Acentra HEALTH

PCS Provider Webinar

March 27, 2025

Housekeeping

- Intended Audience: PCS Medicaid Providers
- Today's Presentation will be 45 minutes
- Q&A: Will be 15 minutes at the end of the presentation
  - This portion of the webinar is for your questions
  - Questions can be entered at any time in the Q&A chat
- There will be a survey at the end of this presentation for you to answer
- A recording of today's presentation and the PowerPoint will be posted on the NCLIFTSS Website hosted by Acentra Health

Topics for Discussion

- Submitting & Processing a PCS referral
  - Requirements for Physician Referral
  - Scheduling In-person face-to-face assessments
- Accessing QiReport Portal for PCS Workflows
  - Provider registration
  - Utility of the interface
  - Submitting service plan
- Important Things to Know
- Q&A Session

Today's Presenter:

Penny Paul, RN

PCS Program Manager

Submitting & Processing A PCS Referral

Policy reference: 3L CCP: Section 5.4.2. – Requirement for Physician Referral

- All PCS referrals must be submitted using the approved Physician Referral form, DHB-3051 - PCS Request for Independent Assessment for Personal Care Services Attestation for Medical Need. The latest update to the DHB- 3051 is dated 9/5/2024

- NC Medicaid Direct beneficiaries shall be referred to PCS by their designated primary care physician.

- If a beneficiary does not have a primary care physician, he or she must obtain a referral from the practitioner who is providing the care and treatment for the medical, physical, or cognitive condition causing the functional limitations requiring PCS.

- The beneficiary, the beneficiary's family, or legally responsible person must contact their primary care or attending physician to request a PCS referral.

Submitting & Processing A PCS Referral

Policy reference: 3L CCP: Section 5.4.2. – Requirement for Physician Referral

- A beneficiary participating in NC Medicaid Direct shall be referred to PCS by their designated primary care physician

- A beneficiary who has not been seen by their practitioner within 90 days of the referral, they must schedule an office visit with their practitioner to ensure their PCS referral is processed. A referral with no evidence of a practitioner visit will not be processed.

- The DHB-3051 must indicate a need for assistance with activities of daily living (ADLs) based on medical diagnosis. If not indicated by the practitioner and there is not impact noted, the request is not processed.

- Once a referral submitted and accepted, NCLIFTSS schedules a face-to-face assessment with a nurse assessor at the beneficiary's primary private residence or residential facility.

Submitting & Processing A PCS Referral

Scheduling In-person face-to-face assessments

- NCLIFTSS will make at least 3 phone call attempts, on 3 separate days, within a 10-business day timespan in effort to schedule an assessment timely.
  - If the contact attempts are unsuccessful, NCLIFTSS will reach out to the current PCS Provider and/or Referring Entity, as appropriate, in efforts to obtain new contact information, as well as any listed alternate contacts on file.
  - NCLIFTSS will, at the request of the beneficiary, attempt to contact additional parties whom the individual or representative wishes to attend the assessment. NCLIFTSS will work to accommodate all attendees' schedules.
  - NCLIFTSS will make every attempt to schedule the assessment for completion within the required timeframe, while still allowing the ability for all desired parties to be in attendance for the assessment.

- Proactive steps Providers can do to reduce delays or disruptions in accessing PCS:
  - Inform the beneficiary of the scheduled appointment
  - Provide NCLIFTSS phone number

Accessing QiRePort Provider Interface

The Provider Interface is a secure, web-based information system that NCLIFTSS uses to support the PCS independent assessment process.

- All individuals using the Provider Interface must be registered users.
  - PCS agencies must submit the user registration form and list the staff or designated representatives that are authorized to use the Provider Interface on behalf of the agency.
  - The Provider Registration form and instructions are available on the Learn More page of the QiRePort Welcome page at www.qireport.net

Accessing QiRePort Provider Interface

The Provider Interface allows the provider organization to:

- Receive and respond to PCS referrals online
- Access electronic copies of independent assessments documents, referrals, and notification letters
- Develop and submit the PCS on-line service plan
- Submit Non-Medical Change of Status requests
- Discharge beneficiaries online
- Change provider National Provider Identification (NPI) numbers for beneficiaries who need to have their service transferred from one provider office to another, within the same agency
- Enter information about counties served by the provider
- Update billing modifiers online
- Receive electronic notification for beneficiary, once an appeal has been entered, and the status of the appeal once it is resolved
- Receive electronic notification of upcoming annual assessments for beneficiaries

Accessing QiRePort Provider Interface

Providers shall develop an on-line PCS service plan through the Provider Interface. The following requirements for the on-line PCS service plan must apply:

- The provider organization accepting the NCLIFTSS referral to provide PCS services shall review the NCLIFTSS independent assessment results for the beneficiary being referred, and develop a PCS service plan responsive to the beneficiary's specific needs documented in the NCLIFTSS assessment;

- Provider organizations shall designate staff they determine appropriate to complete and submit the service plan via the Provider Interface;

- Each NCLIFTSS referral and assessment shall require a new PCS service plan developed by the provider organization that is based on the NCLIFTSS assessment results associated with the referral.

Accessing QiRePort Provider Interface

On-line PCS service plan requirements, continuation:

- The service plan must address each unmet ADL, IADL, special assistance or delegated medical monitoring task need identified in the independent assessment, considering other pertinent information available to the provider;

- The provider organization shall ensure the PCS service need frequencies documented in the independent assessment are accurately reflected in the PCS service plan schedule as well as any special scheduling provisions such as weekend days documented in the assessment.

- The provider organization shall ensure that the beneficiary, or their legally responsible person, fully understands and if possible, participates in the development of the PCS service plan.

- Once the provider organization completes the service plan, the service plan must be validated by the Provider Interface for consistency with the NCLIFTSS assessment, and related requirements for the service plan content.

Accessing QiRePort Provider Interface

EPSDT Service Plan requirements (3L CCP - Section 5.2.3)

- The provider organization must complete the service plan based on the NC Medicaid nurse review of the assessment and documents:
  - ❑ Work and school verification
  - ❑ Verification from Exceptional Children's program
  - ❑ Health record documentation
  - ❑ Primary caregiver's limitation as documented by physician
  - ❑ Any other documentation on ADLs ability and need

- NC Medicaid nurse guidance will be provided to the provider organization prior to acceptance of the referral and in the service plan.

Accessing QiRePort Provider Interface

On-line PCS service plan requirements, continuation:

- The PCS service plan must be developed and validated within 7 business days of the Provider accepting the NCLIFTSS referral.

- 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. The written consent of the service plan must be printed out and uploaded into the Provider Interface, also within 14 business days of the validated service plan;

- The provider shall make a copy of the validated service plan available to the beneficiary or their legally responsible person within 3 business of a verbal request.

Accessing QiRePort Provider Interface

On-line PCS service plan requirements, continuation:

- 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 need frequencies identified in the corresponding NCLIFTSS assessment.

- Provider organizations may continue to request a Non-Medical Change of Status Review and Practitioners can request a Medical Change of Status Review by NCLIFTSS if there has been a significant change that affects the beneficiary's need for PCS since the last assessment and service plan. Any Change of Status reassessment requires a new PCS service plan documented in QiRePort.

Things to Know

- It is important that the providers stay up to date and knowledgeable with the CMS updates, including diagnosis code updates, particularly concerning session law/expanded hours.
- All NCLIFTSS referrals are transmitted to provider organizations through the Provider Interface. No mailed or faxed referrals are provided;
- ** It is important that the provider does not accept the assessment if there are frequency errors affecting the service plan until they reach out to NCLIFTSS to get those corrections made.
- 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 with licensure requirements as specified in 10ANCAC 13J, 10A NCAC 13F and 13G, and 10A NCAC 27G
- Prior approval for PCS hours or units is not granted until the on-line PCS service plan is entered into and validated by the Provider Interface.
- Provider organizations shall be reimbursed only for PCS authorized hours and services specified and scheduled in the validated PCS service plan.

Important things to Know

- DHB Quality Assurance Activities
  - Updating Information in NC Tracks
  - Quality Attestation Forms (3136/3085) upload requirement
  - DHB Audit Requests for information

- Per Diem Rate Change Methodology for Congregate Care Setting begin April 1st

  Congregate Care Webinar Presentation

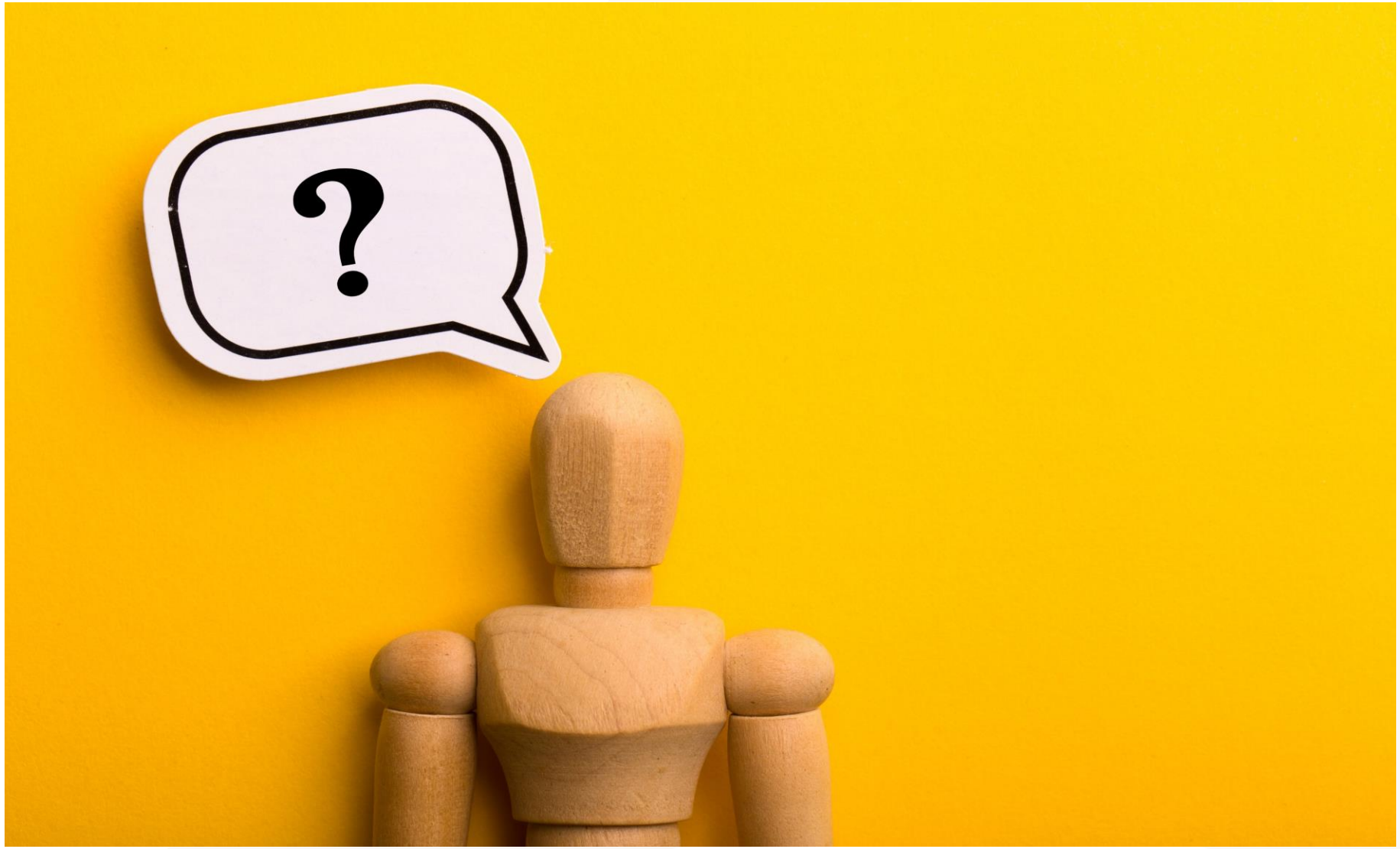
- Provider Ombudsman Contact Information

  Medicaid Managed Care Provider Ombudsman:

  Phone: 866-304-7062

  Email: Medicaid.ProviderOmbudsman@dhhs.nc.gov

Question & Answer



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