PCS Provider Webinar FAQ's
March 26, 2026

Q. Will webinar recording be emailed or placed on a website landing page?

A. Yes. It will be on the website in about 7-10 business days

Q. Can a PCS provider help facilitate the assessment for clients that are not good with the phone?

A. Yes, providers can assist in the assessment process for clients who are not comfortable using the phone.

Q. Can a PCS provider help facilitate the assessment for clients that are not good with the phone?

A. The provider can assist if the beneficiary provides a verbal approval. It's best to call with beneficiary on the line, so NCLIFTSS can obtain the verbal approval and document the record. However, this verbal consent is for this particular call only, it's not considered an overall verbal approval for additional inquiries.

Q. What happens if the beneficiary moves from the address where the assessment was performed?

A. A non-medical change of status must be submitted.

Q. Can we get a copy of this process overview?

A. Yes. You can find these details in the Provider Manual on the Acentra website using the link below.

https://ncliftss.acentra.com/pcs-providers/

Q. My company did a change of status through the portal, and it was removed.

A. Please contact the call center for clarification, as we're unable to address individual situations during this meeting. Our phone number is (833) 522-5429.

Q. If someone transfers to a different location from our agency- a service plan is not generated. Do we still need to complete a Change of Provider request in order to have a service plan at their new location?

A. If beneficiary moves and a service plan was not generated prior to the transfer, you will still need to complete a Change of Provider (COP) request to develop and implement a service plan at the new location. The process ensures that the beneficiary's needs are assessed and met with an appropriate service plan reflecting their current situation and requirements.

Q. In regard to the 2 business day timeline to accept referrals in the provider interface, if results are released after business hours does that count as the 1st business day?

A. No, the 1st day starts the next business day. However, we do provide a courtesy call after 2nd business day, before moving the beneficiary to the next provider. However, it's important to check your portal daily for referrals.

Q. If the client makes up missed time, can they go over 4 hours per day to make the time up on a different day?

A. If a beneficiary misses a day of service, make-up time can only be scheduled on non-service days.

Q. What if a beneficiary requests services M-F because they have support on Saturdays and Sundays within their home? Can they provide the agency documentation to keep in their file, or should they notify their case manager?

A. A Non- Medical Chage of Status would need to be submitted to NCLIFTSS.

Q. We are calling for the initial appt to schedule the assessment client has not heard anything so we called with client on the phone and they said they couldn't tell us

A. Please contact the call center back with beneficiary. If the referral was accepted and is ready for scheduling, and the BNF provides verbal approval for you to assist, the scheduler should allow you to help them with scheduling the assessment.

Q. Just curious, will there be an in-person LTSS Provider Forum as in other years? If so, what are the dates and where?

A. There are plans to have another LTSS Provider Forum, a date has not been determined at this time.

Q. How often is the background check? Just at the beginning of employment? annually?

A. Background checks are only required to be conducted before hiring

Q. Are PCA's required to have CPR and First Aide Training also now?

A. While CPR and First Aid training are not required, DHB strongly encourages completion of both to help ensure aides are better prepared and equipped when providing care to beneficiaries. Although these trainings are not mandated under PCS requirements in Clinical Coverage Policies 3L and 3L-1, providers should also review and adhere to any relevant expectations issued by the Division of Health Service Regulation (DHSR).

Q. Are we allowed to add tasks to our company care plans that are not listed on the PCS service plan? For example, sweeping, sponge bath if shower is not given.

A. Care plans should align with the completed assessment and should not include any information that is not documented within that assessment. If a task the beneficiary performs was not scored, the assessment should be rolled back for correction. If the assessment has already been accepted, a manual service plan should be created to ensure the information accurately reflects the beneficiary's needs.

Q. No one has been calling our company from NCLIFTSS about any referrals. We only see it when it comes through the QiRePort.

A. All referrals come through QiRePort. If they are accepted within 2 business day, then NCLIFTSS wouldn't call. the provider will only receive a call if they haven't accepted the referral within 2 business days.

PCS Provider Webinar FAQ’s
March 26, 2026

Q. If you have a client that is transferring into your agency and the previous agency did not follow the frequency listed. How do you go about that? ex: frequency is 7 days, but previous company provided 3 days and that is what the client wants. (same hours but 3 days)

A. A Non- Medical Chage of Status would need to be submitted.

Q. I think it was said that family that live in the home can't be the PCS caregiver. Is that true?

A. Correct. Anyone who resides in the home is not eligible to serve as the PCS caregiver. Please refer to the PCS Provider Manual Section:1.7 PCS Aides

Q. If a client wanted PCS services 7 days at the time of an assessment, but has since changed their minds they want all their days Monday through Friday are we allowed to do that?

A. A Non- Medical Chage of Status would need to be submitted.

Q. Does a facility such as a family care home have to be registered or is this only for home care providers?

A. In order to receive referrals, all providers must be registered with QiRePort.

Q. If you’re just starting out how are we able to receive patients?

A. Providers can start receiving beneficiaries after completing the enrollment process with NC Tracks. They must first enroll their National Provider Identifier (NPI) in NC Tracks and ensure they are active before providing services

Q. What if the patient declines tasks such as showering or dressing what action is best to take?

A. If they are declining routinely, providers should have a discussion with the beneficiary or their representative. If they still decline, a discharge must be entered because they are not meeting the standards of PCS.

Q. Does our agency use the same NPI number when providing services to beneficiaries who reside in a different county than the main agency office?

A. Typically there is an NPI assigned to that service county.

Q. If a client has 3 hours scheduled for a Tuesday, but the aide could only do 2 hours that day (say because they had to leave for MD appt) can they see that client for the 2 hours or would the provider not get reimbursed?

A. If the aid can only service for two hours, then that is what the provider will need to bill for.

Q. If an assessment notes 3 extensives, requiring a CNA and our nurse's assessment notes that one or more of those ADLs are actually limited assistance, are we able to change the service level to limited and note it on the service plan?

A. Yes, a change in service level from extensive assistance to limited assistance can be made in a PCS service plan if a nurse's assessment indicates that one or more Activities of Daily Living (ADLs) require only limited assistance. It is essential to document this change and ensure that it reflects the beneficiary's current capabilities. The assessment should be used to support the revised service plan, and any changes should be submitted through the appropriate channels for review and validation.

Q. Can a beneficiary receive services at other locations than their home, like facility (like hospitals nursing home assisted living)?

A. Stated Funded PCS does not cover assistance provided in facilities such as hospitals, nursing homes, or assisted living facilities, except under specific conditions related to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for beneficiaries under21. Medicaid only covers PCS delivered in the beneficiary's primary private residence or specific licensed residential settings, such as adult care homes. Therefore, beneficiaries cannot receive PCS in other locations unless they meet certain EPSDT requirements.

Q. What happens if a patient is Discharged from the hospital in the morning, are they allowed to receive their PCS services in the afternoon? Are we allowed to bill for those services under the regular billing code?

A. Yes, a beneficiary can receive Personal Care Services (PCS) on the same day they are discharged from the hospital. If a beneficiary is discharged in the morning, they can indeed start receiving PCS services in the afternoon.

Q. What if a beneficiary requests services M-F because they have support on Saturdays and Sundays within their home? Can they provide the agency documentation to keep in their file, or is this not allowed?

A. A Non- Medical Chage of Status would need to be submitted.

Q. Is there a list of PCS providers? Or does the CM just search company resource list and the web for PCS providers in the members area.

A. Yes, there is a way to find a list of Personal Care Services (PCS) providers. When beneficiaries are assessed for PCS, they are presented with a randomized list of licensed, eligible PCS providers located in their county. This list is generated through QiRePort and is based on provider enrollment data.

Q. If a resident of ours transfers from one of our ACH locations to another and we do an NPI change in Qi- the NPI number changes but no service plan generates. So, we do need to do a COP and an NPI change in that situation."

A. Yes. When a resident transfers from one Adult Care Home (ACH) location to another and an NPI change is required, a Change of Provider (COP) request must be submitted, alongside the NPI change. If the service plan does not generate automatically in Qi for the new NPI, this indicates that a COP is necessary to ensure the smooth transition of services for the beneficiary. It's essential to follow up with the required submissions to confirm that the new provider can begin services without interruption.