

Q: Why does the service plan sometimes show a different date than the original printed version?

A: The plan dates on the service plan should always match the PCS authorization dates.

As a reminder for new admissions, the effective date is the date of the completed new referral if the request is not more than 30 calendar days from the date NC LIFTSS received the completed request form. On new admissions, there will be an authorization table to indicate the effective date.

If you are seeing issues with plan dates or discrepancies with any information on the provider interface, please contact QiRePort Support for assistance.

Q: Why does a beneficiary remain visible in QiRePort after an agency submits a discharge?

A: If it has been less than 1 year since the provider received the PCS authorization notice in QiRePort, it will remain in the Accepted Last 1 Year listing. However, after a discharge is entered, the beneficiary will be removed from the search option and from all caseload reports once the prior authorizations are voided. Usually if the beneficiary is still in the search listing or caseload reports after a discharge is entered, it means that the discharge date entered did not void the PA records. Possibly an incorrect discharge date.

If a provider has entered a discharge and the beneficiary is not removed from their interface within 2 business days, they should contact QiRePort for assistance.

Q: How long does it take for referrals to appear in QiRePort?

A: Referrals appear in QiRePort immediately as they are released by NCLIFTSS. As you know, that can depend on whether the assessment goes through the Assessments for Review queue for a supervisor review before being released to the provider.

Q: How does the referral process work?

A: When a beneficiary selects a provider, a referral is sent through QiRePort to the chosen agency. Providers have 2 business days to accept or reject the referral. Upon acceptance, the provider can review the assessment information and begin developing the beneficiary's service plan.

Q: How should providers handle service plan deviations when agency recommendations differ from the NCLIFTSS assessment?

A: The service plan should be developed based on the approved assessment and authorized services. If a provider identifies a need that differs from the assessment findings, they should contact

NCLIFTSS. Provider should advise NCLIFTSS the rationale for the difference and follow established procedures for addressing the discrepancy. Changes that affect approved services may require additional review or reassessment. Providers should never alter authorized hours without appropriate approval.

Q: What should providers do when there is a discrepancy between the assessment, authorization, and the service plan?

A: Providers should verify the assessment findings, authorized hours, and service plan requirements prior to accepting the assessment. If a discrepancy is identified, providers should contact NCLIFTSS for guidance on the appropriate next steps.

Q: How are provider location or internal provider number changes reflected in QiReport, and when should a new COP service plan be expected?

A: When a provider submits a request to update their provider information for a beneficiary, the request will initially display a status indicating that it has been saved and is awaiting processing. After the system processes the request, the status will update to reflect that the change has been completed.

Providers can verify the status of the request by searching for the beneficiary and reviewing the update request details. If the status indicates an error or processing issue, it may be related to information entered in the request, such as an incorrect effective date. In these cases, providers should contact the appropriate system support team for assistance.

Once the update has been successfully processed, the provider can confirm the change by reviewing the beneficiary's record and applicable system reports, which will display the updated provider information. This confirms that the update has been applied and any associated authorizations have been updated and transmitted through the appropriate channels.

Because the change is occurring within the same organization, the system will not generate a new service plan. Updates such as provider number, location, or NPI changes do not constitute a change in provider and therefore may not trigger the creation of a new service plan. The existing service plan remains in effect while the provider information is updated within the system.

Q: Why do authorization periods sometimes appear to lose days or overlap when an annual assessment is completed, and are there ways to prevent authorization gaps or discrepancies?

A: The effective date of an annual reassessment authorization is based on the beneficiary notification date, which occurs after the referral has been accepted. Annual reassessment authorizations generally become effective after the required notification period has been met.

In some situations, particularly when an annual reassessment is completed more than one year after the previous assessment, it may appear that there is a gap between the dates covered by the prior authorization and the new authorization. This does not always indicate an issue. Certain authorizations may be automatically extended when reassessments are overdue and have not yet been scheduled.

However, if a reassessment has been scheduled but not completed, automatic extensions may not occur, which can result in a gap in authorizations when the reassessment is ultimately processed. When providers identify potential authorization gaps or discrepancies, they should submit the appropriate research request to NCLIFTSS for review.

Providers should also be aware that authorization corrections and retroactive adjustments require appropriate review and approval. For this reason, NCLIFTSS should be the initial point of contact for authorization gap concerns.

If providers believe information in QiRePort is displaying incorrectly or does not reflect expected results, they should contact the QiRePort Support Center. Support staff can review the beneficiary record, explain how the information was processed, investigate potential issues, and coordinate any necessary corrections with NCLIFTSS.

Q: Where should the 3085 and 3136 forms be submitted, and what is the correct process for uploading documentation?

A: Providers should review the announcements and guidance available within the QiRePort Provider Interface for the most current requirements and instructions related to provider documentation. Review the 10/22/2025 – Compliance with 3L and 3L-1 Clinical Coverage Policy. This announcement includes the instructions below on how/where to upload the DHB 3136 and DHB 3085 forms into QiRePort.

Important information you need to know:

- Only individuals at the provider agency authorized with administrative rights can upload the Forms 3136 and 3085
- Forms 3136 and 3085 are uploaded for each provider and are not beneficiary specific.
- Forms 3136 and 3085 are stored and maintained in the QiRePort portal.

If providers have questions about documentation requirements or experience issues during the upload process, they should contact the QiRePort Support Center for assistance. Support staff can

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provide guidance on the upload process, review any issues encountered, and explain any additional steps that may be required.