Liberty Healthcare Corporation of North Carolina

Provider Training MAY 2018 Questions and Responses

The following questions were posted during the May 2018 Provider Trainings that covered the following topics:

- Electronic Visit Verification (EVV)
- PCS Updates
- DMA Internal Audit
- Office of Compliance and Program Integrity (OCPI)
- Other

Electronic Visit Verification

For Frequently Asked Questions and updates related to Electronic Visit Verification, please visit https://medicaid.ncdhhs.gov/electronic-visit-verification.

PCS Updates

Rate Increase

- **Does the rate increase include the CAP program? Has the new rate been implemented?**
  The rate increase effective 1/1/18 included the CAP-C Program. Refer to DMA's December 2017 special bulletin for more details.
  https://files.nc.gov/ncdma/documents/files/SPECIAL_BULLETIN_Rate%20Increase.pdf

ICD-10

- **If we have tried to obtain the ICD-10 form and reached out to Liberty but continue to be unsuccessful, will we still be referred to OCPI?**
  If providers find themselves in situations where the beneficiary's physician will not complete the DMA 3137 ICD-10 Transition Form, clearly document at least three attempts to have this form completed. **After at least three unsuccessful attempts, please report this issue to Liberty Healthcare at 919-322-5944 or 1-855-740-1400 (toll free).** If Liberty Healthcare continues to have issues with the physician completing the form, the issue will then be escalated to NC Medicaid.

- **How do I know if there is an outstanding ICD-10 form needed for my beneficiary or when I get a new client?**
  Providers may log in to their Caseload Report and verify that their beneficiaries are current and up to date with submission of the ICD-10 Transition Form. If the beneficiary has had a New Request or Medical Change of Status since October 1, 2015, a new ICD-10 Transition Form will not need to be submitted.

- **Can Liberty's assessment be uploaded if ICD-10 is outstanding and annual was conducted?**
  Yes, the assessment can be uploaded. The ICD-10 Transition Form allows PCS Staff to verify that beneficiaries indeed have medical conditions that limit their ability to perform ADL's. This form also allows us to verify that beneficiaries are under the ongoing care of a physician.

- **What is the provider's responsibility for determining if the client is under a doctor's care and what their diagnosis code is? Do I need a signed statement from the doctor with this information?**
  Per Clinical Coverage Policy 3L section 3.2.3 (a)(7), beneficiaries must be under the direct care of a physician for the medical condition or diagnosis causing the functional limitations to be eligible for PCS. Providers should verify that the beneficiary is eligible for Medicaid before rendering services to the client. The ICD-10 Transition Form is only required for individuals with active PCS who were admitted into the program prior to 10/01/2015. If a New Request or Medical Change of Status has been processed after 10/01/2015 the ICD-10 Transition Form is not needed.

Outstanding Service Plans

- **Do I have to re-enter a signed service plan for every service change (change in hours/days, etc?)**
  Service plans must be completed, signed, and uploaded any time providers accept a beneficiary's referral, any time there is a change in hours (annual, medical change of status, change of status, mediation, court settlement), and any time the beneficiary is in Maintenance of Service. A new signature is not needed when a revision is made to the service plan, only when a new service plan is developed.

- **I have a Prior Authorization and Service Plan for a client with different monthly hours – which do I follow?**
  Providers are to use the hours awarded in the notification letter if different from what reflects in the assessment and the QiReport generated Service Plan.

- **A Service Plan is not a Plan of Care – does that mean we are allowed to make our own plan of care for the client when we accept a case?**
  Yes, providers should develop their Plan of Care based on applicable DHSR licensure regulations and requirements as a Plan of Care is a licensure requirement and is separate from the Service Plan. Providers can only bill Medicaid for services outlined in the Service Plan.

- **Is it acceptable to accept a referral when there will be an extended amount of time before service will begin? Example: No caregiver in client's area & office will need to recruit and hire before start of service (sometimes weeks to several months).**
  When you are sent a referral, the expectation is that you will review the assessment and the individual's needs to determine if you can provide those services. If you are unable to provide the service at that time, it is recommended that you not accept the request.

- **Is there a maximum # of hours a caregiver can work/day? Example: Client is authorized for 3 days/week but caregiver only able to work 2 days. Can they work greater than 4 hours to service all of client's hours authorized per month?**
  The assessment will indicate which days the beneficiary needs assistance, and the expectation is that the beneficiary will be serviced on those days. If the agency is unable to meet those requirements or to service the needs of the client, it is recommended that they not accept the referral.

- **QiReport – Does the MD need to sign report? If so, why is there not a spot for the MD's signature?**
  Physician signatures are only required on New Requests, Medical Change of Status Forms, and ICD-10 Transition Forms.

- **When is the outstanding service plan requirement effective with MOS?**
  The requirement for Service Plans, regardless if they are for MOS, New Requests, or Annuals, is that the provider has 7 days to complete a Service Plan. Once it is completed you have 14 days for the beneficiary to sign the service plan and upload it into QiReport. The timeline requirements for completing Service Plans remain the same for all types.

- **Is there a way to track how many signed service plans are late or past due once uploaded?**
  No, providers do not have the capability within the Provider Portal to track this, but NC Medicaid staff members can run queries to determine which providers are non-compliant with this policy requirement.

- **Can we update days of service w/out doing a change of status?**
  Temporary deviations may be documented and don't require a Change of Status if the frequency and hours remain consistent with the Service Plan. In the event the beneficiary's needs change permanently, then a Change of Status should be submitted.

- **What can we do if a client has been discharged and the SP has not been uploaded?**
  Service Plans must be completed within 7 business days. In the event, the beneficiary is discharged before those 7 days, the provider should contact Liberty.

- **Should the service plan mirror the plan of care?**
  The Service Plan is a Medicaid requirement per Clinical Coverage Policy 3L and reflects the assessment conducted by the Independent Assessment Entity. The PCS Service Plan is not a plan of care as defined by applicable state licensure requirements. Providers with questions regarding their PCS Service Plan may contact Medicaid and Providers with questions regarding the Plan of Care should contact NC DHSR.

- **How often does the Service Plan need to be uploaded? Each assessment, every time hours change or only the first time?**
  Service plans must be completed, signed, and uploaded any time providers accept a beneficiary's referral, any time there is a change in hours (annual, medical change of status, change of status, mediation, court settlement), and any time the beneficiary is in Maintenance of Service. A new signature is not needed when a revision is made to the service plan, only when a new service plan is developed.

DMA Form 3085

- **Do I need to complete the DMA Form 3085 if I did not have any beneficiaries with this requirement?**
  Only providers servicing beneficiaries who meet the criteria under Session Law 2013-306 are required to submit the DMA 3085.

- **Is the DMA 3085 only for Alzheimer's or for dementia as well?**
  In accordance with Session Law 2013-306; Providers serving beneficiaries seeking additional hours of PCS due to Alzheimer's or other Memory Care complications are required to have caregivers with training or experience in caring for individuals who have a degenerative disease characterized by irreversible memory dysfunction that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty learning, and the loss of language skills. The NC Medicaid PCS program requires that providers intending to claim services rendered to beneficiaries receiving additional hours of PCS under Session Law 2013-306 attest to their aide training curriculum and submit the form to NC Medicaid.

- **How can we verify that the PCS Unit has received a copy of our DMA 3085?**
  You can contact staff either by phone at 919-855-4360 or by sending an email to **PCS_program_questions@dhhs.nc.gov.** Emails are checked daily.

- **Is the DMA form 3085 just for those seeking additional hours?**
  Yes.

- **Where do we submit the required DMA forms 3085?**
  The DMA 3085 should be emailed to Medicaid.PCSTraining@lists.ncmail.net prior to billing for services that were rendered to a qualifying beneficiary.

- **Should the DMA 3085 be completed more than once if your training program changes?**
  Yes, if your training program changes, a new DMA 3085 form is required to document and validate current training being utilized.

- **DMA 3085– Do we submit per employee, per patient, or both?**
  Only one DMA 3085 form is required for each NPI. However, each employee must have documentation that they completed the training curriculum outlined in the 3085. Training must be completed prior to servicing beneficiaries with additional hours in accordance with Session Law 2013-306, regardless of hiring dates. In addition, the 3085 must be submitted to DMA prior to billing for services that were rendered to a qualifying beneficiary; the date of service must reflect a time period after training was completed and the form submitted to DMA.

- **Where do we find training for employees for DMA Form 3085?**
  Training can be found on Liberty's website at https://nc-pcs.com/Alzheimers/.

- **Form 3085-Is it used for every beneficiary with Alzheimer's or only those needing expanded hours?**
  It is only required for those beneficiaries approved for additional hours, under Session Law 2013-306. However, it is suggested that if you are servicing a beneficiary with a degenerative cognitive impairment that you have the appropriate staff complete training and submit the DMA 3085.

- **On the DMA 3085 form, section II reads 'Trainer Qualifications'. Can having formal or informal (ie, family member experience) experience satisfy this requirement?**
  No, informal experience does not qualify. The Trainer must have formal qualifications and documentation indicating that they are experienced in this field and are qualified to conduct training. In addition, the curriculum the Trainer uses must also be listed on the form.

- **How does the facility get a copy of the approved PCS hours?**
  Agencies and facilities receive a notification of approved PCS hours after accepting the beneficiary in QiRePort. A copy of this notification can also be found in QiRePort.

- **What do I do if a client develops Alzheimer's and an aide was already in the home?**
  It is recommended that all aides receive training in providing care to beneficiaries that may require additional hours due to Alzheimer's or other Memory Care complications if a beneficiary's needs change or in the event that the aide is needed to cover the shift of a beneficiary that needs a caregiver experienced in these areas. If providers find themselves in a situation where a beneficiary develops Alzheimer's or other Memory Care complications and requires a caregiver with training or experience in these areas, then the agency would be responsible for ensuring that the appropriate Medical Change of Status is submitted to Liberty Healthcare for processing and also re-staffing the beneficiary with an appropriate aide while the aide in question receives the proper training.

- **How many Alzheimer's modules do aides need to complete?**
  There is no requirement on how many modules aides need to complete. When providers complete the 3085, NC Medicaid validates the training and asks providers to list the trainer's qualifications as well as the curriculum outline. Training is available on Liberty's website and once completed, providers can print certificates to place in their employees' files.

PCS Internal Audit

- **How often are audits reviewed?**
  The PCS Internal Audits are conducted quarterly.

- **Are the PCS Internal Audit letters sent via certified mail?**
  Yes, these letters are always sent certified mail.

- **What does the 7 day grace period mean?**
  The 7 day grace period allows for an additional seven calendar days to conduct the supervisory visit following the due date without penalty.

- **Do providers have 10 days from the date of the letter or from the date the letter is received?**
  Providers have 10 days from the date they receive the letter to submit the requested documentation to NC Medicaid.

- **Do the RN 90 day supervisory visits apply to ACH providers and if so, who conducts these?**
  Residential PCS providers shall ensure that a qualified professional conducts supervision to each beneficiary in accordance with 10 A NCAC 13F and 13G and 10A NCAC 27G. Also, residential providers should ensure appropriate aide supervision by a qualified professional in accordance to 10A NCAC 13F and 13G and NCAC 27G.

- **Is a beneficiary signature needed on a supervisory visit?**
  No, but all components of the supervisory visit must be documented including the date, arrival and departure time, purpose of the visit, findings, and supervisor's signature. Providers may refer to Section 7.10 of Clinical Coverage Policy 3L for the requirements of the supervisory visit.

- **Does the RN have to have a BSN for supervisory visits?**
  Clinical Coverage Policy 3L does not speak to educational requirements for RNs.

- **Is the agency required to do a supervisory visit after client has come home from hospital?**
  It is not required, but is highly recommended to ensure the beneficiary needs have not changed due to the hospital admission.

- **Do supervisory visits need to be done on beneficiaries in family care homes, since the RN is present daily?**
  Per Clinical Coverage Policy 3L, residential PCS providers shall ensure that a qualified professional conducts supervision to each beneficiary in accordance with 10 A NCAC 13F and 13G and 10A NCAC 27G. Also, residential provider should ensure appropriate aide supervision by a qualified professional in accordance to 10A NCAC 13F and 13G and NCAC 27G.

- **Are logs signed by the in-home aide & the beneficiary?**
  Yes, per Clinical Coverage Policy 3L Section 7.10 bG, all logs must be signed by the in-home aide and the beneficiary after services are provided on a weekly basis.

- **How many hours of dementia training are required for audit? How soon after hire are these hours to be completed?**
  The DMA 3085 form was created based on Session Law 2013-306. Providers serving beneficiaries seeking additional hours of PCS due to Alzheimer's or other Memory Care complications are required to have caregivers with training or experience in caring for individuals who have a degenerative disease characterized by irreversible memory dysfunction that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty learning, and the loss of language skills. There is no designated number of hours required, but the curriculum outline must be included on the DMA 3085 Form. Training is can be found on Liberty's website; providers may follow the curriculum and complete the attestation form.

- **Why don't the providers receive a letter with the results of the audit?**
  Providers may call NC Medicaid three weeks after submitting their documentation to NC Medicaid for the results of their audit.

Office of Compliance and Program Integrity

- **Does Liberty/NC Medicaid have suggestions or proper organizational structure for providers to ensure compliance and proper management?**
  Agencies can utilize resources such as Provider Trainings and trainings conducted by NCTracks.

- **What are the discipline guidelines for PCS non-compliance?**
  Noncompliance with program requirements is addressed with Clinical Policy. OCPI works with clinical policy to address fraud, waste, and abuse.

- **How do I report abuse/neglect of audits in each county?**
  Abuse and neglect can be reported by using the following link: https://www2.ncdhhs.gov/dma/fraud/index.htm or calling DHHS Customer Support at 1-877-362-8471.

- **What steps should we take when we visit a client and they have not been truthful with the Liberty nurse during assessment? Example: Beneficiary told Liberty they have no family to assist but they do or beneficiary states they are unable to complete task but in fact can.**
  When you are made aware of this type of information, contact NC Medicaid and/or Liberty.

- **If a person has a felony on their background check and it's been at least 10 years, does this mean they can never be hired? How long can we wait to see if they can be hired?**
  Clinical Coverage Policy 3L, covers what providers need to know when making decisions on hiring staff.

- **Is there specific training available for billing?**
  Check the NCTracks announcement page for information about regional and online training regarding billing.

- **If the resident goes to the hospital at 10 pm at night but we provided services that day. Who bills?**
  If services were provided prior to the hospital admission time, a PCS provider may bill for the service.

- **If an aide has multiple clients, does the aide need to be seen twice a year during Supervisory Visits in all client's homes or just one client's?**
  Yes, the aide must be observed at least twice each year in each beneficiary's home where they provide personal care services.

- **Should black ink be used or blue for aide task sheets?**
  Either. There is no specific requirement or recommendation on whether to use blue or black ink.

- **What will be done with a beneficiary who commits sexual assault or sexual advances toward an aide?**
  The aide must report it to the agency, and the agency must follow up and report to outside agencies when appropriate as well as NC Medicaid.

- **Can a beneficiary be disallowed from participating in the PCS Program?**
  Yes.

Other

- **What is the name and date of the June meeting?**
  The PCS Stakeholder's meetings are held bimonthly on the third Thursday. The next meeting is scheduled for June 21, 2018. To join the PCS Stakeholder Group, call DMA at 919-855-4360 or send an email to PCS_Program_Questions@dhhs.nc.gov.

- **Where can I print off today's presentation?**
  All Provider Training presentations and previous presentations can be found at https://nc-pcs.com/training/.

- **Patient is receiving extra hours under Session Law 2013-306. There is no HC POA or legally responsible person and beneficiary has become unable to sign SP. Can the children of client of the primary caregiver sign for the client?**
  It is recommended that providers encourage the children of the beneficiary to take all of the appropriate steps to either obtain a Healthcare Power of Attorney or obtain Legal Guardianship so that the children can act on behalf of their parent and sign the service plan and it be uploaded into the Provider Portal.

- **Will the available task sheet option in QiReport be modified to a more ideal format for ACH providers?**
  NC Medicaid has received and appreciates feedback provided regarding this. There are no plans to make modifications at this time.

- **Can requests be submitted other than fax? Can this change in the future?**
  At this time, the only way to submit a referral for PCS is via fax.

- **When a task/ADL listed on the service plan is not performed for reasons such as beneficiary request or provider policy, what steps should clinical managers take?**
  If a beneficiary requests that a task not be performed on a date, it must be documented as a deviation as long as the deviation is not an indication of a substantial change in the beneficiary's condition or the informal caregiver's availability. If a beneficiary's home situation changes and a family member may now help with an ADL such as bathing, a Non-Medical COS may be submitted. Providers should review assessments/referrals before accepting to ensure they are able to meet the beneficiary's needs.

- **For beneficiaries who have had a significant change of status, what documentation is required to support the deviation from the SP?**
  A deviation occurs when an individual scheduled aide task cannot be completed (for example, a scheduled tub bath could not be performed even though other scheduled aide tasks could be performed). Deviations can be documented as long as it is not an indication of a substantial change in the beneficiary's condition or the informal caregiver's availability. If there has been a significant change of status or change in the caregiver's availability, the appropriate change of status form must be submitted for processing. If the beneficiary has experienced a change of status and is already receiving the maximum number of hours, any changes made should be documented in the service plan.

- **Is there a way to make service plans available to complete as soon as you accept in QiReport?**
  Service plans do not appear automatically when providers accept beneficiaries in the Provider Portal. Providers may access the service plan by navigating to the 'Plans Tab' and then by clicking on the 'In Process Tab'.

- **Do assessors assess differently? Why do some seem to give more hours than others?**
  No, Liberty's assessors are all trained in the same manner. In addition, assessors receive continual training throughout their course of employment with Liberty to ensure consistency when conducting assessments. To test for variations in assessment performance, Inter Rater Reliability Testing is conducted frequently and while beneficiary demonstrations may vary, the quality of the assessment should remain consistent.

- **Is it now common practice for Liberty nurses to call providers w/clients on the line to request that we accept them?**
  No. However, it may be possible that providers have been called to see if they will accept an expedited request or there may be times when Liberty will call a third party at the request of a beneficiary to set up an assessment with all parties so they can agree on the best time/date for everyone to be there.

- **Can we receive CEU hours and certification for attending this training?**
  The PCS Provider Training is not approved for issuance of CEU credits at this time.

- **I have received multiple calls from PCS clients looking for an agency to provide services, stating they were instructed by Liberty to find their own agency. Is this true?**
  Yes, Liberty is completely independent of the provider choice selection. When we complete assessments, we ask beneficiaries which provider they'd like to choose. If they do not know at that time, we will provide a randomized list of providers. Beneficiaries are encouraged to do research, choose a provider, then call Liberty with their provider selection.

- **Can you see sometime in the future allowing LPN's to provide supervisory visit assistance to the managing RN?**
  At this time, we do not expect to make any changes to this requirement.

- **Does the RN need to sign timesheets?**
  No. However, Clinical Coverage Policy does require that logs are signed by the in-home aide and the beneficiary after services are provided on a weekly basis.

- **Why is there redundancy of a Liberty nurse assessment and a provider's assessment (especially if there is no reimbursement for the provider nurse assessment)?**
  Liberty is required to do an independent assessment; it is mandated by Session Law 2012-142 to determine eligibility for PCS. The assessment providers must complete as an agency to determine the level of care is a DHSR requirement. In addition, this assessment allows providers the opportunity to assess their beneficiaries and determine if their needs line up with the assessment. This assessment also allows providers to be sure the environment is safe for employees to work in.

- **Do clients with traumatic brain injury or stroke need to have an aide with Alzheimer training, requiring Form 3085?**
  The DMA 3085 form was created based on Session Law 2013-306. Providers serving beneficiaries seeking additional hours of PCS due to Alzheimer's or other Memory Care complications are required to have caregivers with training or experience in caring for individuals who have a degenerative disease characterized by irreversible memory dysfunction that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty learning, and the loss of language skills.

- **Is a COS needed when beneficiary prefers 5 days over 7 days? The beneficiary states they made the request for 5 days but the assessor submitted 7. How do we account for this without a cut in hours?**
  If a beneficiary's needs change, a Change of Status may be requested. A Medical Change of Status must be completed by beneficiary's practitioner or attending physician only

but can be faxed/mailed to Liberty by the beneficiary, caregiver, PCS Provider, etc. A Non-Medical Change of Status may be requested any time by the beneficiary, beneficiary's family, or legally responsible person, home care provider or residential provider. If there is a change in caregiver status, a nonmedical COS may be submitted through the portal and Liberty will perform another assessment.

- **How do we get a signature from the client if aide no longer works with the client and they didn't get timesheet signed?**
  Each agency is responsible for having paperwork completed in a timely manner and may not receive payment for all hours if they are unable to have the timesheet signed. Aides should be advised to have the beneficiary sign the timesheet at each visit.

- **Can an LPN do a supervisory visit?**
  No, Per Clinical Coverage Policy 3L, Registered Nurses must conduct the Supervisory Visit.

- **If a patient is on oxygen and has 1 or 2 extensive, do they require a CNA?**
  Refer to DHSR Licensure Rules and Regulations for specific requirements regarding staffing in this situation.

- **What is the proper procedure for MOS?**
  If an appeal is submitted within 10 days of the Change in Services notification, then services will continue with no lapse. There will be a lapse if the appeal is submitted between 11 and 30 days. After 30 days the beneficiary will not be eligible for maintenance of service (MOS). MOS continues until mediation or court settlement. Letters are sent through certified mail to beneficiaries, so it is very important for beneficiaries to keep their addresses updated with DSS. MOS Service Plans are online; there is one in QiR which must be done within 7 days of receiving the appeal.

- **How quickly should a provider receive an assessment on an expedited case?**
  All expedited cases will be done within 48 hours over the phone. If approved, the beneficiary can be awarded up to 60 hours and Liberty will perform a face-to-face assessment within 14 days.

- **How do you void and replace a claim electronically?**
  Refer to NCTracks training and resources on the home page of the NCTracks website.

- **Client received an annual mid-month and hours changed from 60 to 53. How do we calculate the hours for the month with some already used? Does new authorization start with new date and the hours?**
  NC Medicaid provided a formula and encourages you to do monthly calculations on QiReport. If there is a reduction and an appeal is filed, the beneficiary would go into MOS so there will be no immediate change. It is possible that there would be no

immediate change in hours in situations where there is a reduction in hours and an appeal is filed timely resulting in Maintenance of Service for the beneficiary. However, if this situation does occur, providers are responsible for reviewing documentation for the new Prior Approval effective date and using that information to complete the appropriate calculation to determine daily hours:

Monthly Hours/4.35 (round to the nearest quarter)=Weekly Hours
Weekly Hours/Maximum Need Frequency=Daily Hours/Time Needed per Day

- **What do you do if a client refuses service for ADL's and only wants help with IADL's?**
  Assistance with Instrumental Activities of Daily Living (IADLs) are only approved when directly related to the beneficiary's qualifying ADLs and if they are essential to the beneficiary's care at home. If the beneficiary does not need assistance with ADLs, their refusal should be documented and a COS submitted to Liberty Healthcare for processing. Medicaid does not cover home maintenance/management work outside of IADLs associated with qualifying ADLs.

- **Patients think that they would be approved for more hours if they request 7 days instead of 5 days. However, after the assessment they are only approved for 50-60 hours/month with 7 days services. After allocating time, that leaves the patient only receiving a max of 1.5 or 1.75 hours on weekend. Shouldn't the assessor make the decision whether or not they are approved for enough hours to qualify for weekend services?**
  No, the role of Liberty's assessors is to assess beneficiaries and enter information into the assessment tool based on the beneficiary's demonstrated ability and need. An algorithm calculates the number of service hours awarded to beneficiaries based on the data entered by Liberty's Assessor. If you have questions regarding what is entered in the assessment, you may contact Liberty Healthcare or NC Medicaid with your concerns.

- **Can an RN fill in for an aide in their absence?**
  Review Clinical Coverage Policy 3L and licensure requirements for the specific person who may provide care to the beneficiary. Providers should consider the assessment, policy, and licensure regulations when making this decision.

- **How should respite hours be used?**
  Respite care is not covered by the PCS program; providers cannot bill Medicaid for respite hours.

- **There is a gross shortage of CNA's – the classes are expensive and providers cannot afford to pay. Can we use PCA's on ambulatory clients after we check their skills?**
  Review Clinical Coverage Policy 3L and licensure requirements for the specific person who may provide care to the beneficiary. Providers should consider the assessment, policy, and licensure regulations when making this decision.

- **How many clients is the aide supposed to have?**
  There is no limit to how many clients an aide can serve. However, when making assignments please do so within reason, making sure to see what aides can reasonably handle and still provide good service to beneficiaries.

- **If the DMA Form 3051 is rejected, does LHC notify the patient and the referring physician? If so, how, and what are the guidelines regarding the timeframe for notifying them?**
  Liberty will reach out to the referring physician, as they are the ones who are completing and submitting the form. If this is for a Change of Status or a Change of Provider, we'll reach out to the person who submitted the form. They will have two days to resubmit with corrections.

- **Where do we submit the required DMA Form 3136?**
  The DMA 3085 should be emailed to Medicaid.PCSQualityImprovement@lists.ncmail.net by December 31st of each year. If a company has several locations, please call NC Medicaid and inform staff that you have several locations on one attestations form under one NPI #. If you have multiple NPIs, please submit one DMA 3136 per NPI.