Liberty Healthcare Corporation of North Carolina

Provider Training OCTOBER 2017 Questions and Responses

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

- **PCS Updates**
- **Program Integrity Updates**
- **PCS Provider Resources**
- **QiReport**

All questions with responses are provided in this document.

PCS Updates

- **Can billing reps start billing at the new rate that was effective 8/1/17, now?**
  Providers may submit adjustment claims to receive this increased reimbursement. The Division of Medical Assistance (DMA) will systematically reprocess claims at a future date. The systematic reprocessing will not automatically reprice all claims at these revised rates. The systematic reprocessing will reprocess claims based on the previous paid amount and the billed charges submitted on their claim. For example, a claim with a date of service of 9/2/17, billed amount of $3.47 and paid amount of $3.47 will not be reprocessed during the systematic reprocessing to pay the above revised rates. Providers may refer to the December 2017 Special Bulletin for additional information.

- **When will CMS approve the new rate?**
  On December 13, 2017, DMA received approval from CMS to increase the rate for Personal Care Services. Providers may refer to the December 2017 Special Bulletin for additional information.

- **Will adjustments be initiated due to the rate increase?**
  Providers may submit adjustment claims to receive this increased reimbursement. The Division of Medical Assistance (DMA) will systematically reprocess claims at a future date. The systematic reprocessing will not automatically reprice all claims at these revised rates. The systematic reprocessing will reprocess claims based on the previous paid amount and the billed charges submitted on their claim. For example, a claim with a date of service of 9/2/17, billed amount of $3.47 and paid amount of $3.47 will not be

reprocessed during the systematic reprocessing to pay the above revised rates. Providers may refer to the December 2017 Special Bulletin for additional information.

- **Will we be able to refile PCS claims back to 8/1/17 once the rate is approved?** Providers may submit adjustment claims to receive this increased reimbursement. The Division of Medical Assistance (DMA) will systematically reprocess claims at a future date. The systematic reprocessing will not automatically reprice all claims at these revised rates. The systematic reprocessing will reprocess claims based on the previous paid amount and the billed charges submitted on their claim. For example, a claim with a date of service of 9/2/17, billed amount of $3.47 and paid amount of $3.47 will not be reprocessed during the systematic reprocessing to pay the above revised rates. Providers may refer to the December 2017 Special Bulletin for additional information.

- **What does changing the retroactive dates (prior approval) mean for Home Care?** 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.

- **Approval dates for retroactive prior approvals, does the assessment date have an impact on the payment date?** Retroactive prior approval for PCS only applies to initial requests for PCS. The retroactive effective date for authorization will be the request date on the Request for Independent Assessment for Personal Care Services DMA 3051 Form, provided the date on the form is not more than 30 calendar days from the date that the Independent Assessment Entity, Liberty Healthcare, received a completed request form. If the request is received by Liberty Healthcare more than 30 calendar days from the request date on the request form, the authorization will be effective the date Liberty Healthcare received the form. It should be noted that, services can only be billed once the service has been approved and the services have been performed.

- **Please review the 3 key points for Quality Assurance questionnaire needed to meet standard.** There are no requirements for the PCS satisfaction survey. Providers should determine what is important for them and what they would like to measure in determining which questions to ask during the customer service/PCS satisfaction survey. A detailed training presentation on Section 7.7 of Clinical Coverage Policy 3L that includes this topic as well as the Internal Quality Improvement Plan is available on Liberty's website in their Archived Training Materials section.

- **Does the DMA 3085 have to be done on each employee or community?**

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.

- **What does the "internal audit" referred to in the materials mean?**
  DMA conducts internal audits of Provider Supervisory Visit Notes (Clinical Coverage Policy 3L, Section 7.10 b. (1-9)) and Aide Training Documentation (Clinical Coverage Police 3L, 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.

- **If an ADL/IADL is not requested by the client and provider calls Liberty to request the change but never gets it - is there possible recoupment?**
  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. If there is a task where the beneficiary no longer has an assistance need, a Medical Change of Status is required.

- **Does each NPI need its own 3085 form? Form 3136?**
  Yes, one form is needed per NPI. The DMA 3085 is submitted to DMA once per NPI before servicing qualifying beneficiaries under Session Law 2013-306 while the DMA 3136 is submitted annually per NPI before 12/31 of each year.

- **Why are ICD -10 forms being sent for clients that have had 2016 and 2017 assessments?**
  ICD-10 forms are included with the annual letter that is sent to all beneficiaries. If the requirements have been met, the form does not need to be filled out.

- **Are ICD-10 forms to be updated each year?**
  No, 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.

- **How many times should we upload the ICD-10 Transition form?**
  The form only needs to be completed and uploaded once for each beneficiary.

- **When there is a new request can anyone from the provider agency go to that client's home to fill out the form for them, then drive the form to the doctor's office?**

Page 1 and 2 of the DMA-3051 Request Form shall be completed by the beneficiary's physician, nurse practitioner, or physician assistant. Per Clinical Coverage Policy 3L Section 5.4.2 c. *"The beneficiary or the beneficiary's family or legally responsible person is responsible for contacting his or her primary care or attending physician and requesting a referral for Medicaid PCS".*

- **Can Liberty call the provider agency when something is missing or invalid on PCS request 3051 Form?**
  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 an approved 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.

- **How many of the Alzheimer's courses are required? Does the aide have to complete them all?**
  There is no designated number of hours required. All training requirements are outlined within the attestation form and its instructions. Training is also included on Liberty's website; providers may follow the curriculum and complete the attestation form.

- **Does staff need to be both Trained and Certified for the Alzheimer's Training? What credentials are needed to service these beneficiaries?**
  All training requirements are outlined within the DMA 3085 Attestation form and its instructions. Liberty provides an approved training on their website. A certificate will be issued upon completion and should be kept on file. The DMA 3085 must be submitted to DMA prior to billing for services that were rendered to a qualifying beneficiary. Certification is not required.

- **How can we have a group Alzheimer's Training and get certificates for each individual attending?**
  An approved trainer can conduct a group training and the DMA 3085 completed with details regarding the training and trainer; this form must be sent to DMA. Documentation should be kept on file to indicate who completed the training and where the modules came from. In addition, a certificate of completion should be kept on file for each individual employee.

- **Is the Alzheimer's training the only special training you have? Will you add more?**
  At this time, Alzheimer's is the only specialized training provided on Liberty's website.

- **Is Alzheimer's training once a year or once in employment?**
  Training is only required once per aide prior to servicing beneficiaries who meet the qualifications under Session Law 2013-306.

- **Do we have to use Liberty's Alzheimer training or can we use our own?**
  No, providers may use their own training as long as it meets the requirements outlined in the DMA 3085 Form.

- **Does EPSDT hours require Training Attestation?**
  There is no training attestation required to service EPSDT beneficiaries.

- **If the client follows the Turning 21 process correctly, will there be a lapse in services while they are transitioning to the adult services**?
  If the beneficiary or their legally responsible person sends a completed DMA 3051 Form to Liberty prior to the beneficiary turning 21, if the beneficiary is eligible for PCS as an adult, there should not be a lapse in services. Refer to the July 2017 N.C. Medicaid Bulletin or the PCS Provider Manual for additional information.

- **Will PA's be extended automatically after EPSDT's 21st birthday if a timely 3051 form is filled?**
  Once the DMA 3051 is received and processed, Liberty Healthcare will work with beneficiaries and/or their legally responsible person to schedule an assessment in the 10 days following the 21st birthday. If the beneficiary is eligible for PCS as an adult, retroactive PCS approval will be allowed between the date the beneficiary turns 21 and the assessment approval date for the amount previously awarded (if 80 hours or less) or at 80 hours (if more than 80 hours were previously approved). Refer to the July 2017 N.C. Medicaid Bulletin or the PCS Provider Manual for additional information.

- **What is PASRR and how does it affect PCS Providers?**
  The Preadmission Screening and Annual Resident Review (PASRR) is a review of any individual who is being considered for admission into a Medicaid Certified Adult Care Home (ACH). Per Clinical Coverage Policy 3L (3.2.3b), a Medicaid beneficiary residing in or applying for admission to an ACH must be screened for Serious Mental Illness (SMI) using the PASRR prior to an assessment for PCS services.

- **If a client requests a hearing due to a reduction of services, must a RN or LPN go to the client's home to help with the appeal form or can anyone else from the provider help with the appeal?**
  There are no requirements regarding who can assist a beneficiary in completing the Medicaid Services Beneficiary Hearing Request Form, the beneficiary may ask whomever they want to assist them or be their legal representative through the appeal process.

- **If we receive a COP request, how will we know if there is an appeal process already going on?**

Once the provider accepts a beneficiary, they can go into the 'Recipient Record' page in QiReport. If there is an active appeal open, they will see "APPEAL" in red and MOS hours (if they are approved for any).

- **If you do not agree with PCS hours in a SCU, what is the process?**
  Reconsideration requests are for beneficiaries that are at least 21 years of age, that receive an initial approval of less than 80 hours per month. Individuals who requested and were denied additional hours receive appeal rights. There may be some exceptions to the rules, so please call Liberty for further clarification.

- **Why doesn't Liberty or OAH send denial notifications to providers?**
  All communication is sent to the beneficiary or their legal representative.

- **Viebridge stated they would add a pop up flag when a denial notification is received, but never did to the portal. Why?**
  DMA welcomes feedback on system functionality improvements in the QiReport system. All suggestions will be reviewed. Providers are advised to check the 'Denied Last 6 Months' tab in QiRePort daily to ensure that they are aware of any beneficiaries that have received a reduction in hours or denial of services.

- **What is the plan to improve the notifications sent to beneficiaries for appeals? Some are receiving their notifications too late**.
  It is the responsibility of the beneficiary to make sure their address remains current with the Department of Social Services (DSS). All mailings are sent to the address on file with DSS.

PCS Provider Resources

- **Is there a program available to input patient information that generates plans of care and aide task sheets?**
  QiReport generates the Service Plan and populates the aide task sheet. Per Licensure, a Plan of Care must also be completed. This is similar to the Service Plan but is a separate requirement. Refer to DHSR Licensure Rules and Regulations for specific requirements on the Plan of Care.

- **If you have your employee manual can we add the PCS Policy as an amendment? The policy is available to the public.**
  Providers should have Clinical Coverage Policy 3L as a resource/reference for their staff, but cannot claim the policy as proprietary.

QiReport

- **How does an agency add another user to the QiReport portal when there has been a change in staff?**
  Contact Viebridge directly for support. Their contact information can be found on the main home page of QiReport.

- **Once the referral is accepted, how many business days does the agency have before they can begin services**?
  Effective dates vary for many reasons. Providers should refer to the effective date on the authorization letter to determine the service start date. If the date on the provider's letter is different from the date on the beneficiary's letter, providers should go by the date on the beneficiary's letter. For a detailed breakdown on effective dates, providers can reference the PCS Provider Manual on Liberty's website.

- **If you accept a referral from another office how do you change the provider back to the office the referral belongs to?**
  Providers can change the NPI assigned to the beneficiary as long as all of the affiliated NPI's are registered in QiReport. If they are not all registered, contact Viebridge for assistance.

- **Why can I see referrals from multiple offices/areas?**
  Providers may see this if there are multiple offices and NPI's that are affiliated with their agency/facility. Contact VieBridge to set a limit on the number of associated NPIs.

- **Why do we receive referrals for existing clients on annual assessments? Do we have to accept them again if they are already our client?**
  At each assessment, the beneficiary is given the opportunity to continue with their current agency or to change providers. In addition, when providers receive the referrals on existing clients, it is an opportunity for staff to evaluate the new assessment and determine if they are still able to meet the beneficiary's needs, especially if there has been a change in hours.

- **After completing the Service Plan, do we have to upload the signed copy to Liberty's site?**
  Yes, 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).

- **If the agency's RN identifies a task on her assessment, whether admission or interim that is not on the independent assessment, are we allowed to add the tasks per our Licensure rules to our Service Plan's or POC?**

Providers are only able to bill for tasks that are approved via the independent assessment. If you are concerned that a task has been omitted from the assessment, contact Liberty with questions regarding how to proceed.

- **After the manual Service Plan has been uploaded to QiReport, no call was made to Liberty. Does Liberty ever check QiReport for that beneficiary to see if the plan was uploaded? What happens if there is no call for manual service plans?**
  Liberty does not receive a notification when the provider uploads a manual service plan for a beneficiary. It is the responsibility of the agency to call Liberty to have the service plan requirement checked as met and have the PA's released.

- **Why doesn't the change in service letters require a signature to verify receipt?**
  The 'Notification of a Change in Service' letters are sent via Priority Mail so they can be tracked, but no signature is required. This ensures that beneficiaries that cannot drive to the Post Office or get to their door quickly receive their letters.

- **Do we upload all developed Service Plans or does this only need to be done once?**
  A signed copy of the service plan is required to be uploaded any time a provider accepts a beneficiary through the referral page and develops a new service plan. This can be for new clients or existing.

- **What is the deadline for uploading signed service plans to QiReport?**
  Per Section 6.1.4 j of Clinical Coverage Policy 3L, the provider organization shall obtain the written consent in the form of the signature of the beneficiary or their legally responsible person within 14 business days of the validated service plan.

- **How do we create a manual SP when, for example, the hours reflect zero in QiReport but the approved hours in the letter are 48?**
  Anytime the approval letter indicates hours that do not match the assessment, a manual Service Plan is needed. Providers can use their desired format for the manual Service Plan that captures all tasks, assistance levels, frequencies, etc. Once completed, the manual Service Plan should be uploaded to Supporting Documents in QiRePort and the provider should immediately contact Liberty Healthcare to receive prior approval to bill.

- **If the beneficiary was approved for weekend assistance, but chooses not to receive assistance on the weekend, do the total number of hours move to M-F?**
  In the event that 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.

- **With deviations, do you have to put the time change and/or reason?**
  Yes, provide detailed documentation of any deviations that occur. Detail specifics of the change and why the change was needed. The aide task sheet generated by QiRePort has a section to document deviations.

- **Is there a way Liberty could make it simpler for patients to understand hours? It can be confusing, for example, a client is approved for 80 hours/month for 7 days/wk. QiReport Service Plan shows 74 hours; is that because some months are longer and others are shorter?**
  One way to figure out how much time is needed for beneficiaries is to divide the average weekly hours that QiRePort computes and displays for providers in the service plan template by the number of days the aide tasks must be performed. For example, if the maximum need frequency is five days a week, divide the weekly hours estimate by five.

- **We see that the modifier is often not changed when a beneficiary goes from a facility to a SCU. What can be done to correct this?**
  Adult Care Home providers are able to change modifiers in QiRePort. If you need assistance with this, please reach out to Liberty Healthcare or VieBridge for support.

MISC

- **Is there a list of all your abbreviations and can you put it on Liberty's website**?
  Please refer to Liberty Healthcare's website for a list of Definitions, Acronyms, and Abbreviations relative to Personal Care Services.

- **When does the telephony system requirement begin and will Liberty provide or recommend the system to use?**
  Effective January 1, 2019 for Personal Care Services, the 21st Century Cures Act requires the use of an Electronic Visit Verification (EVV) System for personal care services requiring an in-home visit by a provider that are delivered under a state plan or a waiver of the plan. Additional guidance to the regulation is expected from the Centers for Medicare and Medicaid (CMS) in January of 2018 and DMA will inform providers of these details as they become available. Liberty will not provide or recommend a system to use.

- **Is the TB skin test a requirement for an in-home aide CNA or PCA?**
  Refer to DHSR Licensure Rules and Regulations for specific requirements.

- **If a patient has "No Extensive" overall but is on oxygen, can a PCA work them?**
  To make an appropriate determination on the level of aide, review the beneficiary's PCS assessment in conjunction with Clinical Coverage Policy 3L and applicable licensure rules.

- **We attended the last provider training via telephone. Is this still an option for those who cannot attend training in person?**
  Liberty conducted a live webinar on November 15, 2017 following the onsite Provider Trainings. It can be viewed on Liberty Healthcare's website.

- **Can RN's receive CEU's for training? If so, how do you get documentation?**
  No.

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