

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.

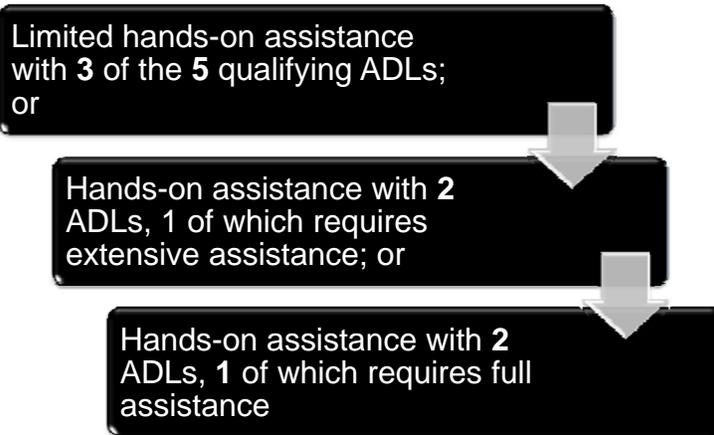
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Who are PCS Eligible Beneficiaries?



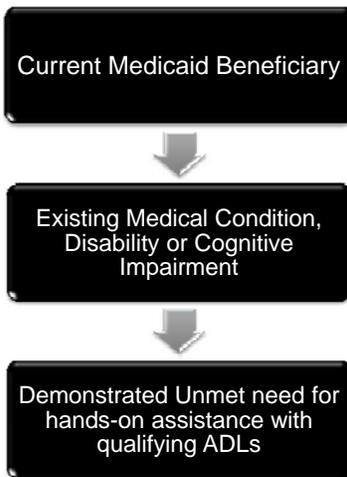
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Who Are PCS Eligible Beneficiaries?



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Who Are PCS Eligible Recipients?



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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

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

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N.C. Department of Health and Human Services – Division of Medical Assistance
PERSONAL CARE SERVICES
INDEPENDENT ASSESSMENT REQUEST FOR LICENSED FACILITY RESIDENT, NEW REFERRAL
 Completed form serves as authorization to conduct eligibility assessment to receive PCS in licensed care home.

Send completed form to CCME via fax at 877-272-1942.
 Or mail to: CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598.
 Receipt may be confirmed with CCME at 800-228-3365. E-mail questions to PCSAssessment@the-carolinascarecenter.org.

Form must be completed by patient's Primary Care or Attending Physician and signed by Physician, Nurse Practitioner, or Physician Assistant.

PLEASE COMPLETE ALL FIELDS.

Date of Request: (mm/dd/yyyy) Requested By: PCP Attending MD Licensed Facility PCS Provider

Section A. Beneficiary Demographics
 Medical ID: _____
 Beneficiary name (as shown on Medicaid Card): First: _____ MI: _____ Last: _____
 Date of Birth: (mm/dd/yyyy) Gender: Male Female Primary Language: English Spanish Other
 Address: _____ City: _____
 County: _____ State: _____ Zip: _____ Phone: (____) _____-_____
 Alternate Contact/Parent/Guardian (required if beneficiary under 18): First: _____ Last: _____
 Relationship to Beneficiary: _____ Phone: (____) _____-_____
 Facility Name (Current Residence): _____ Provider Number: _____

Section B. Patient Information
 Provide only the ICD-9 codes associated with conditions that currently limit recipient's ability to independently perform Activities of Daily Living (eating, dressing, mobility, continence, walking, coherent speech, and managing medications).
 Primary Diagnosis: _____
 Secondary: _____ Secondary: _____ Secondary: _____
 Secondary: _____ Secondary: _____ Secondary: _____
 Conditions listed are: Chronic Medical Physical Disability Mental Illness MR/Developmental Dementia (only in the elderly)
 Medically Stable: Yes No Check if Active Adult Protective Services: Yes No
 Date of Last Visit with Referring Practitioner: (mm/yyyy)
 Patient Currently Hospitalized or in Medical Facility: Yes No If yes, Planned Discharge Date: (mm/dd/yyyy)
 Other Federal/State Programs Beneficiary is Currently Receiving: CAP Medicare HI PDN Hospice
 In the absence of caregivers, is resident at risk of any of the following? (check all that apply):
 Falls Malnutrition Skin Breakdown Adverse Consequences of Medication Non-Compliance
 Is 24 hour caregiver availability required to ensure resident safety? Yes No
 (i.e., Does resident have a caregiver who meets or exceeds the supervision or oversight level of a resident under 7 years for extended periods?)

Section C. Attending Practitioner Information
 Practitioner Last Name: _____ First Name: _____ NPI# _____
 Attending Practitioner: PCP Attending MD NP PA
 Date of Reseater's Last Visit with Attending Practitioner: (mm/dd/yyyy)
 Practice Name: _____
 Office Contact Last Name: _____ First: _____ Position: _____
 Phone: (____) _____-_____. Fax: (____) _____-_____. E-mail: _____
 Practitioner Signature: _____ Date: (mm/dd/yyyy)
 (Date signature is verification that information in Section B is accurate for this patient and authorization to conduct PCS eligibility assessment.)
 DMA-3068
 Revised 12/19/2012

Licensed Residential Facility New Referral (DMA 3068)

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N.C. Department of Health and Human Services – Division of Medical Assistance
REQUEST FOR INDEPENDENT ASSESSMENT FOR PERSONAL CARE SERVICES (PCS)
NEW REFERRAL

Complete this form and send to The Carolinas Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail to: CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598.
 For questions, contact CCME at 800-228-3365 or PCSAssessment@the-carolinascarecenter.org.

Referral Entity: PCP Attending MD Date of Referral: (mm/dd/yyyy)

Section A. Beneficiary Demographics
 Medical ID: _____
 Beneficiary Name (as shown on Medicaid Card): First: _____ MI: _____ Last: _____
 Date of Birth: (mm/dd/yyyy) Gender: Male Female Primary Language: English Spanish Other
 Address: _____ City: _____
 County: _____ State: _____ Zip: _____ Phone: (____) _____-_____
 Alternate Contact/Parent/Guardian (required if beneficiary under 18): First: _____ Last: _____
 Relationship to Beneficiary: _____ Phone: (____) _____-_____
Section B. Beneficiary Medical History
 Provide ICD-9 codes for Current Medical Diagnoses – Related to need for hands-on assistance with Activities of Daily Living (ADL) _____ Check or Elaboration (Enter O or E) _____ Date (mm/yyyy) _____

 Medically Stable: Yes No Check if Active Adult Protective Services
 Date of Last Visit with Referring Practitioner: (mm/yyyy)
 Patient Currently Hospitalized or in Medical Facility: Yes No If yes, Planned Discharge Date: (mm/dd/yyyy)
 Other Federal/State Programs Beneficiary is Currently Receiving: CAP Medicare HI PDN Hospice

Section C. Referring Practitioner
 NPI# _____ Practitioner First Name: _____ Last Name: _____
 Facility Contact Name: _____ Contact Position: _____
 Phone: (____) _____-_____. Fax: (____) _____-_____. E-mail: _____

Section D. Primary Care Physician Demographics
 Same As Referring Practitioner: Yes No If yes, go to Section C.
 NPI# _____ Practitioner First Name: _____ Last Name: _____
 Facility Contact Name: _____ Contact Position: _____
 Phone: (____) _____-_____. Fax: (____) _____-_____. E-mail: _____

Section E. Authorization For PERSONAL CARE SERVICES (PCS) Assessment
 Referring Practitioner Signature: _____ Date: (mm/dd/yyyy)
 If hospital or medical facility discharge, signed order from referring practitioner available in medical records? Yes No
 Signature of facility representative: _____ Date: (mm/dd/yyyy)

DMA-3041
 06/01/11 Rev 12/31/12

Home Care Agency New Referral (DMA 3041)

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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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New Referral

Change of Status requests may be submitted by

- the provider,
- the beneficiary,
- the beneficiary's family, guardian, or person with Power of Attorney
- the beneficiary's physician.
- COS shall include documentation that supports the need to conduct the reassessment.

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**N.C. Department of Health and Human Services – Division of Medical Assistance
PERSONAL CARE SERVICES
INDEPENDENT ASSESSMENT REQUEST FOR LICENSED FACILITY RESIDENT: CHANGE OF STATUS**

Complete this form and send to The Carolina Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail: CCME, ATTC, Consolidated PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary, NC 27518-8596. For questions, contact CCME at 800-228-3365 or PCSAssessment@thecarolinacenter.org.

Requested By: PCP Attending MD Licensed Facility PCS Provider Beneficiary/Responsible Party
 Other If Other, Relationship to Beneficiary _____

Date of Request: ____/____/____ (mm/dd/yyyy)

Section A. Beneficiary Demographics

Medicaid ID# _____

Beneficiary Name (as shown on Medicaid Card) First _____ M: _____ Last _____

Date of Birth: ____/____/____ (mm/dd/yyyy) Gender: Male Female Primary Language: English Spanish Other

Address: _____ City: _____

County: _____ State: _____ Zip: _____ Phone: (____) _____-____

Alternate Contact/Parent/Guardian (required if beneficiary under 18): First _____ Last _____
Relationship to Beneficiary: _____ Phone: (____) _____-____

Section B. Beneficiary Medical History

Provide ICD-9 Codes for Current Medical Diagnoses – Related to need for hands-on assistance with Activities of Daily Living (ADL)	Onset or Escalation (Enter O or E)	Date (mm/yyyy)

Medically Stable: Yes No Check if Active Adult Protective Services

Reason for Change in Condition Requiring Reassessment for Services:

Change in medical condition Change in caregiver status Change in recipient location affecting ability to perform ADLs
 Hospitalization (Discharge Date: ____/____/____ (mm/dd/yyyy)) Other _____

Briefly describe the change in condition and its impact on beneficiary's need for assistance (required for all reasons):

Section C. Facility PCS Provider Information. (Complete if request submitted by Licensed Facility PCS Provider)

Facility PCS Provider Name: _____ NPI# _____
Medicaid Provider Number: _____ Facility License Number: _____ License Date: _____

Location: _____
Facility Type: Family Care Home Adult Care Home BLF-5000a JCF-5000b Adult Care bed in Nursing Facility
Special Care Unit? Yes No (Select Yes if stand-alone Special Care Unit/22 SCU bed)

Facility Contact Name: _____ Contact Position: _____
Phone: (____) _____-____ Fax: (____) _____-____ E-mail: _____

Section D. Referring Practitioner Demographics (Complete if request submitted by PCP or Attending MD)

NPI# _____ Practitioner First Name: _____ Last Name: _____
Facility Contact Name: _____ Contact Position: _____
Phone: (____) _____-____ Fax: (____) _____-____ E-mail: _____

DMA-3069
12/19/2012



Licensed Residential Facility Change of Status (DMA 3069)

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**N.C. Department of Health and Human Services – Division of Medical Assistance
PERSONAL CARE SERVICES
INDEPENDENT ASSESSMENT REQUEST FOR HOME CARE AGENCIES: CHANGE OF STATUS**

Complete this form and send to The Carolina Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail: CCME, ATTC, BIC Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary, NC 27518-8596. For questions, contact CCME at 800-228-3365 or PCSAssessment@thecarolinacenter.org.

Requested By: PCP Attending MD PCS Agency Beneficiary/Responsible Party

Date of Referral: ____/____/____ (mm/dd/yyyy)

Section A. Recipient Demographics

Medicaid ID# _____

Recipient Name (as shown on Medicaid Card) First _____ M: _____ Last _____

Date of Birth: ____/____/____ (mm/dd/yyyy) Gender: Male Female Primary Language: English Spanish Other

Address: _____ City: _____

County: _____ State: _____ Zip: _____ Phone: (____) _____-____

Alternate Contact/Parent/Guardian (required if recipient under 18): First _____ Last _____
Relationship to Recipient: _____ Phone: (____) _____-____

Section B. Recipient Medical History

Provide ICD-9 Codes for Current Medical Diagnoses – Related to need for hands-on assistance with Activities of Daily Living (ADL)	Onset or Escalation (Enter O or E)	Date (mm/yyyy)

Medically Stable: Yes No Check if Active Adult Protective Services

Reason for Change in Condition Requiring Reassessment for Services:

Change in medical condition Change in caregiver status
 Change in recipient location affecting ability to perform ADLs
 Hospitalization (Discharge Date: ____/____/____ (mm/dd/yyyy)) Other _____

Briefly describe the change in condition and its impact on recipient's need for assistance (required for all reasons):

Section C. Referral Source if not Recipient or Recipient's Responsible Party.

NPI# _____ First Name: _____ Last Name: _____
Facility Contact Name: _____ Contact Position: _____
Phone: (____) _____-____ Fax: (____) _____-____ E-mail: _____

Section D. Primary Care Physician Demographics

Same As Referring Practitioner Y N. If yes, request is complete, submit to CCME

NPI# _____ Practitioner First Name: _____ Last Name: _____
Facility Contact Name: _____ Contact Position: _____
Phone: (____) _____-____ Fax: (____) _____-____ E-mail: _____

DMA-3042
6/20/11 Rev 12/01/12



Home Care Agency Change of Status (DMA 3042)

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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



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**N.C. Department of Health and Human Services – Division of Medical Assistance
PERSONAL CARE SERVICES (PCS)
REQUEST FOR CHANGE OF PROVIDER FOR HOME CARE AGENCY BENEFICIARIES**

Complete this form and send to The Carolina Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail: CCME, ATTN: Home Care Agency Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598. For questions, contact CCME at 800-228-3365 or PCSAssessment@thecarolinacenter.org

Requested By PCP Attending MD Beneficiary Beneficiary's Responsible Party
Date of Request: ____/____/____ (mm/dd/yyyy)

Section A. Beneficiary Demographics
Medicaid ID# _____
Beneficiary Name (as shown on Medicaid Card): First _____ MI _____ Last _____
Date of Birth: ____/____/____ (mm/dd/yyyy) Gender: Male Female Primary Language: English Spanish Other
Address: _____ City: _____
County: _____ State: _____ Zip: _____ Phone: (____) _____-_____
Alternate Contact/Parent/Guardian (required if Beneficiary under 18): First _____ Last _____
Relationship to Beneficiary: _____ Phone: (____) _____-_____
Date of Birth: ____/____/____ (mm/dd/yyyy)

Section B. Provider Information
Reason for Provider Change:
 Beneficiary choice
 Current agency unable to continue providing services
 Other _____
Status of PCS Services:
 Discharged on ____/____/____ (mm/dd/yyyy)
 Scheduled for discharge on ____/____/____ (mm/dd/yyyy)
 Continue receiving services until established with a new provider agency; no discharge planned at this time
Beneficiary's Preferred Provider (if known):
Agency Name: _____
Location: _____
Phone: (____) _____-_____
Agency Name (Alternate): _____
Location: _____
Phone: (____) _____-_____
Date of Birth: ____/____/____ (mm/dd/yyyy)

Section C. Contact Information for Questions about Change of Provider Request (if not Beneficiary or Alternate Contact listed in Section A)
Contact Name _____ Relationship to Beneficiary: _____
Phone: (____) _____-_____ Fax: (____) _____-_____ E-mail: _____
DMA-3043
06/5/11

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
PERSONAL CARE SERVICES (PCS)
REQUEST FOR CHANGE OF PROVIDER FACILITY TRANSFER FOR LICENSED FACILITY RESIDENT**

Complete this form and send to The Carolina Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail: CCME, ATTN: Consolidated PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598. For questions, contact CCME at 800-228-3365 or PCSAssessment@thecarolinacenter.org

Requested By PCP Attending MD Beneficiary Beneficiary's Responsible Party
 Licensed facility provider (check only if beneficiary transfer to a licensed facility is planned or occurred)
Date of Request: ____/____/____ (mm/dd/yyyy)

Section A. Beneficiary Demographics
Medicaid ID# _____
Beneficiary Name (as shown on Medicaid Card): First _____ MI _____ Last _____
Date of Birth: ____/____/____ (mm/dd/yyyy) Gender: Male Female Primary Language: English Spanish Other
Current Address: _____ City: _____
County: _____ State: _____ Zip: _____ Phone: (____) _____-_____
Alternate Contact/Parent/Guardian (required if beneficiary under 18): First _____ Last _____
Relationship to Beneficiary: _____ Phone: (____) _____-_____
Date of Birth: ____/____/____ (mm/dd/yyyy)

Section B. Provider/Facility Information
Reason for Provider/Facility Change (select one):
 Beneficiary choice Current agency/facility unable to continue providing services
 Other _____
Status of PCS Services (select one):
 Discharged/Transferred on ____/____/____ (mm/dd/yyyy) Scheduled for discharge/transfer on ____/____/____ (mm/dd/yyyy)
 Continue receiving services until established with a new provider agency; no discharge/transfer planned at this time
Beneficiary's Preferred Provider/Facility (if known):
Agency/Facility Name: _____ Phone: (____) _____-_____
Medicaid Provider Number: _____ Facility License Number: _____ License Date: _____
Location: _____
Facility Type: Family Care Home Adult Care Home SLF-5600a SLF-5600c Adult Care bed in Nursing Facility
Special Care Unit? Yes No (Select Yes if stand-alone Special Care Unit SCU bed)
Beneficiary's Alternate Preferred Provider/Facility (if known):
Agency/Facility Name: _____ Phone: (____) _____-_____
Medicaid Provider Number: _____ Facility License Number: _____ License Date: _____
Location: _____
Facility Type: Family Care Home Adult Care Home SLF-5600a SLF-5600c Adult Care bed in Nursing Facility
Special Care Unit? Yes No (Select Yes if stand-alone Special Care Unit SCU bed)

Section C. Contact Information for Questions about Change of Provider Request (if not Beneficiary or Alternate Contact listed in Section A)
Contact Name _____ Relationship to Beneficiary: _____
Phone: (____) _____-_____ Fax: (____) _____-_____ E-mail: _____
DMA-3075
12/16/02

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.



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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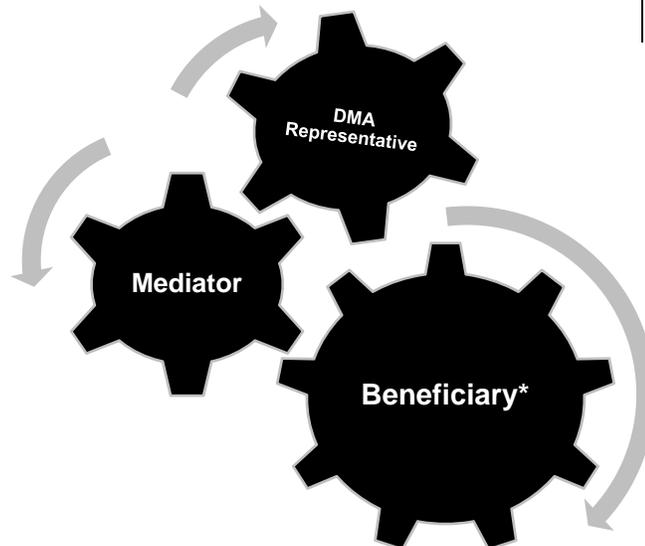
Mediations



- ◆ **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.

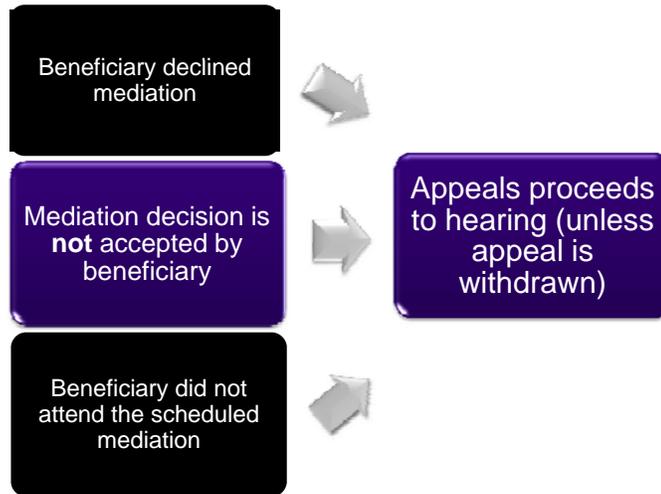
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Mediations



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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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Beneficiary's Overall Self-Performance Capacity			
ADL	Limited Assistance	Extensive Assistance	Full Dependence
Bathing	35	50	60
Dressing	20	35	40
Mobility	10	20	20
Toileting	25	30	35
Eating	30	45	50
Medication Assistance			
Reminders/ Set-Up	Routine Administration (8 or Fewer)	Routine Administration Plus PRN	Polypharmacy and/or Complex
10	20	40	60

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Section G. Recipient Declaration and Assessor Observation of ADL and Related IADL Self-Performance Capacities – Bathing and Personal Hygiene

Assistive Devices Used (check all that apply)	
1. Shower chair	<input checked="" type="checkbox"/>
2. Long handle scrub brush	<input type="checkbox"/>
3. Grab bars	<input checked="" type="checkbox"/>
4. Handheld shower	<input type="checkbox"/>
5. Tub bench	<input type="checkbox"/>
6. Transfer bench	<input type="checkbox"/>
7. Other, Specify below:	<input type="checkbox"/>

Comments: Beneficiary requests shampoo twice a week. Daughter does shampoo on Saturday during visit. Aide will do shampoo on Wednesday as requested. Beneficiary able to step into shower with no difficulty, steady and balanced, used grab bars for support; required limited assistance for upper and lower body could do 50% but needed assistance to complete. Did not require assistance with hygiene tasks. Staff provides all IADL care.

Bathing & Personal Hygiene Tasks	Demonstrated Ability?	Check if Required	Assistance Level	Frequency (days/wk)	Need Fully Met (days/wk)	PCS Need Frequency (days/wk)	Weekend (Y/N)
ADL Task Needs							
1. Tub bath or shower	Yes	<input checked="" type="checkbox"/>	1 - limited	4	0	4	Yes
1.a. Upper body	Yes	<input checked="" type="checkbox"/>	1 - limited	4	0	4	Yes
1.b. Lower body	Yes	<input checked="" type="checkbox"/>	1 - limited	4	0	4	Yes
2. Tub/shower transfer/position	-- select --						
3. Bed bath	-- select --						
4. Sponge bath	Yes	<input checked="" type="checkbox"/>	1 - limited	3	0	3	Yes
5. Additional transfer, i.e., reposition in bed, change occupied bed	-- select --						
6. Shampoo/hair care	Yes	<input checked="" type="checkbox"/>	1 - limited	2	1	1	No
7. Skin care (includes wash face/nails, foot care)	Yes						
8. Nail care	Yes						
9. Mouth/oral/denture care	Yes						
10. Shave	Yes						
IADL Task Needs							
1. Change linens	N/A	<input checked="" type="checkbox"/>	1 - limited	1	0	1	No
2. Make bed	N/A	<input checked="" type="checkbox"/>	1 - limited	7	0	7	Yes
3. Tidy/clean bathroom	N/A	<input checked="" type="checkbox"/>	1 - limited	7	0	7	Yes
4. On-site laundry tasks	N/A	<input checked="" type="checkbox"/>	1 - limited	1	0	1	No

Assessor's Overall Self-Performance Capacity Rating: Can do with limited hands-on assistance

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Section H. Recipient Declaration and Assessor Observation of ADL and Related IADL Self-Performance Capacities – Dressing

Assistive Devices Used (check all that apply)

1. Sock aide	
2. Reacher	✓
3. Button hook device	
4. Velcro shoes	
5. Other, Specify below	

Comments: Beneficiary able to remove shirt but couldnt get back on, able to start with sleeves but couldnt completed due to pain. Could remove pants to knee level but unable to remove past that and could put on pants once aide had put feet in and to knee height

Dressing Tasks	Demonstrated Ability	Check if Required	Assistance Level	Frequency (days/wk)	Need Fully Met (days/wk)	PCS Need Frequency (days/wk)	Weekend (Y/N)
ADL Task Needs							
1. Don clothing/socks/shoes	Yes	✓	1 - limited	7	0	7	Yes
2. Remove clothing/socks/shoes	Yes	✓	1 - limited	7	0	7	Yes
3. Clothing and shoe fasteners	Yes	✓	1 - limited	7	0	7	Yes
4. Assist with TEDS	-- select --						
5. Assist with braces/splints	-- select --						
6. Assist with binders							
7. Assist with prosthetics	-- select --						
IADL Task Needs							
1. Hang/retrieve clothing	N / A	✓	1 - limited	7	0	7	Yes
2. On-site laundry tasks	N / A	✓	1 - limited	1	0	1	No

Assessor's Overall Self-Performance Capacity Rating: Can do with limited hands-on assistance

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Section I. Recipient Declaration and Assessor Observation of ADL and Related IADL Self-Performance Capacities – Mobility

Assistive Devices Used (check all that apply)

1. Braces and crutches	
2. Wedges/Positioning devices	
3. Trapeze	
4. Bed cane	
5. Walker/stroller	✓
6. Rollator	
7. SP cane/Curved cane	✓
8. Manual or electric scooter	
9. Hoyer lift	
10. Transfer board	
11. Stander	
12. Wheelchair	
13. Pressure relief device	
14. Gait belt	
15. Protective helmet	
16. Other, Specify below	

Comments: Beneficiary able to get up from chair/couch/bed with no assistance; one standing used s/p cane to balance and ambulate. No pain, no abnormal gait noted. Staff reports 2 falls over last 30 days.

Mobility Tasks	Demonstrated Ability	Check if Required	Assistance Level	Frequency (days/wk)	Need Fully Met (days/wk)	PCS Need Frequency (days/wk)	Weekend (Y/N)
ADL Task Needs							
1. Transfer to/from bed	Yes	✓	Set up/Sup	7	0	7	Yes
2. Transfer to/from chair	Yes	✓	Set up/Sup	7	0	7	Yes
3. Ambulation room to room	Yes	✓	Set up/Sup	7	0	7	Yes
4. Assist with stairs inside the home	-- select --						
5. ROM	-- select --						
6. Turn/reposition	-- select --						
IADL Task Needs							
1. Clear pathways/minimize clutter	N / A	✓	Set up/Sup	7	0	7	Yes
2. Retrieve/return equipment	N / A	✓	Set up/Sup	7	0	7	Yes

Assessor's Overall Self-Performance Capacity Rating: Needs verbal cueing or supervision only

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Section J. Recipient Declaration and Assessor Observation of ADL and Related IADL Self-Performance Capacities – Toileting

Assistive Devices Used (check all that apply)

1. BSC	<input checked="" type="checkbox"/>
2. Elevated toilet seat	<input type="checkbox"/>
3. Urinal	<input type="checkbox"/>
4. Bed pan	<input type="checkbox"/>
5. Transfer board	<input type="checkbox"/>
6. Other, Specify below	<input type="checkbox"/>

Comments: Observed beneficiary walk into bathroom, sit on toilet without assist but demonstrated need for assist to remove clothing. Pantomimed actions of hygiene, needed hands-on assist to complete task, confirmed with staff.

Toileting/Incontinence Mgt Tasks	Demonstrated Ability	Check if Required	Assistance Level	Frequency (days/wk)	Need Fully Met (days/wk)	PCS Need Frequency (days/wk)	Weekend (Y/N)
ADL Task Needs							
1. Remove/pull up/fasten garments	Yes	<input checked="" type="checkbox"/>	1 - limited	7	0	7	Yes
2. Hygiene after toileting/incontinence	Yes	<input checked="" type="checkbox"/>	1 - limited	7	0	7	Yes
3. Transfer to/from BSC or toilet	Yes	<input type="checkbox"/>					
IADL Task Needs							
1. Clean BSC/urinal/bedpan/toileting area	N / A	<input checked="" type="checkbox"/>	1 - limited	7	0	7	Yes
2. Empty trash, dispose of incontinence supplies	N / A	<input checked="" type="checkbox"/>	1 - limited	7	0	7	Yes
3. On-site laundry tasks	N / A	<input checked="" type="checkbox"/>	1 - limited	1	0	1	No

Assessor's Overall Self-Performance Capacity Rating: Can do with limited hands-on assistance

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Section K. Recipient Declaration and Assessor Observation of ADL and Related IADL Self-Performance Capacities – Eating and Meal Preparation

Assistive Devices Used (check all that apply)

1. Adaptive utensils	<input type="checkbox"/>
2. Adaptive dishes	<input type="checkbox"/>
3. Tube feeding supplies	<input type="checkbox"/>
4. Pump	<input type="checkbox"/>
5. IV pole	<input type="checkbox"/>
6. Bag/tubing, etc.	<input type="checkbox"/>
7. Other, Specify below	<input type="checkbox"/>

Comments: Facility staff prepares, serves and clears for all meals 7 days per week. Beneficiary otherwise independent.

Eating Tasks	Demonstrated Ability?	Check if Required	Assistance Level	Frequency (days/wk)	Need Fully Met (days/wk)	PCS Need Frequency (days/wk)	Weekend (Y/N)
ADL Task Needs							
1. Assist with cutting food	-- select --	<input type="checkbox"/>					
2. Assist with feeding	-- select --	<input type="checkbox"/>					
3. Assist with utensil usage	-- select --	<input type="checkbox"/>					
4. Lift limb to mouth	Yes	<input type="checkbox"/>					
5. Tube feeding	-- select --	<input type="checkbox"/>					
6. Equipment setup	-- select --	<input type="checkbox"/>					
7. Chop/grind/puree/thicken	-- select --	<input type="checkbox"/>					
8. Meal Preparation: Open packages	N / A	<input checked="" type="checkbox"/>	1 - limited	7	0	7	Yes
9. Meal Preparation: Heat/assemble food	N / A	<input checked="" type="checkbox"/>	1 - limited	7	0	7	Yes
IADL Task Needs							
1. Clean meal service area	N / A	<input checked="" type="checkbox"/>	1 - limited	7	0	7	Yes
2. Clean utensils/dishes, empty trash	N / A	<input checked="" type="checkbox"/>	1 - limited	7	0	7	Yes

Assessor's Overall Self-Performance Capacity Rating: Can do with limited hands-on assistance

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Section M. Conditions Affecting Recipient's ADL Self-Performance/Assistance Time

(Assess if Recipient symptoms/conditions affect time required to self-perform/assist with ADLs.)

Conditions Potentially Affecting ADL Self-Performance	Check if Present	Evaluation of Condition Severity (Where Indicated by non-shaded boxes)	ADLs Affected							
			None	All	Bathing	Dressing	Mobility	Toileting	Eating	
Respiratory										
Dyspnea/Shortness of Breath	✓	Moderate exertion - dressing, commode use, walking les			✓	✓		✓		
Use of Oxygen										
Cardiovascular										
Impaired endurance										
Symptoms of Heart Disease										
Orthopnea										
Edema or self-reported weight gain										
Dyspnea										
Gastrointestinal/GU										
Incontinence - Urine	✓	Incontinent day and night			✓	✓		✓		
Urinary Ostomy										
Incontinence - Bowel										
Bowel Ostomy										
Neurological										
General Neurological Symptoms										
Adult Seizure Disorder										
Child Seizure Disorder										
Tremors/Parkinsonism										
Muscle Dystonia										
Late Effects of CVA, Hemiparesis, Aphasia										
Lack of Balance										67
Cognitive Impairment	✓	Requires prompting in unfamiliar situations only			✓	✓		✓		



Plan of Care



Bathing and Personal Hygiene	Assistance Level	PCS Need Frequency	Show aide task schedule by placing (x) in each day that aide service is needed.						
			Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
ADL Tasks									
1. Tub bath or shower	1-limited	4	X		X		X	X	
1.a. Upper body	1-limited	4	X		X		X	X	
1.b. Lower body	1-limited	4	X		X		X	X	
2. Help w. getting in tub/shower	1-limited	4	X		X		X	X	
3. Bed bath	n/a	0							
4. Sponge bath	1-limited	3		X		X			X
5. Additional transfer	n/a	0							
6. Shampoo/Hair care	1-limited	2					X		
7. Skin care (inc. wash face/hands& foot ca	n/a	0	X	X	X	X	X	X	X
8. Nail care	n/a	0	X	X	X	X	X	X	X
9. Mouth/oral/denture care	n/a	0	X	X	X	X	X	X	X
10. Shave	n/a	n/a							

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Calculating A Monthly Authorization for Services



1. Activities of Daily Living				
ADL	Level of Assistance	Qualifying ADL?	Minutes per day	Minutes per week
Bathing	Limited	Yes	35	245
Dressing	Limited	Yes	20	140
Mobility	Supervision	No	0	0
Toileting	Limited	Yes	25	175
Eating	Limited	Yes	0*	0
* Because basic meal prep only			Total	80
560				
2. Medication Assistance				
Number of meds	Any PRN?	Any complex?	Minutes per day	Minutes per week
7	No	No	20	140
3. Base Time				
ADLs	Meds	Min/Week	Min/Month	
560	140	700	3045	
4. Exacerbating conditions				
Number	Additional percentage	Min/Month		
3	20%	609		
5. Monthly Service Authorization				
ADLs/Meds	Exacerbating Conditions	Total minutes	Hours (Min/60)	Authorized monthly service level
3045	609	3654	60.9	61 hours

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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Bubba Smith Home Care
REC'D DEC 08 2010
Deviation Report
Date: 3-2-10
Patient name: Goofy Dog
Aide name: Minnie Mouse
Classification: CAP PCS Private Other:
Missed 2 hours of care today due to MD 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: *Suzi Staffer*

Sample deviation documentation

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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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QiRePort: Getting Started



The Carolinas Center for Medical Excellence
Provider Registration For PCS Agency Use of QiRePort

Complete this form and send to The Carolinas Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail: CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598. For questions, contact CCME at 800-228-3365 or PCSAssessment@thecarolinascenter.org.

Agency Identification and Primary Contact Information

Owner/Corporate Identity (Full name)		Main Phone		Main Fax	
Agency Name If Different Than Corporate Identity (dba):		NPI		DHSR License #	
Agency Mailing Address					
Street Address or PO Box	City	State	NC	Zip	
Agency Staff Contact Information For QiRePort Support and Communications (For the agency as a whole)					
Last Name	First Name	Position	Telephone	E-Mail	
Last Name	First Name	Position	Telephone	E-Mail	

List Agency Medicaid Provider Numbers Used For PCS Billing (List up to 15 agency Medicaid provider numbers below)

List Staff Requiring Access To Recipient Information For All Agency Medicaid Provider Numbers Listed Above (Up to 5 agency staff)

Last Name		First Name		Agency Staff or Designated Representatives		Telephone	
				Type of Access To QiRePort *	E-Mail Address		

* Type of Access: Select either Add/Edit or View Only

Home Care Agency providers will continue to utilize the same form and registration process.

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QiRePort: Getting Started



The Carolinas Center for Medical Excellence
Provider Registration For Licensed Facility PCS Provider Use of QiRePort

Complete this form and send to The Carolinas Center for Medical Excellence [CCME] via fax at 877-272-1942 or mail: CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598. For questions, contact CCME at 800-228-3365 or PCSAssessment@thecarolinascenter.org.

Facility Identification and Primary Contact Information

Owner/Corporate Identity (Full name)		Main Phone	Main Fax
Facility Name if Different Than Corporate Identity (If/Be)			
Street Address or PO Box		Facility Mailing Address	
City	State	NC	Zip

Facility Staff Contact Information For QiRePort Support and Communications (For the organization as a whole)

Last Name	First Name	Position	Phone	E-Mail

List Facility Medicaid Provider Numbers Used For PCS Billing (List up to 15 agency Medicaid provider numbers below)

List Staff Requiring Access To Beneficiary Information For All Facility Medicaid Provider Numbers Listed Above (Up to 5 staff)

Agency Staff or Designated Representatives				
Last Name	First Name	Type of Access To QiRePort *	E-Mail Address	Phone

Licensed Facility PCS Providers are to complete and fax registration forms to CCME
 1-877-272-1942

QiRePort

Welcome

User Login

User Name:

Password:

[Log In](#)

Forgot password?

Information

[Terms of Use](#)

[Safety and Usage Requirements](#)

Contact Us

Your Email:

Enter Question:

[Send](#)

Call Center Phone Number:
1-800-228-3365



Learn more about PCS Independent Assessments and PACT Reviews: The DHHS, Division of Medical Assistance is implementing new policies and procedures for personal care services. Agencies and organizations interested in knowing more about this new initiative should [click here](#) to learn more. You do NOT need to log-in with a user name and password to see this information.



QiReport is a new web service developed to support quality improvement and utilization management initiatives sponsored by the NC Department of Health and Human Services, Division of Medical Assistance. The Carolinas Center For Medical Excellence administers QiReport on behalf of the Division Medical Assistance.



Visit www.qireport.net

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?



QiRePort Home | Referrals | Reports

Referrals

Referral Info

Referrals for Review

Accepted (last 60 days)

Denials (last 6 months)

Recipients w/ IA

Search Recipient

Recipient Summary

Change of Status Request

Discharge

Provider Number Change

Recipient w/o IA

Change of Status Request

Discharge

Provider Number Change

Maintenance

Countless Saved

Name	MID	Request Type	Assmt / Request Date	Provider No.	Referral Letter	Hours
LEESY,BETTY	000012345L	Change of Provider	9/11/2010	4408912	[Letter.]	80
BOPE,BARBARA	000051689M	New Request	4/27/2010	4409516	[Letter.]	28

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*)



QiRePort Home | Referrals

Referrals

Referral Info
[Referrals for Review](#)
[Accepted \(last 60 days\)](#)
[Denials \(last 6 months\)](#)

Recipient Info
[Search Recipients](#)
[Recipient Summary](#)
[Discharge](#)

Referrals / Notifications for Review

Name	MID	Notification Type	Action Date	Provider No.	Notification Letter	Hours
------	-----	-------------------	-------------	--------------	---------------------	-------

Licensed Residential Facility (LRF)

QiRePort Home | Referrals | Reports

Referrals

Referral Info
[Referrals for Review](#)
[Accepted \(last 60 days\)](#)
[Denials \(last 6 months\)](#)

Recipients w/ IA
[Search Recipient](#)
[Recipient Summary](#)
[Change of Status Request](#)
[Discharge](#)
[Provider Number Change](#)

Recipient w/o IA
[Change of Status Request](#)
[Discharge](#)
[Provider Number Change](#)

Maintenance
[Counties Served](#)

Referral for Acceptance Review

Print * = Required

Recipient Data			
Recipient Name	LEESY,BETTY	Medicaid ID	000012345L
Address 1	4001 TAMER LANE	Address 2	
City, State Zip	CHARLOTTE,NC 28205	County	MECKLENBURG
Phone	980-226-2642	DOB	1/29/1947
Gender	Female		

Requests for Independent Assessment				
Recipient Name	MID	Phone Number	Request Date	Request Type
LEESY,BETTY	000012345L	980-226-2642	7/23/2010	Change of Provider

Independent Assessments on file for Recipient			
Assessment Date	Comments	Assessment Type	Hours
8/11/2010	[Comments.]	Change of Provider	80

Referral Decision * -- select --

Comment

HOME CARE AGENCY (HCA) PROVIDERS

Q: How do I accept or decline a referral?

83

Accepting & Declining Referrals

A: From "Referrals For Acceptance Review Screen":

1. Click on underlined beneficiary's name, under "Requests for Independent Assessment" to view request

QiRePort Home | Referrals | Reports

Referrals Referral for Acceptance Review

Print * = Required

Recipient Data			
Recipient Name	DREWRY, CONNIE	Medicaid ID	000062198P
Address 1	1224 Main Street	Address 2	213 FOREST TRAILING
City, State Zip	CLINTON, NC 283280000	County	SAMPSON
Phone	919-555-1212	DOB	7/23/1916
Gender	Female		

Requests for Independent Assessment				
Recipient Name	MID	Phone Number	Request Date	Request Type
DREWRY, CONNIE	000062198P	919-555-1212	9/20/2010	Annual Assessment

Independent Assessments on file for Recipient			
Assessment Date	Comments	Assessment Type	Hours
9/20/2010	[Comments]	Annual Review	28

HCA

Accepting & Declining Referrals

Request will appear:



PCS Services Request - Change of Provider

Print * = Required

Request / Recipient Information			
Request Date *	07/23/2010	Date COME Received *	07/23/2010
Requested by *	Recipient	Recipient Language	English
Phone	980-226-2642	MO Phone *	<input type="checkbox"/>
First Name	Parent/Guardian (if patient is under 18)		
Relationship	--select--	Last Name	
		Alt. Phone	
Provider Information			
Reason for Change *	Recipient choice		
Other Reason			
Status of PCS Services *	Scheduled for discharge		
(Scheduled) Discharge Date	07/26/2010		
Preferred Provider Lookup			
Provider Name *	INTERCARE HEALTH SERVIC	Number	6601558
Address	1801 NORTH TRYON	City	CHARLOTTE
Zip Code	282062607	Phone	704-332-9880
Alternate Provider Lookup			
Provider Name		Number	
Address		City	
Zip Code		Phone	
Contact Information for Questions about Change of Provider Request			
Contact Name *	DR HEATHER MANOS	Relationship to Recipient *	DR
Contact Phone *	704-446-1000	Contact Fax	704-446-1018
Contact Email			
Is Request Complete? *	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date Request Complete	07/23/2010



Accepting & Declining Referrals

2. Click on underlined assessment date under "Independent Assessments on File for Recipient"



Home | Referrals | Reports

Referrals Referral for Acceptance Review

Print * = Required

Recipient Data			
Recipient Name	DREWRY,CONNIE	Medicaid ID	00062198P
Address 1	1224 Main Street	Address 2	213 FOREST TRAILING
City, State, Zip	CLINTON,NC 283280000	County	SAMPSON
Phone	919-555-1212	DOB	7/23/1916
Gender	Female		
Requests for Independent Assessment			
Recipient Name	MD	Phone Number	Request Date
DREWRY,CONNIE	00062198P	919-555-1212	9/20/2010
			Annual Assessment
Independent Assessments on file for Recipient			
Assessment Date	Comments	Assessment Type	Hours
<u>9/20/2010</u>	[Comments]	Annual Review	28




Accepting & Declining Referrals

PDF of 12-page IA document will appear:



NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE (DMA)
Independent Assessment For Personal Care Services

Section A: Assessment Identification		Assessment Date: 09/20/2010		Travel (Mileage #):	
Assessment Type: Annual Review	Assessment Start Time:	Assessment Completion Time:	Assessor Name:	Assessment Method:	Face to Face
Assessment Completed In (Location):		Recipient Residence:			
Other Present Family Assessment:					
Name of Person Attending:	Relationship to Recipient:	Name of Person Attending:	Relationship to Recipient:		
John Smith	Spouse	Kevin Goddard	Legal rep (not fam)		
Fred Barnes	Friend	Tony Soprano	Friend		
Just Added:	Friend		- select -		
Section B: Recipient Identification					
Manual Assessment ID: 30109020-65673-159765	Medicaid ID: 000062198P				
Recipient Last Name: DREWRY	First Name: CONNIE	M:	B:		
Gender: Female	Date of Birth: 07/29/1916	Recipient Language:	Date of Last Physician/Practitioner Visit:		
Recipient Primary Physical Location Address:					
Street: 1315 B JASPER ST	City: CLINTON	State: NC	Zip: 28328-0000		
Street:	City:	State:	Zip:		
Alternate Contact:					
Relationship to Recipient:	Some Alternate Contact Live with Recipient?	Alternate Contact First Name:	Alternate Contact Telephone:		
Alternate Contact Last Name:					
Alternate Contact Address, if applicable:					
Street:	City:	State: NC	Zip:		

1 of 12



Accepting & Declining Referrals

3. Click on "Comments" to view overflow comments from IA document



QiRePort Home | Referrals | Reports

Referrals Referral for Acceptance Review

Referral Info

[Referrals for Review](#)

[Accepted \(last 60 days\)](#)

[Denials \(last 6 months\)](#)

Recipients w/ IA

[Search Recipient](#)

[Recipient Summary](#)

[Change of Status Request](#)

[Discharge](#)

[Provider Number Change](#)

Recipient w/o IA

[Change of Status Request](#)

[Discharge](#)

[Provider Number Change](#)

Maintenance

[Counties Served](#)

Print * = Required

Recipient Data			
Recipient Name	DREWRY,CONNIE	Medicaid ID	000062198P
Address 1	1224 Main Street	Address 2	213 FOREST TRAILING
City, State Zip	CLINTON,NC 283280000	County	SAMPSON
Phone	919-555-1212	DOB	7/23/1916
Gender	Female		

Requests for Independent Assessment			
Recipient Name	MD	Phone Number	Request Date
DREWRY,CONNIE	000062198P	919-555-1212	9/20/2010
			Request Type
			Annual Assessment

Independent Assessments on file for Recipient			
Assessment Date	Comments	Assessment Type	Hours
9/20/2010	[Comments]	Annual Review	28



Accepting & Declining Referrals

PDF of assessment comments will appear:

Assessment Comments for DREWRY, C - 20100920-65673-159765

Section N Comments
(none)

Section O Safety/Risks Comments
Threat to Patient Safety Comment
test
Home Safe to Provide PCS Comment
test2

Section P Comments
not too bad

Section Q EPSDT Comments
Caregiver Needs Comment
(none)
Location of Services Comment
(none)
Day Care Comment
(none)
Patient Amelioration Comment



Accepting & Declining Referrals

4. Click on drop-down arrow in “Referral Decision” box & make a selection of Accepted or Denied.

QiRePort

Home | Referrals | Reports

Referrals

Referral Info
[Referrals for Review](#)
[Accepted \(last 60 days\)](#)
[Denials \(last 6 months\)](#)

Recipients w/ IA
[Search Recipient](#)
[Recipient Summary](#)
[Change of Status Request](#)
[Discharge](#)
[Provider Number Change](#)

Recipient w/o IA
[Change of Status Request](#)
[Reschedule](#)
[Provider Number Change](#)

Maintenance
[Outlines Served](#)

Referral for Acceptance Review

Recipient Data

Recipient Name	DREWRY, CORNIE	Medicaid ID	00002198P
Address 1	1224 Main Street	Address 2	213 FOREST TRAIL JMS
City, State Zip	CLINTON, NC 281200000	County	SAMPSON
Phone	919-555-1212	DOB	7/23/1916
Gender	Female		

Request for Independent Assessment

Recipient Name	MOI	Phone Number	Request Date	Request Type
DREWRY, CORNIE	00002198P	919-555-1212	9/29/2010	Annual Assessment

Independent Assessments on the Ref Recipient

Assessment Date	Comments	Assessment Type	Hours
9/29/2010	[Comments]	Annual Review	28

Referral Decision *

Comment

Save

Make a selection



Accepting & Declining Referrals



5. Click “Save” to submit (once the save button turns gray, the system has accepted your decision). Do not try to navigate away from the page until the save button turns gray.

Independent Assessments on file for Recipient			
Assessment Date	Comments	Assessment Type	Hours
9/20/2010	[comments]	Annual Review	28

Referral Decision *	Accepted
Comment	

← Click “Save”



Q: How do I view CCME letters for my clients?



Viewing Records for Current Clients



A: You can only view records for your current clients who have had an IA completed.

1. Click on "Accepted (last 60 days)". The "Referrals Ready to Review" screen will open.

QiRePort Home | Referrals | Reports

Referrals

Referral Info
[Referrals for Review](#)
[Accepted \(last 60 days\)](#) ←
[Denials \(last 6 months\)](#)

Recipients w/ IA
[Search Recipient](#)
[Recipient Summary](#)
[Change of Status Request](#)
[Discharge](#)
[Provider Number Change](#)

Recipients w/o IA
[Change of Status Request](#)
[Discharge](#)
[Provider Number Change](#)

Maintenance
[Counties Served](#)

Name	MID	Request Type	Assmt / Request Date	Provider No.	Referral Letter	Hours
LEESY, BETTY	000012345L	Change of Provider	8/11/2010	4408912	[letter]	80
POPE, BARBARA	000051689M	New Request	4/27/2010	4409516	[letter]	28

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Viewing Records for Current Clients



2. Click on "letter" next to beneficiary's name to view Referral Letter or Notice of Decision Letter of current clients.

QiRePort Home | Referrals

Referrals

Referrals Accepted/Reviewed Last 60 Days

Name	MID	Assmt Date	Request Type	Effective Date	Provider No.	Notification Letter	Recipient Notice	Hours
Way, Ernest		9/17/2012	ACH Transition	1/1/2013	7806232	N/A	[letter]	80
Hurston, Nellie		1/1/2013	Apparel Resolution	1/1/2013	7806232	[letter]	[letter]	80

Letters

Licensed Residential Facility (LRF)

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NOTICE OF DECISION ON A CONTINUING REQUEST FOR MEDICAID SERVICES

(See original for notice date)

LARRY EVANS
WALDEN ASSISTED LIVING
2345 PEACEFUL WAY
RALEIGH, NC 27610

WALDEN ASSISTED LIVING
2345 PEACEFUL WAY
RALEIGH, NC 27610

RE: LARRY EVANS
MID: 999999999T
Service Requested: Personal Care Services

Dear LARRY EVANS:

As required by the N.C. Session Law 2012-142, Sections 10.9F (b) and 10.9F (c); North Carolina State Plan for Medical Assistance, and Division of Medical Assistance (DMA) Clinical Coverage Policy 3L, all Medicaid beneficiaries receiving Personal Care Services (PCS) must receive an independent assessment by a registered nurse affiliated with DMA or the Independent Assessment Entity (IAE) designated by DMA. The Carolinas Center for Medical Excellence (CCME) is the IAE designated by DMA to conduct independent assessments.

CCME completed an assessment on January 21, 2013. After reviewing the assessment results, Medicaid approved 80 hours of PCS per month until the earlier of January 21, 2014 or the next assessment completed by DMA or the IAE designated by DMA. This is an increase to the service hours your currently receive.

The above named provider agency was selected by you and will be providing these services. This approval of services is effective 10 days from the date this notice was mailed.

Your approved service level is based on your assessed self-performance levels and days of unmet need for assistance with the five qualifying Activities of Daily Living (ADLs). Your assessed self-performance levels and days of unmet need for assistance with the five qualifying ADLs are as follows:

Si necesitas ayuda para leer y entender la carta, por favor contáctese con al 1-800-642-7330. DICA AL OPERADOR QUE LA NOTIFICACION DMA 3504-CPCS-Continuing.
DMA 3504-CPCS-Continuing-HC
12/21/2012



Viewing Records for Current Clients

Mr. Evans' notice of decision (page 1)

Licensed Residential Facility (LRF)

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LARRY EVANS
99999999T
:

ADL	Self-Performance Level	Days of Unmet Need per Week
Barthng	Can do with extensive hands-on assistance	3
Dressing	Can do with limited hands-on assistance	7
Mobility	Can do with extensive hands-on assistance	7
Toileting	Can do with limited hands-on assistance	7
Eating	Can do with limited hands-on assistance	7

The above named provider was selected by you and will be providing these services. If you wish to select a different provider, please contact CCME at 1-800-228-3365.

Sincerely,
Independent Assessment Department
The Carolinas Center for Medical Excellence
1-800-228-3365
C: Provide



Viewing Records for Current Clients

Mr. Evans' notice of decision (page 2)

Providers are encouraged to print and save a copy of letters in the beneficiary's medical records as the letters will not be accessible in QiRePort after 60 days.

Licensed Residential Facility (LRF)

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Q: How do I submit a change of status?

97

Submitting a Change of Status (COS)



1. Click on "Search Recipients" tab

The screenshot shows the QiRePort web application. At the top, there is a navigation bar with 'Home | Refe'. Below this is a green header for the 'Referrals' section. On the left, there is a sidebar menu with various options: 'Referral Info', 'Referrals for Review', 'Accepted (last 60 days)', 'Denials (last 6 months)', 'Recipients w/ IA', 'Search Recipients', 'Recipient Summary', 'Change of Status Request', 'Discharge', 'Provider Number Change', 'Recipients w/o IA', 'Change of Status Request', 'Discharge', 'Provider Number Change', 'Maintenance', and 'Countries Served'. A yellow arrow points to the 'Search Recipients' option. In the main content area, there is a 'Recipient List' section with a search form. The form includes a legend: '* = Required', 'Last Name (partial)', 'First Name (partial)', and 'Medical Id'. The search fields contain 'A' for Last Name, 'DORA' for First Name, and an empty field for Medical Id. A 'Search' button is located below the fields. In the bottom right corner, there is a circular logo with 'HCA 98'.

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. On the left is a navigation menu with options like 'Referrals for Review', 'Accepted (last 60 days)', 'Denials (last 6 months)', 'Recipients w/ IA', 'Search Recipients', 'Recipient Summary', 'Change of Status Request', 'Discharge', 'Provider Number Change', 'Recipients w/o IA', 'Change of Status Request', 'Discharge', 'Provider Number Change', 'Maintenance', and 'Counties Served'. The main area is titled 'Referrals' and contains a 'Recipient List' table. A yellow arrow points to the name 'ALLEN, DORA' in the first row of the table.

Name	MID	Date of Birth	Phone	Last Action	Provider No.
ALLEN, DORA	987654321N	04/21/1939	919-555-1212	10/10/2012	6600738

Submitting a Change of Status (COS)

3. The "Recipient Summary" will appear for the selected beneficiary.



The screenshot shows the QiRePort interface with the 'Recipient Summary' page for the selected beneficiary. A red circle highlights a question mark icon in the navigation menu. The main area displays detailed information for 'ALLEN, DORA'.

Recipient Data	
Recipient Name	ALLEN, DORA
Address 1	123 ALLEN DRIVE
City, State Zip	WENDELL, NC 27591
Phone	919-555-1212
Gender	Female
Medicaid ID	987654321N
Address 2	
County	DURHAM
DOB	04/21/1939
Status	OK

Requests for Independent Assessment				
Recipient Name	MID	Phone Number	Request Date	Request Type
Independent Assessments on file for Recipient				
Assessment Date	Comments	Assessment Type	Hours	
10/10/2012	[Comments]	Annual Review	56	
11/12/2010	[Comments]	Annual Review	0	
10/27/2011	[Comments]	Annual Review	47	

Submitting a Change of Status (COS)

The screenshot shows the QiRePort Referrals interface. A help window titled 'Change of Status Request' is open, providing instructions on how to submit a request. The background shows a list of requests for ALLEN, DORA.

Change of Status Request

Click on this option if you need to send the independent assessment entity (CCME) a change of status request for assessment.

If there have been any prior change of status requests for the same recipient, they will appear in a list. You can click on any listed request and see the request. Otherwise, click on the Add button.

Use this option ONLY for recipients with an independent assessment already completed. If you have not already "looked up" a recipient, click the "Search Recipients" selection and enter a name (or partial name), or MID to find the recipient you are looking for.

If you have already selected a recipient, selecting this option will display a listing of Change of Status requests for this recipient. You may select an existing request to review, or click the Add button to create a new Change of Status request for this recipient.

Requests for ALLEN, DORA

Request ID	Complete Date	Disposition
1		

Submitting a Change of Status (COS)

4. Complete the fields on the "PCS Services Request – Change of Status page.

The screenshot shows the 'PCS Services Request - Change of Status' page in QiRePort. It displays recipient information and request details for ALLEN, DORA.

PCS Services Request - Change of Status

* = Required

Independent Assessments on file for Recipient

Assessment Date	Comments	Assessment Type	Hours
10/10/2012	[comments]	Annual Review	56

Recipient Data

Recipient Name	ALLEN, DORA	Medical ID	987654321N
Address 1	123 ALLEN DRIVE	Address 2	
City, State Zip	WENDELL, NC 27591	County	DURHAM
Phone	919-555-1212	DOB	04/21/1999
Gender	Female	Status	

Request / Recipient Information

Request Date * Recipient Language

Phone NO Phone

Alternate Contact / Parent / Guardian (Required if Recipient under 18 or NO Phone)

First Name Last Name

Relationship Alt. Phone

Recipient Medical History

Diagnoses Information

QiRePort Resources



QiRePort Home | Referrals

Home Welcome Jack

Home
Logout
Personal
Preferences
Information
Learn More
Frequently Asked Questions
Getting Started
Policy Guidelines

Announcements

- 9/13/2010** - Reminder to Providers: Medicaid recipients who receive notification of reduction or denial of PCS hours are entitled to an appeal. During the appeal process, recipients are entitled to maintenance of service at the previously authorized service level. For example, a recipient was receiving 40 hours per month of PCS services. An Independent Assessment is completed that results in a reduction of service to 20 hours per month. The recipient then appeals this decision within the appeal deadline (30 days). The recipient is entitled to "maintenance of service" effective the date the appeal is filed, and he or she may then resume receiving 40 hours per month of PCS until the appeal is resolved, either by mediation or formal hearing. (Note that if the appeal is filed by the notice effective date - within 10 days of the notice, services will continue without interruption). Please allow 10 days for processing of the appeal notices before billing claims at the previous authorized service level.
- 9/13/2010** - Please advise your clients that CCME independent assessment nurses will be wearing a photo ID badge and will present a business card upon their arrival at the home.
- 9/9/2010** - When completing the "QiReport Provider Registration Form", please be sure to enter the PCS provider number for the agency, NOT the home health provider number. Agency Medicaid provider numbers used for PCS billing (and required to complete the registration form) have the prefix, 660-. If you have submitted a registration form with incorrect PCS provider numbers, this form cannot be processed. Please re-submit the registration form with corrected numbers to CCME as soon as possible.
- 9/1/2010** - Beginning September 1, 2010, providers can register as users of QiRePort. We encourage early registration. You will have access to the provider interface of QiRePort on October 4, 2010. During September, look for additional information on agency use of QiRePort. Also, consider attending one of the scheduled CCME training sessions in September that will cover

Give us your Feedback!
Have a Comment, Problem or a Suggestion? Tell us.
[Text Input Field]
[Send]

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Websites and Online Resources



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CCME Personal Care Services Website

The Personal Care Services (PCS) webpage on the CCME Website has been updated to reflect the January 1, 2013 transition.

www.thecarolinascenter.org/PCS

DMA, Consolidated PCS Webpage:
www.ncdhhs.gov/dma/pcs/pas.html



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[News Room](#) | [Events](#) | [Careers](#) | [Login/Registration](#)

Who We Are Who We Serve What We Do My CCME

Search:

Home > What We Do > State Programs Management > Personal Care Services

Font Size:

Home Care Agencies

- [Licensed Residential Facilities](#)
- [PCS FAQs](#)
- [PCS Trainings](#)
- [PCS Forms](#)
- [PCS Important Links](#)

Personal Care Services (PCS)

The North Carolina Division of Medical Assistance (DMA) has contracted with The Carolinas Center for Medical Excellence (CCME) to conduct Independent Assessments for Personal Care Services (PCS) for Medicaid recipients in North Carolina. Medicaid PCS for recipients in all settings – including private residences and licensed adult care homes (ACH), family care homes, 5600a and 5600c supervised living homes, and combination homes with ACH beds – will be provided under a consolidated Clinical Coverage Policy 3L, PCS benefit.

Quick Links

- [PCS Webinar Registration](#)
- [HCA Announcements](#)
- [LRF Announcements](#)

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[Accessibility](#) | [Plug-In Downloads](#)



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[News Room](#) | [Events](#) | [Careers](#) | [Login/Registration](#)

Who We Are
Who We Serve
What We Do
My CCME

Home > What We Do > State Programs Management > Personal Care Services > Home Care Agencies
Font Size A A A

[HCA Announcements](#)

[HCA FAQs](#)

[HCA Forms](#)

[HCA Important Links](#)

[HCA Archived Announcements](#)

Home Care Agencies (HCA)

Announcements

1/4/2013 - Personal Care Services (PCS) Webinar
 Personal Care Services (PCS) Webinar for Licensed Home Care Providers and Licensed Adult Care Home Providers is scheduled for Thursday, January 10, 2013. For more information and to register visit the [PCS Webinar section](#).

[< Previous](#) [Next >](#)

Home Care Agencies (HCA) cover the services of a paraprofessional aide in the recipient's residence to assist with the recipient's unmet need for personal care. Personal care for unmet need focuses on hands-on assistance for qualifying activities of daily living that are directly linked to a medical condition, disability, or cognitive impairment. The services do not include skilled medical or skilled nursing care. More information on HCA, please refer to the [North Carolina Division of Medical Assistance webpage](#).

Quick Links

- [• PCS FAQs](#)
- [• PCS Trainings](#)
- [• PCS Forms](#)
- [• PCS Important Links](#)

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[News Room](#) | [Events](#) | [Careers](#) | [Login/Registration](#)

Who We Are
Who We Serve
What We Do
My CCME

... > What We Do > State Programs Management > Personal Care Services > Licensed Residential Facilities
Font Size A A A

[LRF Announcements](#)

[LRF FAQs](#)

[LRF Forms](#)

[LRF Important Links](#)

[LRF Archived Announcements](#)

Licensed Residential Facilities (LRF)

Announcements

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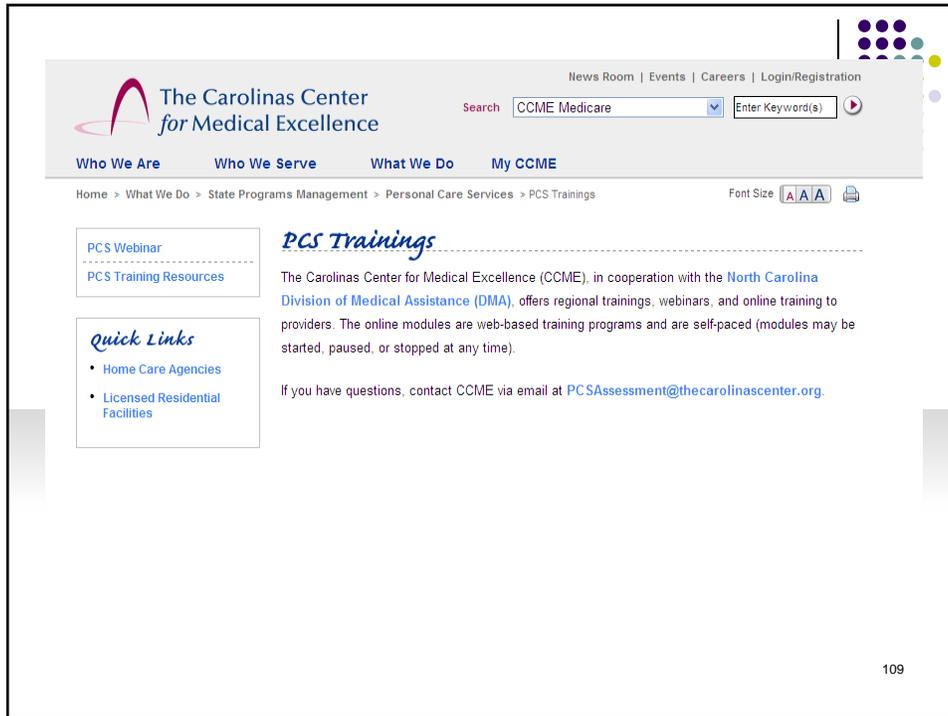
[< Previous](#) [Next >](#)

Licensed Residential Facilities (LRF) provide room and board and 24-hour supervision and services for people needing assistance with activities of daily living (ADLs) and some health care needs due to normal aging, a chronic illness, a cognitive disorder, or a disability. LRFs bridge the gap between independent living and nursing facility care that provides medical and nursing care in addition to help with ADLs. The LRF is not a substitute for the nursing facility, but rather another level of care appropriate for those who cannot live by themselves and need assistance with bathing, dressing, ambulation, eating, toileting, and/or medication administration.

Quick Links

- [• PCS FAQs](#)
- [• PCS Trainings](#)
- [• PCS Forms](#)
- [• PCS Important Links](#)

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The screenshot shows the website for The Carolinas Center for Medical Excellence. The header includes the logo and navigation links: News Room | Events | Careers | Login/Registration. A search bar contains "CCME Medicare". Below the header are navigation tabs: Who We Are, Who We Serve, What We Do, and My CCME. A breadcrumb trail reads: Home > What We Do > State Programs Management > Personal Care Services > PCS Trainings. The main content area is titled "PCS Trainings" and includes a paragraph about the center's cooperation with the North Carolina Division of Medical Assistance (DMA) to offer regional trainings, webinars, and online training. A "Quick Links" sidebar lists "Home Care Agencies" and "Licensed Residential Facilities". A footer number "109" is visible.

The Carolinas Center for Medical Excellence

News Room | Events | Careers | Login/Registration

Search CCME Medicare Enter Keyword(s)

Who We Are Who We Serve What We Do My CCME

Home > What We Do > State Programs Management > Personal Care Services > PCS Trainings

Font Size A A A

PCS Webinar
PCS Training Resources

PCS Trainings

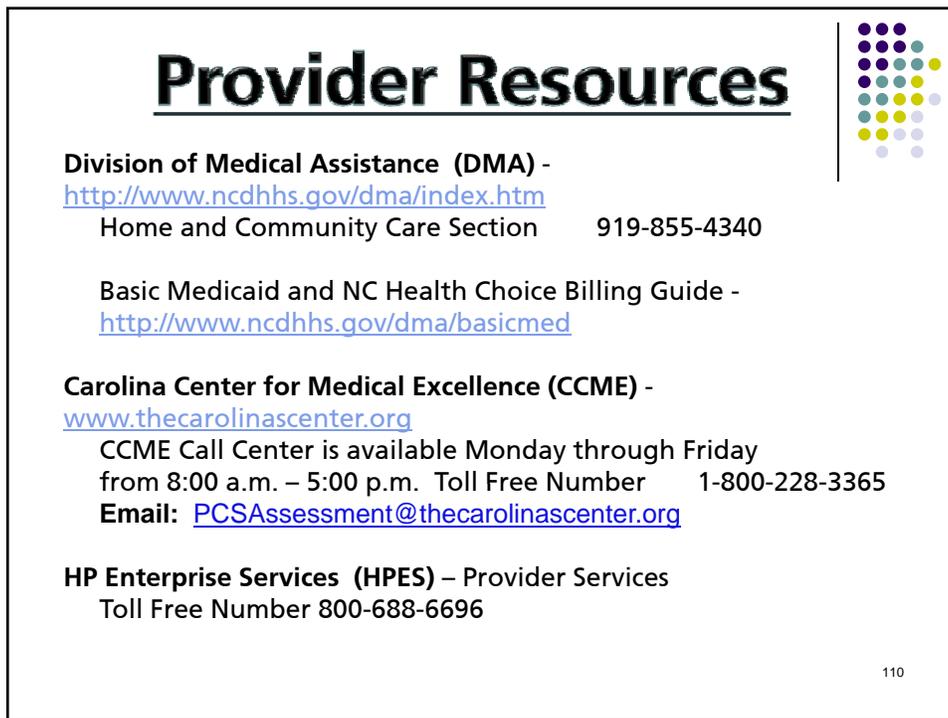
The Carolinas Center for Medical Excellence (CCME), in cooperation with the [North Carolina Division of Medical Assistance \(DMA\)](#), offers regional trainings, webinars, and online training to providers. The online modules are web-based training programs and are self-paced (modules may be started, paused, or stopped at any time).

If you have questions, contact CCME via email at PCSAssessment@thecarolinascenter.org.

Quick Links

- [Home Care Agencies](#)
- [Licensed Residential Facilities](#)

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The screenshot shows a page titled "Provider Resources" with a decorative dot pattern on the right. The content lists resources for the Division of Medical Assistance (DMA) and the Carolina Center for Medical Excellence (CCME). The DMA section includes a URL and phone number for the Home and Community Care Section. The CCME section includes a URL, call center hours, toll-free number, and email address. The HP Enterprise Services (HPES) section includes a toll-free number for provider services. A footer number "110" is visible.

Provider Resources

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

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