Liberty Healthcare Corporation of North Carolina

Provider Training (October/November 2016) Questions and Responses

The following questions were posted during the October and November 2016 Provider Trainings that covered the following topics:

- Quality Overview
- Provider Requirements
- QiReport/Provider Portal
- Reconsideration Process
- Mediations and Appeals
- Miscellaneous PCS Questions

All questions with responses are provided in this document.

Quality Overview

- **What is Liberty's timeframe for correcting pullbacks?**
  Liberty's internal process provides 72 hours for the pullback process; this includes review, determination, and provider follow-up.

- **We often see several new clients indicated they need services on the weekends but they didn't ask for them; what is Liberty's approach for this?**
  Beneficiaries are evaluated by their need for assistance with an ADL, whether it is by an aide or family member. If services are needed 7 days a week, that will be indicated. If a family member can help can assist on the weekends, then the assessor will indicate needs met for those 2 days. Independent Assessors will take the word of the beneficiary when it comes to documenting the number of days that they feel assistance is needed.

- **Will Liberty allow provider RN's to undergo Liberty training?**
  Liberty provides training to their assessors and to the provider community at the request of DMA. There are several training resources posted on Liberty's website to be utilized by the PCS Provider community. Liberty will not allow provider RN's to undergo Liberty training.

- **After an assessor is trained are there ever any joint visits or supervision?**
  Yes. Liberty conducts four bi-annual joint visits each year and as needed otherwise.

- **Who do we report inaccurate assessments to? Is there a standard form?**
  There is no standard form. Call Liberty's call center to report inaccurate assessments and staff will forward your statement to the appropriate person in Clinical Services through an internal escalation process.

- **Does a nurse have to be present during the assessment in an ACH?**
  No, the beneficiary has the right to have anyone present during the assessment that they chose. The person present does not have to be a nurse, but it is encouraged that the person(s) present are able to speak accurately to the ability of the beneficiary to perform their ADL's.

- **Sometimes we are advised that an assessment is scheduled for a certain time, but when we show up, the assessment is finished; how do we ensure we are present during the assessment?**
  If the beneficiary requests that a third party be present, Liberty will make reasonable efforts to coordinate the assessment at a time when both parties can be present. With this understanding, Assessors are limited in changing their scheduled appointment times to ensure the third party is in attendance. If they see that a third party was requested to be present during the assessment, but is not present at the time of the assessment, the Assessor will ask if the beneficiary would like to proceed with the assessment. Beneficiaries have the right at any time to request a reschedule if they strongly desire third party presence. Though third parties are strongly encouraged to attend, Liberty is not required, and will not wait, for other individuals, such as aides, if they are not specifically identified by the beneficiary. If the beneficiary has a legal guardian or Power of Attorney on file with Liberty Healthcare. The documented POA or Legal Guardian should be contacted first in the attempts to schedule.

- **Sometimes during the assessment, the assessor will drive the beneficiary to do their ADL's to the point of exhaustion, they do it because pushed, but it is not their ability on a typical day. How do we deal with this? How do we get an accurate assessment?** The survey that DMA conducts includes this question to be sure that beneficiaries are not being pushed past their abilities. Assessors must see the beneficiary demonstrate, or attempt to demonstrate the ADL task to complete the assessment, and apply their clinical judgement to assess ability. If the assessor does not feel that the beneficiary can continue, they will offer to reschedule or allow the beneficiary to rest. If the beneficiary does not feel that the assessment is accurate, they may request a Reconsideration or an Appeal depending on which applies to their situation.

- **If a client is diabetic or has high blood pressure why is Liberty not adding BP/CBG monitoring?**
  At the time of the assessment, the nurse assessor asks the beneficiary if blood pressure or blood sugar checks are needed for a report to the physician or if these checks are needed for a blood pressure or blood sugar monitoring record. If the answer to that question is yes OR if the beneficiary is in a facility and the assessor sees an order on their care plan, it is included.

- **Why would a client be visited by 2 nurses from Liberty in 2 months?**
  An assessment may be requested by DMA at any time per clinical coverage policy 3L. There are several scenarios where an assessment may be needed within a two month period. Likely scenarios include when a beneficiary turns 21 or if a medical change of status is requested.

- **Why does the assessor only spend 10 mins with the client during the PCS assessment, and is this why the PCS hours drop significantly?**
  Assessments are expected to take between approximately 60 and 90 minutes per beneficiary. If a beneficiary experiences anything different, they are encouraged to contact the Liberty Call Center and/or DMA to report their experience.

- **Are partial hours being granted? For example ACH getting 0 hrs or 80 hrs, no partial.**
  Hours are determined by demonstrated level of need as well as the frequency of need. Hours are awarded in amounts that range from 0 to 80 and up to 130 for those who qualify for the additional safeguards.

- **What if Liberty allows the PA or causes the PA to expire, do we still have lapse although it is not our fault?**
  If the Provider feels a PA expired at the fault of Liberty, the Provider is encouraged to call Liberty so that Liberty and/or DMA staff can make a determination on whether or not the lapsed period will be covered.

- **I had a re-assessment that was several weeks overdue due to no nurse assessor available. Hours were approved in the interim, but moving forward will this continue?**
  No, this will not continue. Liberty experienced a time when they were short on assessors in a few areas which caused a backlog of assessments, but this has been corrected and should not be an issue going forward.

Provider Requirements

- **Is the ICD-10 form required once or every time they have their annual?**
  This form is required once and should be submitted to Liberty by January 31, 2017.

- **Why can't providers fill out transition forms from physician diagnosis codes given rather than make Dr. do paperwork?**
  The PCS Policy requires documentation of each PCS beneficiary's medical diagnosis or diagnoses, related medical information that results in the unmet need for PCS, and the current diagnosis codes associated with the identified medical diagnosis. In addition to this requirement, the PCS policy states that beneficiaries must be under the ongoing direct care of a physician for the medical condition or diagnosis causing the functional limitation.

- **Will physician offices be notified of the need to sign the ICD-10 form?**
  DMA will work with CCNC to notify physician offices of the required completion of the ICD-10 Transition Form in relation to Personal Care Services. Providers are also responsible for notifying the provider of this requirement and assisting the beneficiary in getting the form completed.

- **How are the providers notified of the ICD-10 Transition Form 60 days prior to the annual?**

Months prior to the annual assessment, Providers receive notification on the provider portal stating that the annual assessment is due. At this time, they will also receive a copy of the ICD-10 Transition Form. If you have already completed the form, you do not need to do so again.

- **What if there has been a change of provider since 10/1/2015, who is responsible for the ICD-10 form?**
  If the beneficiary still requires the form to be completed, the current provider will need to submit the completed ICD-10 Transition Form to Liberty by January 31, 2017.

- **Upon receiving a new client from another agency we find out that no ICD-10 transition form was done. Will the new agency be penalized or have more time?**
  The deadline to turn in all transition forms is January 31, 2017. All providers are encouraged to turn these forms in as soon as possible.

- **I have a PCS beneficiary whose MD would not complete the ICD-10 transition form and now the patient is no longer receiving PCS; am I still required to get the form completed?**
  No, the ICD-10 transition form is only required for individuals with active PCS and who were admitted into the program prior to 10/1/2015. If you are having difficulty getting a physician to complete the transition form, be sure to have all attempts thoroughly documented and then reach out to DMA or Liberty for assistance. DMA will look at these situations on an individual basis.

- **Can we get a list of people with no ICD-10 form on file?**
  A provider can identify who is still in need of a transition form by reviewing their 'Case Load Report' in QiReport.

- **Is there a way to check on the QiReport for the outstanding ICD-10 transition forms?**
  This can be found in the 'Case Load Report'.

- **The caseload report only shows whether or not LHC has the ICD-10 form, not if the client needs it or if LHC has received it. When the letters go out, who will be identified?**
  This is done by the IT vendor; they will provide a report to Liberty that will show everyone who should have a form but does not have one on file. If beneficiaries were serviced prior to 10/1/15, the form is required. Those coming into the program or with a change of status after 10/1/15 do not require the ICD-10 transition form.

- **If it's uploaded but has a (N) does that mean it's not filled out correctly?**
  If the Case Load report has "N" under 'Transition Form', it means that the form itself may have been received but it is either incomplete or it has not yet been verified for completion. If you have questions about this, please contact Liberty and staff will check for you.

- **How does Liberty notify a provider that the 3137 form that was uploaded is incorrect?**
  Liberty will call the provider and/or send a fax to advise them of the information needed to correctly complete the form.

- **What do you do if a patient was discharged before the MD signed the ICD-10 transition form?**

The form is required to be completed by the beneficiary's PCP or attending physician. Either physician can complete and sign the form.

- **When a patient goes into a hospital and we do not know they are coming back to the facility, how long do I wait before I discharge the patient off my patient list?**
  If the beneficiary is still in their approved period for PCS, the facility may resume PCS services. If the beneficiary is outside of their approved period, a new request will be required. If the facility does not have an estimated time of return and feels the need to discharge the beneficiary, then they should discharge the beneficiary from QiReport as well.

- **Can LHC add the ICD 10 to the beneficiary profile main page in QiReport so the provider can see the diagnosis as well?**
  This is a very good suggestion that DMA will take into consideration.

- **Where in PCS policy or licensure it is written that PCS Providers are required to submit DMA 3137? And then threaten "Program Integrity"? Where in writing is this agency requirement?**
  The PCS Policy requires documentation of each PCS beneficiary's medical diagnosis or diagnoses, related medical information that results in the unmet need for PCS, and the current diagnosis codes associated with the identified medical diagnosis. In addition to this requirement, the PCS policy states that beneficiaries must be under the ongoing direct care of a physician for the medical condition or diagnosis causing the functional limitation. Completion of this form ensures policy and program compliance.

- **Does the Service plan and plan of care (agency) have to be separate forms? Can the agency upload a plan of care and not have client sign 2 separate forms?**
  Refer to Section 6.1.4 of the PCS Clinical Coverage Policy 3L. **The PCS service plan is not a plan of care** as defined by the applicable state licensure requirements that govern the operation of the provider organizations. Provider organizations are expected to complete a separate plan of care in accordance to licensure requirements as specified in 10ANCAC 13J, 10A NCAC 13F and 13G, and 10A NCAC 27G. In the case where a manual service plan is required (hours approved do are not reflected by the most recent assessment), the plan of care can be used as the service plan. In these instances, providers must upload the manual copy of their service plan and/or plan of care and contact Liberty Healthcare immediately to receive prior approval to bill.

- **Does the signed Service Plan need to be signed and uploaded within 14 days of accepting the beneficiary or within 14 days of completing the SP?**
  The PCS Provider has 7 days from acceptance to complete the Service Plan and then 14 days from the date the Service Plan was completed to have it signed and uploaded to Qireport.

- **Why is a new service plan required when a recipient goes into MOS? Why can't the old SP be used?**
  The system should forward the previous year's assessment so that you may complete the Service Plan with easy duplication. It must be done this way because Service Plans are linked to prior approvals. If the assessment forwarded does not reflect the correct number of hours, the provider will be required to complete a manual service plan, upload it to QiReport, and contact Liberty Healthcare immediately to be issued prior approval to bill.

- **How do we obtain a signature on a service plan If we cannot get the POA to sign a care plan because the client fails to return calls, respond to 2 certified letters and the patient has Alzheimer's/Dementia?**
  In the case where the PCS Provider is not able to obtain a signature, they will need to show documented proof of all outreach efforts in an attempt to get the beneficiary/POA approval on the service plan.

- **Can DMA make available a list of providers that have not done their SP in time?**
  No, but PCS Providers can view all outstanding service plans by going to their 'Plan' tab in QiReport and then by looking at 'In Process Plans'.

- **How often do we need to upload the SP for EPSDT?**
  A Service Plan is needed every time a PCS Provider accepts a beneficiary in their portal as well as any time there is a change in the beneficiary's approved hours.

- **Why can't the task sheet be revised for decreased hours from appeals? Because of this a manual service plan has to be done.**
  DMA is currently working with Viebridge to add to the Service Plan functionality in QiReport. When there is an adverse decision and information is provided to support the need for PCS, the DMA appeal nurse will have the ability to update the current assessment to reflect the need determined during the hearing settlement process without scheduling a face-to-face assessment. This will allow for the assessment to be updated and resubmitted to the provider for acceptance in their referrals for review queue, accept, and complete a new service plan based on what was changed during the appeals process. This functionality should be available sometime in 2017 and will hopefully decrease the number of manual Service Plans by up to half. A bulletin with additional information will be posted to DMA's website.

- **Customer service has said you do not have to call for a manual service plan, is this true?**
  That is not correct. Every time a provider has to do a manual service plan, they need to call Liberty in order to receive approval on the submitted service plan and have PAs released.

- **Will the agency be held responsible if the following occurs: Liberty finds an error on assessment and has the assessment pulled back and the agency is asked to create a manual plan? The agency then uploads their service plan however the Liberty service plan still shows months later.** If Liberty pulls back an assessment and it is corrected, the provider is able to complete the required on-line service plan as the corrected assessment will be resubmitted to the provider portal for accept/reject. In other cases, when a manual plan is needed, the on-line service plan requirement will be removed. Providers must upload the manual service plan and contact Liberty immediately to receive prior approval.

- **Why is it that the agencies do not get paid for all the weekly hours determined by Liberty for the beneficiary? The agency is paying the aide the weekly hours, but the agency is not getting paid for all of the hours.**

Liberty does not determine hours, they assess the beneficiary and enter the information gathered and the demonstrated need. There is an IT vendor and an algorithm that calculates the hours. As for not being paid, there may be times the Service Plan says one thing but the hours do not match up. This occurs due to there being a different number of days in months. The system requires average weekly hours, so providers have the responsibility to look at the hours that are awarded each month and make any adjustments to ensure coverage based on the beneficiaries PCS need frequency. This must be done on the provider's end. DMA is working on a functionality that will help providers look at each month and the hours awarded, and overlay on the days of the week. Providers are responsible for providing the number of hours authorized in the beneficiary/provider notification.

- **Why are providers penalized twice for not submitting a service plan in a timely manner? We do not get a PA and are reported to Program Integrity; this seems excessive.**
  Submitting completed service plans is a program requirement. DMA is responsible for making sure that the providers are in compliance with policy by billing accurately for services they have provided. Prior approval for PCS hours are not granted until the on-line PCS service plan is entered into and validated by the Provider Interface.
  A referral may be made to Program Integrity because failing to submit the Service Plan within identified time constraints is an indicator of policy non-compliance. Refer to PCS Policy Section 6.1.4.

- **If a client has a dementia diagnosis but less than 80 hours, is the DMA 3085 and training required?**
  No, but it is strongly encouraged that Providers complete this training as the beneficiary's condition could change, resulting in an award of additional safeguard hours in accordance with Session Law 2013-306. If the Provider provides care to a beneficiary without ensuring that the aide has completed these training requirements prior to billing for services, the provider would be in violation of policy.

- **If none of your PCS clients have a Alzheimer's/Dementia Diagnosis, do you still have to do Alzheimer's/Dementia training?**
  No. Training is only required for aides that service beneficiaries who meet the qualifications under Session Law 2013-306.

- **When is the 3085 due?**
  The 3085 must be turned in to DMA prior to billing for services that were rendered to a qualifying beneficiary. The dates of service must reflect a time period after training was completed and the form submitted to DMA.

- **Is there a certain number of hours (training hours) required for the session law?**
  There is no designated amount of hours required. All training requirements are outlined within the attestation form and its instructions. Training is also included on Liberty's website; you may follow the curriculum and complete the attestation form.

- **Can a home care agency train a PCA to do the job of a CNA? The majority do a better job than a CNA.**

Providers should contact DHSR with licensure questions.

- **Can the nurse consultants answer questions regarding PCS staffing? i.e. If I need a CNA or not?**
  Please reach out to DHSR with any licensure questions. Liberty Assessors are not in a position to give advice on whether you are required to staff a beneficiary's home with a PCA or CNA. Review the beneficiary's PCS assessment in conjunction with licensure rules to make an appropriate determination on the type of aide the beneficiary needs.

- **On criminal background Policy 3L: how old do the felonies related to manufacture distribution of prescription or dispensing of a controlled substance have to be?**
  Refer to Section 6.0 of the PCS Clinical Policy 3L. The requirement states Providers shall not bill for Medicaid PCS services provided by an individual with any of the following convictions on the criminal background check conducted in accordance with 7.10(d.1) of this policy. There is no time limit on the conviction indicated.

- **If a patient's Medicaid is suspended due to some glitch and the problem is not resolved immediately, do we have to discharge within 7 days?**
  No. Contact the beneficiary's county DSS Medicaid Worker to resolve. If the beneficiary is approaching their annual assessment due date, contact Liberty to notify them of the system error. An annual assessment will not automatically be scheduled if the NCTracks shows the beneficiary is not eligible.

- **Is there any way to recoup payment for services if client's Medicaid is stopped and the agency didn't know it and services were continued?**
  In the case where a beneficiary's Medicaid is not active, payment will be denied for services. It is the provider's responsibility to ensure eligibility see section 2.0 of the PCS Policy "Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered."

- **Policy 3L states that providers should attend all DMA/Liberty Regional trainings; how should we document that we attended?**
  Providers should print out your registration sheet and keep a copy of it. You may also keep a copy of the agenda or any other supporting documentation.

- **With the detailed assessment that Liberty is doing, do providers still need to do such a detailed assessment at the initial visit or should we depend on what your RN has completed?**
  Refer to licensure regulations regarding the information providers are required to capture at the time of the initial visit in compliance with Licensure. **Again, the service plan is not the Plan of Care.**

- **Are there specific requirements to stay in compliance with annual PCS surveys?**
  Yes. Refer to Section **7.7 Internal Quality Improvement Program** of the PCS Policy.

- **Can the satisfaction survey be a call assuming the results can be printed?**
  No, this must survey must be a written type of survey that the beneficiary can sign. There must be documentation of what questions are being asked and the results as indicated by the beneficiary.

- **How many years do we have to keep records of 3136 forms for audit purposes?** Providers should refer to their NC DHHS Provider Administrative Participation Agreement for maintenance of records requirements.

QiReport/Provider Portal

- **How can I get my own username and password for QiReport?**
  You may call Viebridge directly or refer to the home page at www.qireport.net.

- **What do you do when the referral comes in on the wrong locator code? I always have to call.**
  Call VieBridge and request that they set up locator codes in your profile; this will provide you the ability to change locator codes when necessary.

- **Is there a "print" option for accepting the referral for agency documentation for timely acceptance?**
  Not currently, but use the approval letter for documentation purposes. Providers are encouraged to print these out and keep the documents in your file.

- **If the 1st provider does not accept the referral in time, does Liberty tell the beneficiary to find their own PCS provider?**
  When a provider does not accept timely, Liberty will follow up with that provider. If that provider decides to reject the referral or Liberty is unable to get a hold of the 1st choice provider, then Liberty will reject on behalf of the provider and move to the 2nd selection. In the case where Liberty has exhausted all options selected by the beneficiary, they will mail the beneficiary a new, full list of providers and advise them they need to select three new choices.

- **Where is the caseload report in QiReport?**
  You can find this by clicking on the "Reports" tab from the top, right task bar.

- **How will discharges be removed from QiReport?**
  Discharges are removed systematically. Beneficiary profiles remain in QiReport for up to 6 months so they can be accessed if historical data or documentation is needed**.**

- **What do we do when the hours in the month do not match the hours in the service plan?**
  Document any deviations that occur because the system rounds hours up and down based on the average number of days in a month. Providers will be reimbursed for the approved amount of hours each month, but need to document deviations that account for all hours.

- **If a client's schedule changes must they upload a new service plan?**
  If a beneficiary's schedule changes, but the hours for each day/week/month remain the same, then the PCS Provider simply has to 'edit' the service plan. If there's a change to frequency of tasks or days required, a Change of Status must be requested since the beneficiary's needs have changed.

- **Client gets 80 hrs monthly and then goes on vacation or into hospital; can their 80 hrs be adjusted through the month to give all 80 hrs of service to client?**
  No – if you cannot provide services for a beneficiary on a particular day, it is not billable.

- **Why can't we have better access to QiReport to make changes? Ex: Instead of manual service plan – change hours on plan as needed.**
  The provider organization accepting the IAE referral to provide PCS services shall review the IAE independent assessment results for the beneficiary being referred, and develop a PCS service plan responsive to the beneficiary's specific needs documented in the IAE assessment; If a manual service plan is needed because the last assessment does not reflect the beneficiary's current approved hours, a manual service plan must be submitted to Liberty Healthcare for review/validation before prior approvals are issued. DMA is working with our IT Vendor to release functionality that will reduce the number of manual service plans needed when hours are awarded during the appeal settlement process.

- **How do you modify an assessment in QiReport?**
  You will not be able to modify an assessment in QiReport. If you see an issue that may be an error, contact Liberty so it can be referred to the Clinical Services Department for review.

- **Who can submit a medical COS?**
  A medical COS must be completed by a physician, but can be faxed/mailed to Liberty by the beneficiary, caregiver, PCS Provider, etc.

- **Beneficiary requests 5 days a weeks of service instead of 7 after their assessment. How long after the COS form has been faxed can a response be expected?**
  Once Liberty receives the request, the request will take 2 business days to process and scheduling is done within 14 business days.

- **How do ACH providers see a copy of the denied assessments? Denials do not show in QiReport for new admissions and the beneficiary does not receive a copy of the assessment.**
  The beneficiary can request a copy of their assessment at any time. In regards to denial notifications, communication goes to authorized persons. If a beneficiary had a new request that was not approved, then there is no approved PCS Provider on file in which to communicate so notification goes to the beneficiary only.

Reconsideration Process

- **Is the process exclusive to denied new/initial requests for PCS?**
  The process applies only to beneficiaries who submitted a new request and was awarded more than 0 hours but less than 80 hrs. If there is a full denial, the beneficiary receives appeal rights and is encouraged to go through that process if they do not agree with the outcome of their assessment. If the new request had a completed attestation for additional safeguards, then the beneficiary is eligible for both reconsideration and appeal rights. Appeals must be submitted

within 30 days; reconsideration requires waiting until at least day 31 before submitting the request.

- **If hours decrease during the Reconsideration process, are there appeal rights?**
  Hours will not be decreased during the reconsideration process; hours remain the same or they are increased. If hours remain the same, the beneficiary will receive appeal rights.

- **Does the beneficiary need an agency to actually accept the beneficiary before Liberty will reconsider?**
  Yes.

- **Can an Alzheimer's Unit request a reconsideration review if the units are under 130 hours?**
  No. The reconsideration process applies to beneficiaries who submitted a new request that received more than 0 hours but less than 80 hrs.

Mediations and Appeals

- **Can the provider fax or mail the appeal form for the beneficiary?**
  There is no restriction on who can fax or mail the appeal form.

- **Define "good cause" in the mediation process.**
  The Office of Administrative Hearings will determine if there is a reasonable excuse for a beneficiary to not appear at mediation, such as a hospitalization or another type of emergency.

- **When a beneficiary does not file an appeal within 10 days because they did not receive the denial letter but files within 30 days, why is the benefit not retro to the first day of the denial?**
  It is the responsibility of the beneficiary to make sure their address remains current with DSS. All mailings are sent to the address on file with DSS. To prevent a lapse in service, a beneficiary must file their appeal within 10 days from the date on the notification.

- **Do MOS PAs continue to be retroactive?**
  If the appeal is filed within 10 days, then MOS will be made retroactive with no lapse. After 10 days, the period will be lapsed and MOS will become effective the day the appeal is filed.

- **During Maintenance of Service, which services (assessment) should the client receive? Can the MOS letter have specific date of which assessment is now active?**
  When a beneficiary receives MOS, a MOS service plan will populate in QiReport. That service plan will indicate the hours and ADL needs approved during the MOS period.

- **Why would the hours of a beneficiary decrease if they do not demonstrate for the nurse the ability to perform the ADL's?**
  If a beneficiary does not demonstrate their ability to perform their ADL's, then an accurate assessment cannot be conducted. The IA scores each ADL based on demonstration; if no demonstration is conducted, then the IA cannot score that ADL and therefore it could impact the outcome of the assessment.

- **What should take place if a client never receives papers due to wrong address (due process?)**
  The beneficiary should call Liberty and request a copy of the notification be sent to a requested address. In addition, the beneficiary should update their contact information with DSS immediately to ensure that all important notifications are received in the future.

- **MOS service plans, do you recommend a format to use?**
  If a MOS Service Plan is being manually updated, any format may be used as long as the frequency of tasks match the number of hours.

- **If you have an appeal resolution and the hours are different than the service plan hours, what do you do? Ex: The beneficiary was awarded 80 hrs in the settlement but the assessment says 60 hours.**
  You would complete a manual Service Plan, upload it into the system, and notify Liberty that it has been uploaded. Liberty will review and manually remove the requirement for the electronic Service Plan. Any time a manual Service Plan is completed, the Provider must notify Liberty via phone call.

Miscellaneous PCS Questions

- **Do children under 10 years old still have to go through the Liberty process to get services and is there a quicker way for them to receive PCS? If so, what is that process?**
  Any person requesting PCS must have an independent assessment conducted by Liberty. The process for approval of any person under 21 may take longer as these individuals also require approval from DMA, in addition to assessment completion by Liberty.

- **For Adult care homes/ALF why is it so hard for DMA and State Licensure (DHHS) to get together on the required care plan and Independent Assessment?**
  DMA and DHSR are working together to understand and consider potential solutions that could increase consistency between the required plan of care, the independent assessment, and the service plan.

- **What can be done for beneficiaries that do not have anyone to get groceries?**
  Beneficiaries should reach out to their local Department of Social Services for referrals to programs that may assist with running errands and providing transportation. Personal Care Services does not cover these issues.

- **When will this PCS provider training be on-line so that other office RNs/staff can review?**
  A live Webinar was provided on October 28, 2016 and should be posted on-line shortly after. Please call Liberty if you cannot access it.

- **Who do I contact if I am having trouble getting my calls answered/returned?**
  Any caller is able to escalate their concern beyond the Customer Support line at any time. When calling in, simply ask to speak with a supervisor. In addition, the contact information for all Directors is on the Liberty website.

- **Is the DMA internal audit a desk review or onsite and who will conduct it, DMA or Program Integrity?**
  This is a desk review conducted by the PCS team at DMA. Providers will receive letters in the mail, which will include the specifics of the request as well as the timeframe in which they have to submit this information to DMA. If the requested information is not received in a timely manner or is incomplete, the PCS Provider will be referred to Program Integrity.

- **Regarding the DMA internal audit, a nurse consultant called at 4:12pm asking for timesheets on two clients for the entire year, as well as the aide information, and wanted them "now." Can we have at least 5 days to submit information?**
  DMA has changed its processes regarding the internal audit. Providers will receive letters in the mail, which will include the specifics of the request as well as the timeframe in which they have to submit this information to DMA.

- **Is there a minimum number of hours that Liberty should approve per day if the beneficiary qualifies for PCS?**
  Liberty does not calculate hours, approve, or deny services. An algorithm calculates the number of hours awarded based on the data entered at the time of the assessment. There is no minimum hours per day, hours are awarded per month.

- **If a beneficiary is approved for PCS hours but gets only 1 hour per day x 5 days, will the aide be able to complete all of the ADL's and IADL's in one hour?**
  Providers must review the assessment of each beneficiary they receive as a referral and make a determination if they are able to accept and provide services for the beneficiary within the program requirements.