PCS Provider Webinar
June 25, 2026

Q: What should providers do if they notice discrepancies in a referral or service plan?

A: Providers are encouraged to review the assessment and/or the PCS Online Service Plan carefully upon receiving a referral to check for any discrepancies before completing the plan. If a discrepancy is identified, the provider should contact NC LIFTSS to request a correction. In certain situations, a rollback of the assessment or service plan may be requested, as long as the request is made before the service plan is completed and prior authorizations (PAs) are generated.

This rollback process can help prevent the need to complete a manual service plan. (Note: The Assessment Rollback Process was discussed in the most recent webinar.)

Q: Where can providers find guidance on completing the PCS Online Service Plan and when a manual plan is required?

A: Providers should refer to the PCS Provider Manual, which includes detailed guidance on completing the PCS Online Service Plan in QiRePort. Specifically, Section 1.11 (PCS Online Service Plan) on page 17 outlines scenarios in which the provider may be unable to complete the online service plan and when a manual service plan is required.

Q: If there is an appeal and the approved hours differ from the original assessment, should a manual service plan be completed?

A: Yes, a manual service plan should be created when an appeal results in hours that differ from the original assessment.

Q: If I do not know the diagnosis code or modifier, is there a resource where I can find this information for newly approved residents?

A: Yes, diagnosis codes and modifiers can be found in PCS (Personal Care Services) program documentation. These include ICD-10-CM codes and PCS-specific modifier guidance.

Q: How do you request a manual service plan adjustment through NC LIFTSS?

A: Requests can be made by contacting the NC LIFTSS call center at 833-522-5429 or by emailing NCLIFTSS@acentra.com.

Q: Are prior authorizations placed on hold if a client has an upcoming annual assessment? If so, when are they released so agencies can bill?

A: No, prior authorizations are not placed on hold. They are typically extended until the annual assessment is completed. If billing issues occur, please complete and submit a PA Research form for review.

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Q: If a provider's assessment indicates a client only needs services five days per week, but the automated service plan reflects seven days, how should this be corrected?

A: In this case, a manual service plan must be created to reflect the updated service needs. The revised plan should be completed within seven business days and uploaded to the "Supporting Documents" section.

Q: When submitting an expedited request, where can I access the service plan if one is not available in the system?

A: For expedited requests where a service plan is not automatically generated, a manual service plan must be created. Agencies may use an internal template, ensuring it reflects the total approved hours based on the expedited assessment.

Q: Where can I verify diagnosis codes and modifiers for newly approved residents?

A: Diagnosis codes and modifiers can be verified through PCS (Personal Care Services) program documentation and provider manuals. These resources include ICD-10-CM codes and applicable modifiers. Claims and authorization details may also be reviewed in NCTracks or agency records.

Q: When submitting a manual service plan adjustment via email, is it a secure method for sharing protected health information?

A: Yes. Secure email protocols must be used when submitting any protected health information to ensure HIPAA compliance.

Q: How do you cancel or return a referral that was previously accepted but cannot be serviced?

A: Agencies should notify the beneficiary and enter a discharge immediately so that the beneficiary can find another agency to provide service.

Q: Do service plans need to be updated in QiReport every time a beneficiary requests a change in hours?

A: Service plans should be updated whenever there is a verified change in service needs that impacts authorized hours.

Q: If a provider is Medicaid-approved but has not received referrals, is there anything that needs to be done?

A: Ensure the agency is fully registered and active in required systems (e.g., QiReport) and available to receive referrals.

Q: Can a client receive additional hours after a significant medical change (e.g., amputation)?

A: Yes, a new assessment or reassessment can be requested to determine if additional hours are medically necessary based on the change in condition.

Q: Who is authorized to manually create or update service plans?

A: Authorized personnel typically include designated agency staff such as nurses or qualified administrative personnel, following program guidelines.

Q: What should be done if a client needs more hours but is already at the 80-hour maximum?

A: Additional hours beyond the standard cap require medical justification and may be approved through an exception or enhanced review process.

Q: Why are retroactive disenrollment expedited authorizations limited in duration?

A: Authorization limits are based on program policy. Providers may need to submit additional requests, updated service plans, and PA research forms to address gaps in coverage or billing.

Q: Why must a new DHB 3051 be completed when authorizations expire (every 6 months)?

A: Updated documentation ensures continued eligibility, medical necessity, and compliance with program requirements.

Q: Can third-party clearinghouses be used for billing?

A: Providers should confirm with NCTracks whether their selected clearinghouse is approved for billing submission.

Q: Can a nurse obtain a verbal signature from the client when updating service plans?

A: Agencies must follow documentation and compliance guidelines regarding signatures, including whether verbal consent is acceptable.

Q: Is there a test or “sandbox” environment available for new users?

A: Providers may follow up with the system vendor (e.g., VieBridge) to inquire about training or testing environments.

Q: Why do payments from managed care plans take up to 30 days?

A: Payment timelines are determined by payer processing cycles and claim review procedures.

Q: Can clients with a diagnosis of dementia qualify for higher hours (e.g., 120 hours)?

A: Eligibility for increased hours depends on assessed needs, medical necessity, and program criteria, not solely the diagnosis.

Q: If an automated service plan is generated in QiReport, is a manual service plan also required?

A: A manual service plan is only required in specific situations, as outlined in the Provider Manual.

Q: If a client transfers to another agency but was not accepted, is a new admission required if they return?

A: This depends on system status and timing. Agencies should verify whether the original admission remains active or if re-enrollment is necessary.

Q: What should be done if a client's annual assessment is delayed and authorization is not extended?

A: Providers should follow up on the authorization, request extensions if applicable, and submit a PA Research form if billing issues arise.

Q: If a service plan is completed late, will previously provided services still be paid?

A: Payment eligibility depends on compliance with authorization and documentation requirements.

Q: If a client is approved for 7 days but only wants services on select days (e.g., every other weekend), can a manual plan be created?

A: Yes, a manual service plan can be created to reflect the client's actual service preferences and schedule.

Q: Can a client request a different RN assessor?

A: Clients may request reassignment; however, approvals depend on program policies and availability.

Q: What is the maximum number of billable hours per day?

A: This is defined by program billing guidelines and should be referenced in the Provider Manual.

Q: Can services consist of only housekeeping/cleaning?

A: No, PCS services must include personal care tasks. Cleaning alone does not meet program requirements.

Q: What should be done if a client consistently refuses personal care services?

A: Agencies should document refusals and follow program guidance for reassessment or service adjustment.

Q: What should I do if my clients have not received assessment or reassessment outreach?

A: Follow up with NCLIFTSS to check the status and ensure scheduling.

Q: If a client has not received services for a period of time but remains active, can services resume?

A: Yes, services may resume if the client remains active and authorized; providers should verify current authorization status before restarting.