No, this can be done with an edit to the Service Plan – this functionality is in QiReport. The beneficiary does not need to re-sign it. If a change is needed temporarily, such as for a specific week, the Service Plan does not have to be edited. Document the deviation.

- **Beneficiary receives a letter asking them to call to schedule an appointment but when they call, why are they sometimes told they will be called back at a later time? Why have them call just to be redirected?**
  That should not occur, please let Lyneka Judkins know if this happens.

- **How do you discharge a beneficiary if they have been awarded 0 hours?**
  There is no requirement to discharge them – they will be moved to your Denial tab in QiReport and you should keep them there for 6 months to one year so you can refer back to their records if you need to.

- **If the company has several locations, does each office or area have to complete a DMA QI attestation form annually?**
  One is sufficient – please call into DMA and let staff know that you have several locations on one attestation form under one NPI #. If you have multiple NPI's please submit a DMA 3136 per NPI.

- **When the beneficiary name does not appear or no longer appears on QiR as a beneficiary to your company, does that mean they have been discharged by Liberty as well?**
  Yes, that will be automatic – the only time they will come off of your portal without you having to do anything is when there is a Change of Provider.

- **What happens if a beneficiary only selected one provider and that provider does not respond?**
  When this occurs, the beneficiary is sent to "All Provider Reject Status." Liberty sends the beneficiary another randomized provider list and instructs them to select 3 more providers. They must notify Liberty within 30 days or they will be terminated and will have to start the process all over again. Liberty will reach out to the beneficiaries to be sure they understand.

- **Are providers reported to Program Integrity if they do not discharge beneficiaries within 7 business days?**
  This is a possibility. Liberty submits a report each month to DMA, identifying the providers who did not discharge on time.

- **We audit client/employee charts and time sheets quarterly. Are there other topics/areas we can review quarterly?**
  Whatever you feel is important and should be reviewed, you absolutely may review.

- **If client enters an ACH facility and comes out, can the provider resume services? What needs to occur for the provider to bill again?**
  If the beneficiary was in short-term rehab and you didn't discharge them because you anticipated that they would return, then you may resume services. If there has been a change in their health, submit a COS to Liberty. If the beneficiary went into assisted living and then came back home, you would need to start the process again.

- **Is the 3136 Attestation required per agency or for each site/facility?**
  DMA looks at it per each NPI.

- **Will uploading service plans after 15 days affect service authorization and reimbursement?**
  Service plans are required to be uploaded within 14 business days of the completion of the validated service plan. The effective date will remain the same, but the provider will not receive prior approval until the service plan is complete. Failure to meet the service plan timelines may result in a referral to Program Integrity. For appeal resolutions and EPSDT assessments, complete a manual service plan and call Liberty.

- **Is there a way to check whether or not all service plans have been submitted on time to avoid billing issues?**
  There is currently no alert that notifies Liberty that someone has or has not submitted the service plan. If having billing issues, call Liberty.

- **Please clarify: is the 14 days to get service plan signed and uploaded start at 7 days from time it is completed by provider or is it 14 days total?**
  It is 14 additional business days after the Service Plan is completed for it to be printed, signed, and uploaded back into the system.

- **How long do we have to upload the manual service plan, and how long will it take to get a response?**
  Depending on the reason for the manual upload, providers should work to complete the manual upload within 7 business days of accepting the beneficiary. For EPSDT, providers should upload the manual within 7 business days of accepting the hours in the system and for appeals; the manual service plan should be uploaded within seven days of the appeal resolution. When Liberty goes to release the PA's for the service plan it takes 24 hours to be put into NCTracks. When uploading the completed manual service plan make sure to always call Liberty. Note – The provider organization shall obtain the written consent in the form of the signature within 14 business days of the submission/upload of the manual service plan. For Questions, please contact Liberty Healthcare.

- **If the provider is asking satisfaction questions during 90 day supervisory visit on the case review form, does that satisfy that requirement?**
  The requirement is that you have to make it available for every beneficiary. The Provider should refer to Section 7.7 Internal Quality Improvement Program of the PCS Policy. Questions may be directed to DMA.

- **Does Liberty still send a RN to perform an annual review if the ICD-10 form has not been submitted?**
  Yes, the transition form is required for all beneficiaries prior to their annual assessment; however, we will move forward with the assessment. Failure to submit the ICD-10 transition form could potentially hold up the assessment from being processed.

- **Can the RN put in a referral for Change of Status if already receiving services?**
  Yes, if it is a non-medical COS. If it is a medical COS, that must come from a physician and submitted on a 3051 form. The beneficiary must approve any changes to days and times submitted as a non-medical COS and the frequency will most likely change the amount of hours.

- **What kind of assessment request would you send to Liberty when the client gets out of hospital? How many days do you have for post hospital visit?**
  If there has been a change in their health condition, submit a medical COS that is signed by a physician if they need more hours. There is no timeframe of when to submit this after they have been discharged. However, if the beneficiary is already at the maximum number of hours and has a change in health condition which requires help with other tasks, Liberty will not do another assessment. At that point, the PCS Provider should indicate that the patient has been hospitalized and note any deviations in the Service Plan and what tasks you are now assisting with.

- **For the DMA internal audit, what happens if DMA has the wrong fax number and a provider does not respond in 5 days?**
  Once lists are provided by Viebridge, DMA will make a call to the facility to verify the NPI number, confirm the fax number, and ask who will be responsible for getting the information submitted within 5 days. This process is under review.

- **What is the consequence of failure to complete the service plan in 7 business days?**
  This is a policy requirement and providers not in compliance may be subject to an audit.
- **What should a provider do when they are late in any step of service plan or discharge completion?**
  Be sure to do each step as soon as possible. Providers are required to comply with the Service Plan requirements outlined in the PCS Policy.

- **In cases where referrals for another provider are showing up on our referral list, what should we do to have them removed?**
  We do see this happen within NPI sites. The best thing to do is not to accept or reject – give Liberty a call.

- **If a beneficiary loses hours and the facility appeals the decision, when should we discharge the beneficiary in QiR?**
  If the appeal is filed within 30 days from the date on the notice, then the beneficiary will receive MOS and therefore continue to be approved to receive PCS; there is no need to discharge at this time.

- **In the ACH setting, does the QI program that is part of the STAR rating form satisfy the QI program requirement?**
  No, this is separate.

- **How does the PCS provider know if the doctor has faxed in the ICD10 Transition Form?**
  If Liberty still needs the form, they will call the PCS Provider. Providers may contact Liberty if they suspect the ICD-10 form was submitted.

- **If we receive a discharge request by a fax from Liberty to stop services, do we still have to discharge within 7 days?**
  No.

- **If a client discharge is not done by the former agency for 6 months after the client goes to another agency, do I still do the discharge?**
  The only time you need to do a discharge is if you are no longer providing services.

- **What do I do if my client has 0 hours or PCS is denied?**
  The beneficiary has the right to go through the appeal process. The beneficiary receives the appropriate notification that includes appeal rights and a Hearing Request Form.

- **When an ACH transfers ownership, do Medicaid residents without PASRRs have to get a PASRR number?**
  It's a new NPI number but same location then no; the PASRR is good unless it has an expiration date on it.

- **If you miss the 30 day window to obtain a new PASRR, can you re-apply for a new assessment once a PASRR is obtained?**
  Yes.

- **Would it not be more beneficial if the IAE updated the Service Plan completed in the system for MOS to match the outside plan done manually?**
  The current process does not allow caseload reports or aide task sheets to reflect the manual Service Plan that is more accurate of beneficiaries' needs.

- **Are the Eating ADL's going away for ACH facilities?**
  No, beneficiaries will still be assessed. Eating tasks 6-9 will be scored as needs met as they are covered under services paid for by Sate/County Special Assistance and are considered duplicative. The other ADL's will still be scored based on demonstrated needs.

- **Has there been a change in Special Assistance since November, 2012?**
  Please contact the Division of Aging with any questions about Special Assistance.

- **Do we need to notify Liberty when a patient is receiving Hospice?**
  Currently, when Liberty performs assessments they will consider Hospice care and the schedule of those services; how much time Hospice is in the home and assisting. There is no need to contact Liberty to do a reassessment. Any individual denied will be reinstated, and if there has been a change it will be captured on the annual. If a beneficiary is receiving Hospice in the home setting, it should be documented. It is not considered a "needs-met" component in their assessment.

- **Are we still able to appeal a denial over reduction in hours or is the reconsideration process to be followed in these cases?**
  The Reconsideration Review process is used for individuals who were not awarded the maximum hours and did not get appeal rights on their initial assessment. In most cases, you will not be required to decide between appealing and reconsideration. However, beneficiaries who are new to the program, have a dementia-related disease and did not receive additional hours, may appeal. If they don't receive extra hours after appeal, the reconsideration process can be followed.

- **Moving forward, if there are cognitive issues, will a third party's presence be required due to the settlement?**
  In instances where a cognitive impairment or difficulty communicating is present which may result in diminished capacity to remember, understand, or communicate, including where the assessor determines during the assessment that the beneficiary has a cognitive impairment or difficulty communicating which results in diminished capacity to remember, Liberty will use all reasonable efforts to schedule or reschedule the assessment, at a time when a third person has indicated he or she can be present.

- **Is the Reconsideration form on QiReport? Will it need to be signed by a physician?**
  The form is not on QiReport, it will be implemented on July 1. A physician's signature is not required.

- **If a client gets zero hours on their first assessment, are they eligible for reconsideration? Are they eligible at an annual reassessment?**
  The reconsideration review process is only for initial assessments. If the beneficiary received zero hours, they would not be eligible for the reconsideration process, but they may appeal the decision.

- **Does the Reconsideration Review Request apply only to 80 hour maximum awards? Does it apply if additional hours have been requested?**
  Reconsideration applies to beneficiaries requesting an initial assessment (new admission) and only applies for those who received more than 0 but less than 80 hours. This is detailed in the Medicaid bulletin and on DMA's webpage and the PCS Clinical Coverage Policy.

- **If the beneficiary is reinstated under the settlement, will hours be from 7/1/15 or from the original date of termination of benefits?**
  It will be from the date that they call Liberty and they are reinstated.

- **When beneficiaries are reinstated, will retroactive payments be made to the providers?**
  No, they will not.

- **What is the time period for the reinstatement process?**
  Anyone who has been denied under 3L that meets the criteria of having cognitive issues with no third party present at the assessment or was denied due to receiving Hospice will be reinstated.

- **During the Reconsideration process, will another nurse complete the assessment review?**
  Yes, this will be approached the same way as the appeal process.

- **Can documentation that is submitted for reconsideration include social media?**
  Social media is not completely excluded and could potentially be considered; it would not be the sole documentation.

- **What date do we use that an annual assessment will be due? Is it the date on the Liberty notification or the date the case was actually opened?**
  Providers should refer to the date indicated in the notification provided.

- **What is the criteria for the additional 50 hours for beneficiaries if they already have 80 hours and they have dementia?**
  The criteria are listed out in session law 2013-306. In addition, they are listed on the 3051 form in the optional attestation box.

- **How do providers check to be sure their agency is on the random provider choice list?**
  Be sure that in QiReport you have checked all of the counties that your agency serves. Providers may contact QiReport customer support if you have additional questions.

- **How do you handle a beneficiary who will not consent to RN quarterly visits?**
  Supervisory visits are required in the PCS Policy and DHSR licensure rules. If they wish to receive services they must comply. Providers should direct the beneficiary and or legally responsible party to DMA or DHSR for questions.

- **Will DMA reassess those individuals who were assessed under the fall 2015 assessment criteria which changed in April 2016?**
  The assessment criteria for PCS has not changed however, the guidance provided to Liberty specifically addressed the PCS policy requirements. Beneficiaries who receive adverse decisions have the right to file an appeal. A timely appeal will result in Maintenance of Service. Beneficiaries are encouraged to provide documentation during the appeal process that supports their need for hands on assistance.

- **With change of provider requests, is there a way to see previous supporting docs?**
  Medical documentation is proprietary for providers who own that documentation and it is typically not shared. You will need to do your own assessment, ask your own questions, and gather your own historical documentation.

- **What are the requirements of the quarterly survey?**
  The only requirement is that a quarterly survey needs to be done and every beneficiary must have the opportunity to complete one. Evaluate what type of feedback is important to you to determine your questions.

- **What should we do if a beneficiary refuses to sign the service plan?**
  Beneficiaries receiving services under PCS are required to adhere to PCS and providers must ensure they do that in order to be compliant with policy. Providers may direct the beneficiary to the PCS policy or DMA if they have questions.

- **What do we do if a physician will not or does not complete ICD transition form, even after numerous attempts?**
  You may call Liberty Healthcare; Liberty has been working with DMA to reach out to physicians and explain the purpose and importance of completing the ICD-10 forms.

- **When beneficiaries bounce from provider to provider due to aide convincing them to switch because they refuse to be accountable or in compliance with program and agency policy. What safety precaution does LHC have in place to be sure the beneficiary is aware they are being switched over to another provider other than a phone call? And is there some verification to ensure that we have the beneficiary making the call to make the switch?**
  Liberty has a set of questions that we ask to try our best to ensure that the individual we are speaking to is the beneficiary. We may hold off on processing and call alternate numbers to be sure that the individual calling is actually the beneficiary who is requesting the COP.

- **What should we do if you did not discharge the beneficiary at the time of denial and it has been several months?**
  A provider is not required to discharge a beneficiary solely due to the denial of PCS. Once the provider has determined that they will discharge the beneficiary the discharge should be entered into QiReport within 7 business days of the beneficiary discharge.

Miscellaneous PCS Questions

- **If the provider observes what they feel to be poor customer service by the assessor, to who should this be reported?**
  Call our Liberty office and ask to speak with Denise Hobson or Lyneka Judkins. Liberty has a formal process of reporting to DMA all complaints that we receive about assessors.

- **When a beneficiary chooses a provider, how long does it take for a referral to come to QiReport?**
  Once the assessment is conducted, Liberty has a 72-hour (3 business days) process to review it and be sure it is accurate and doesn't need any corrections or clarifications. At that point, it is approved and then sent to the provider, so you should see it within 3-5 business days. Call Liberty if you are seeing this take more than 3-5 business days.

- **Do you have to have a CNA for a client with 1 extensive and severe/intractable pain or cognitive impairment?**
  PCS Providers should review the assistance level identified in the Independent assessment and apply to their Licensure requirements to determine the level of aide required. You may contact the home care consultants at DHSR with questions.

- **Do you ever decline PCS services based on environmental or safety issues?**
  Yes. There have been cases where an individual has been denied PCS for environmental issues or lack of safety. The requirement per policy is that the beneficiary must be in a safe environment.

- **Are the assessors clinicians? If so, what are their credentials?**
  The assessors are all registered nurses with experience in home care, Hospice, case management, or long-term care.

- **If a client loses Medicaid for one month, do you still have to discharge in QiReport?**
  Check for Medicaid status frequently. If they are still in their approved period, you won't provide services or bill during the time their Medicaid is not active.

- **Can this presentation be placed on webinar for future reference and education?**
  Yes.

- **What rights do beneficiaries have to choose their caregiver?**
  The choice of a caregiver is 100% the beneficiary's. Liberty has nothing to do with that other than asking who they choose.

- **Why are some of the patient's dates to be started after acceptance and on the client letter in QI state to start service the next business day and others state to wait 10 days after patient notification?**
  There are times when Liberty will do an expedited COP, such as situations where the current agency has discharged them or gone out of business and they are without service. We need to get them services as soon as possible, so they can get started with the new provider within one day. The standard is 10 days, which gives the current provider the opportunity to finish out the plan of care and discharge the beneficiary properly.

- **If a client goes into the hospital, comes out weaker than his first assessment, can the hospital discharge planner send a referral for a change of status before they leave the hospital?**
  If there is a Medical COS, it must be signed off by a physician. It would certainly be appropriate for discharge planner to submit a Medical COS with the physician's approval on it.

- **Can a person receive PCS short term due to broken bones, surgery, etc., and then be discharged when healed?**
  If that's what their needs are at that time, yes. The person can consent to be discharged at any time they feel they no longer need that service.

- **Will Liberty continue service into 2017?**
  There has been no discussion for Liberty to not continue as the IAE into 2017.

- **On Assistance Level, how many "Extensive" ADL's does a client have to have in order to have a CNA? Is it 2 or more? 3 or more?**
  Providers should refer to their DHSR licensure requirement or contact DHSR to determine the appropriate aide based on the assistance levels identified in the PCS independent assessment.

- **When a patient's hours are cut and they appeal, what are the correct procedures? Do we leave everything the same, or do we create a new care plan?**
  If the hours are reduced and the beneficiary submits an appeal within 10 days, they can continue to stay at the previous hours (MOS.) Providers will see in QiReport the requirement to do a Service Plan for the MOS 80 hours, and will continue to provide services at 80 hours until it goes through the appeal process. If the appeal is submitted after 10 days but within 30 days, the beneficiary can still get MOS but there will be a lapse and this will not go into effect until the appeal is received.

- **If we are unhappy with our current assessor, who do we contact to voice our concerns? Can we request another assessor to come to our building?**
  Liberty does have a formal complaint process. You may also call Director of Clinical Services, Denise Hobson, to discuss any concerns with her. Unless this is a substantiated concern, providers may not choose their assessors. They are trained to be competent on the same level.

- **If a client resides in a senior community that has a separate laundry facility on premises, is the aide allowed to do the laundry even though it is not in the apartment or even the same building?**
  Yes, as long as it is on the facility campus and is part of their living arrangements.

- **If a family member is no longer available to assist with needs of the beneficiary, how does a reassessment get scheduled?**
  Submit a non-medical COS request if their needs have changed.

- **What dementia training is provided to Liberty RNs?**
  Liberty RN's go through additional training for completing assessments for populations diagnosed with dementia, Alzheimer's or cognitively-impaired assessments.

- **Will a COS assessment be performed even if the beneficiary is at the maximum hours? (This is needed if the condition has changed as the service plan may be different.)**
  If they are already at the maximum hours, you can update the Service Plan. Document the information and create your own manual Service Plan until the annual reassessment is conducted.

- **Why have total denials for existing PCS recipients increased since Nov 2015 across all settings on annual reassessments?**
  DMA and LHC are consistently looking at data and trends, which was discussed in November 2015. DMA provided additional guidance to Liberty relating to assessing beneficiaries in accordance with policy. Once the guidance was implemented, DMA identified a decrease in annual approvals and reduction of hours. Beneficiaries who were reduced, denied, or terminated have the right to file an appeal. Questions regarding assessments may be addressed to Liberty.

- **What can a beneficiary do if their hours are reduced and they believe they need additional hours or the assessment did not accurately reflect their needs?**
  There are several avenues that can be taken. If it is an Initial assessment, there is the reconsideration process. If it is an annual assessment, there is the appeal process, and if there has been a change, a COS. We encourage you to call Liberty for guidance to be sure you know which process would be most appropriate, depending on the scenario.

- **Is Dementia non-specific an allowable diagnosis for extra 50 hours?**
  Liberty's assessment is the same regardless of the number of hours they are being evaluated for; they are all based off of demonstrated need. Criteria outlined in Session Law 2013-306 must be met to be eligible for additional hours of PCS.

- **What should a provider do if QiRePort does not generate a service plan after a referral is accepted?**
  This would be an extremely unusual circumstance; if this occurs, please contact Liberty.