PCS 101 for Providers Training

Agenda

- Introduction and Overview

- Personal Care Services 101

- Questions and Answers

- Training Feedback

Personal Care Services 101

- The goal of this training is to provide broad overview of:
  - Personal Care Services
  - Provider Requirements
  - QiRePort

Medicaid Personal Care Services (PCS)

What are PCS?

- State provided assistance with Activities of Daily Living (ADLs).

- Services provided in the Medicaid beneficiary's primary private residence.

- Services provided by paraprofessional aides employed by licensed home care agencies, licensed adult care homes, or home staff in supervised living homes.

- The amount of prior-approved service is based on an assessment conducted by an independent assessment entity (IAE), Acentra Health, to determine the beneficiary's ability to perform ADLs.

Activities of Daily Living (ADLs)

- Bathing

- Dressing

- Mobility

- Toileting

- Eating
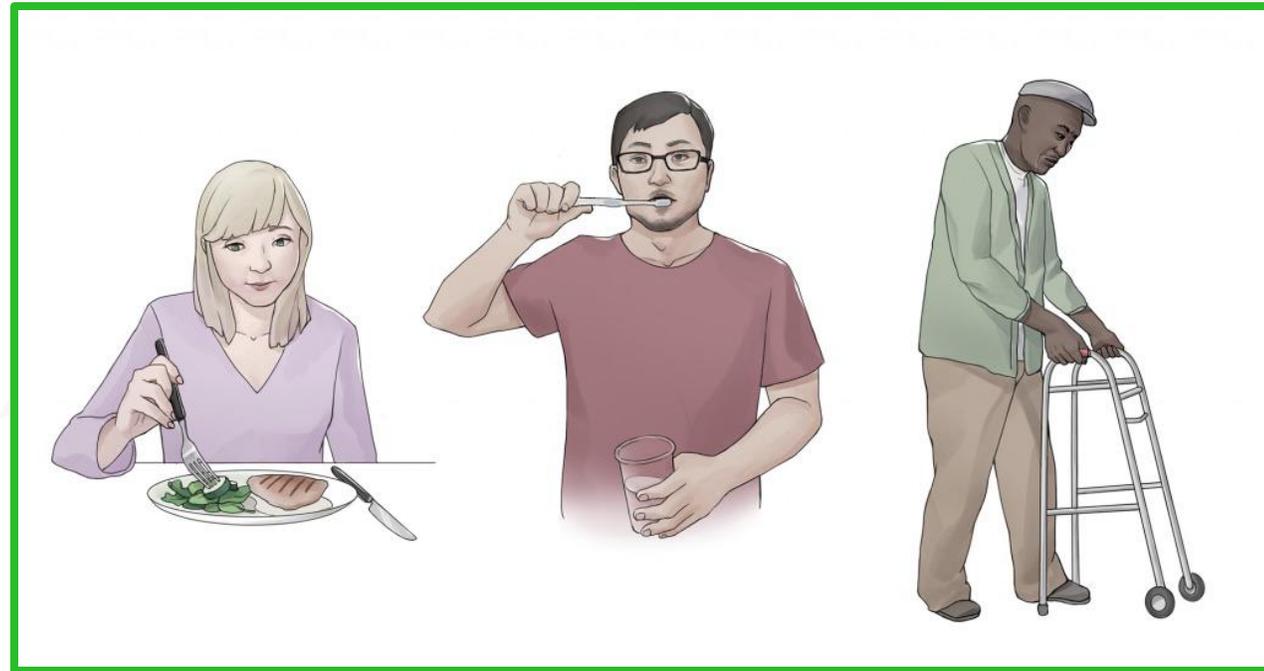
Covered Services Include:

- Assistance to help with qualifying ADLs
- Assistance with medications that treat medical conditions that effect the qualifying ADLs
- Assistance with devices directly linked to the qualifying ADLs

PCS Tasks Not Covered

- Skilled nursing by LPN or RN

- Respite care

- Care for pets or animals

- Yard work

- Medical or non-medical transportation

- Financial Management

- Errands

- Companion sitting

PCS Eligibility Criteria

- Have active Medicaid

- Have a medical condition, cognitive impairment or disability that limits them from performing their activities of daily living

- Be considered medically stable

- Be under the care of their primary care physician or attending physician for the condition causing limitations

- Have seen their treating physician within the last 90 days

- Reside in a private living arrangement, or in a residential facility licensed by the State of North Carolina as an adult care home, a combination home, or a group home as a supervised living facility

- Not have a family member or caregiver who is willing and able to provide care

How Does The Beneficiary Qualify For PCS?

The beneficiary must have at a minimum:

- 3 of the 5 qualifying ADLs with limited assistance;

- 2 ADLs, one of which requires extensive assistance; or

- 2 ADLs, one of which requires assistance at the full dependence level.

How Many Hours Can A Beneficiary Receive?

- **80 Hours**
  - For a beneficiary who does not meet the criteria for Session Law 2013-306.

- **60 Hours**
  - EPSDT on the initial assessment hour generation.
  - All EPSDT assessments go to NC Medicaid for final hour calculation/evaluation.

- **180 Hours**
  - For a beneficiary who meets the criteria for Session Law 2013-306

PCS Requirements for Physician Referral

- A beneficiary, family or legally responsible person must contact his/her primary care or attending physician and request they complete the 'Request for Independent Assessment for PCS Form (DHB-3051 form) in order to have an assessment for PCS.

- The form can only be completed by a MD, NP, or PA.

- The beneficiary is required to have seen the referring physician within the last 90 days from the date received by the IAE.

The Assessment

Once the MD, NP, or PA completes a DHB-3051 Form and sends it to the IAE (Acentra Health), the PCS assessment is performed by a Nurse Assessor at the beneficiary's home or residential facility.

The Nurse Assessor captures the following during the assessment:

- Demonstrations of a beneficiary's ability to perform their activities of daily living (ADLS)
- Available caregivers
- Daily medicine regimen
- Diagnosis information
- Paid supports/Non-Paid supports
- Special assistive tasks
- Exacerbating conditions that impact their ability to perform their ADLs
- Environmental conditions and home safety evaluation
- Beneficiary preferred providers
- Return frequency

Assistance Levels

Assistance Levels	Defined
Totally Able	Self-perform 100% of the activity with or without assistance of aid or assistive devices and without supervision to set up supplies and environment for task.
Verbal Cueing or Supervision	Self-perform 100% of the activity with or without assistance of aid or assistive devices and requires, monitoring or assistance to retrieve or set up supplies or equipment.
Limited Hands-on Assist	Self-perform 50% of the activity and requires hands-on assistance to complete the remainder of the task.
Extensive Hands-on Assist	Able to self-perform less than 50% of the activity and requires hands-on assist to complete remainder of activity.
Cannot Do At All	Unable to perform any of the activity and is totally dependent on another person to perform the activity.

PCS Independent Assessment Process

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┌─────────────────────┐     ┌─────────────────────────┐     ┌─────────────────────────┐
│   Referral Request  │ ──▶ │ Scheduling Coordinator  │ ──▶ │    Assessor visits      │
│     is Received     │     │ Schedules Appointment   │     │   Beneficiary Home      │
│                     │     │  with Beneficiary for   │     │ to Complete Independent │
│                     │     │       Assessment        │     │       Assessment        │
└─────────────────────┘     └─────────────────────────┘     └─────────────────────────┘
                                                                         │
                                                                         ▼
┌─────────────────────┐     ┌─────────────────────────┐     ┌─────────────────────────┐
│ The Selected Provider│◀── │   The Assessor Submits  │◀── │ If necessary, at the time of│
│  Accepts Care for the│     │    the Assessment for   │     │      the assessment,    │
│ Beneficiary and Initiates│ │          Review         │     │  Assessor Provides the  │
│         Care        │     │                         │     │ Beneficiary with a List of│
│                     │     │                         │     │ Providers, the Beneficiary│
│                     │     │                         │     │     Can Select up to 3  │
└─────────────────────┘     └─────────────────────────┘     └─────────────────────────┘
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Overview Of The DHB-3051 Form

DHB-3051 Request for Independent Assessment for Personal Care Services (PCS) Attestation of Medical Need

- All PCS providers, regardless of setting, use the DHB-3051 form.

- DHB-3051 is the only form that allows physicians to provide written attestation to the medical necessity for up to 50 additional PCS hours per NC Session Law 2013-306.

- Download the current form (Effective 12/07/2023) at:

  download (ncdhhs.gov)

Completing the DHB-3051 Form: Key Information

- The DHB-3051 Form has 7 sections – A through G. You are not required to complete all the sections of the DHB-3051 Form each time you submit the form, just those specific to type of request.

- Sections A through D must be completed by the *Primary Care Physician or Attending Physician Only.*

- Sections E, F and G must be completed by the *Beneficiary, Caregiver, or PCS Provider Only.*

- Completion of **ALL** fields ensures timely processing of the submitted requests.

NOTE: Forms received with blank information fields are returned to the referring physician. If not completed timely, the request will be denied.

- Refer to the Request for Independent Assessment for Personal Care Services (PCS) Form DHB-3051 with Instructions available at:

    download (ncdhhs.gov)

Completing PCS DHB-3051 – New Request

Complete the Following Sections for New Requests:

Section A	• Beneficiary Demographics
Section B	• Beneficiary's Conditions That Result in Need for Assistance with ADL's
Section C	• Practitioner Information

Completing PCS DHB-3051 – New Request (continued)

Section A: Beneficiary Demographics

SECTION A. BENEFICIARY DEMOGRAPHICS

Beneficiary's Name: First:_____ MI: ____ Last:_____ DOB:____ / ____ / ____

Medicaid ID#:_____ RSID#(ACH Only):_____ RSID Date:____ / ____ / ____

Gender: ☐ Male ☐ Female   Language: ☐ English ☐ Spanish ☐ Other_____

Address:_____ City:_____

County:_____ Zip:_____ Phone: (____)_____

Alternate Contact (Select One): ☐ Parent   ☐ Legal Guardian (required if beneficiary < 18) ☐ Other

Relationship to Beneficiary (NON-PCS Provider):_____

Name:_____ Phone: (____)_____

Active Adult Protective Services Case? ☐ Yes ☐ No

Beneficiary currently resides: ☐ At home ☐ Adult Care Home ☐ Hospitalized/medical facility ☐ Skilled Nursing Facility

☐ Group Home ☐ Special Care Unit (SCU) ☐ Other_____ D/C Date (Hospital/SNF):____ / ____ / ____

Completing PCS DHB-3051 – New Request (continued)

Section A: Beneficiary Demographics (continued)

- Enter Beneficiary Name, Date of Birth, Address and Phone

- Medicaid ID Number – Only active Medicaid participants are eligible

- Beneficiary's alternate contact – Parent, Guardian, or Legal Representative **Note:** A PCS Provider cannot be listed as an alternate contact

- Indicate if the beneficiary has an active Adult Protective Services case.
  - If yes, request will be expedited.

- RSID# and RSID Date (For ACH Beneficiaries Only)

- Indicate where the beneficiary currently resides Note: Those being discharged from the hospital, a Skilled Nursing Facility, or part of the Transition to Community Living Initiative will be expedited.

Completing PCS DHB-3051 – New Request (continued)

Section B: Beneficiary's Conditions That Result in Need for Assistance With ADLs

Completing PCS DHB-3051 – New Request (continued)

Section B: Beneficiary's Conditions That Result in Need for Assistance With ADLs (continued)

- Enter both the Medical Diagnosis related to the beneficiary's need for assistance with ADLs, the Diagnosis Code(s), and the date of onset. Incomplete or inaccurate codes may result in request processing delays.

- Indicate, for each diagnosis, if the condition impacts the beneficiary's ability to perform ADLs.

- Indicate the expected duration of the ADL limitations.

- Indicate if the beneficiary is medically stable and if 24-hour caregiver availability is required.

Completing PCS DHB-3051 – New Request (continued)

Section B: Optional Attestation

- If the criteria listed in this section is applicable to the beneficiary, the Practitioner should initial each line item that applies for consideration in the assessment for PCS.

OPTIONAL ATTESTATION: *Practitioner should review the following and initial only if applicable:*	
Beneficiary requires an increased level of supervision.	Initial:
Beneficiary requires 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 in learning, and the loss of language skills.	Initial:
Beneficiary requires a physical environment, regardless of setting, that includes modifications and safety measures to safeguard the beneficiary because of the beneficiary's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.	Initial:
Beneficiary has a history of safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.	Initial:

Completing PCS DHB-3051 – New Request (continued)

Section C: Practitioner Information

SECTION C. PRACTITIONER INFORMATION

Attesting Practitioner's Name:_____ Practitioner NPI#:_____

Select one: ☐ Beneficiary's Primary Care Practitioner ☐ Outpatient Specialty Practitioner ☐ Inpatient Practitioner

Practice Name:_____ NPI#:_____

Practice Contact Name:_____

Address:_____

Phone:_(____)_____ Fax:_(____)_____

Practice Stamp

Date of last visit to Practitioner:_____/_____/_____ **Note: Must be < 90 days from Received Date

Practitioner Signature AND Credentials

Date

___/___/___

Signature stamp not allowed

"I hereby attest that the information contained herein is current, complete, and accurate to the best of my knowledge and belief. I understand that my attestation may result in the provision of services which are paid for by state and federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement or representation may be prosecuted under the applicable federal and state laws."

Completing PCS DHB-3051 – New Request (continued)

Section C: Practitioner Information (continued)

- Attesting Practitioner's Name and NPI#

- Practice Name and NPI#

- Practice Contact Name, Address, and Phone
  - *Note: Practice stamps are accepted vs. completing each of these fields*

- Date of last visit to the Practitioner - The last visit date must have occurred within 90 days of the request date.

- The 3051 Form for the New Referral MUST be signed by the referring practitioner and credentials indicated along with the date; acceptable credentials include a MD, NP, or PA.
  - *Note: Signature stamps are not accepted*

Completing PCS DHB-3051 – New Request (continued)

What Happens Next:

- If the New Referral Request is complete and meets the requirements as outlined in *Clinical Coverage Policy 3L,* the request will be processed and entered into QiRePort within 2 business days of receipt.

- If the information is not complete, the request form will be returned to the referring physician via fax within 2 business days.

- Acentra Health will verify that the beneficiary has active Medicaid coverage, and the recipient will be contacted to schedule a Medicaid PCS eligibility assessment.

- If the beneficiary is determined to be eligible for PCS, the Provider of Choice will receive the referral via the QiRePort Provider Interface.

Completing PCS DHB-3051 – Change of Status Medical

Complete the Following Sections for Medical Change of Status Requests:

Section A	• Beneficiary Demographics
Section B	• Beneficiary's Conditions That Result in Need for Assistance with ADLs
Section C	• Practitioner Information
Section D	• Change of Status: Medical

Completing PCS DHB-3051 – Change of Status Medical (continued)

Section D Required Fields

- Describe in detail the change in medical condition which results in a need for decreased or increased hours of PCS.

- *For clarification when completing the DHB-3051 form, "Medical" is defined as any change in a person's health condition.*

SECTION D. CHANGE OF STATUS: MEDICAL Complete for medical change of status request only.

Describe the specific medical change in condition and its impact on the beneficiary's need for hands on assistance (Required):

Completing PCS DHB-3051 – Change of Status Medical (continued)

Things to remember:

- The Change of Status: Medical should be submitted when there is a change in the beneficiary's medical condition, and

- Must be completed and submitted by the beneficiary's Primary Care Physician or Attending Physician.

- **Note:** "Medical" is defined as any change in a person's health condition that results in improved or decreased ability to perform their Activities of Daily Living.

Completing PCS DHB-3051 – Managed Care Disenrollment

Complete the Following Sections for Managed Care Disenrollment Requests:

Section A	• Beneficiary Demographics
Section B	• Beneficiary's Conditions That Result in Need for Assistance with ADLs
Section C	• Practitioner Information
Section E	• Managed Care Disenrollment

Completing PCS DHB-3051 – Managed Care Disenrollment (continued)

SECTION E: Managed Care Disenrollment was added to the DHB 3051 effective 7/1/2021 and should be completed if a beneficiary is disenrolling from Medicaid Managed Care and wishes to continue with PCS as a participant of Medicaid Direct.

Completing PCS DHB-3051 – Managed Care Disenrollment (continued)

When completing the Managed Care Disenrollment section be sure to indicate:

1. Managed Care Plan name the beneficiary is disenrolling from.
2. Disenrollment effective date.
3. Current PCS hours being received from the Managed Care Plan.
4. Beneficiary's Current PCS Provider Agency's information.

Completing PCS DHB-3051 – Change of Status: Non-Medical

Non-Medical Change of Status Request, Complete The Following Sections of Page 3 only:

Top Section	• Beneficiary Demographics (all fields required to be completed)
Section F	• Change of Status: Non-Medical

Completing PCS DHB-3051 – Change of Status: Non-Medical (continued)

- Non-Medical Change of Status should be submitted when there is a:
  - Change in beneficiary's location
  - Change in caregiver status
  - Change in days of need
- Can be submitted by the beneficiary, caregiver, legal guardian, or PCS Provider

Completing PCS DHB-3051 – Change of Provider

For Change of Provider Requests, Complete The Following Sections of Page 3 only:

Top Section	• Beneficiary Demographics (all fields required to be completed)
Section G	• Change of Provider Request

Completing PCS DHB-3051 – Change of Provider (continued)

Things to remember:

- Change of Provider requests can be made by completing the DHB-3051 form or by calling Acentra Health. *Form completion is not required. Request can be made by a call to Acentra Health by the beneficiary or legal guardian.*

- For an IHC Change of Provider, a request may only be submitted by the beneficiary, Power of Attorney, or Legal Guardian.

- An ACH facility may submit a Change of Provider request if a current PCS beneficiary is admitted.

- If a beneficiary needs assistance in selecting an 'Alternate Preferred Provider', an Acentra Health Customer Support Representative can assist.

- Acentra Health will confirm all Change of Provider requests with the beneficiary or legal guardian.

Completing PCS Form DHB 3051 – Change of Provider (continued)

New Request vs. Change of Provider?

Beneficiary Moves From:	Required Request Type
ACH to ACH	COP request – Effective in 1 day
IHC to IHC	COP request – Effective in 10 days
IHC to ACH	New Request
ACH to IHC	New Request

Completing DHB-3051

Form Completion Recap

REQUEST TYPE	COMPLETED BY	REQUIRED PAGES	REQUIRED SECTIONS
NEW REQUEST	PRACTITIONER	1& 2	SECTION A, B,C
CHANGE OF STATUS: MEDICAL	PRACTITIONER	1 & 2	SECTION A, B, C, D
MANAGED CARE DISENROLLMENT	PRACTITIONER & PCS PROVIDER	1 & 2	SECTION A, B, C, E
CHANGE OF STATUS: NON-MEDICAL	BENEFICIARY,CAREGIVER, PCS PROVIDER	3	TOP SECTION AND F
CHANGE OF PROVIDER	BENEFICIARY, CAREGIVER, ACH FACILITY	3	TOP SECTION AND G

Completing DHB-3051 (continued)

Submitting the Completed Form

- Complete all appropriate sections

- Fax the completed form to: 833-521-2626 or for PCS Expedited Assessments, fax 833-551-2602.

- If preferred, forms can be mailed to:

  Acentra Health

  Attn: NCLIFTSS PCS

  2000 CentreGreen Way, Suite 220

  Cary, NC 27513

Reminder: Practitioners must submit pages 1&2; Non-Practitioners should submit page 3.

- Keep copies of all forms and fax confirmations for your records.

- For questions regarding the form,

  email: **NCLIFTSS@Kepro.com** or call 919-568-1717 or 833-522-5429 (toll free).

PCS Expedited Process – Eligibility

Requirements:

- There is an active Adult Protective Services (APS) case; or

- The beneficiary is currently hospitalized in a medical facility or in a Skilled Nursing Facility (SNF); or

- Is under the Transition to Community Living Initiative (TCLI).

- For those being admitted to an Adult Care Home (excluding 5600 facilities), the beneficiary must have a Referral Screening ID.
  - To learn more on this form and process, please go to:

    [RSVP-Fact-Sheet.pdf (nc.gov)](RSVP-Fact-Sheet.pdf)

- The beneficiary is medically stable.

- The beneficiary has active or pending Medicaid.

Expedited Process – Submitting the Form

- Form should be completed and submitted by one of the following –
  - Hospital Discharge Planner
  - Skilled Nursing Facility Discharge Planner
  - Adult Protective (APS) Worker
  - An approved LME-MCO Transition Coordinator*

- Persons submitting the 3051 will need to have the beneficiary select a provider of services **PRIOR** to calling Acentra Health and completing the expedited process.

- Completed forms should be sent to Acentra Health via fax at 833-551-2602 followed by a call to Acentra Health at 919-568-1717 (local) or 833-522-5429 (toll free).

LME-MCO Transition Coordinators, who are approved through NC Medicaid, are able to execute the expedited process.

Expedited Process – Next Steps

1. Once connected with Acentra, the request will be reviewed and immediately approved or denied based on eligibility only, by a Customer Service Team Member.

2. If eligibility is approved, the caller will be transferred to a Acentra Health nurse who will conduct a brief phone assessment.

3. If a need for PCS is identified, the beneficiary will be immediately awarded temporary hours for personal care services, up to 60 hours, and the referral is sent to the selected PCS Provider for acceptance.

4. Then, Acentra Health contacts the beneficiary within 14 business days to schedule a complete assessment in person.

Provider Requirements

Forms, Forms, and More Forms

- NC Medicaid-3085: Session Law 2013-306 PCS Training Attestation Form

- NC Medicaid-3136: Internal Quality Improvement Program Attestation Form

NC Medicaid-3085: Session Law 2013-306 PCS Training Attestation Form

North Carolina Department of Health and Human Services-NC Medicaid

SESSION LAW 2013-306
PCS TRAINING ATTESTATION FORM

Send completed form, and supporting documentation, to NC Medicaid at Medicaid.PCSTraining@dhhs.nc.gov. For questions, contact 919-855-4360, or send an email to PCS_Program_Questions@dhhs.nc.gov.

PROVIDER TYPE (select one):   **DATE OF SUBMISSION:** _____ (mm/dd/yyyy)

- [ ] Home Care Agency
- [ ] Family Care Home
- [ ] Adult Care Home
- [ ] Adult Care Bed in Nursing Facility
- [ ] SLF-5600a
- [ ] SLF-5600c
- [ ] Special Care Unit (stand-alone SCU or SCU bed)
- [ ] Non-Provider: _____

PART I: SUBMITTER INFORMATION

National Provider Identifier (NPI#): _____
Provider Name: _____
Submitter Name: First: _____ Last: _____ M.I: _____
Address: _____ City: _____
County: _____ Zip: _____ (zip code + 4 digit extension) Phone: _____
Suite: _____ Email: _____ Fax (If Applicable): _____

PART II: TRAINER QUALIFICATIONS

[ ] Check the box to the left if you have attached additional documentation for this section.

List Trainer Qualifications.

_____
_____
_____
_____
_____
_____
_____
_____

PART III: CURRICULUM OUTLINE

[ ] Check the box to the left if you have attached additional documentation for this section.

Outline the structure and training methodology. Include goals, core competencies, and skills validation.

_____
_____
_____
_____
_____
_____
_____

SUBMITTER SIGNATURE: **DATE:** (mm/dd/yyyy)

_____ (_____ / _____ / _____)

NC Medicaid-3085   Session Law 2013-306 PCS Training Attestation Form   9/2019

Who is required to submit this form?

- Any provider servicing or who plans to service a beneficiary that receives additional hours mandated by N.C. Session Law 2013-306.

  NOTE: Providers who are non-compliant with submission of the NC Medicaid-3085 Form are subject to audit by Office of Compliance and Program Integrity.

N.C. 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 PCS Provider Must Include:

- **Trainer Qualifications**

  If the training requires qualifications for the trainer, those qualifications should be listed in Part II.

  - **Example:** If the training curriculum requires that the course may only be taught by an RN, RN should be documented in this section. If using an online pre-developed module, list reference to the module.

- **Curriculum Outline**

  The curriculum should include the following:

  - Description of training goals

  - Core competencies

  - Skills Validation

  - General Training Methodology

NC Medicaid-3085: Session Law 2013-306 PCS Training Attestation Form (continued)

Submitting the NC Medicaid-3085 Form to NC Medicaid

Complete the NC Medicaid-3085 and submit along with any required materials as noted on the form by:

- **Email: Medicaid.PCSTraining@dhhs.nc.gov**

- **Provider Portal:** Upload directly to QiRePort

  - **Note:** If uploading via the QiReport Provider Interface, you must have Administrator level access for your agency.

NC Medicaid-3136: Internal Quality Improvement Program Attestation Form

N.C. Department of Health and Human Services – NC Medicaid

INTERNAL QUALITY IMPROVEMENT PROGRAM ATTESTATION FORM

Completed form should be submitted via email to NC Medicaid at Medicaid.PCSQualityImprovement@dhhs.nc.gov. For questions, contact 919-855-4360 or send an email to PCS_Program_Questions@dhhs.nc.gov.

SUBMISSION REQUIREMENTS

PCS Providers shall submit this Attestation to NC Medicaid by December 31st of each year certifying compliance with "a" through "d" of Clinical Coverage Policy 3L Section 7.7 by initialing each of the items described below.

PROVIDER TYPE (select one)

☐ Home Care Agency ☐ Family Care Home ☐ Adult Care Home ☐ Adult Care Bed in Nursing Facility ☐ SLF-5600a

☐ SLF-5600c ☐ Special Care Unit (stand-alone Special Care Unit or SCU bed) ☐☐ Non-Provider: _____

SUBMITTER INFORMATION

NPI: _____

Provider Name: _____

Address: _____ City: _____

County: _____ Zip: _____ (zip code + 4-digit extension) Phone: _____

Suite: _____ Email: _____ Fax (If Applicable): _____

INTERNAL QUALITY IMPROVEMENT REQUIREMENTS Clinical Coverage Policy 3L Section 7.7	INITIAL
a. Develop, and update at least quarterly, an organizational Quality Improvement Plan or set of quality improvement policies and procedures that describe the PCS CQI program and activities;	
b. Implement an organizational CQI Program designed to identify and correct quality of care and quality of service problems;	
c. Conduct at least annually a written beneficiary PCS satisfaction survey for beneficiaries and their legally responsible person;	
d. Maintain complete records of all CQI activities and results	

Person Completing this Form:

_____   _____

Name (Printed)   Title

_____   _____

Signature   Date (mm/dd/yyyy)

(LEGIBLY SIGN YOUR NAME, STAMPS and ELECTRONIC SIGNATURES ARE NOT ACCEPTABLE FOR THIS FORM.)

I hereby attest that I am in compliance with the items described in Clinical Coverage Policy 3L Section 7.7. I also agree to provide any of the referenced documents to NC Medicaid, or a DHHS designated contractor upon request in conjunction with any on-site or desktop quality improvement review.

NC Medicaid-3136   INTERNAL QUALITY IMPROVEMENT PROGRAM ATTESTATION FORM   4/2019

NC Medicaid-3136: Internal Quality Improvement Program Attestation Form (continued)

What are the requirements for the PCS Provider regarding an Internal Quality Improvement Program?

- Develop, and update at least quarterly, an organizational Quality Improvement Plan or set of quality improvement policies and procedures that describe the PCS CQI program and activities

- Implement an organizational CQI Program designed to identify and correct quality of care and quality of service problems

- Conduct at least annually a written beneficiary PCS satisfaction survey for beneficiaries and their legally responsible person

- Maintain complete records of all CQI activities and results.

NC Medicaid-3136: Internal Quality Improvement Program Attestation Form (continued)

Key Points

- Required to be submitted to NC Medicaid by December 31st each year

- There is no standard regarding the format of the required documents

- All documents are not required to be submitted to NC Medicaid, just the NC Medicaid-3136 Form

- Providers who are non-compliant with submission of the NC Medicaid-3136 Form are subject to audit by OCPI

Submitting the 3136 Form to NC Medicaid:

- Complete the NC Medicaid-3136 Form and submit by:
  - **Email: Medicaid.PCSQualityImprovement@dhhs.nc.gov**
  - **Provider Portal:** Upload directly to Qi Report

Location of Forms

All forms with instructions can be found in the following locations:

1. Acentra Health NCLIFTSS website:

   NCliftss | Home (kepro.com)

1. NC Medicaid PCS webpage under "Forms."

   Adult Care Home and Personal Care Services Forms | NC Medicaid (ncdhhs.gov)
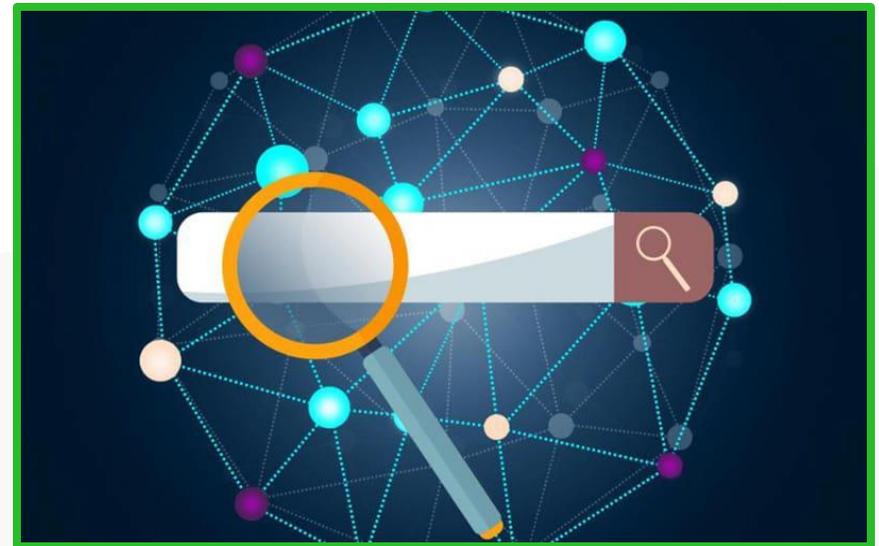
QiRePort Overview

What is QiRePort?

QiRePort is an integrated web service designed to support the operation of the PCS program. QiRePort was developed and is hosted by VieBridge, Inc.

Important: Registration is required for all PCS Providers. A registration form and instructions can be obtained by visiting **https://www.QiRePort.net**

What can I do with QiRePort?

Provider Agencies utilize QiRePort to do the following:

- Receive service referrals and accept/reject them electronically

- Manage servicing beneficiaries' accounts, including access to historical assessments and PAs

- Submit Discharges

- Submit Service Plans

- Submit Change of Status Requests

- Upload the Beneficiary Consent Form

- Manage Servicing Territories

- Update/Correct Modifiers

- Update NPI association

Home Page

Providers are able to:

- View training resources
- Ask Viebridge questions
- Ask NC Medicaid questions

Referrals and Provider Acceptance

- Referrals are located in QiRePort on the 'Referrals' page.

- If a PCS Provider does not respond in two business days, Acentra Health rejects the referral and submits the referral to the next provider choice.

- PAs are based on the beneficiary service authorization date.

NOTE: PAs will not be made retroactive for failure to respond to a referral timely.

Referrals

Access to all beneficiary information and account management can be found under the 'Referrals' tab

Referrals for Review

Referrals

Referral for Acceptance Review

* = Required   Print

Recipient Data

Recipient Name		Medicaid ID	
Address 1		Address 2	
City, State Zip		County	
Phone		DOB	
Gender		Status	

Requests for Independent Assessment

Recipient Name	MID	Phone Number	Request Date	Request Type

Independent Assessments on file for Recipient

Assessment Date	Comments	Assessment Type	Hours
4/25/2014	[comments]	Change of Status	39
5/7/2013	[comments]	Admission	39

Referral Decision *   -- select --

Comment

Click here to access a copy of the assessment

Provider should select a response to request by selecting the appropriate response decision

Hours awarded is displayed here

Save

Referral Info – Accepted (last 1 year) - continued

Referral Info – Accepted (last 1 year) - continued

Select a beneficiary to access the Beneficiary Summary page

Click date to access assessment

Displays assessment type

Displays total hours

Referral Info – Denials (last 6 months)

- This page displays almost identical to the 'Accepted (last 1 year)' page. The 'Denials' page provides a list of beneficiaries who have been accepted by the provider agency but since denied PCS. From this page you can:
  - Access notifications regarding the denial of PCS for a beneficiary
  - Review current approved hour totals
  - Access historical assessments
  - Review demographic information

Accepted and Active Recipients

Search Recipients/Recipient Summary:

The 'Search Recipients' link allows you to search for a particular beneficiary and access the following:

- Review demographic information
- Review the request entry entered by the IAE
- Review current approved hour totals
- Access historical assessments

Accepted and Active Recipients (continued)

Recipient Summary (continued)

Beneficiary Profile

What is the Beneficiary Profile?

- The beneficiary profile is used to store and maintain key information about a beneficiary in a single location.

- The profile uses information collected from the assessment and NC Tracks.

- Providers may update and add information to the profile record including current contact information and current diagnosis codes.

- Acentra Health Coordinators may reference the information in the profile in order to obtain the most up to date information.

Beneficiary Profile (continued)

How to access the Beneficiary Profile

- Once you have searched for a beneficiary, you will want to click 'Beneficiary Profile' from the left index bar in order to access their profile.

Beneficiary Profile (continued)

Beneficiary Contact Information			
Physical Address (If living in a private residence)			
Address 1 *			
Address 2			
Apt #			
City *			
State *			
Mailing Address/Facility Address			
Mailing Address 1			
Mailing Address 2			
Mailing City			
Mailing State	-- select -- ▾ Zip		
Alternate Address			
Alternate Address 1			
Alternate Address 2			
Alternate Apt #			
Alternate City			
Alternate State	-- select -- ▾ Zip		

Home Phone	Cell Phone	Work Phone	Email
336-567-6437			

Assigned Aide/History			
Assigned Aide	**Qualifications**	**Effective Date**	**Reason**

Assigned Aide Entry

Informal Caregivers/Contacts				
Last Name	**First Name**	**Relationship**	**Emerg**	**Prim?**

Contacts Entry

Medical Professional Providers			
Name	**Practice**	**Provider Type**	**Office Phone**

Provider Entry

Supporting Docs

- Once you have searched for a beneficiary, click 'Supporting Docs' from the left index bar in order to access documents that have been uploaded to the beneficiary's account or to upload a new document.
- To upload a new document, click 'Add', locate the document from your computer, and upload.
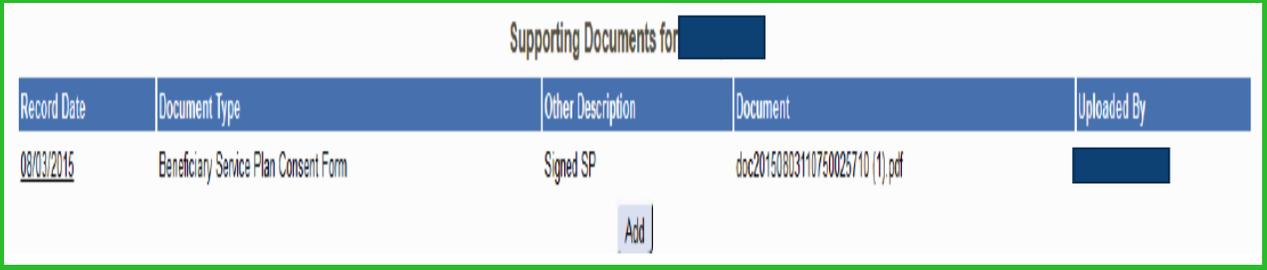
- Providers are required to upload all signed service plans to Supporting Docs.
- If a provider is unable to complete a service plan in QiRePort, they must upload a copy of the manually generated service plan to Supporting Docs.
- Providers may upload any other medical or personal information pertaining to the beneficiary to supporting docs.
- Acentra Health can view all information uploaded to supporting docs.

*Supporting documents do not transfer with a beneficiary when they request a change of provider.

Service Plan

- The service plan requirement became effective June 10, 2015.

- Each time a provider accepts a referral for new or existing beneficiary, a service plan must be completed.

- A service plan will need to be completed after each of the following:
  - New admission assessments
  - Annual assessments
  - COS assessments
  - COP requests
  - MOS notifications

Completing the Service Plan

- A Service Plan is required in order for the PA approval to be sent to NCTracks.

- PCS Providers who do not complete their service plans will be referred to Office of Compliance and Program Integrity.

NOTE: PAs will not be made retroactive for beneficiaries in which a service plan was not completed, and the beneficiary is no longer under the care of the PCS Provider.

Completing the Service Plan (continued)

To access a beneficiary's service plan a provider

- Selects the 'Plan' tab at the top of their screen
- Next, selects 'In Process Plans' from the left index bar to view all service plans awaiting completion

To view new or in process service plans

Note: Providers have 7 business days after acceptance to complete and submit the online service plan

Completing the Service Plan (continued)

This is where provider enters the shifts to calculate the daily hours.

Weekly hours are already divided by 4.35

Completing the Service Plan (continued)

Providers must ensure the frequency listed matches the number of days selected for each task.

Completing the Service Plan (continued)

Before submitting service plan provider needs to select if the service plan is completed.

Once complete, select save to submit the service plan

Service Plan Revision

Accessing a completed Service Plan

- Go to the "Plan" tab and perform a search for the beneficiary.

- Click on the beneficiary's name to display their Beneficiary Summary

- IHC - select "Beneficiary Service Plan List" found on left index of the QiRePort

- ACH - select "Plan List" found on the left index of the QiRePort

Service Plan Revision (continued)

- Once you select 'Beneficiary Service Plan List', a list of completed service plans will populate, click the date of the service plan you wish to access.

Service Plan Revision (continued)

Revising a Completed Service Plan

- Click on 'Revise Service Plan' to make changes to the Service Plan. A revision date will need to be entered to indicate when the changes will be effective.

  NOTE: Changes in days of service can be made and which days a task will be completed, but frequency must still match what has been indicated in the assessment. These changes must be documented as deviations. Not applicable to EPSDT.

Completing a Manual Service Plan

- The PCS Provider should complete a manual service plan when the amount of approved hours does not match the hours reflected in the assessment, upload into QiRePort, and call Acentra Health.

  NOTE: All manually drafted service plans must be uploaded to supporting docs. in the provider portal.

Scenarios
EPSDT Temporary Summer Hours Change
Settlements
Expedited Assessments
COP with Active Appeal
COP and Bene had Settlement for More Hours than Reflected on Assessment

Change of Status Requests

- The 'Change of Status (COS) Request' link allows the provider to submit an electronic COS non-medical request form directly to the IAE as well as access historical requests submitted and review the status of approval.

  NOTE: Physician attestation cannot be submitted through the provider portal.

Discharges

- Discharges for a PCS beneficiary are completed through QiRePort.

- If the PCS Provider continues to provide services, but they are not reimbursed by Medicaid, they must discharge the beneficiary in QiRePort.

- Discharges must be completed in 7 business days.

- The PCS Provider is required to discharge a beneficiary from QiRePort if they are no longer providing PCS that is reimbursed through Medicaid.

Additional Questions?

For any additional questions regarding the use of QiRePort, please contact Viebridge at **888-705-0970**.

Support

PCS Provider Resources

- **Resources:**
  - Clinical Coverage Policy 3L
  - Provider Manual
  - Trainings/Webinars
  - Stakeholder and Focus Group Meetings

- **Websites:**
  - Personal Care Services (PCS) | NC Medicaid (ncdhhs.gov)
  - QiReport
  - Home | NC Medicaid (ncdhhs.gov)
  - Home of NCTracks - Home of NCTracks

PERSONAL CARE SERVICES CONTACTS

- **NC Medicaid**
  - Phone: 919-855-4360
  - Fax: 919-715-0102
  - Email: **PCS_Program_Questions@dhhs.nc.gov**

- **Acentra Health-NCLIFTSS**
  - Request forms and general inquiries:

    Acentra Health-NCLIFTSS PCS

    2000 CentreGreen Way, Suite 220

    Cary, NC 27606
  - Call Center: 919-568-1717 or 833-522-5429 (toll free)
  - Fax: 833-521-2626 or for Expedited Assessments, fax 833-551-2602
  - Email: **NCLIFTSS@Kepro.com**
  - Website: NCliftss | PCS (kepro.com)

Questions and Answers