

Learning Objectives



Participants will understand the:

- Submission of referral process and what to expect with request processing (New/COS/COP/Annuals)
- Technical Denials
- Appeal timeline and process
- Concept of "maintenance of service" (MOS)
- Purpose and process of mediation

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Learning Objectives



Participants will understand the:

- Requirements for plan of care development and aide documentation
- QiRePort Provider Interface functionality to access beneficiary information, review decision notices, submit beneficiary discharges and change of status
- Navigation options on the revised CCME Personal Care Services (PCS) Webpage

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Clinical Coverage Policy 3L, Personal Care Services



Effective **January 1, 2013**, Medicaid PCS for beneficiaries in all settings – including private residences and licensed adult care homes, family care homes, 5600a and 5600c supervised living homes, and combination homes with adult care home (ACH) beds – are provided under a consolidated PCS benefit.

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Who are PCS Eligible Beneficiaries?



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Who Are PCS Eligible Beneficiaries?



- Limited hands-on assistance with 3 of the 5 qualifying ADLs; or
- Hands-on assistance with 2 ADLs, 1 of which requires extensive assistance; or
- Hands-on assistance with 2 ADLs, 1 of which requires full assistance

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Who Are PCS Eligible Recipients?



- Current Medicaid Beneficiary
- Existing Medical Condition, Disability or Cognitive Impairment
- Demonstrated Unmet need for hands-on assistance with qualifying ADLs

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Beneficiary's Self-Performance Rating	Description
0 – Totally able	Beneficiary is able to self-perform 100 percent of activity, with or without aids or assistive devices, and without supervision or assistance setting up supplies and environment
1 – Needs verbal cueing or supervision only	Beneficiary is able to self-perform 100 percent of activity, with or without aids or assistive devices, and requires supervision, monitoring, or assistance retrieving or setting up supplies or equipment
2 – Can do with limited hands-on assistance	Beneficiary is able to self-perform more than 50 percent of activity and requires hands-on assistance to complete remainder of activity
3 – Can do with extensive hands-on assistance	Beneficiary is able to self-perform less than 50 percent of activity and requires hands-on assistance to complete remainder of activity
4 – Cannot do at all (full dependence)	Beneficiary is unable to perform any of the activity and is totally dependent on another to perform all of the activity

New Referrals



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New Referral

Who may submit a new referral?

- Primary care or attending physicians
- Nurse practitioners
- Physician Assistants

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New Referral

Completed referrals should be printed legibly and faxed to CCME at 877-272-1942 or mailed to:

CCME
ATTN PCS Independent Assessment
100 Regency Forest Drive, Suite 200
Cary, NC 27518-8598



Licensed Residential Facility New Referral (DMA 3068)



Home Care Agency New Referral (DMA 3041)



New Referral



Unable To Process Missing Information	Incomplete Missing Information	Complete Non-Qualifying
<ul style="list-style-type: none"> ○ Beneficiary Name ○ Beneficiary Address ○ Medicaid Number ○ Date of Birth ○ Date of Request ○ Referring Entity ○ Required Signatures ○ Referral Source Name and NPI 	<ul style="list-style-type: none"> ○ Date of last MD visit is not answered ○ Medical stability question is not answered ○ ICD 9 diagnoses codes are not listed 	<ul style="list-style-type: none"> ○ Date of last visit with referring MD is greater than 90 days ○ Medical stability question is marked no

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New Referral



If the referral is complete:

- Beneficiary will be contacted by a CCME Scheduler
- Assessment will be conducted on the resident
- Providers will receive the referral on the QiRePort Provider Interface or via fax
- Provider will accept or decline the referral.
- Upon acceptance of the referral an authorization notice will be issued to beneficiary. The provider will receive a copy.

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Q: Who Can Submit A Change of Status Request?



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Change of Status (COS)



Effective January 1, 2013, providers may report status changes for beneficiaries approved for PCS services. A Change of Status reassessment should be requested for a beneficiary who, since the previous assessment, has experienced a change in condition that affects the needs for hands-on assistance with Activities of Daily Living (ADLs) or other services covered under **Clinical Coverage Policy 3L**.

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Requests: Change of Status



A change of status (COS) should be submitted when:

- There has been a change in the beneficiary's health that affects their ability to perform ADLs
- There has been a change in caregiver status
- There has been a change in location or environment that affects ability to perform ADLs

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Requests: Change of Status



Do not submit a Change of Status request when:

- You need to **discharge a client** from PCS
- Client wants to **increase # of hours of service**
- You need to notify CCME of a **change of address**.
- You need to **put beneficiaries' services on hold**

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Requests: Change of Status



A technical denial will be issued if the Change of Status request:

- Is missing description of change in beneficiary's condition.
- Does not document the need for a reassessment based on Policy 3L

NOTE: This is a denial of the request. There is *no change* to the current PCS authorization.

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Q: Who Can Submit an Annual Assessment Request?



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Beneficiary Annual Reassessment



- Providers **are not** required to contact CCME to initiate assessments for beneficiaries.
- The IAE will determine when the annual assessment is due based policy 3L (5.4.7d).

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Q: Who Can Submit a Change of Provider Request?

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Change of Provider

Change of Provider requests may be submitted by:

- Physician Assistant
- Nurse Practitioner
- Attending Physician
- Beneficiary
- Beneficiary's responsible party

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Change of Provider

Indicate who is the requesting entity

- May include Physician Assistant or Nurse Practitioner, Attending Physician the beneficiary or beneficiary's responsible party

Licensed Residential Facility Providers may request a change of Provider *if* the transfer of the beneficiary to a licensed facility is planned or has occurred.

Complete all information related to beneficiary demographics.

Indicate the reason for the provider change.

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Change of Provider Submission

Indicate if the beneficiary has been or anticipates being discharged from the provider and the date of discharge.

List information about the beneficiary's preferred provider.

Complete contact information if person requesting the provider change is not the beneficiary.

Completed referrals should be printed and faxed to CCME at 877-272-1942 or mailed to CCME:
ATTN: PCS Independent Assessment
100 Regency Forest Drive, Suite 200
Cary, NC 27518-8598



N.C. Department of Health and Human Services - Division of Medical Assistance
MEDICAID, CARE SERVICES (PCS)

REQUEST FOR CHANGE OF PROVIDER (DMA 3043) FOR LICENSED RESIDENT

Complete this form and attach the following forms for Medical Assistance (DMA) only for 4/1/12 (DMA) or mail to HHS, ATTN: Independent PCS Assessment, 100 Regency Forest Drive, Suite 200, Cary, NC 27518-8598. For questions, contact DMA at 888 (24 7443) or 919 (919) 744-3333.

Requested By: PCP (Attending MD) Beneficiary's Responsible Party
Date of Request: _____

Section A: Beneficiary Information

Beneficiary ID #: _____
Beneficiary Name (as shown on Medicaid Card): First _____ MI _____ Last _____
Date of Birth: _____/_____/_____. Gender: _____ Race: _____ Ethnicity: _____ Primary Language: _____ English _____ Spanish _____ Other _____
Address: _____ City: _____
County: _____ State: _____ Zip: _____ Phone: _____
Medical Condition/Problem(s) (attach if beneficiary under the care of _____)
Relationship to Beneficiary: _____
Residence: _____

Section B: Provider Information

Reason for Provider Change:
 Beneficiary choice Current agency unable to continue providing services
 Other _____

Notes of PCS Services:
 Discharged Anticipated Scheduled for discharge on _____
 Current hearing services will be continued with a new hearing agency. No discharge planned at this time.

Beneficiary's Preferred Provider (if known):
Agency Name: _____
Location: _____
Phone: _____
Agency Name (alternate): _____
Location: _____
Phone: _____

Agency or Contact Information for Questions about Change of Provider Payment of Cost Beneficiary or Alternate Contact Under DMA 3043:
Contact Name: _____ Relationship to Beneficiary: _____
Phone: _____ Fax: _____ E-mail: _____
Date: _____

HCA logo

Change of Provider (DMA 3043) for a Beneficiary of a Home Care Agency

N.C. Department of Health and Human Services - Division of Medical Assistance
MEDICAID, CARE SERVICES (PCS)

REQUEST FOR CHANGE OF PROVIDER (DMA 3070) FOR LICENSED RESIDENTIAL FACILITY

Complete this form and attach the following forms for Medical Assistance (DMA) only for 4/1/12 (DMA) or mail to HHS, ATTN: Independent PCS Assessment, 100 Regency Forest Drive, Suite 200, Cary, NC 27518-8598. For questions, contact DMA at 888 (24 7443) or 919 (919) 744-3333.

Requested By: PCP (Attending MD) Beneficiary's Responsible Party
Date of Request: _____

Section A: Beneficiary Information

Beneficiary ID #: _____
Beneficiary Name (as shown on Medicaid Card): First _____ MI _____ Last _____
Date of Birth: _____/_____/_____. Gender: _____ Race: _____ Ethnicity: _____ Primary Language: _____ English _____ Spanish _____ Other _____
Current Address: _____ City: _____
County: _____ State: _____ Zip: _____ Phone: _____
Medical Condition/Problem(s) (attach if beneficiary under the care of _____)
Relationship to Beneficiary: _____
Residence: _____

Section B: Provider/Facility Information

Reason for Provider/Facility Change (attach card):
 Beneficiary choice Current agency/facility unable to continue providing services
 Other _____

Notes of PCS Services (attach card):
 Discharged/Transferred on _____ Scheduled for discharge/transfer on _____
 Current hearing services will be continued with a new hearing agency. No discharge/transfer planned at this time.

Beneficiary's Preferred Provider/Facility (if known)
Agency/Facility Name: _____
Medical Provider Number: _____ Facility License Number: _____
Location: _____
Facility Type: _____ Family Care Home _____ Adult Care Home _____ SN _____ ICH _____ JCH _____
Special Care (SNF) _____ Yes _____ No _____ (Check "Yes" if Special Care Special Care (SNF) (SC) (SC) (SC))

Beneficiary's Alternate Preferred Provider/Facility (if known)
Agency/Facility Name: _____
Medical Provider Number: _____ Facility License Number: _____
Location: _____
Facility Type: _____ Family Care Home _____ Adult Care Home _____ SN _____ ICH _____ JCH _____
Special Care (SNF) _____ Yes _____ No _____ (Check "Yes" if Special Care Special Care (SNF) (SC) (SC) (SC))

Agency or Contact Information for Questions about Change of Provider/Payment of Cost Beneficiary or Alternate Contact Under DMA 3070:
Contact Name: _____ Relationship to Beneficiary: _____
Phone: _____ Fax: _____ E-mail: _____
Date: _____

Licensed Residential Facility (LRF) logo

Change of Provider (DMA 3070) for a Beneficiary of a Licensed Residential Facility

Fair Hearing Procedures

Understanding It All



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Appeals



Medicaid beneficiaries (or their *authorized personal* representatives) have the right to appeal adverse decisions of the State Medicaid agency and receive a fair hearing pursuant to the Social Security Act, 42 C.F.R. 431.200 *et seq.* and N.C.G.S. §108A-70.9.

Medicaid beneficiaries have a constitutional right to due process because Medicaid is an entitlement program.

Due process means notice and an opportunity for a hearing when a Medicaid service is denied, reduced, terminated, or suspended.

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UNDERSTANDING THE FAIR HEARING (APPEAL) PROCESS



Fair Hearing Procedures (OAH and Final Decisions)
— must be completed in 90 days from the date hearing request received by OAH.

Three Phases

- **Mediation (voluntary)**—completed within 25 days of receipt of hearing request by OAH
- **OAH Proceeding**—completed within 55 days of receipt of hearing request by OAH
- **Final Decision**—ALJ issues the final decision

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Adverse Decision Notices



If a beneficiary's service is **denied, reduced, or terminated** the beneficiary must receive an explanation that contains the following pieces of information:

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Adverse Decision Notices Include:



- Why the service was denied, reduced, or terminated
- The service (if any) and how much of it is approved
- The effective date
- How to appeal the decision

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Adverse Decision Notices Include:



- The legal authority supporting the decision in that case
- Contact information for someone who can answer questions about the decision in the case
- Citation(s) and website(s) supporting the action
- Hearing request form and instructions

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Types of Notices Applicable to PCS

- Unable to Process Notice
- Notice of Approval of Service Request
- Notice of Denial of Initial Request
- Notice of Denial of Continuing Request
- Notice of Change in Services
- Technical Denials



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TYPES OF NOTICES
Appeal Rights Not Included

Unable to Process Notice
This notice is mailed or electronically transmitted to the referring practitioner when a referral is received that lacks required information necessary for the UR vendor to recognize and process it as a request for prior approval.

Notice of Approval of Service Request
This notice is mailed or electronically transmitted to the selected provider and beneficiary when DMA or CCME has approved the referral for PCS.



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TYPES OF NOTICES
Appeal Rights Included

Notice of Denial of Initial Request
• This notice is mailed by trackable mail to the recipient when an adverse decision is made on a referral for PCS and the recipient was NOT authorized to receive PCS on the day prior to the referral. A recipient who appeals a denial of an initial request is not entitled to maintenance of service during the appeal period.

Notice of Change in Services
• This notice is mailed by trackable mail to the beneficiary and first class mail to the provider when an adverse decision is made on a reassessment.
• Effective date of change shall be no sooner than 10 days after date notice is mailed. If fewer hours are approved, beginning date of change is 10 days after mailing.

Technical Denials- unable to contact, no shows, duplicative services 39



Filing an Appeal



If the beneficiary chooses, he or she may appeal DMA's decision to deny, reduce or terminate PCS services.



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The Appeals Process for Beneficiaries



1. Request for Hearing Form Completed by beneficiary or authorized representative

- The beneficiary must complete the form found in the adverse decision letter received from CCME.

2. Request for Hearing Form Submitted by beneficiary or authorized representative

- The form must be received 10 days from the date of the notice to prevent a lapse in PCS
- If the appeal form is received at OAH after the 10th day from the date of the notice, but within 30 days of the date of the notice, MOS will be effective the date the appeal request is received at OAH.

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The Appeals Process



2. Request for Hearing Form to be Submitted by beneficiary or authorized representative

- Send the request by U.S. mail or facsimile to the Office of Administrative Hearings (OAH) and a copy to the Department of Health and Human Services (DHHS).

OAH	NC DHHS
Clerk of Court	CPP Appeals Section
Medicaid Recipient Appeals	2501 Mail Service Center
6714 Mail Service Center	Raleigh, NC 27699-2501
Raleigh, NC 27699-6714	FAX: 919-716-7679
FAX: 919-431-3100	

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The Appeals Process for Beneficiaries



- A beneficiary who has filed a timely appeal is entitled to maintain the same hours of service **he or she** was receiving the day before the Notice of Decision letter was mailed (up to 80 hours per month*).
 - Special Care Unit beneficiaries will be allowed 161 MOS hours.
- A beneficiary is eligible to receive services while the appeal is pending as long as he/she remains otherwise eligible for Medicaid.

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Appeals: Maintenance of Service



Maintenance of Service (MOS) applies to an adverse decision on a continuing request if a timely appeal is filed.

Maintenance of Service (MOS) will not apply in the following situations:

- Initial Requests
- Reassessments where the beneficiary and/or legal representative filed an appeal more than 30 days after the date of the notice.

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Mediation

A way to resolve an appeal



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Mediation Outcomes



- Withdrawal of appeal
- Offer of a new Assessment
- Resolution of issues relating to technical denials (TDs).
- Mediation decision accepted by beneficiary
- Services authorized as agreed during mediation
- Impasse

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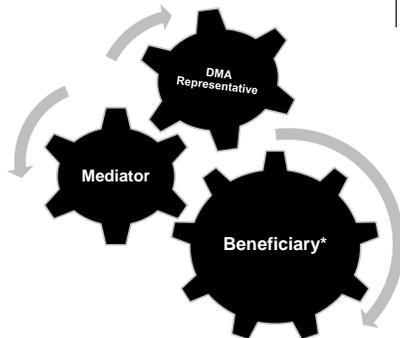
Mediations



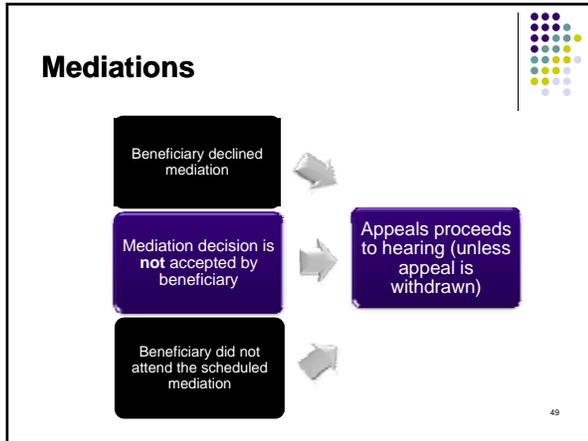
- ◆ **The mediation process is**
 - ◆ Voluntary
 - ◆ Free of charge to beneficiaries
 - ◆ Confidential
 - ◆ Legally-binding
- ◆ Must occur within 25 days of receipt of the beneficiary's appeal request by OAH.

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Mediations



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Settlements

A way to resolve an appeal

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Settlements

Settlements after mediation or on the day of the hearing:

- Even if an agreement cannot be at the mediation, beneficiaries can still reach a settlement of their appeal prior to hearing or on the day of the scheduled hearing.
- If the beneficiaries has new medical evidence to present at the hearing, let the Assistant Attorney General (AAG) assigned to the case know.
- The AAG and/or the UR Vendor may talk to the beneficiaries or the beneficiary's personal representative about settlement options.

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Settlements



Settlements after mediation or on the day of the hearing:

- When a settlement agreement is reached outside of mediation or hearing the provider will receive a copy of the settlement notice via QiRePort or by fax and the beneficiary will receive the closure from OAH.
 - This will include the settlement date, hours authorized, the effective date and the end date.
- The UR Vendors have contractual deadlines in which to enter the agreed-upon authorization into the system.



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Office of Administrative Hearing (OAH)

A way to resolve an appeal



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OAH



Hearing scheduled

- For beneficiaries who do not accept offer of mediation or the mediation does not result in resolution of the case
- Beneficiary is notified by trackable mail of the date, time and location of the hearing.
- Continuances will NOT be granted on the day of the hearing except for good cause (not defined by N.C. General Statute §108A – 70.9B(b)(4)).

Hearing Conducted

- Takes place before an Administrative Law Judge.
- Judge makes final decision to uphold or overturn the adverse decision.

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OAH



Administrative Law Court Decision

- Beneficiary receive copies of both the administrative law judge's decision.
- If the beneficiary wishes to appeal the decision to the Superior Court, an appeal must be submitted within 30 days of mailing of the final decision.

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Superior Court Review



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Superior Court Judicial Review



- If residents do not agree with OAH final Decision, he or she may ask for a judicial review in Superior Court.
- Beneficiary may represent himself/herself, hire an attorney, or ask a relative/friend to speak in court.



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Plan of Care and Aide Documentation



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NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE (DMA)
Independent Assessment for Personal Care Services to Licensed Homes

Section A. Assessment Identification

Assessment Type	ACH Transition	Assessment Date	11/07/2012	Topic Minor (Y/N)	36
Assessment Start Time	8:00 am	Assessment Completion Time	9:00 am	Topic/Topic (Y/N)	30
Assessor's Office/State Location	Residence (ACH/SLF Post)	Assessor Name	Caprianna, Ash/Assessor		

Section B. Recipient Identification

Manual Assessment ID	20121107-22160-221402	Medicaid ID	197654323R	LMI PL-DMH2 Date	10/16/2012
Recipient Last Name	LYONG	First Name	EVELYN	MI	1
Gender	F	DOB	2/25/1959	Height	5'10"
Requires Physical Assistance	Yes	Requires Limited Assistance	Yes	Requires Personal Care	Yes

Section C. Assessment Summary

Assessment Date	11/07/2012	Assessor Name	James	Assessor Title	Assessor
Facility Name	ABOVE ALL OTHERS	Facility License Number	MHL-999-999	Facility License Date	01/01/2012
Assisting Physician	James	Physician License Number	123456789	Assisting Physician Type	PCP/Attending MD

EVELYN

Section C. Assessment (Continued)

Diagnosis Description (Enter description)	Comments/Explanation
Primary: Rheumatoid Arthritis	
Secondary: Cognitive Heart Failure	
Secondary: Dementia	
Secondary: Diabetes	
Secondary: Hypertension	
Secondary: Urinary Incontinence	
Secondary:	
Secondary:	
Secondary:	

Section D. Medications

Medication	Prescription or OTC	Routing	Scheduled or PRN	Frequency	# of Doses in 24 Hour Period	Medication Admin (Complex)?
Laxix	Prescription	Oral	Scheduled	Daily	1	No
Lipitor	Prescription	Oral	Scheduled	BID	2	No
Plavix	Prescription	Oral	Scheduled	Daily	1	No
Glucophage	Prescription	Oral	Scheduled	Daily	1	No
Multivitamin	OTC	Oral	Scheduled	Daily	1	No
Aspirin	Prescription	Oral	Scheduled	Daily	1	No
Calcium	OTC	Oral	Scheduled	Daily	1	No

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How to Write A Care Plan

Monthly Hours	Divide by 4.35=	Round down to next ¼ hour to obtain weekly POC hours
61	14.02	14.00
59	13.56	13.50
38	8.74	8.50
26	5.97	5.75

What Are the Requirements for Aide Documentation?



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Aide Documentation Requirements

- Document performance of ADL tasks
- Frequency of performance
- Date of services and tasks were provided
- Name of the aide



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Bubbe Smith Home Care
REVO DEV 0.8 2010

Deviation Report

Date: 3-2-10
Patient name: Gandy Day
Aide name: Winnie Brown

Classification: CAP PCS Private Other:

Missed 2 hours of care today due to RD appointment. Patient's daughter is taking and will be gone most of the day. No PCS is needed. Resume tomorrow at regularly scheduled time.

Signature of agency staff: *Suey Steffer*

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QiRePort



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Overview of the QiRePort Provider Interface to access beneficiary information

- Review decision notices
- Submission of change of status requests

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Features of the Provider Interface For QiRePort

- Electronic Referral Process**
 - Receipt from CCME
 - Agency accept or decline
- Access to CCME generated PCS documents for your agency's clients/referrals only**
 - IA documents
 - Accept or decline letters
 - Notification letters
- Online submission of information**
 - Change of Status

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Viewing Referrals

Q. How do I view referrals CCME has sent to my agency?

HOME CARE AGENCY (HCA) PROVIDERS

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Viewing Referrals

Q. How do I view referrals CCME has sent to my agency?
(LRF provider view)

Licensed Residential Facility (LRF)



Q: How do I submit a change of status?

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Submitting a Change of Status (COS)

1. Click on "Search Recipients" tab



The screenshot shows the QiRePort interface. On the left is a navigation menu with 'Search Recipients' highlighted. On the right is a 'Recipient List' form with input fields for Last Name (partial), First Name (partial), and Medicaid ID, and a Search button.



Submitting a Change of Status (COS)

2. From the Recipient List select the correct beneficiary by clicking on their name.



The screenshot shows the QiRePort interface with a table of recipients. The table has columns for Name, ID#, Date of Birth, Phone, Last Action, and Provider ID. The first row is highlighted, and an arrow points to the name 'BUELL, COBA'.

Name	ID#	Date of Birth	Phone	Last Action	Provider ID#
BUELL, COBA	98794321N	04/22/1939	918-555-1212	10/19/2012	600738

The screenshot shows the website for The Carolinas Center for Medical Excellence. The header includes the logo and navigation links: Home Room | Events | Careers | Login/Registration. A search bar contains 'CCME Medicare'. Below the header are tabs for 'Who We Are', 'Who We Serve', 'What We Do', and 'My CCME'. The main content area is titled 'PCS Trainings' and includes a 'PCS Webinar' section, 'PCS Training Resources', and 'Quick Links' for Home Care Agencies and Licensed Residential Facilities. A paragraph describes the center's cooperation with the North Carolina Division of Medical Assistance (DMA) to offer regional trainings, webinars, and online training to providers. A footer note says '109'.

The screenshot displays a 'Provider Resources' page. It features a large heading 'Provider Resources' and a list of services with contact details:

- Division of Medical Assistance (DMA) -** <http://www.ncdhhs.gov/dma/index.htm>, Home and Community Care Section, 919-855-4340
- Basic Medicaid and NC Health Choice Billing Guide -** <http://www.ncdhhs.gov/dma/basicmed>
- Carolina Center for Medical Excellence (CCME) -** www.thecarolinascenter.org, CCME Call Center is available Monday through Friday from 8:00 a.m. – 5:00 p.m. Toll Free Number 1-800-228-3365, Email: PCSAssessment@thecarolinascenter.org
- HP Enterprise Services (HPES) – Provider Services**, Toll Free Number 800-688-6696

 A footer note says '110'.
