Acentra HEALTH

Provider Webinar: Personal Care Services

October 30, 2024

Welcome

PCS Provider Webinar Discussion Topics:

- Assessment Process Overview
- Billing and Prior Authorizations
- Question & Answers

Today's Presenters:
Penny Paul, PCS Program Manager and Jeremy Owen, Director of Operations

Housekeeping

- Today's Presentation will be 45 minutes
- Q&A – 15 minutes at the end of the presentation
    - Questions can be entered during the presentation through the Q&A chat feature
        - Please **do not** enter any PHI in your questions. For specific beneficiary inquiries, please reach out to NCLIFTSS
- There will be a post-presentation survey directly following the presentation
- A recording of today's presentation and the PowerPoint will be posted on the Acentra Health NCLIFTSS Website: ncliftss.acentra.com

PERSONAL CARE SERVICES

Assessment Process Overview

Types of PCS Assessments

- New Admission
- Medical Change of Status
- Non-Medical Change of Status
- Annual
- Expedited
- Reconsideration
- Mediation

Note: Assessments can be performed in person or telephonic**

**Telephonic assessments are only conducted when approved by DHB

Assessment Types

- **New Admission Assessment**
  - When a beneficiary is being referred for PCS by a physician, nurse practitioner, or physician assistant. The PCS Request for Independent Assessment for Personal Care Services Attestation for Medical Need form must be submitted to NCLIFTSS via secure fax or mail.
- **Change of Status – Medical**
  - Submitted by the beneficiary's Physician when the beneficiary has experienced a change in their medical condition affecting their activities of daily living (ADL's).
- **Change of Status - Non-Medical**
  - Submitted when the beneficiary has experienced a change in their informal caregiver availability or environmental condition that affects the beneficiary's ability to self-perform.
- **Annual Reassessment**
  - Annual reassessments occur on or before the end of the current services authorization date. They are system generated each year.
  - Reassessments may vary in type and frequency depending on the beneficiary's level of functional disability and his or her prognosis for improvement or rehabilitation, as determined by NCLIFTSS, but not less frequently than once every 365 calendar days.

Assessment Types, continued

- **Expedited Assessments**
  - The expedited process must be requested by a hospital discharge planner, skilled nursing facility discharge planner, or Adult Protective Services (APS) Worker, LME-MCO Transition Coordinator
    - If the beneficiary qualifies for the expedited assessment process, the expedited assessment is conducted over the phone to determine eligibility.

- **Reconsideration Request/Assessment**
  - A beneficiary, 21-years of age or older, who receives an initial approval for less than 80 hours per month may submit a Reconsideration Request Form (NC Medicaid-3114) to NCLIFTSS if they do not agree with the initial level of service determined. Another assessment may also be ordered.

- **Result of Mediation Assessment**
  - These can be ordered through an appeal

NCLIFTSS: PCS Assessment Process Overview

- The 3051 referral is received and processed by NCLIFTSS
  - If the referral is complete, it is processed within 2-business days of receipt
  - If the referral is incomplete, NCLIFTSS will notify the physician
- Once processed, the 3051 is sent to the NCLIFTSS scheduling department
  - The assessment will be scheduled within 14-days of the processed referral
- The assessment is scheduled by an NCLIFTSS scheduler and assigned to the Independent Assessor (IA)
  - The beneficiary/caregiver will receive a reminder call at least 24-hours before the assessment
- The Independent Assessor conducts and completes the assessment, and submits it for quality review
- Once the assessment has been reviewed and accepted by NCLIFTSS, the Provider of Choice will receive the assessment
- Once accepted by a provider, notification is mailed to the beneficiary

Assessment Outcomes

If the beneficiary or caregiver feels the assessment does not properly reflect to be accurate in the current abilities and health condition of the beneficiary, the following actions can be taken:

- **Appeal** the decision
- **Reconsideration** for New Requests
- Submit a **Change of Status** Referral

Timelines for Assessment and Beneficiary Notification

Acentra Health will notify the beneficiary of the assessment and reassessment results:

- Within 14-business days of a completed initial assessment, Annual, or change of status for PCS
- Annual Assessments must be completed on or before the end date of the completed authorization period
- Within two business days of an expedited assessment request for a beneficiary with a planned discharge from a hospital or inpatient facility; skilled nursing facility; or under adult protective services

Providers: PCS Assessment Process Overview

- The Provider of choice will accept or reject the assessment
  - This must be completed within 2-business days
    - If rejected, this will move to the next provider of choice
- Once accepted, a service plan will populate in the Provider Portal to be completed by the provider
  - This must be completed within 7-business days
- The Provider will obtain a written consent for the service plan from the beneficiary/3rd party
  - This must occur within 14-days of the validated service plan
- The Provider will provide a copy of the service plan to the beneficiary/3rd party
  - This must occur within 3-business days from the date the consent is received

Provider Assessment Reminders

- Develop a PCS service plan responsive to the beneficiary's specific needs documented in the PCS assessment
- The service plan is not a plan of care. The Provider is expected to complete a separate plan of care, per licensure requirements
- Prior approval for PCS daily rate or units is not granted until the online PCS service plan is entered into and validated by the Provider Interface
- PCS providers shall report discharges to NCLIFTSS within 7 business days of the beneficiary discharge via the Provider Interface

Rollback Process

- Once the Provider has received notification of a completed assessment, the provider will look over the assessment and review it **PRIOR** to accepting.
  - If there are any discrepancies noted, the Provider **SHOULD NOT** accept the assessment
    - The Provider must notify NCLIFTSS, and the Program Lead/Director will check the assessment for the noted discrepancies
    - If the discrepancies are valid, the Program Lead/Director will perform a 'rollback'
    - If the discrepancies are not valid, the Program Lead/Director will contact the Provider to discuss why the rollback is not necessary
- If the Provider accepts the assessment and the PAs have generated, the assessment cannot be rolled back for correction. At this point, an appeal would need to be filed or complete a manual service plan.

PERSONAL CARE SERVICES

Billing & Prior Authorizations

Resolving Billing Denials

NC Tracks
Does the beneficiary have active Medicaid?
Does the beneficiary have any active Prior Authorizations?
Have I already billed for all approved hours this month?
Am I billing within the approved effective dates?

Resolving Billing Denials Cont.

QiReport
Did I complete a service plan for the most current assessment for the beneficiary?
Does the modifier on the PA match the modifier assigned in NC Tracks?
Am I using the correct billable ICD-10 code?

Resolving Billing Issues

- After reviewing the common reasons for denials and assistance is still needed with billing, please complete the PA Research Form (PA Research Form) found on the Acentra Health NCLIFTSS website and submit it via fax or email

- Acentra Health does not have full access to NC Tracks and is limited to addressing billing issues

- If a provider is experiencing a billing issue for other reasons that do not involve the PA for PCS, they are strongly encouraged to contact NC Tracks

- Billing per Policy 3L can be found in Attachment A: Claims-Related Information (pages 44-46)

Retroactive Prior Approval

- Retroactive prior approval is only applied to initial requests for PCS.
  - The retroactive effective date for authorization will be the request date on the Request for Independent Assessment for Personal Care Services DHB-3051 form, provided the date is not more than 30 calendar days, from the date that Acentra Health received the completed request form.
  - If the request is received by Acentra Health more than 30 calendar days from the request date on the request form, the authorization will be effective the date Acentra Health received the form.
- If the initial request is missing information, the received date will not be effective until the correct information is provided to process the referral.
- If a beneficiary requesting admission to an Adult Care Home, Licensed under G.S. 131D-2.4, has not been referred to an LME-MCO for the Referral Screening Verification Process (RSVP), retroactive prior approval does not apply. PCS authorization is effective the date beneficiary receives their RS ID.

Prior Authorization Examples

Request Date:	08/01/2024
NCLIFTSS Received Date:	08/26/2024
Effective Date:	08/01/2024

Request Date:	08/01/2024
NCLIFTSS Received Date:	09/12/2024
Effective Date:	09/12/2024

Prior Approval Effective Dates

- For all other request types, the PA effective dates are as follows:
  - **Change of Status**
    - Increase in Hours: 1-day from the date of provider acceptance
    - Decrease in Hours or New Provider Selection During COS Assessment: 10-days from the notification date
  - **Change of Provider**
    - In-Home: 10-days from the notification date
    - Adult Care Home: 1-day from the notification date
    - Lapse (all settings): 1-day from the notification date
  - **Reconsideration**
    - Increase in Hours: Same provider selection 1-day from the date of provider acceptance
    - All Outcomes: New provider selection 10-days from the date of provider acceptance

Transitioning to a Standard or Tailored Plan

- Viebridge receives eligibility updates from NC Tracks with the SP/TP information and eligibility segment dates.

- Viebridge updates the beneficiary record in QiRePort to reflect the beneficiary being in a SP/TP.

- The most recent independent assessment and online service plan is sent to the SP/TP via file transfer by Viebridge. (**Note:** Files are transmitted to the plans once a week)
  - If the workflow is active, the documents are sent with the next transmission after the workflow is completed.

- For the TP, PAs are being sent to NC Tracks through 01/31/2025 (**Note:** VieBridge does not send PAs directly to the SP/TP)

Medicaid Managed Care Provider Ombudsman

Medicaid Managed Care Provider Ombudsman Contact Information:

- Phone: 866-304-7062 (Toll-Free)
- Email: Medicaid.ProviderOmbudsman@dhhs.nc.gov

Provider Notifications

- Providers always receive a notification indicating the effective date on all prior approvals. If an end date is not indicated for the effective period, the servicing provider can expect the service period to be effective for 365 calendar days from the effective date.

- Providers are expected to accept/reject referrals within 2-business days. If the PAs end for a beneficiary and the PCS Provider did not accept within 2-business days of the referral, NC Medicaid will not authorize retroactive pay for the lapsed time.

- PAs are still being extended for any annuals outstanding that are past due. If any provider finds that a beneficiary has not had their PAs extended, they should follow the current Billing inquiry process that we have outlined which includes submitting the billing form to NCLIFTSS.

NCLIFTSS Contact Information

NCLIFTSS can be notified by:

- Email: NCLIFTSS@acentra.com
- Phone: 833-522-5429 (Toll-Free)
- Fax:833-521-2626
- Website: https://ncliftss.acentra.com/

Questions & Answers