Provider Training (Sept. 2015) Questions and Responses

The following questions were posted during the September 2015 Provider Trainings that covered the following topics:

- ICD-9 to ICD-10 Transition
- Quality Improvement Program
- Service Plan
- Agency Change of Ownership
- Assessment Changes
- Miscellaneous PCS Questions

All questions with responses are provided in this document.

ICD-9 to ICD-10 Transition

- **What is the name of the form that will be taking place of the 3051 form?**
  The 3051 form is not being replaced – it will still be used for new requests, change of provider and change of status requests. The 3137 ICD10 Transition Form is a new form which is used for ICD-10 codes.

- **Exactly what is an ICD-10 code?**
  International Classification of Diseases is a standardized coding methodology used to identify conditions that are associated with a medical diagnosis.

- **When completing the ICD-10 will the codes be the same as ICD-9?**
  No, the ICD-10 codes will be different.

- **Are all diagnosis codes needed or just main diagnosis codes?**
  Per policy, the diagnosis codes that are needed are the ones that impact a beneficiary's ability to perform their ADL's resulting in the need for PCS.

- **Do new clients have to have ICD-10 codes, or only the annual assessments?**
  Everybody must have ICD-10 codes after October 1, 2015.

- **Why does Liberty or DMA not send out a paper copy of the new ICD-10 codes in a booklet form?**
  Liberty and DMA do not send this out because it is not their requirement – it is a national requirement. You may order your own manual from the CMS and NCTracks websites; in addition, there is also an online ICD-10 code lookup application.

- **Who will monitor codes for information for correctness of ICD-10 codes?**
  Anytime the ICD-10 codes are sent into Liberty on a Transition Form, they will check to be sure the codes are valid.

- **Is the ICD-10 effective with the Date of Service or the Billing date?**
  It is the date of service.

- **What is going to be the difference in ICD-9 to ICD-10 as far as clients being eligible for home health care?**
  There will not be any changes regarding the diagnoses and ADL's. The process will remain the same.

- **What should be done if a patient has a diagnosis that affects their performance but is not on the list of diagnoses?**
  DMA requires that medical diagnoses are provided on the DMA 3051 or the ICD-10 transition form which must be completed by the beneficiary's practitioner.

- **The website Liberty has provided for converting IC9 codes to ICD-10 codes will list more than one code to select from; how do we know which one is the correct one to use?**
  The conversion code is for a one-to-one. If there are many ICD 10 codes for one ICD 9 code, you must have a practitioner involved to make sure the correct diagnosis is used.

- **ICD-10 codes some are only 3 digits and the form says 4 or 5 digits are required what is the format for ICD-10 codes?**
  There is an ICD-10 Look-up form on the CMS.gov website for your reference in verifying the codes.

- **When the DMA 3137 Transition Form was returned, there were only 3 diagnoses listed (ICD-10.) The patient had many more diagnoses – should I only list those 3?**
  Only diagnoses that have a direct effect on the ADL's for PCS need to be listed on the 3137 Form. Include any diagnoses that the doctor has attested for.

- **80 hours per month, 74 hours/4 weeks, 2.64 hours per day. Is a manual assessment required for the 6 hours for a 30/31 day month?**
  If the hours awarded are more than the assessment then a manual service plan must be done. However, this is asking about the rounding up and down of hours which will require a manual deviation to be applied for the differences in hours each month. The provider is still awarded and paid for the 80 hours each month but it is their responsibility to document the deviation on the individual weeks and account for the differences of hours; just like in previous times. DMA is looking to improve this part of the process.

- **How many numbers does Liberty want in the ICD9 – ICD -10 codes?**
  Practitioners are responsible for providing appropriate ICD10 codes. No specific number of codes is required. Liberty will check the transition form and validate the ICD-10 codes.

- **How many days prior does the DMA 3137 need to be uploaded?**
  It must be uploaded prior to the annual assessment.

- **Can we complete the ICD-10 Transition Form and submit anytime or does it have to be submitted close to the assessment date?**
  It can be submitted at any time.

- **Does the PCS Provider have to take the DMA 3137 to the beneficiary's doctor?**
  The requirement is that the doctor has to sign it – it may be faxed, taken by the beneficiary, etc.

- **If the physician signature is needed on the ICD-10 transition form, how can we upload the form?**
  You can give the form to the practitioner on the beneficiary's behalf, and upload it when the form is completed and returned to you. The beneficiary may also bring the form when they see their doctor, or give it to the aide to turn in with their time sheet, and then upload when it is returned to you. Doctors should be sure to fax the form to the number that is provided on the form if they wish to do it themselves.

- **PCS Providers do not have the responsibility to put diagnoses or codes on any forms, correct?**
  All the 3051 and 3137 forms are to be completed by a practitioner, physician, MD or PA. The Physician should be the one attesting to this information; not the provider.

- **Are physicians aware of the importance of the new PCS ICD-10 Transition Form and the requirement for the provider to get this form filled out?**
  Physicians are aware of the effective date of the change to ICD-10's and that everyone must be using them as of 10/1, but they may not be aware that the 3137 Transition Form needs to be filled out for beneficiaries who have PCS.

- **How often will the ICD-10 Transition Form be required? After a year, we will not need the ICD-10 transition form because the 3051 will include the ICD-10 codes, correct?**
  The ICD-10 Transition Form is required on every beneficiary before the next annual assessment after 10/1/15. Once the valid codes have been received, the transition has occurred and the form will not need to be sent again. It is correct that the Transition Form will not be needed after one year.

- **It is my understanding that Liberty will not attempt to get the ICD-10 Transition Form from the patient's Physician. Is it completely on the provider and beneficiary?**
  Yes - the ICD-10 transition form must be received by Liberty before the annual assessment is due for all beneficiaries currently receiving PCS, and each person's beneficiary profile will require ICD-10 codes. If there is some difficulty in receiving this information, Liberty will assist in obtaining the necessary codes, beginning two weeks prior to the annual assessment.

- **We are consistently seeing no codes on the Liberty assessment. Should we reject them?**
  Every diagnosis that we have for the beneficiary has already populated into the assessment. These should not be rejected - call Liberty if you see any assessments without a diagnosis or diagnosis code. You may also see a validation error of 0000 if the ICD-9 code is invalid.

- **In billing Medicaid, does this affect only diagnosis codes? Will there be a need to register more than one major diagnosis code?**
  The requirement in NCTracks has not changed for billing purposes. For PCS, DMA needs to get updated, current diagnoses from your practitioner.

- **I use a third party to submit all of my billing. The company that does my billing said they did the conversion for the primary diagnoses for my clients and all I need to do is fill out the demographics on the form. Is this correct?**
  The doctor is responsible for reviewing, attesting to, and signing the form. Please make sure that your billing agents have converted the diagnoses from ICD-9 to ICD-10's. Providers should reach out to practitioners to identify ICD-10 codes for beneficiaries.

- **How can a PCS provider obtain ICD-10 codes from client's PCP for current PCS client to be able to bill correctly for the change over?**
  The same information for billing is provided on the 3137 Form, where the ICD 10 codes for any diagnoses that pertain to ADL's for PCS are given.

Quality Improvement Program

- **Can this QI Program be the same as what is needed under the star rating to earn extra points?**
  It may be used if it meets the criteria.

- **If a facility has 2 points on its STAR rating form for a QI plan, is that plan OK for PCS purposes?**
  If you already have a process in place to support your STAR ratings, include this in your Qi plan. However, this does not replace the requirement for the PCS QI compliance plan.

- **Each quarter there seems to be an increased number of hoops to jump for PCS, is this a way to do away with this program?**
  DMA is focused on health outcome and recognizes that the PCS program is very beneficial to the community it serves. They are constantly monitoring the program to identify ways to improve it, such as the QI program, and to ensure that providers can continue to provide the best care to the beneficiaries.

- **Who needs to complete the DMA 3136 form (Quality Improvement Attestation)?**
  DMA has not designated that any particular person must complete the 3136. An individual who represents the agency must attest that the program is in place and meets all criteria.

- **Who signs the 3136 Quality Program attestation form?**

Anyone within your agency or supportive staff; it does not need to be an RN or the owner.

- **How do we submit the 3136 form to DMA?**
  The appropriate fax number is at the top of the actual form.

- **When does the DMA 3136 take effect?**
  It is due by December 31, 2015 and will continue to be due annually on December 31 of each year.

- **Is Form DMA 3136 to be filled out for each client? Does it have to be sent in? I am confused about the 12/31 due date.**
  The 3136 Form details the QI Plan that you have in place for your organization, so it must be filled out per agency, not for each individual beneficiary. The DMA 3136 is due by 12/31 of each year, beginning in 2015.

- **The DMA 3136 must be submitted annually, however, the training attestation for Alzheimer and Dementia training was one time, right? Why would there be a double standard for these two attestations?**
  The quality form is for quality improvement process and the other is for training to attest that your staff is specifically trained in this area. They are completely different.

- **Is there a Program Integrity self-auditing form available for PCS compliance and Qi?**
  Not currently.

- **What happens if a facility does not complete DMA-3136?**
  This is the attestation for DMA and is a policy requirement. You would be out of compliance and may come up for a Program Integrity audit.

- **Can anyone within the office create and update a client's Quality Improvement folders or must it be done by a RN?**
  The QI folders are for your agency or facility, not for direct beneficiaries. Any staff in your company (director, supervisor, part of QI department, etc.) can be designated to keep track of the Quality Improvement processes and folders.

- **Will the information being submitted to PI related to Service Plan deviations also be submitted to 3rd party audit reviewers like PCG?**

Yes, the information discussed between DMA and PI is always distributed to third party audit reviewers such as PCG.

- **We measure falls, med errors, etc. Do we have to show these records upon request to PI, DMA, etc.?**
  If your agency is audited, you may be requested to provide this information at that time. You are required to send the 3136 form by 12/31 each year confirming that you have a QI program in place and attesting that you are doing everything that is required.

- **Does the required QI program have to be directed to PCS only?**
  The Policy requires a QI program for PCS services; however, you may use the customer satisfaction survey for all residents you provide health care services for.

- **QI as it relates to discharge letters, can those be housed through the QiReport?**
  Once someone is discharged, they will come out of your system and you will no longer have access. If they have been denied PCS, they will stay under your denials. You will want to have a personal individual file for each of your clients for reference purposes.

- **Do all aides have to be CNA's for PCS after 10/1/2015?**
  No, they do not.

- **Where do we get money to hire extra staff to develop and keep QI plans in compliance with DMA?**
  The size of your company and the number of people you serve will affect the process and the approach that you take. The requirement has always been there, but now an attestation must be done to ensure that the process continues to happen.

- **How are ACH and SCU residents going to participate in the QI paperwork?**
  DMA does not expect that every beneficiary will complete the customer service survey. The expectation is that they be provided an opportunity to complete it. If you would like feedback for a cognitively-impaired beneficiary, you can ask their legal guardian, POA or caregiver for feedback.

- **Many of the Customer Satisfaction Survey examples seem to be geared towards In Home Care. Can you provide more examples of how this would benefit Adult Care Homes?**

It depends on what type of questions you would like to ask. Some examples include: did letters go out to family on time, did staff introduce themselves when they entered the room, is food hot, and do they wash their hands?

- **Section 7.7 states the beneficiary and their legally responsible person must complete the survey, can you explain with an example?**
  It is not required that a survey be completed by each beneficiary or legally responsible party. You would offer the clients you select the opportunity to complete the satisfaction survey. If the beneficiary is cognitively-impaired or unable to complete the survey, their guardian or POA may do so.

- **Does the PCS QI requirement have anything to do with the state surveys?**
  No, PCS is completely separate. If you already have something in place that meets all of the criteria for state survey requirements, you may use that.

- **Do residents who are not receiving PCS money have to be part of the QI surveys and QI program?**
  No, this is a requirement for DMA's PCS Program.

- **How can we obtain a copy of a sample customer service survey**?
  There are no requirements for the survey. Providers should determine what is important for them and what they want to measure in determining the questions to ask in the customer service survey.

- **With a QI survey, an example was given of a survey by phone. But policy says written – Is the verbal acceptable?**
  It does need to be written, per policy. If you choose to conduct them by phone, you will need to record the responses on a form for your records.

- **Liberty does the reassessment yearly at the patient's home, why can't the patient satisfaction survey be obtained by the Liberty RN at that time?**
  Liberty is not the agency and therefore does not determine what information is most important for an agency to measure. Each agency should ask questions that will help

them improve the quality of care and customer service provided to the beneficiaries. In addition, the agencies, not Liberty, are required per policy to provide the survey.

- **Once client satisfaction surveys are sent in and the data has been tabulated for QI, must those completed surveys be retained? If so, for what length of time? If they are anonymous we cannot put them in a client's chart.**
  It is recommended that you keep the information in some type of survey file so it will be available if asked for it. We are unaware of any requirements for keeping the information, but would suggest keeping it as far back as you would anything subject to an audit.

- **Other than surveys, what other incentives or methodologies do you use to retain clients and ensure satisfaction?**
  It is recommended that you have consistent contact and communication with the beneficiary and responsible parties. Obtain feedback, try to be sure they are satisfied, and respond to any requests in a timely manner.

- **Every year we average about 30% return on surveys, but send to 100%, any suggestions on better response?**
  Unfortunately, we do not have control over who returns the surveys, but 30% is an average on return rates. Get creative – use joint supervisory visits to hand deliver the survey, ask them to complete it when the aide is there and send it in with their time sheets, call and tell them how important the survey is, send reminder letters, etc.

<u>Service Plan</u>

- **Do Service Plans need to be done quarterly or yearly?**
  Service plans are done within 7 business days of accepting the client in QiReport.

- **For existing PCS clients when should the service plan be completed via NCTracks?**
  The Service Plan should be completed in QiReport within 7 business days of the time the beneficiary is accepted.

- **What are the consequences if a provider does not complete the Service Plan in QiReport within the 7 day timeframe?**
  If it is not completed within 7 bus days the provider would not be in compliance with the requirements for PCS services and may be audited. In addition, no PA's will be generated and the provider may not bill for services.

- **Understanding that the provider has 7 days from the day of accepting the client to provide a service plan, what do we do if we are unable to contact the beneficiary or family or to schedule the home visit and assessment within the 7 days?**
  It is still required that the service plan be completed; you may need to reach out to other avenues such as going to the beneficiary's home. You can draft up the service plan without their consent or a home visit, and will have 14 days after that to get consent. If the day or times do not work for the beneficiary, you will have the opportunity to edit the service plan.

- **We have had a problem with the client changing to the agency from another and after the annual assessment gets sent to the wrong provider, how do we correct that?**
  At the time of assessment, the beneficiary is able to choose their provider. If they make an error or change their mind, they must notify Liberty. This situation also occurs when providers don't complete their Service Plans within 7 days – they will not reflect as the current provider.

- **Who is required to sign the service plan?**
  The beneficiary or responsible party.

- **When counting 7 days and 14 days, are weekends included or business days?**
  Business days.

- **I completed the Service Plan – how can the beneficiary's signature on the Service Plan be uploaded?**
  Print out the Service Plan and take it to the beneficiary, POA or responsible party for them to review and sign. Use the supporting documents to enter into system within 14 business days.

- **What if a beneficiary's POA or responsible party lives in another state and is unable to sign the service plan within the 14 day timeframe?**
  You are required to have the service plan signed and uploaded. A signed service plan must be submitted within 14 business days of the validated service plan. Document attempts made to obtain the signature and the reason provider could not obtain for reference in the event of an audit.

- **I didn't know the service plan had to be signed by the client. Can we go back and take the SP out of the chart and have it signed by the client, then send this to Liberty and call since it's been longer than 14 days?**
  The Service Plan is a policy requirement and must be signed and agreed upon by the beneficiary, their responsible party, POA or guardian – even if it has been longer than 14 business days. It can be uploaded directly into the supporting documents on QiReport through the portal. Be aware that you may be subject to an audit.

- **How long do I have to upload the Attestation Form attached to the Service Plan?**
  14 business days.

- **What happens when a COP occurs after the provider has accepted and completed the service plan, but the owner of agency does not wish to upload the plan and the plan has not been signed within the 14 day period?**
  You will be out of compliance. Contact Liberty if there is some reason you cannot submit the service plan or provide care so they can move forward with finding another provider. Be sure to check the frequency of required services to be sure you can meet the requirements in that assessment before accepting.

- **After printing the service plan, if the client becomes hospitalized – what happens for the provider to upload it?**
  If the beneficiary goes to the hospital before you can obtain a signature, this needs to be documented so you have it on file. As soon as they are out and you can get the signature you need, then you can upload the Service Plan.

- **Where can we find out if we have service plans that have not been uploaded?**
  You can find that within your portal. It will show in the beneficiary's status tab for Service Plans – New, In Process, and Completed. In addition, when you log into your portal, click on the "Plans" tab at the top, then "In Process Plans" in the left column. This will display all SP's that are still outstanding, as well as the dates they were sent to you.
- **Can we split visits when beneficiaries go to the doctor? For example, go in and quickly sponge the person off and dress them for the appointment then come back after the appointment to more thoroughly bathe, toilet, feed, and complete the care plan?**
  You are certainly able to visit a beneficiary more than once in a day, but you will only be able to bill for the time that is slotted for that day. If you must deviate from the Service Plan due to the timing of a doctor's appointment, mark in the deviation section to indicate you came back later. You may only do the time that is slotted for that day.

- **In the event a service plan cannot be prepared, may a Licensed Residential Facility (LRF) upload the 3050 as a substitute?**
  If a Service Plan has to be done manually outside of the system, you may use a template of your choosing so long as it covers tasks, frequency and full hours. If the 3050 form covers all of this information, you may use it as a template.

- **Where can we get the template for the manual service plan?**
  There is no specific template for a manual Service Plan. You may use any format you wish, as long as it covers what is needed for plan of care – tasks, frequency, hours awarded, etc.

- **Can we make adjustments on the printed service plan and use this for our manual service plan?**
  Information on the printed Service Plan will not match the manual service plan and so would not be valid. It is recommended that you use a separate template of your own, making sure it follows all requirements.

- **Do we leave the Service Plan on the system "incomplete" when we are submitting a manual service plan?**
  When a manual service plan must be completed because the hours awarded don't match the hours on the assessment, leave the Service Plan as it is, do a manual service plan, upload within 7 business days, and then contact Liberty. Once Liberty confirms that the service plan is there, they will remove it from the step process and it will move forward.

- **Can we go back and submit a manual Service Plan for all of our clients whose hours have not matched what was approved?**
  If the hours awarded on the letter you receive do not match the hours on the assessment and it is not due to rounding up or down of hours (deviation), a manual service plan must be done. Contact Liberty with any further questions.
- **When we have to do a Service Plan outside of the system, can't we upload a Plan of Care with the approved hours per month?**
  If you have your POC you can use that template but you must make sure that the hours, the tasks identified, and the frequencies match.

- **Our Agency received an annual referral on QiReport. It was accepted prior to June 10, so we began completing our agency Service Plan/POC. The QiReport interface later**

shows an incomplete service plan. We called Liberty and were told that the Service Plan template generated based on the date the recipient letter was generated, not the date accepted. Our agency has a POC completed and signed by the recipient. How do we correct this on the interface?
If the Service Plan has been generated and you have a POC that meets all of that information, you may duplicate what is on your Plan of Care into the Service Plan that is in the system.

- **Can you mail the signed service plans to Liberty instead of uploading them?**
  It is a requirement that service plans must be uploaded within the QiReport portal. If you have any problems uploading, contact Liberty.

- **Do we upload POC for appeals and is there no Service Plan for appeals?**
  When there is a settlement from an appeal, complete a manual Service Plan and upload it into supporting documents. Providers may use their own template.

- **Service plans for appeals – annual, MOS and appeal settlements: Are all of these required to be signed and uploaded?**
  If the beneficiary does not appeal within the time period of 7 days, the Service Plan should be completed to be within compliance. If they submit an appeal after 10 days but within 30 days, a MOS SP will need to be completed within the system, and then another when settlement is reached.

- **Please review how to process the service plan when the client may or may not appeal their hours. When should the RN complete her /his assessment – within 7 days or after the appeal process is completed?**
  If the beneficiary has a reduction in hours and appeals within 10 days, they will receive MOS hours. In that instance, you will get a MOS Service Plan to be completed. If you know the beneficiary will appeal within that 10 day timeframe, it is ok to wait. However, this is a judgement call based on communication between you and the beneficiary. If they do not appeal, you must complete the Service Plan within 7 business days.

- **If a beneficiary switches providers and the Service Plan wasn't done by the former agency, can the new provider back bill?**
  The PA's and generation will stay the same regardless of the service plan. When you receive notification in your portal, the date on the COP letter will be the effective date for billing. It won't go backwards – if you choose to provide services before you receive notification, you will not be able to bill.

- **Is it mandatory to upload a POC after a patient comes out of MOS? Do I have to call Liberty every time I upload this POC?**
  Every time you need to do a manual service plan, you need to call Liberty so they can be sure to update your PA's and get that over to NCTracks. If there has been a settlement with different hours, another Service Plan must be completed.

- **A person has 45 hours & is given 80 hours of MOS on appeal. Do you need to do another Service Plan for the MOS hours?**
  Yes. Prior approvals for services will not be sent to NCTracks until the Service Plan is complete and validated.

- **Are you fixing the glitch in the system that does not allow you to do a service plan with new appealed hours? If client was increased with more or less days, when the client appeals, their hours get cut. The service plan does not show the MOS hours. When will this be fixed?**
  When there is a decrease in hours, the MOS Service Plan should pull from the year before. If that doesn't happen, contact Liberty for assistance. If the hours don't match, it cannot be done in the system and it will need to be done manually. You do not need to do a Service Plan in QiReport that does not match the hours you are billing for. In the future, DMA will be working on another version where they can assist with that but it has not yet been developed.
- **If a client is allotted 80 hours a month why does QiReport only allow you to schedule 74 hours. Does the client just lose those excess hours?**
  No, the service plan template uses a formula based on the average weeks in a month to determine weekly hours either rounding up or down to the nearest quarter hour for the granted hours that are given each month. Because there are a different amount of days in each month the provider has to account for that by applying a deviated documentation plan. You will not have to do a manual service plan.

- **When there are 'Additional Safeguards' (additional 50 hours) is another service plan required? How are those hours accounted for?**
  Assessments are the same standardized assessments; this has not changed. The information completed by a physician on the form; the medical change of status properly attested to, a new request with attestation section is what goes into the determining of hours along with the evaluation, and the calculations are uploaded into the QiReport. Service Plans will reflect the total hours awarded and the other details of the assessment.

- **When a mistake is made on the Service Plan by the IA/Liberty, can the process of correcting it be quicker?**
  Liberty has reexamined the entire process to see how it can be improved and become more efficient. If you find a mistake, hold off on completing the Service Plan and call LHC. They will correct the error and advise you on when you can submit the Service Plan.

- **What are the steps involved in manually processing a Service Plan? How do we process PCS that requires manual processing?**
  A manual Service Plan outside of the system can be filled out using your POC template. The task frequencies and hours for MOS must match. Providers must also perform their own assessments to determine the frequency based on the hours for MOS. The assessments should be uploaded within 7 business days. Contact Liberty so they can remove the Service Plan step and your PA's will generate for the MOS.

Agency Change of Ownership

- **If one NCTracks enrolled provider buys another, is a new NPI enrollment required? Can't you use your current NPI and have the beneficiary submit a COP?**
  We suggest that you seek guidance on this from Provider Enrollment.
- **Does a Change of Ownership (CHOW) require an onsite review the same way new enrollment would?**
  If you are completing a change of ownership and need to be licensed, that will require following the same process.

Assessment Changes

- **When will Liberty begin sending out the 60 day notice to schedule the annual assessment?**
  It will start coming out in mid-September and beginning of October.

- **Why does it take so long for Liberty to enter assessments in QiReports?**
  Liberty is required to schedule an assessment within a 14 business day timeframe of receiving a new request, or an annual assessment before the annual due date. Liberty's data indicates that this is done within 9 days. There are some exceptions for various reasons where it may fall outside of the timeframe, but that is not normally the case. It takes approximately 5 more business days for the assessment to be uploaded, reviewed by a quality manager, and then approved.

- **Why are annuals being scheduled a month after the annual due date?**
  Liberty does currently have instances where the annual cannot be completed by the due date. You can contact Liberty if you need to have your authorization extended due to this so you will still be able to bill for services. If a beneficiary is in a rehabilitation facility or the hospital, this may also affect the assessment date.

- **Why is there at times a 2-3 day delay in doing new client assessments from the IAE?**
  Once the assessment is completed, it must be uploaded within 24 hours, and then there are 3 business days to review for quality & correctness. The assessor will make any necessary changes and will then resubmit the assessment. This does make the process take longer, but ensures that the assessments are complete and accurate.

- **How far in advance will the annual assessment notifications be sent out to the providers?**
  Notifications will be sent out as many as 60 days in advance of the assessment due date.

- **As it pertains to assessments, there have been instances where clients tell assessors that they are able to do something, and they assume that they are capable of executing the task.**
  Liberty's assessments are based on demonstrated need to the best of the beneficiary's ability and that is how the assessments are scored. The beneficiary must demonstrate ability to do tasks for the assessor.

- **Will liberty still call to schedule Annual Assessments or will it only be scheduled when the client calls Liberty?**

The annual notification will come through the provider portal and LHC will continue to schedule as usual. LHC would like to eliminate the additional technical denials and "unable to contact" by working with the providers on current beneficiary information.

- **We have a client whose authorization ended 9/22; Liberty has not yet reassessed them. We called 9/15 to ask about it and were told we could have them extended until Liberty conducted the assessment. How long can we extend services to get payment?**
  There are several reasons that beneficiaries may not be reassessed, such as not being eligible for Medicaid, or because Liberty may not physically have assessors available. If Liberty is unable to schedule before the due date, they will extend the PA's. Once the assessment has been completed and uploaded, those calculated hours will carry forward.

- **Where in the portal will we find the information about upcoming assessments?**
  It will be under the New Referral Tab under "Other Notifications."

- **The computerized time in QiReport seems to be based on 4 weeks a month, but does not always equal the total hours awarded, how do we resolve this discrepancy?**
  The system is set up for a typical month and splits the awarded hours into weeks. Providers should look at the hours at the beginning of each month since some months are longer or shorter and the formula may require the hours to be adjusted. Remaining hours should be appropriately distributed so the same amount of care is provided each day; for example, perhaps adding 15 minutes each day to capture hours. This must be documented in the Deviation Section.

- **In dual recipient households, are we required to cook one meal, make one bed, and do one laundry task for both?**
  On the assessments, they are each assigned these tasks. Each beneficiary should have their own aide, and that person should be sure that the care and times are individualized.

- **Why are clients being denied based on diagnosis only? The diagnosis codes do not accurately portray a client's needs?**

The assessment tool takes into account the diagnoses and all other factors attested to at the time of assessment based on demonstrated need. All information is factored together, and the diagnoses must affect the ADL's.

- **Why do we have to wait for the client to have an assessment before they can change providers?**
  Beneficiaries have the right to change providers at any time. There are a very few instances when they will be asked to wait until the time of the assessment to make the change, but that only occurs when the annual assessment has already been scheduled.

- **We are getting new patient referrals months after the initial assessment. Why is there a delay on new clients?**
  There may be a delay between the time you accept the client in the portal and the initial assessment. There are some circumstances where there may be a delay, such as assessments being selected for additional review or change of ownership – if we don't have a provider choice we cannot upload the assessment. However, there should not be a gap of months; contact Liberty if you see that.

- **Why does it seem to be a pattern now with residents in ACHs losing hours? And why is it now taking so long for hours to be on QiRePort?**
  Assessments are conducted based on demonstrated need, and are then entered into the system. The assessment may be included for a quality review by the Regional Manager before it is uploaded. If anything is found, they are sent back to the nurses for clarification or correction. This process alone takes three business days. Hours are calculated by QiRePort after upload. Delays may also occur if the providing agency is not in NCTracks or if the Service Plan is not completed in a timely manner.

- **What action should be taken if a beneficiary is assessed as needing more or less care than is actually provided, i.e., receiving baths or changing bed linens?**
  If the information stated from the assessment is not in line with the actual amount of care being provided for medical reasons, send a Medical COS. If the reason is not medical (the days or time are changing) a COS may be sent through QiReport. If there is a specific discrepancy with the assessment – days of frequency, Service Plan, etc., contact Liberty so they can review and make any necessary adjustments.

- **When a beneficiary is evaluated for extended or given reduced hours, why is the provider agency not consulted?**
  When scheduling the assessment, Liberty informs the beneficiary or POA that they have the right to have other individuals present, such as the aide. The Independent Assessment is based on demonstrated need, and beneficiaries may appeal a reduction in hours or have a doctor submit a COS request.

Miscellaneous PCS Questions

- **How can we make sure Liberty has the correct contact phone numbers when they change?**
  Call Liberty and give them the updated contact information for the beneficiary. They can change the demographics within QiReport.

- **How do we upload forms with MDs signatures?**
  Go to the provider portal and "supporting docs" link.

- **When issuing a technical denial, why do you not give a confirmation in writing of reinstatement of PCS?**
  If a TD is issued for Unable to Contact, and Liberty is called within 10 days, they will be reinstated. A manual letter will be sent after the reinstated assessment is completed and will be uploaded to the provider portal. This practice was established in May 2015.

- **Are there plans to provide notification in QiReport for Denials, as promised in the May 2015 Training?**
  If it is a new beneficiary to be admitted, you will not receive any form of denial notification because you haven't been selected as the provider of choice. If the beneficiary is currently in your care, you should receive the denial letter but you will not receive appeal paperwork.

- **Why aren't we notified of a rejection of PCS services? Why is it that Liberty says they didn't receive it when we have a fax confirmation?**

If it is a new beneficiary to PCS, you would not receive any notification unless the beneficiary chooses you, at which time you would receive notification and the number of hours awarded. If the beneficiary was rejected for PCS, no notification is sent because there is no provider choice and no hours awarded. Liberty won't back-date to that date. Liberty goes by the form we receive and the date on the form. If the form is completely filled out and correct, it will then be processed. If there is a specific issue with faxing, contact Liberty. We need to review each case individually to see if they can be backdated.

- **Client was denied PCS due to ADL, but never received a certified letter to appeal; can the client call to get the appeal paper faxed to the agency?**
  The beneficiary has the right to contact Liberty and request that their information be sent to another place. However, it must be at the beneficiary's request. Providers are encouraged to remind beneficiaries to update their contact information with Social Services.

- **I requested a COS on a client who was much improved and no longer needed the services and was told that a physician had to make the request – is this true?**
  If there is any change in the beneficiary's medical condition that requires more or less care, it must come from a physician. If the beneficiary states they do not need care and no longer wish to have PCS services, you would discharge them for "Condition improved."

- **If you are waiting on a PASRR number, how far back will the PCS service dates be backdated?**
  Liberty will come and conduct the assessment, which will be updated, processed and put into a hold status for up to 30 days until we get that PASRR #. As of 1/1/13, it has been required to have a PASRR before entering ACH facilities, although PCS has been making an allowance to help with this process by allowing the assessment to be done and then held for 30 days. However, PA's will NOT be given prior to the PASRR's effective date.

- **We are having delays with being able to submit initial Liberty requests due to delays in the Special Assistance (SA) process for new Medicaid admissions. Is there any way to improve that process and narrow the gap with billing delays?**
  Medicaid applications are handled by DSS, not by Liberty. DMA has identified an issue in the system, starting with the county processes that are used to enter Medicaid eligibility for SA. When Liberty goes to check eligibility, the system shows they do not

have Medicaid. When Liberty receives completed requests from practitioners or physicians, they are able to key them but cannot process them. You can contact your county DSS or DMA. Once it has been identified that this error has caused the problem, we can retro the PA's back to the date of the request.

- **Who do aides contact when they are not being paid for the last 10 days after the beneficiary switches providers if the aide is still working there?**
  Communication will be sent through the portal to the providing agency, stating effective date of service and end date. It is the responsibility of the owner or director of the agency to communicate that information to the aide. If an aide is not being paid properly by their current provider, they should contact N.C. Department of Labor.

- **If a client has passed away and did not sign a timesheet, can we still bill?**
  If you have provided services for the days as outlined, you must do a discharge to reflect the date they passed and be sure everything is in line for the date of discharge and date of services. Only bill for those times that you provided care and document any deviation for audit purposes.

- **How does one go about removing a patient who is deceased?**
  Discharge them within QiReport by using the "Deceased" Discharge function in the drop down options.

- **Can a beneficiary call to find out if the provider is still billing while not receiving services?**
  The beneficiary is more than welcome to call, but if there is a question about billing or claims, the contact should be directed to NCTracks or Program Integrity. Billing information will not be shared with beneficiaries.

- **If the client goes into the hospital after the services have been provided for that day, can we still bill?**
  Providers should contact DMA if claims have denied due to inpatient hospital stay after services were rendered. DMA will work with provider and NCTracks to address denied claims.

- **Have there been any updates on the 1% rate reduction submitted to CMS? When will providers be notified?**
  There have been no updates. Once it has been passed, providers will be notified.

- **What process do providers need to go through with Liberty when changing providers (doctors) for clients?**
  Liberty does not require any additional information when the physician changes.

- **Why is a change of provider taking sometimes 3 weeks to months?**
  One possible reason could be that the Service Plan was not completed by the current provider (after June 10.) In addition, beneficiaries frequently call Liberty and say that their provider has not been providing services. Liberty must then verify this with the provider, which may take up to 10 days. Providers should be sure to discharge beneficiaries if they are not providing care.

- **When a client changes providers for the reason of "choice", are we allowed to continue service until the 10-day time frame is up in order to ensure that the client is not without service within the 10 day time?**
  If one of your beneficiaries chooses to change providers, you will receive a letter telling you the effective end date for providing services for that beneficiary. Be sure to read this notification so you are aware of the timeframe you are authorized to provide care for billing purposes.

- **If you own multiple facilities and the client changes from one facility to another, what is the simplest way to change that client in the system?**
  An NPI change may be made for a beneficiary within the provider portal if all of the facilities are listed. If all of your facilities are not listed, contact Viebridge. They can get all of your NPI's listed within your portal.

- **How often do we need to run the reports from nurse's registry on employees?**
  That is a licensure requirement and is not a requirement for PCS.

- **How is it determined if a beneficiary requires a CNA or a PCA, and can a PCA provide them svc while going to class to get certified?**
  This is a licensure question – look at your Home Care regulations, which speak to aide requirements, specific assistance, and the level of aide needed for a beneficiary. Contact DHHS with any specific questions.

- **Is it going to be mandatory for only CNAs to be able to service clients? If so, when is this going to be mandatory?**

DMA has not been informed if this will be mandatory. Licensure rules for home care agencies and adult care homes are determined by DHSR. You can contact your Home Care or ACH licensing agency, DHSR, with any questions.

- **Are any service providers currently offering PCS in Transylvania County? If not, are any providers willing to expand into Transylvania?**
  Current providers are able to designate the counties they are willing to serve within QiReport. Be sure that the current set-up on NC Tracks has all of the locations that you serve. If that information is updated, your facility will be presented as a choice when the provider lists are generated and given to beneficiaries.

- **Have the NC Administrative Codes changed? How do we know when they change?**
  The administrative codes have not changed. You can access them on NC's Division of Health and Service Regulations Website and contact DHSR with any questions. DHSR will release information and provide training if the codes change.

- **Will the procedure ever be cut back in order for a new company to be able to provide home care services; it's a very long procedure, almost a year?!**
  The current process begins at DHSR through licensure, and then to NC Tracks for proper registration and processing. A company may provide PCS services but must be properly licensed, and registered with the state of North Carolina as an approved Medicaid Provider and have a valid NPI and be properly enrolled in QiReport.

- **Will aides with criminal charges who were hired before June 10 be grandfathered to continue working with Medicaid clients?**
  There is no grandfathering. If an aide has one of the convictions listed in the policy, as of 6/10/15 the Provider should not bill Medicaid for services conducted by the convicted aide.

- **How often do background checks need to be conducted?**
  DMA requests this at the time of hire, per licensure requirements. No additional background checks are required.

- **Candidates for hire with felony records, what are the rules/restrictions for hiring? Type of record? What capacity can they serve in the company?**
  DMA will follow the guidelines stated in the policy; auditors will be looking for felonies and convictions as listed. Aides with felony records may not provide direct care for

beneficiaries, and agencies may not bill for services provided by the aide. Providers may decide if they want them to serve in other capacities in the agency.

- **A provider in my area is offering certified and uncertified aides $10/hour to bring their clients to them. Is this not a kickback that should not be done?**
  If you are aware that this type of Program Integrity issue is occurring, contact Program Integrity or DHSR in order to report it.