April 12, 2023

2023 Provider Training

Personal Care Services

Presented by: Liberty Healthcare of North Carolina

Liberty Healthcare Corporation
THE FREEDOM TO SUCCEED™

Agenda

- Introductions
- Managed Care Disenrollment
- Overview of Compliance and Integrity
- Questions and Answers
- Training Feedback

Presenters

- Jeremy Owen, Director of Operations, Liberty Healthcare of North Carolina

- Barbara Awad, Team Lead Nurse Consultant, Division of Health Benefits OCPI Provider Investigations Unit

Personal Care Services Provider Training

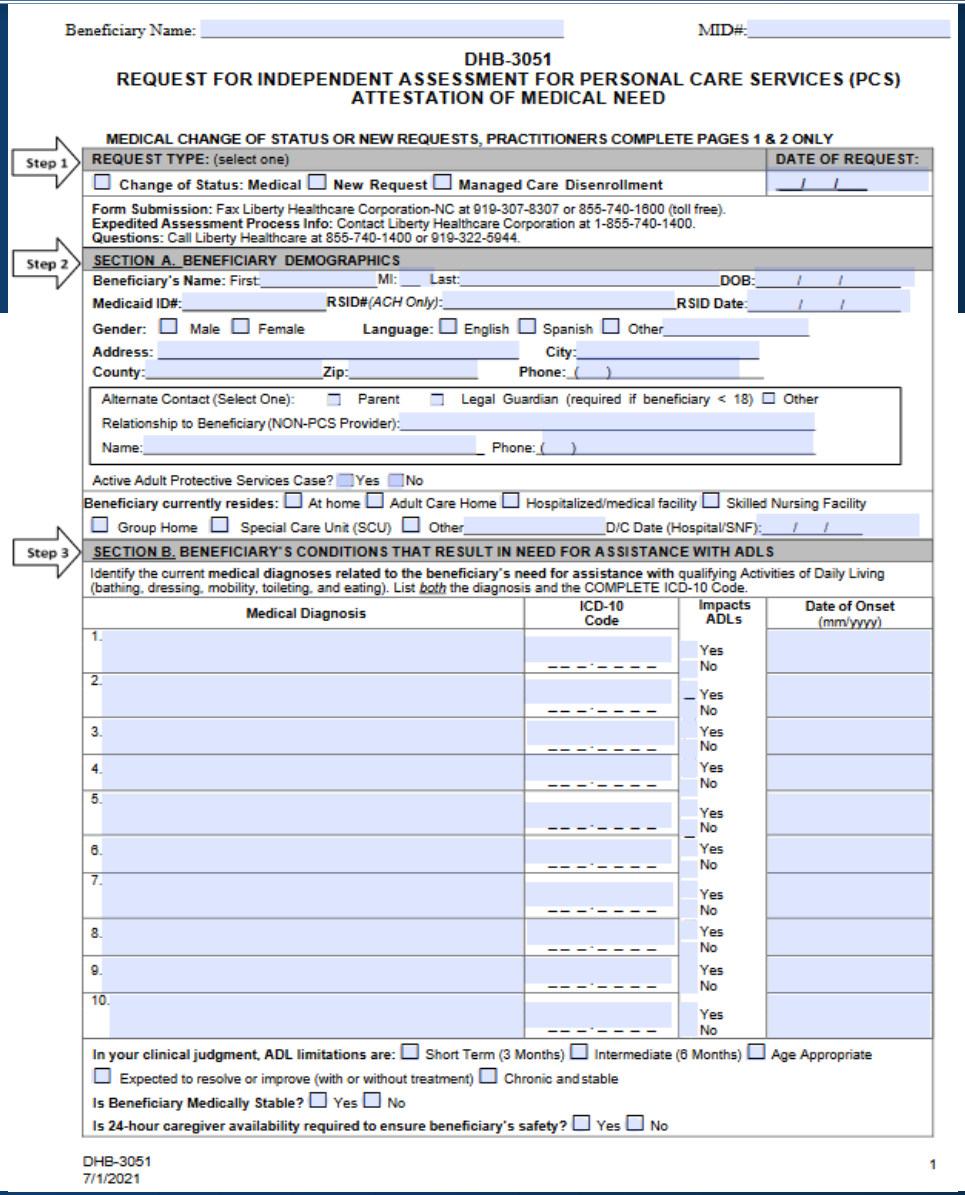
The goal of this training is to provide information regarding:

- Managed Care Disenrollment
- Compliance and Program Integrity

DHB-3051 Form

DHB-3051 Request for Independent Assessment for Personal Care Services (PCS) Attestation of Medical Need

- All PCS providers, regardless of setting, use the DHB-3051 form.
- DHB-3051 is the only form that allows physicians to provide written attestation to the medical necessity for up to 50 additional PCS hours per NC Session Law 2013-306.
- Download the current form (Effective 7/1/2021) at:
  - https://nc-pcs.com/Medicaid-PCS-forms/



Beneficiary Name: _____ MID#: _____

DHB-3051
REQUEST FOR INDEPENDENT ASSESSMENT FOR PERSONAL CARE SERVICES (PCS)
ATTESTATION OF MEDICAL NEED

MEDICAL CHANGE OF STATUS OR NEW REQUESTS, PRACTITIONERS COMPLETE PAGES 1 & 2 ONLY

Step 1

REQUEST TYPE: (select one) | **DATE OF REQUEST:**

☐ Change of Status: Medical ☐ New Request ☐ Managed Care Disenrollment

Form Submission: Fax Liberty Healthcare Corporation-NC at 919-307-8307 or 855-740-1600 (toll free).
Expedited Assessment Process Info: Contact Liberty Healthcare Corporation at 1-855-740-1400.
Questions: Call Liberty Healthcare at 855-740-1400 or 919-322-5944.

Step 2

SECTION A. BENEFICIARY DEMOGRAPHICS

Beneficiary's Name: First: _____ MI: ___ Last: _____ DOB: ___/___/_____
Medicaid ID#: _____ **RSID#***(ACH Only)*: _____ **RSID Date:** ___/___/_____
Gender: ☐ Male ☐ Female **Language:** ☐ English ☐ Spanish ☐ Other _____
Address: _____ **City:** _____
County: _____ **Zip:** _____ **Phone:** (___) _____

Alternate Contact (Select One): ☐ Parent ☐ Legal Guardian (required if beneficiary < 18) ☐ Other
Relationship to Beneficiary (NON-PCS Provider): _____
Name: _____ Phone: (___) _____

Active Adult Protective Services Case? ☐ Yes ☐ No

Beneficiary currently resides: ☐ At home ☐ Adult Care Home ☐ Hospitalized/medical facility ☐ Skilled Nursing Facility
☐ Group Home ☐ Special Care Unit (SCU) ☐ Other _____ D/C Date (Hospital/SNF): ___/___/_____

Step 3

SECTION B. BENEFICIARY'S CONDITIONS THAT RESULT IN NEED FOR ASSISTANCE WITH ADLS

Identify the current **medical diagnoses related to the beneficiary's need for assistance with** qualifying Activities of Daily Living (bathing, dressing, mobility, toileting, and eating). List *both* the diagnosis and the COMPLETE ICD-10 Code.

	Medical Diagnosis	ICD-10 Code	Impacts ADLs	Date of Onset (mm/yyyy)
1.			Yes No	
2.			Yes No	
3.			Yes No	
4.			Yes No	
5.			Yes No	
6.			Yes No	
7.			Yes No	
8.			Yes No	
9.			Yes No	
10.			Yes No	

In your clinical judgment, ADL limitations are: ☐ Short Term (3 Months) ☐ Intermediate (6 Months) ☐ Age Appropriate
☐ Expected to resolve or improve (with or without treatment) ☐ Chronic and stable
Is Beneficiary Medically Stable? ☐ Yes ☐ No
Is 24-hour caregiver availability required to ensure beneficiary's safety? ☐ Yes ☐ No

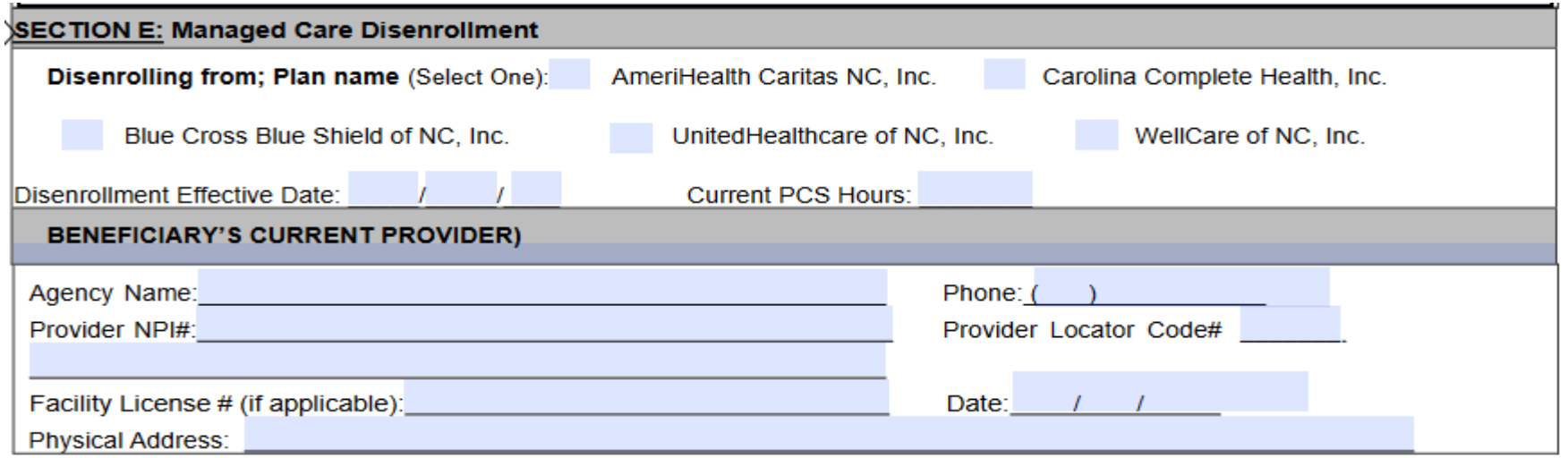
DHB-3051
7/1/2021
1

Completing PCS DHB-3051 Managed Care Disenrollment

Complete The Following Sections for Managed Care Disenrollment Requests:

Section A	• Beneficiary Demographics
Section B	• Beneficiary's Conditions That Result in Need for Assistance with ADLs
Section C	• Practitioner Information
Section E	• Managed Care Disenrollment

Completing PCS DHB-3051 Managed Care Disenrollment



SECTION E: Managed Care Disenrollment

Disenrolling from; Plan name (Select One): AmeriHealth Caritas NC, Inc. Carolina Complete Health, Inc.

Blue Cross Blue Shield of NC, Inc. UnitedHealthcare of NC, Inc. WellCare of NC, Inc.

Disenrollment Effective Date: / / Current PCS Hours:

BENEFICIARY'S CURRENT PROVIDER)

Agency Name: Phone: ( )

Provider NPI#: Provider Locator Code#

Facility License # (if applicable): Date: / /

Physical Address:

SECTION E: Managed Care Disenrollment was added to the DHB 3051 effective 7/1/2021 and should be completed if a beneficiary is disenrolling from Medicaid Managed Care and wishes to continue with PCS as a participant of Medicaid Direct.

Completing PCS DHB-3051 Manage Care Disenrollment

When completing the Managed Care Disenrollment section be sure to indicate:

1. Managed Care Plan name the beneficiary is disenrolling from.
2. Disenrollment effective date.
3. Current PCS hours being received from the Managed Care Plan.
4. Beneficiary's Current PCS Provider Agency's information.

Support

PCS Provider Resources

Resources:

- Clinical Coverage Policy 3L
- Provider Manual
- Trainings/Webinars
- Stakeholder and Focus Group Meetings

Websites:

- www.nc-pcs.com
- www.QiRePort.net
- https://medicaid.ncdhhs.gov
- https://www.nctracks.nc.gov

PERSONAL CARE SERVICES CONTACTS

NC Medicaid

Phone: 919-855-4360

Fax: 919-715-0102

Email PCS_Program_Questions@dhhs.nc.gov

Liberty Healthcare of NC

Request forms and general inquiries:

Liberty Healthcare Corporation-NC PCS Program
5540 Centerview Dr., Suite 114
Raleigh, NC 27606

Call Center: 919-322-5944 or 855-740-1400 (toll free)
Fax: 919-307-8307 or 855-740-1600 (toll free)
Email: NC-IAsupport@libertyhealth.com
Website: www.nc-pcs.com

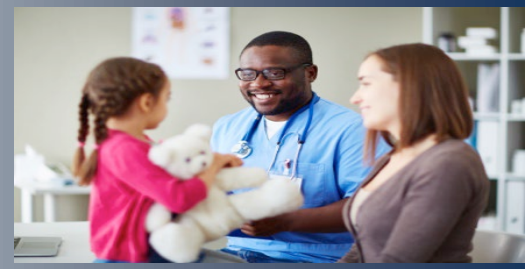
QiRePort Contact

For any additional questions regarding the use of QiRePort, please contact Viebridge at

888-705-0970.







NC Department of Health and Human Services

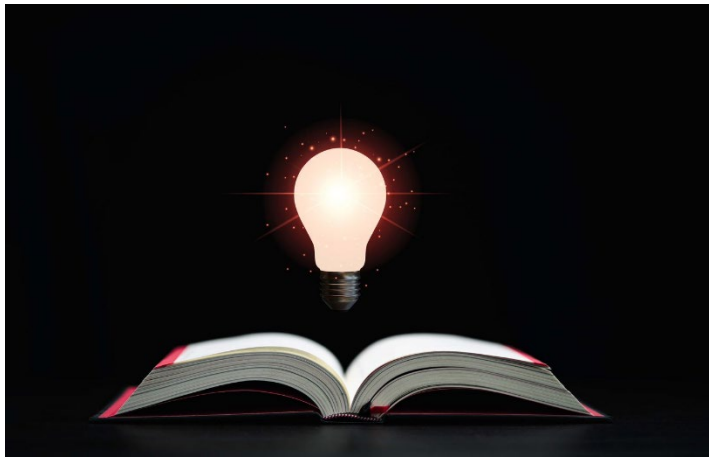
Overview of Compliance and Program Integrity

Barbara Awad, BSN RN
Investigations

April 12, 2023

Objectives

- Participant will be able to identify the appropriate clinical coverage Policy for PCS
- Participant will be able to define fraud
- Participant will be able to list four examples of fraud/abuse
- Participant will be able to list top five post-payment review errors
- Participant will be able to list top three prepayment review errors



Program Integrity Authority

- North Carolina General Statutes N.C.G.S. 108A and 108C
- North Carolina Administrative Code (NCAC)10A NCAC 22F
- 42 CFR § 455 & 456 (Program Integrity & Utilization Control)
- 42 CFR § 455 Subpart A (Medicaid Agency Fraud & Detection & Investigation Program)
- DHB Clinical Coverage Policies and Bulletin Articles

Resource

- Medicaid State Plan [Medicaid State Plan Public Notices | NC Medicaid]

- Medicaid State Plan Public Notices

  Title XIX of the Social Security Act requires that North Carolina provide a plan to administer and manage the North Carolina Medicaid Program. The North Carolina Medicaid State Plan outlines the organization and function of the Division of Health Benefits. It provides amount, scope and duration of services, as well as eligibility requirements.

Medicaid Office of Compliance and Program Integrity

- Federally mandated
- Protects the resources of Medicaid by reducing or eliminating fraud, waste and abuse through the NC Medicaid program (Medicaid Mission)
- Ensures North Carolina's Medicaid Program funds are used appropriately
- Protects the "integrity" of the NC Medicaid Program

OCPI Responsibilities

Include (but are not limited to)

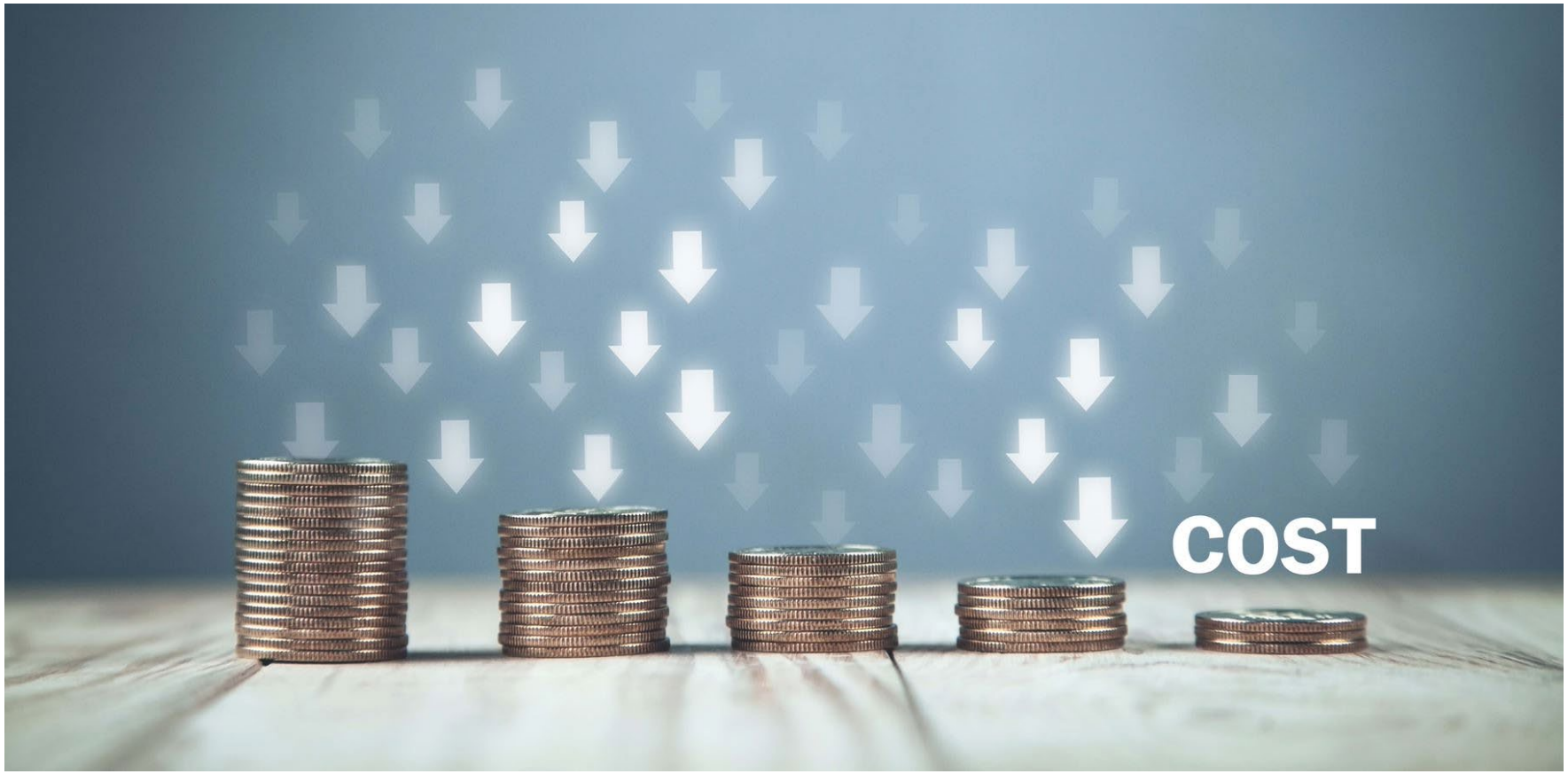
- Receiving complaints and referrals of possible provider or beneficiary fraud, waste or program abuse
- Detecting/identifying potential provider fraud, waste or program abuse
- Conducting investigations of suspected provider fraud, waste, program abuse or noncompliance

What is Fraud

Intentional deception or misrepresentation made by a person with the **knowledge** that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

What is Waste

Cost that could have been avoided without a negative impact on quality



Examples of Waste

Beneficiary has a small cut. The aide is qualified to perform a dry dressing change daily for five days. The aide takes out an entire box of gloves when five pairs of gloves would be sufficient for this to heal in five days.

What is Abuse

Provider abuse includes any incident, services or practices that are inconsistent with acceptable fiscal or medical practice and result in an unnecessary cost to Medicaid or its beneficiaries, or which are not reasonable or necessary.

Examples of Fraud/Abuse

- Provider who deliberately submit claims for services not actually rendered
- Provider submits claims for payment for which there is no supporting documentation available
- Billing for care and services that are provided by an unauthorized or unlicensed person

Public Concern

- An important mission of OCPI is to identify, investigate, prevent and recover money billed improperly to Medicaid.
- Fraud and abuse cost taxpayers millions of dollars each year. Whether you are a Medicaid provider, beneficiary or simply a taxpayer, fraud and abuse is costly to YOU.

Sources of Complaints

- Beneficiaries
- Family members
- General public
- Medicaid contractors
- Medicaid program consultants
- Providers
- Provider employees
- Former provider employees

Other Sources of Complaints

- Federal Agencies
  - Office of Inspector General (OIG)
  - Centers for Medicare and Medicaid Services (CMS)

- State Agencies

  Department of Health and Human Services (DHHS) Partners
  - Division of Health Service Regulation (DHSR)
  - Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS)

Other Sources of Complaints

Other State Agencies

- Office of Internal Auditor (OIA)
- Office of State Auditor (OSA)
- Department of Justice Medicaid Investigations Division (DOJ-MID)
- Department of Labor
- Department of Revenue
- Department of Social Services (DSS)

OCPI Vendors and Partners

- Post Payment Review Vendors
  - Provider Consulting Group (PCG)
  - Gainwell Technologies
- Review Audit Contractor (RAC)
  - Gainwell Technologies
- Prepayment Review Vendor
  - Carolinas Center for Medical Excellence (CCME)

OCPI Vendors and Partners

- **Data Analytics Vendor**

  IBM provides detailed analytics for OCPI

- **CMS Contractor**

  SafeGuard Services (SGS) / Peraton

- **Medicaid Business Units Contractors**

Types of Reviews

- Desktop Reviews
- On-site Review — Announced
- On-site Review — Unannounced

OCPI Desk Review

- Currently most common type of review is a Post Payment Review
- Provider is notified of review via written request for records by certified mail
- Timeframe and instructions for submission are included within the request
- Contact information is listed for provider questions
- The written request for records includes description of items requested and required for the review
- OCPI uses correspondence address listed in NCTracks
- Provider is required to keep their service and business addresses, as well as contact phone number, fax number and email up to date in NCTracks to avoid any unnecessary administrative action

Onsite Review Announced

Provider is given advance notification of an OCPI or Vendor Post Payment onsite visit via:

- Fax
- Letter
- Telephone call
- Or Email

(# days advance notice may vary per scope of review)

Onsite Review Unannounced

- OCPI or Post Payment Vendor arrives day of review to provider site (no prior fax, letter, phone call or email)
- Introductory discussion with provider management and staff
- Medical Records request is given to provider
- Provider furnishes or allows electronic access to OCPI/Vendor staff for beneficiary and employee files for date span of review and sample beneficiaries
- OCPI/Vendor Exit Discussion per Scope of Review
- OCPI goal is to be as minimally disruptive as possible

Categories of Review

For every date of service (DOS) being reviewed, each category below is addressed:

- Services Authorized/Approved in Accordance with Program Requirements.
- Documentation Supports Billed Codes/Modifiers/Claim Detail
- Licensing/Training/Credentialing Requirements Met.
- Required and/or Covered Components of Service Completed and Provided in accordance with Clinical Coverage Policy #3L.
- Documentation supports clinical appropriateness in accordance with clinical coverage policy requirements.

Top Five Post Postpayment Review Errors for SFY 2021 & 2022

1. Missing criminal background checks, Healthcare Personnel Registry checks.
2. HCPR missing. Aides have substantiated of abuse or neglect.
3. Billing errors which substantiate services not rendered, billing more service units than were provided to the client.
4. EVV — consistently see provider patterns of change to manual time entries, frequent editing.
5. Policy required trainings and skills validation by an RN.

Self Audits

Medicaid providers are encouraged to

- Implement necessary policies, processes and procedures to ensure compliance with federal and state laws, regulations and policies relating to the Medicaid programs
- Voluntarily disclose any overpayments or inappropriate payments of Medicaid and Managed Care funds
- Refer to link below to complete a provider Self Audit
  Office of Compliance & Program Integrity (OCPI) | NC Medicaid
  then scroll down to Self Audit, and click on Self Audit

Prepayment Review

Provider claims may be subject to prepayment review due to

- Credible allegation of fraud
- Identification of aberrant billing practices as a result of data analysis or investigations
- Other grounds identified by the Department

Prepayment Review Process

- Provider receives written notification from CCME
- Claims are temporarily pended in NCTracks
- Provider submits documentation to Medicaid contractor (CCME)
- Documentation is reviewed by CCME
- Provider must obtain 70% accuracy rate with no less than 50% of provider's average billing for three consecutive months

Top Three Prepayment Review Errors for PCS for All SFYs

1. Licensing & Credentialing not met (~50% not compliant)
    a. Aides not credentialed to appropriate level of care provided (either via NA1 or skills validation by the RN).
    b. Failure to conduct required background checks (HCPR & Criminal Records search) prior to assignment of care.
2. Services not rendered per policy requirements (~42% not compliant)
    a. Tasks performed do not align with treatment plan or the assessed needs of the recipient.
    b. Services not supervised within the policy timeframes.
3. Services not billed in accordance with policy (~30% not compliant)
    a. Overbilling of units of services provided/no documentation submitted to support billed services.

Most Common Error

Not following Medicaid Clinical Coverage Policy 3L

clinical coverage policies page

Community-Based Services

3L, State Plan Personal Care Services (PCS)

Tips for Providers

- Always check billing before it is submitted
- Ensure you have the documentation to support your billing
- Update NCTracks with any changes
- Do background checks; know the staff you are hiring
- Make sure your staff are trained

Tips for Providers

- Know your beneficiaries
- Maintain good record keeping
- When records are requested, send them
- Read and understand the Clinical Coverage Policy 3L, State Plan Personal Care Services (PCS)
- Ask questions

Reporting Fraud/Waste/Abuse

Office of Compliance & Program Integrity (OCPI) | NC Medicaid

Medicaid Fraud, Waste and Program Abuse Tipline 877-362-8471


QUESTION
ANSWER

Contact Information

Barbara Awad, BSN RN, CPC, LNC, CPIP

Team Lead Nurse Consultant Medicaid Direct

Office of Compliance and Program Integrity

NC Medicaid

NC Department of Health and Human Services

Office: 919-817-7647

Fax: 919-831-1808

Barbara.awad@dhhs.nc.gov

2501 Mail Service Center

Raleigh, NC 27699-2501

Questions and Answers

Liberty Healthcare Corporation

THE FREEDOM TO SUCCEED™

Thank you!