Liberty Healthcare Corporation of North Carolina

Provider Training MAY 2017 Questions and Responses

The following questions were posted during the May 2017 Provider Trainings that covered the following topics:

- PCS Updates
  - ICD-10 Transition Forms
  - Request for EPSDT Summer Hours
  - EPSDT Assessment/Documentation Requirements
- Preparing for a Great Assessment
- Review of Pre/Post Payment Audits - Program Integrity

All questions with responses are provided in this document.

PCS Updates

- **When you make a change on a modifier or NPI for an individual on QIReport, how does this affect claims processed? For example - effective date, processing claims for dates of new info; processing claims that are older with the prior modifier in NPI.**
  The modifier is specific to setting and must match the indicated modifier on the prior approval or claims will be denied. This means the modifier in QiReport must match the correct modifier associated with the specific setting where the beneficiary receives their PCS.

- **Why are we not able to receive retro-funds for PCS Services?**
  Services can only be billed once the service has been approved and the services have been performed. However, effective August 1, 2017, the allowable retroactive period for prior approvals was extended from 10 days to 30 days upon the same conditions that are currently required for retroactive prior approval for personal care services (Clinical Coverage Policy 3L, Section 5.5). Medicaid will not reimburse personal care services provided within the retroactive period in excess of the number of hours approved through the prior approval process.

- **Is there consideration for an increase in PCS payment rates?**
  At the time of May 2017 PCS Regional Trainings, DMA and Liberty were not aware of considerations for an increase in the PCS rate. However, as of 07/31/17, The Department of Health and Human Services, Division of Medical Assistance provided notice of its intent to amend the Medicaid State Plan to increase the rate for PCS from $3.47 to $3.88 per 15-minute unit effective August 1, 2017 and $3.90 per 15-minute unit effective January 1, 2018.

- **Are the assessors or Medicaid cutting the number of hours people are receiving for PCS 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 DMA with your concerns.

- **What do we do if the provider is unable to get a beneficiary or guardian to sign off on the service plan?**
  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 required forms.

- **Why are the addresses different on the acceptance letter and the assessment? How do you know which is correct if you can't reach the client?**
  The assessment contains the primary physical address. The address on the notification is the current mailing address on file in NCTracks through DSS. If you note that the mailing address on the notifications is no longer valid, please encourage your clients to update their mailing address with their county DSS office.

- **Is DMA still doing a 5 day review?**
  DMA still conducts internal audits of Provider Supervisory Visit Notes (Section 7.10 b. (1-9)) and Aide Training Documentation (Section 6.1.2 (a-g)). Randomly selected Providers receive a certified letter in the mail requesting the necessary documentation and are required to fax this information back to DMA Nurse Consultants for review within 10 days of the date on the letter.

- **Can Liberty respond to us, the providers, when forms are not properly filled out? For example, a New Request?**
  No, New Requests must come from the beneficiary's primary care practitioner or attending physician; because this is a New Request, the beneficiary has not been assessed or approved for PCS, and does not have a provider of record on file and there would be no way to notify a Provider that there are issues with the request. Any needed follow-up on the New Request will be with the referring physician.

- **Is a manual Service Plan a company's Plan of Care?**
  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 are not reflected by the most recent assessment), the Plan of Care can be used as the PCS 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.

- **Is there a standard format for manual Service Plans?**
  No, there is no standard format for manual Service Plans. Providers can use their desired format that captures all tasks, assistance levels, frequencies, etc. Once completed, it should be uploaded to Supporting Documents in QiReport and the Provider should immediately contact Liberty Healthcare to receive prior approval to bill.

- **Why can't Service Plans be revised?**
  Refer to Section 6.1.4 of the PCS Clinical Coverage Policy 3L. Provider organizations may enter PCS service plan revisions in the Provider Interface at any time as long as the changes do not alter the aide tasks or conflict with frequencies identified in the corresponding IAE assessment.

- **Why is the Service Plan available for an appeal sometimes, and other times it is not? What would be the difference?**
  A service Plan is not an appealable event; an adverse assessment is. Any time an assessment is completed, a COP is completed, or Maintenance of Service is provided, a Service Plan is required. Also, anytime an appeal is filed and the case is settled with an award of hours, the provider is required to complete a Service Plan to account for the hours awarded during the appeal. If the hours awarded are not based on the last assessment conducted, the provider is required to complete a manual service plan and contact Liberty Healthcare immediately to review and receive prior approval.

- **Is there a way to generate time sheets from a manual Service Plan to reflect the appropriate hours/month?**
  There is no functionality in QiReport that allows for the generation of timesheets. However, aide task sheets can be generated from a PCS service plan created within the QiReport system, but this functionality is not available for service plans uploaded manually.

- **Does Liberty have a blank Service Plan format for providers to use in cases when a manual SP must be entered?**
  No, Liberty does not have a blank PCS service plan template for manual Service Plans. Providers can use their desired format that captures all tasks, assistance levels, frequencies, etc. Once completed, it should be uploaded to Supporting Documents in QiReport and the Provider should immediately contact Liberty Healthcare to receive prior approval to bill.

- **When a client comes from another agency and it states to start 10 days later, how can we meet the 7-day requirement to submit the Service Plan?**
  The Service Plan must be completed within 7 days of acceptance, but services cannot begin until the approved date indicated in the notification. Refer to the PCS Provider Manual for additional information on the processing of Change of Provider Requests.

- **With the Service Plan – after the 14th day when the client signs, do we upload or just file?**
  Per Section 6.1.4 j of Clinical Coverage Policy 3L, the signed, written consent of the service plan must be printed out and uploaded into the Provider Interface (QiReport).

- **Does the 2 day accept/reject count for weekend days?**
  Providers have two business days to accept or reject the referral. If the Provider does not accept the referral, the IAE shall make a referral to the second provider on the beneficiary's list and, if necessary, the third provider on the list.

- **When the month has 31 days, the hours of PCS are exceeded if you follow the Plan of Service. Can you go to hours per week instead of hours per month?**
  The provider would need to complete the calculation for each month based on the number of days in the month. 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 in each month.

- **If an assessment has "No" for the weekend, but it's an Assisted Living Facility and the resident's shower day is Saturday or Sunday, does this impact compliance?**
  This incident could be an error on behalf of the assessor. The provider should immediately reach out to Liberty Healthcare and request that this assessment be reviewed. The assessment should indicate the number of days PCS is needed. The provider should not attempt to complete a service plan based on an assessment that incorrectly identifies PCS need frequency. Also, caregiver availability is a component of determining the number of days PCS is needed. In instances where a caregiver is identified as available to provide care on the weekends, the assessment would reflect no PCS need on those days.

- **How do we indicate if the beneficiary's needs change after hospitalization?**
  Refer to Section 5.4.6 of the PCS Clinical Coverage Policy 3L. A beneficiary may receive a Change of Status: Medical (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.) or a Change of Status: Non-Medical (may be requested any time by the beneficiary, beneficiary's family, or legally responsible person, home care provider or residential provider.

- **Do we need an ICD-10 Transition Form on new patients since a 3051 request has been filled out and signed by the doctor?**
  No. Any beneficiary who has submitted a completed 3051 after Oct. 1, 2015 does not require an ICD-10 Transition Form.

- **Why do we need ICD 10 form since every patient has been either renewed or is new with a signed doctor's 3051 request?**
  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 a New Request or Medical Change of Status has been processed after 10/1/2015 the ICD-10 form is not needed.

- **Does the ICD-10 form have to be completed at each assessment?**
  No, the form is only required once.

- **Do you have to submit an ICD-10 form for claims to go through NC Tracks?**
  Submission of the ICD-10 currently does not impact claims processing through NCTracks, however, Medicaid shall only cover PCS for a beneficiary who has a medical condition, disability, or cognitive impairment and demonstrates unmet needs with ADLs. DMA required beneficiaries who received services prior to 10/1/2015 and have not submitted a new request or Medical COS to submit the ICD-10 transition form that indicates their current medical condition, disability, or cognitive impairment.

- **If a client does not have a doctor to send an ICD 10, what do we do?**
  Refer to Section 3.2.3 of the PCS Clinical Coverage Policy 3L. The beneficiary must be under the ongoing direct care of a physician for the medical condition or diagnosis causing the functional limitations in order to be eligible for PCS.

- **If a recipient is a New Referral Request to agency, why would the agency have to request the ICD-10 Transition Form from the doctor's office?**
  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 a New Request or Medical Change of Status has been processed after 10/1/2015 the ICD-10 form is not needed.
  An ICD-10 Transition form is not required with a New Request.

- **If the patient has medication list that includes diagnoses, does the assessor include the new diagnoses that may not be on ICD-10 form, or should a new ICD-10 form be sent in?**
  If the medication list includes diagnoses and codes, then the assessor will document. The assessor will not add a diagnosis based on a "typical use" ie… cannot add diabetes just because the beneficiary is on metformin, as it can be prescribed for other diagnoses.

- **Doctors are very reluctant to return the ICD 10 forms, causing delays and missed deadlines. What do we do? How can we be held accountable for the ICD-10 forms?**
  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 I see the ICD-10 forms that were mailed to LHC?**
  No, these are not available to be viewed in the Provider Portal. If you wish to keep a record, make copies of forms for your records prior to sending to Liberty.

- **Do you have suggestions for providers as far as documentation of attempts to obtain the ICD 10 form and reaching out to Liberty?**
  Documentation should include a minimum of 3 attempts with the following information: beneficiary name, date attempt made, practice name, person spoke with, phone number called and outcome of call.

Early and Periodic Screening Diagnosis and Treatment (EPSDT)

- **Why is the EPSDT summer hours request so difficult? For example, an additional request for a parent's employment letter even if given within 2 months.**
  Medicaid may authorize services that exceed the PCS service limitations if determined to be medically necessary under EPSDT based on various documents, including, but not limited to parents work verification. A parent's schedule can change from week to week and because of this, each time there is a new request, DMA requires work verification and must verify employment.

Preparing for a Great Assessment

- **Can the beneficiary be assessed at home and choose an ACH provider without having a PASRR number?**
  No. The beneficiary must be assessed in the setting in which they will receive personal care services. If a beneficiary is seeking admission into an ACH, they will require a PASRR# prior to admission.

- **If a client wants an assessor other than the one that usually does the assessment, can another assessor be assigned?**
  No, it is not protocol to allow assessors to be requested. If you have concerns or feel there is a conflict of interest, please contact Denise Hobson. All assessors are trained in the same manner and the outcome of the assessment is not dependent on the assessor.

- **When Liberty goes into the home for yearly assessments, are the nurses required to put their name on the 15 pages? If so, what can be done to correct this?**
  No, the assessment does not require the assessor's name to be included. However, Liberty assessors leave a business card with Liberty's call center telephone number for any follow up questions. This practice is done so that Liberty can collect data, track questions, and offer the quickest response or resolution to the caller.

- **Can the nurse leave a card with her name so if client has a question, she can be identified?**
  Liberty assessors leave a business card with Liberty's call center telephone number for any follow up questions. This practice is done so that Liberty can collect data, track questions, and offer the quickest response or resolution to the caller.

- **Who provides an interpreter for the visiting nurse? (i.e, supervisory visit)**
  It is the responsibility of the provider to coordinate interpreter services for supervisory visits. Liberty is responsible to ensure any interpretive needs are met for the assessment**.**

- **What if the assessor comes early, ahead of the scheduled time?**
  At the time of scheduling the assessment, the scheduler confirms an appointment time as well as informs the beneficiary or 3rd party if applicable, of a one hour window for the assessor's arrival. If the assessor has a change in their schedule, they may call the beneficiary and ask if the beneficiary approves of an earlier or later time. Only if approved may the assessor arrive at a different time than originally scheduled.

- **Why are providers not allowed to be a part of coordinating the visits for assessments?**
  Liberty is expected to communicate with the beneficiary to schedule assessments. It is the beneficiary's choice if they wish to coordinate with providers to be present for assessments**.**

- **FOR ACH – Is the question option for 3rd party present during assessment only done with scheduling, or does the Liberty RN ask beneficiary at assessment if they want a staff member present?**
  This is discussed at the time of scheduling assessments by Liberty's Scheduling Department. During ACH assessments, Liberty does request that a staff member familiar with the beneficiary's needs accompany the assessor for the assessment. This allows for the best assessment experience for the capture of beneficiary needs. In addition, this would be required for any beneficiary with a cognitive impairment or communication barrier.

- **How would you work or schedule with an Alzheimer's or dementia patient who is unable to understand?**
  In instances where a cognitive impairment or difficulty communicating is present and may result in diminished capacity to remember, understand, or communicate, including where the assessor determines during the assessment that the beneficiary has a cognitive impairment or difficulty communicating, which results in diminished capacity to remember, Liberty will use all reasonable efforts to schedule or reschedule the assessment, at a time where a third person has indicated he or she can be present.

- **Is there a separate assessment that needs to be done other than the NC DMA? In other words, can the nurse do an assessment for patients and can it be billed?**
  Per Clinical Coverage Policy 3L, the amount of prior approved service for PCS is based on an assessment conducted by an independent entity to determine the beneficiary's ability to perform Activities of Daily Living. Medicaid will not cover PCS if the beneficiary has not been assessed by the independent assessment entity and found eligible for services. For additional information refer to Clinical Coverage Policy 3L as well as billing requirements for providers.

- **In addition to 90 day supervisory visits, are there specific requirements around an agency completing an annual assessment?**
  Please refer to DHSR Rules and Regulations regarding assessments required by the Provider. Information regarding 90 day supervisory visits can be found in Clinical Coverage Policy 3L Section 7.10 b.

- **How do you address adding a task the aide performs for a client that is not on Liberty's service plan (assisting with medical equipment)?**
  If you feel there is an error on the assessment, providers may contact the Liberty Call Center for instruction. If the beneficiary has newly identified needs or conditions that require additional PCS assistance medical change of status (COS) would be needed.

- **Exactly what needs to be in each chart for the beneficiaries?**
  Please refer to Clinical Coverage Policy 3L as well as DHSR Licensure Rules and Regulations as appropriate.

- **How do you document PCS to keep it from turning into skilled nursing notes?**
  The award of PCS is determined by the beneficiary's ability to perform their Activities of Daily Living (ADLs) for the purposes of this program are bathing, dressing, eating, mobility, and toileting. PCS also allows for time to assist with medication assistance and exacerbating conditions that may contribute to the beneficiary's inability to perform their ADLs, all of which are indicated on the beneficiary's assessment. The provider should document PCS based on the Independent Assessment and subsequent Service Plan.

- **What if the provider's assessment scores an ADL as limited or setup, but Liberty scores it as extensive?**
  Liberty's internal process provides 72 hours for the pullback process; this includes review, determination, and provider follow up. If you feel there is an error on the assessment, providers may contact the Liberty Call Center for instruction prior to accepting the assessment. If the assessment has been accepted and the beneficiary has a change in their condition resulting in a need for a new assessment, a Medical Change of Status must be submitted.

- **How can you determine if clients can bathe themselves without having them wet and squeeze out the cloth?**
  The assessment is a simulation of how the beneficiary typically performs ADLs, including tasks associated with bathing. It is not a requirement to see the beneficiary bathe, but have them simulate the steps. The use of a cloth could be simulated as well.

- **Why would an RN assessor state to wash hair 7 days/week?**
  The assessment includes what the beneficiary's needs are and the frequency of the need. If daily shampoo is what the needs are, this would be appropriate. The assessment records Shampoo/ Hair Care together. This could, if appropriate to the beneficiary, mean daily hair care vs shampoo.

- **If at the time of the assessment, the client is not prepared to make a provider or agency selection – how many days do they have to contact Liberty to have the agency added before the beneficiary must start the process all over?**
  If the beneficiary does not make a provider selection at the time of the assessment visit, the assessor will inform the call center and advise the beneficiary to contact the call center when a selection is made. The beneficiary must inform Liberty of their provider selection within 30 days or else a new request would be needed

- **If a beneficiary now wants 5 days a week of PCS instead of 7, can we change it or does the beneficiary have to call Liberty to change it?**
  To reduce the hours from what was reported at the time of the assessment, a non-medical change of status must be submitted to Liberty. The NM-COS can be submitted by the provider in QiReport. Once submitted, Liberty will reach out to the beneficiary to confirm the request for a reduction before approving the COS and conducting another assessment.

- **How do you review an assessment before you accept it?**
  Assessments can be reviewed in the Referrals for Review Queue in QiReport prior to the provider accepting. Providers may click on the assessment, view the details of the assessment, and decide on whether they feel as if they can provide needed services to the beneficiaries. Providers have two business days to accept or reject a referral.

- **If a client is approved for 80 hours or "x" number of hours a month or runs over the daily hours, can the company provide for those hours if the formula doesn't add up?**
  This occurs due to there being a different number of days in each month. 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 beneficiary's PCS need frequency. Providers are responsible for not exceeding approved hours of prior approval. Medicaid will not reimburse personal care services provided in excess of the number of hours approved through the prior approval process.

- **For a client who is approved for 80 hours but the family assists with care for 3 days and desires only 53 hours. What if there is a change in the family schedule and they decide that the beneficiary needs the 80 hours? Advise how to process.**
  Any time there is a change in caregiver status from what was reported at the time of the assessment, a non-medical change of status must be submitted to Liberty. Liberty will then reach out to the beneficiary to confirm the request for an increase in hours before approving the COS and conducting another assessment.

- **Why would a nurse set up a plan for 22 hours/month for a beneficiary who lives in a rural area? We can't afford to even pay driving time.**
  Liberty does not calculate, approve, or deny services. 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. Providers are responsible for reviewing a beneficiary's assessment in their review queue before accepting and should do so to determine whether they have the staff to appropriately meet the beneficiary's need.

Background Checks

- **After the initial criminal check, how often does this need to be repeated? Are they due yearly for existing employees, or just at hire?**
  Refer to DHSR Licensure Rules and Regulations for specific requirements on criminal background checks.

- **What are the requirements and limitations as far as backgrounds? Is checking the heath care registry a sufficient background check? What does an adequate background check consist of?**
  Refer to DHSR Licensure Rules and Regulations for specific requirements on criminal background checks.

- **Is SBI required? Can a local background check be used instead of SBI?**
  Refer to DHSR Licensure Rules and Regulations for specific requirements on criminal background checks.

- **What is considered a "timely" background check? Local backgrounds can be done immediately, but universal for out-of-state employees is different.**
  Refer to DHSR Licensure Rules and Regulations for specific requirements on criminal background checks.

- **Are police reports accepted for hiring aides?**
  Refer to DHSR Licensure Rules and Regulations for specific requirements on criminal background checks.

- **If staff background verification is not done upon hire, how is this corrected?**
  The background check should be completed prior to the aide providing services to the beneficiary. If audited, providers may not be paid for the hours that person worked prior to the background check due to non-compliance with Clinical Coverage Policy 3L.

- **Exactly what needs to be in each employee's chart?**
  Refer to DHSR Licensure Rules and Regulations for specific requirements on employee's charts.

Other/Miscellaneous

- **Where do you provide annual training?**
  Training is provided twice a year in 6 regions across the state. Locations include: Asheville, Charlotte, Greensboro, Raleigh, Fayetteville, Greenville.

- **Are there any plans to separate IHC/ACH training for PCS?**
  The PCS Program is managed comparable to setting; because of this management approach, it is not anticipated that training will be separate based on setting.

- **How often is the DMA website updated?**
  The website is updated as needed to ensure information is up to date and accessible to providers.

- **Is the training power point from this provider training available online?**
  Yes, the power point can be found at http://nc-pcs.com/training/.

Important Note: Questions and answers from the Office of Compliance/Program Integrity's portion of Spring and Fall 2017 PCS Regional Trainings will be compiled and posted at a later date.