



Provider Webinar: Personal Care Services

March 26, 2026



Housekeeping

Intended Audience: Personal Care Services (PCS) Medicaid Direct Providers

Presentation Details:

- The presentation will last 45 minutes
- There will be time for Q&A at the end
 - You can type in questions about today's topics in the Q&A chat at any time



After the Presentation:

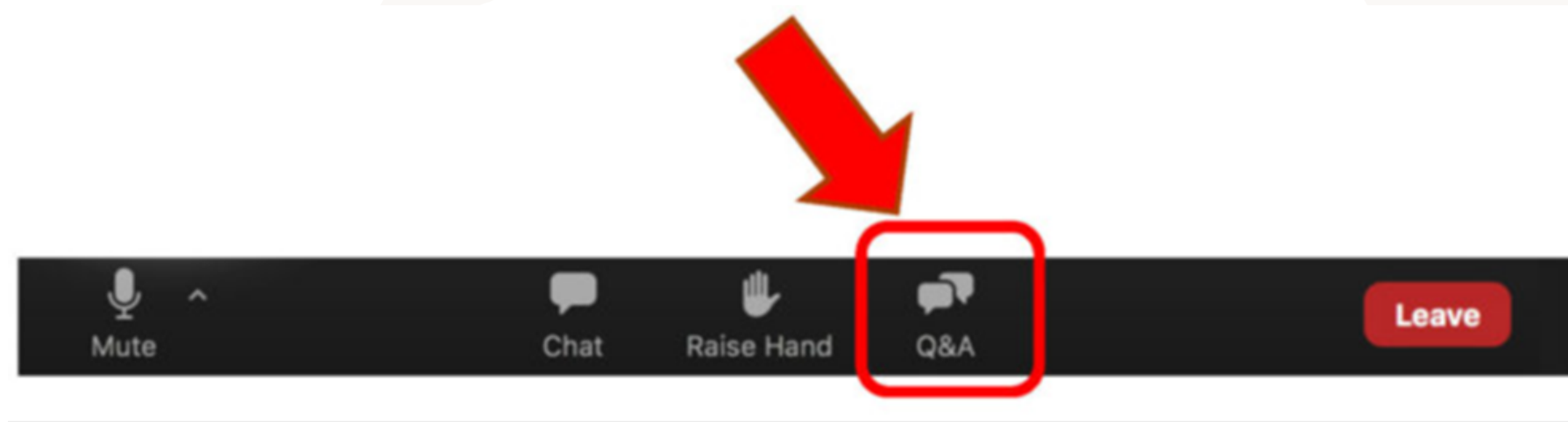
- A survey will prompt (We want to hear your feedback)
- The recording, Q&A and PowerPoint will be posted on the NCLIFTSS Website (hosted by Acentra Health) within 14 business days



Question & Answer Session

How to ask a question:

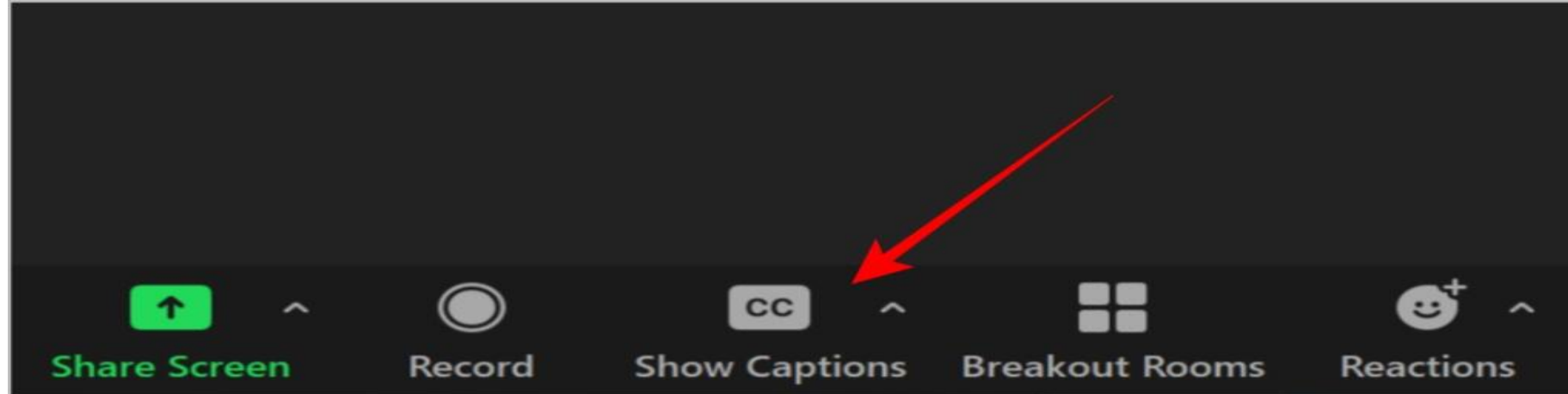
- To ask a question, click the Q&A button at the bottom of your Zoom screen (icon below).
- A box will pop up, and you can type your question there.



Show Captions

How to display captions:

- Click on the Show Captions button
- If your language is not already set, click on the language you want.
- Once selected, the captions will display at the bottom of your screen.



Today's Discussion Topics

- Process Overview
- Monthly Service Hours
- Assessment Rollback Process
- Prohibited Aide
- Q&A Session
 - Open discussion and questions on today's topics

Today's Presenter's:

Penny Paul, RN – PCS Program Supervisor for NCLIFTSS

Shannon Malorzo, RN - PCS Program Manager for NCLIFTSS



PERSONAL CARE SERVICES

Process Overview



Process Overview

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.
- ❖ 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.
 - A beneficiary who has not been seen by their practitioner within 90 days of the referral, 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 no impact noted, the request is not processed.



Process Overview

- Once a referral is submitted, it takes about 2 business days for processing, unless it needs to be faxed back to the physician for corrections or missing information.
- Once the referral is complete and accepted, NCLIFTSS schedules a face-to-face assessment with a nurse assessor at the beneficiary's primary private residence or residential facility.



Process Overview

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 an effort to schedule an assessment in a timely manner.
 - ❑ 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.



Process Overview

- Once the assessment is scheduled, an Independent Assessor from NCLIFTSS will come out and perform the assessment.
 - All PCS assessments shall be performed by Independent Assessors. All assessments for new admissions to PCS shall be face-to-face and conducted in the beneficiary's primary private residence.
 - A comprehensive assessment must determine the beneficiary's eligibility for PCS and their need for assistance with activities such as bathing, dressing, mobility, toileting, and eating. A physician's attestation of medical necessity is required as part of the assessment process.
 - At the end of the assessment process, beneficiaries can choose a Personal Care Services (PCS) agency by selecting from a list of licensed providers available in their county. They are provided options to select at least three agencies from a randomized list.



Process Overview

The provider agency 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.

- Providers shall develop an on-line PCS service plan through 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;
- 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.



Process Overview

On-line PCS service plan requirements, continuation:

- The PCS service plan must be created and approved within 7 business days after the provider accepts the NCLIFTSS referral.
- The provider must get written consent, shown by the signature of the beneficiary or their legally responsible person, within 14 business days after the service plan is approved. The signed service plan must also be printed and uploaded into the Provider Interface within the same 14-business-day period.
- The provider must give the beneficiary or their legally responsible person a copy of the approved service plan within 3 business days after they ask for it verbally.
- The beneficiary notice is sent to the provider interface the business day after the PCS referral is accepted by the provider. The beneficiary notification explains when PCS services can begin. The PAs will be sent to NC Tracks the business day after the online service plan is completed; the PA start date is based on the beneficiary notification authorization effective date. The provider must begin services based on the effective date from the notification; this is usually 1 or 10 days from the date of the beneficiary notification or the effective date specified on an appeal resolution notification.



Provider Interface

- PCS Referrals are sent to PCS agencies through the Provider Interface (QiRePort).
- 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 Counties Served must be entered by IHC providers to ensure their agency is included on the Random Provider lists provided by NC LIFTSS to beneficiaries for each of their licensed counties. ACH providers are not required to enter this information.
 - ❑ The QiRePort Provider Registration Form for PCS providers and the instructions for completion and submission is located on the QiRePort Provider Interface Home Page in the “Training Resources” section of the left-index menu.



Provider Interface

The Provider Interface allows the provider organization to:

- Receive and respond to PCS referrals online
- Access electronic copies of independent assessment documents, referrals, and notification letters
- Develop and submit the PCS online 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 the counties served by the provider (IHC Providers Only)
- Update billing modifiers (ACH Providers Only)
- Receive electronic notification that an appeal has been submitted, and the status of the appeal once it is resolved.
- Receive electronic notification of upcoming annual assessments for beneficiaries
- Receive the Old Provider Discharge notification that informs the provider the beneficiary has selected and different provider and the need to properly discharge the beneficiary.



Things to Remember

- If the provider does not accept the assessment referral within 2 business days, NCLIFTSS shall make a referral to the second provider on the beneficiary's list and, if necessary, the third provider on the list.
- 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 online 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.



PERSONAL CARE SERVICES

Monthly Service Hours



Monthly Service Hours

- Hours are based on the ADL (Activities of Daily Living) tasks that are identified as requiring hands-on assistance by the in-home aide.
- Hours are awarded as a cumulative total for the month based on the number of days the beneficiary has requested PCS services.
- Hours cannot be compiled onto other PCS days. They are distributed according to the beneficiary's daily needs.
 - Example: The beneficiary requests 7 days a week of PCS services but misses one day due to another obligation/appointment. The hours cannot be made up on another PCS service day.



Monthly Service Hours

- If the beneficiary is awarded 7 days a week, the hours cannot be added M-F just because there is a lack of aide assistance on the weekends.
- If the beneficiary is receiving less than 7 days a week of PCS services but misses a day, the hours can be made up on another non-PCS day if the beneficiary chooses to do so and the provider can provide the services.
 - Example: The beneficiary receives M-F PCS service days, but misses a day due to another obligation/appointment, then the hours can be made up on Saturday/Sunday.
- In the above example, the hours can also be made up at a later time during the same day if the beneficiary misses the normal scheduled time, as long as the provider can provide the services on the same day.



Things to Remember

Things we hear from our beneficiaries:

- My agency only provides services M-F. Not on the weekends but I need help 7 days
 - If the assessment says 7 days, the service plan must match, and PCS must be provided as such.



PERSONAL CARE SERVICES

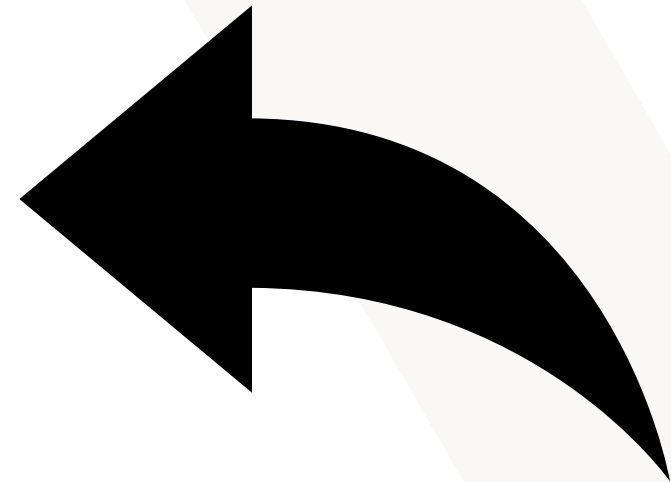
Assessment Rollback Process



The Assessment Rollback Process

Assessment Rollback refers to the process where a beneficiary's assessment can be revisited. The main reason assessment rollbacks are needed is when there is a frequency error listed on the assessment.

- If the assessment does not match the service plan, the provider should call the NCLIFTSS call center for help.
 - NCLIFTSS Contact number is 919-568-1717



The Assessment Rollback Process

The call center will:

1. Add the request to the rollback tracker
2. CC the right person to handle the problem

That person will:

1. Get an email with the beneficiary's information and a description of the issue
2. Review the assessment to see if a rollback is needed
3. Ask VieBridge to roll back the assessment, if necessary



The Assessment Rollback Process, continued

VieBridge will:

1. Return the assessment to the review queue

The rollback requestor will:

1. Send the rolled back assessment to the appropriate Independent Assessor (IA) with a list of needed changes

The IA will:

1. Fix the issues
 2. Return the assessment, so it can be accepted again
- The provider will receive the Assessment Pulled Back for Reprocessing notice on the provider interface to confirm the assessment was returned to NC LIFTSS for corrections.



Things to Remember

When you accept the assessment, you are accepting the beneficiary's case and agreeing to develop a service plan based on the assessment.

- You are responsible for completing the online service plan within 7 business days of acceptance, the upload should occur within 14 business days.
- You are responsible for providing Personal Care Services until:
 - The beneficiary has switched to a new agency, and you have received a notice.
 - You have properly discharged them in QiRePort.



PERSONAL CARE SERVICES

Prohibited Aide



Prohibited Aide

- PCS agency must ensure that their aides have undergone background checks
 - Aides cannot work if they have certain criminal backgrounds or past problems that raise concerns about safety and proper care. This includes anyone who has a confirmed record in the North Carolina Health Care Registry for things like neglecting a client, abusing a client, committing fraud, or being involved in making or selling illegal drugs.
 - This background check should include looking at the North Carolina Health Care Registry to see if the person has any confirmed problems, such as neglecting a client, stealing or selling a provider's drugs, abusing a client, stealing a client's property, or committing fraud.



Prohibited Aide

The PCS agency must ensure that the aide hired/assigned to the beneficiary is not:

- An individual related to the beneficiary, such as legally responsible persons (parent, spouse, child, grandparent, sibling or equivalent step or in-law)
- An individual living with the beneficiary



Things to Remember

- PCS agency must ensure that their aides have undergone training as mandated by Medicaid and state regulations.
 - Typically, aides are required to have certifications in CPR and First Aid, along with any other pertinent training related to personal care services.
 - Aides must be at least 18 years old or older or have a high school diploma or GED
 - Aides should also have good communication skills and show kindness, because they work closely with people who may have disabilities or need special care.
 - There are no gender-based restrictions on who can serve as a PCS Aide.



Question & Answer



NCLIFTSS PCS Contact Information

- Email Address: NCLIFTSS@acentra.com
- Phone: 1-919-568-1717 or 1-833-522-5429
- PCS Fax: 833-521-2626
- Website: ncliftss.acentra.com



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