Transforming Lives.
Building Community Well-Being.

Trillium HEALTH RESOURCES

Personal Care Services

For Providers and Trillium Staff

ACCREDITED NCQA HEALTH PLAN

Glossary/Acronyms

- **ADL:** Activities of Daily Living
- **APS:** Adult Protective Services
- **CCH:** Carolina Complete Health
- **EVV:** Electronic Visit Verification
- **HHAX:** HHAeXchange
- **HHCS:** Home Health Care Services
- **ICD:** International Classification of Diseases
- LME: Local Management Entity

Glossary/Acronyms

- **NC LIFTSS:** NC Linking Individuals and Families to Long Term Services and Supports
- **NPA:** No Prior Authorization
- **PCP:** Primary Care Physician
- **PCS:** Personal Care Services
- **TCL:** Transition to Community Living

Learning Objectives

Determine how to locate the 3051 form.

Review tips for successfully completing the 3051 form.

Explain where to find assistance.

Describe Electronic Visit Verification's impact on Personal Care Services.

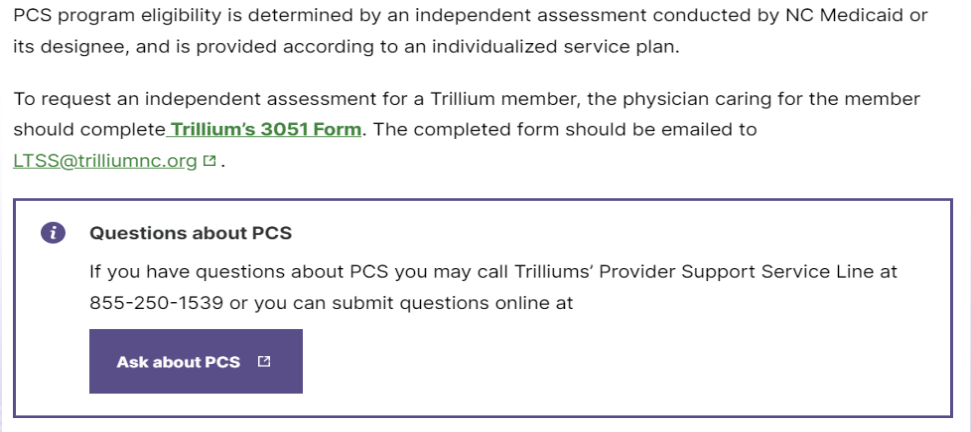
1 Locating the 3051 Form.

3051 Form

- Must be completed to request independent assessment conducted by North Carolina Medicaid or its designee
- Carolina Complete Health (CCH) completes form for Trillium Health Resources.

How to Locate the 3051 Form

- Link to Trillium's 3051 form on Personal Care Services (PCS) page on Trillium website
- Contact information for questions about PCS below form link



PCS program eligibility is determined by an independent assessment conducted by NC Medicaid or its designee, and is provided according to an individualized service plan.

To request an independent assessment for a Trillium member, the physician caring for the member should complete **Trillium's 3051 Form**. The completed form should be emailed to LTSS@trilliumnc.org.

Questions about PCS

If you have questions about PCS you may call Trilliums' Provider Support Service Line at 855-250-1539 or you can submit questions online at

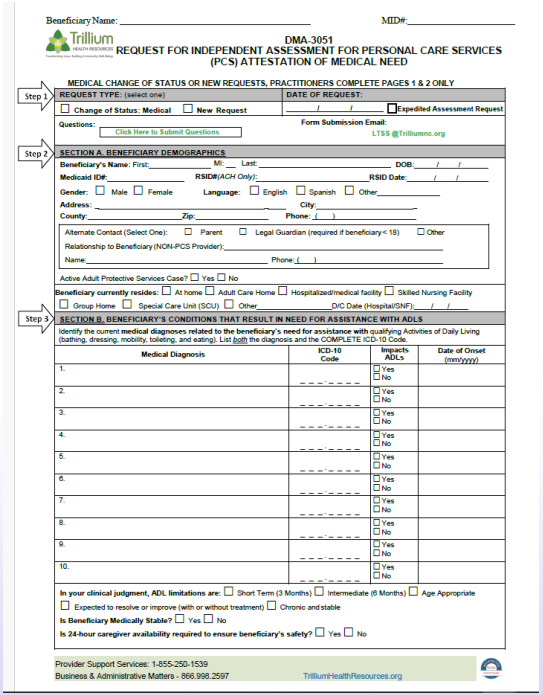
Ask about PCS

2 Tips for Successfully Completing the 3051 Form.

How to Request Independent Assessment

1. Physician caring for member should complete Trillium's 3051 Form
   - *Non-medical change of status or change of provider requests complete page three only.
2. Completed form emailed to LTSS@trilliumnc.org or just click "Submit".

3051 Request for Independent Assessment



Beneficiary Name: _____ MID#: _____

Trillium HEALTH RESOURCES

DMA-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	___/___/___ ☐ Expedited Assessment Request

Questions: Click Here to Submit Questions

Form Submission Email: LTSS @Trilliumnc.org

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

Provider Support Services: 1-855-250-1539
Business & Administrative Matters - 866.998.2597 TrilliumHealthResources.org

Request for Independent Assessment: Step 1 – Request Type

Step 1

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

REQUEST TYPE: (select one)	**DATE OF REQUEST:**
☐ **Change of Status: Medical** ☐ **New Request**	_____ / _____ / _____ ☐ **Expedited Assessment Request**
Questions: Click Here to Submit Questions	**Form Submission Email:** LTSS @Trilliumnc.org

Request for Independent Assessment: Step 2 - Section A Beneficiary Demographics

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): 02 / 02 / 2024

Request for Independent Assessment: Step 3 - Section B Beneficiary's Conditions

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.

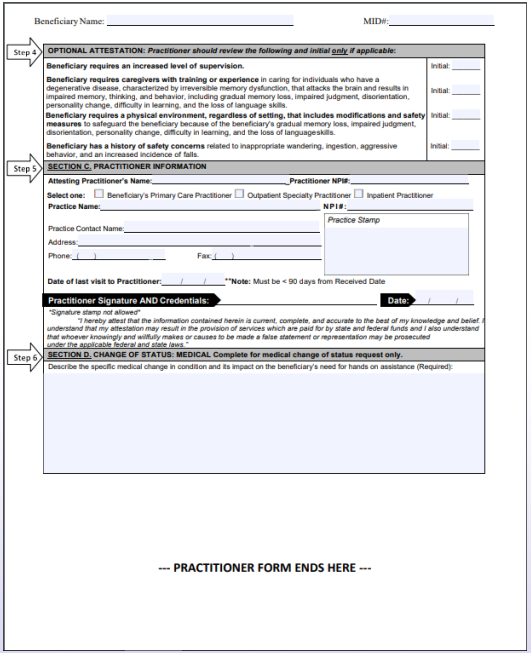
	Medical Diagnosis	ICD-10 Code	Impacts ADLs	Date of Onset (mm/yyyy)
1.		_ _ _._ _ _ _	☐ Yes ☐ No	
2.		_ _ _._ _ _ _	☐ Yes ☐ No	
3.		_ _ _._ _ _ _	☐ Yes ☐ No	
4.		_ _ _._ _ _ _	☐ Yes ☐ No	
5.		_ _ _._ _ _ _	☐ Yes ☐ No	
6.		_ _ _._ _ _ _	☐ Yes ☐ No	
7.		_ _ _._ _ _ _	☐ Yes ☐ No	
8.		_ _ _._ _ _ _	☐ Yes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

Request for Independent Assessment – Page 2



Beneficiary Name: _____ MID#: _____

Step 4

OPTIONAL ATTESTATION: ***Practitioner should review the following and initial only if applicable:***

Beneficiary requires an increased level of supervision. Initial: _____

Beneficiary requires caregivers with training or experience in caring for individuals who have a degenerative disease, characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills. Initial: _____

Beneficiary requires a physical environment, regardless of setting, that includes modifications and safety measures to safeguard the beneficiary because of the beneficiary's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of languageskills. Initial: _____

Beneficiary has a history of safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls. Initial: _____

Step 5

SECTION C: PRACTITIONER INFORMATION

Attesting Practitioner's Name: _____ **Practitioner NPI#:** _____

Select one: ☐ Beneficiary's Primary Care Practitioner ☐ Outpatient Specialty Practitioner ☐ Inpatient Practitioner

Practice Name: _____ **NPI#:** _____

Practice Contact Name: _____

Address: _____

Phone: (___) _____ Fax: (___) _____

Practice Stamp

Date of last visit to Practitioner: ___/___/___ ***Note:** Must be < 90 days from Received Date

Practitioner Signature AND Credentials: _____ **Date:** ___/___/___

"Signature stamp not allowed"

"I hereby attest that the information contained herein is current, complete, and accurate to the best of my knowledge and belief. I understand that my attestation may result in the provision of services which are paid for by state and federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement or representation may be prosecuted under the applicable federal and state laws."

Step 6

SECTION D: CHANGE OF STATUS: MEDICAL Complete for medical change of status request only.

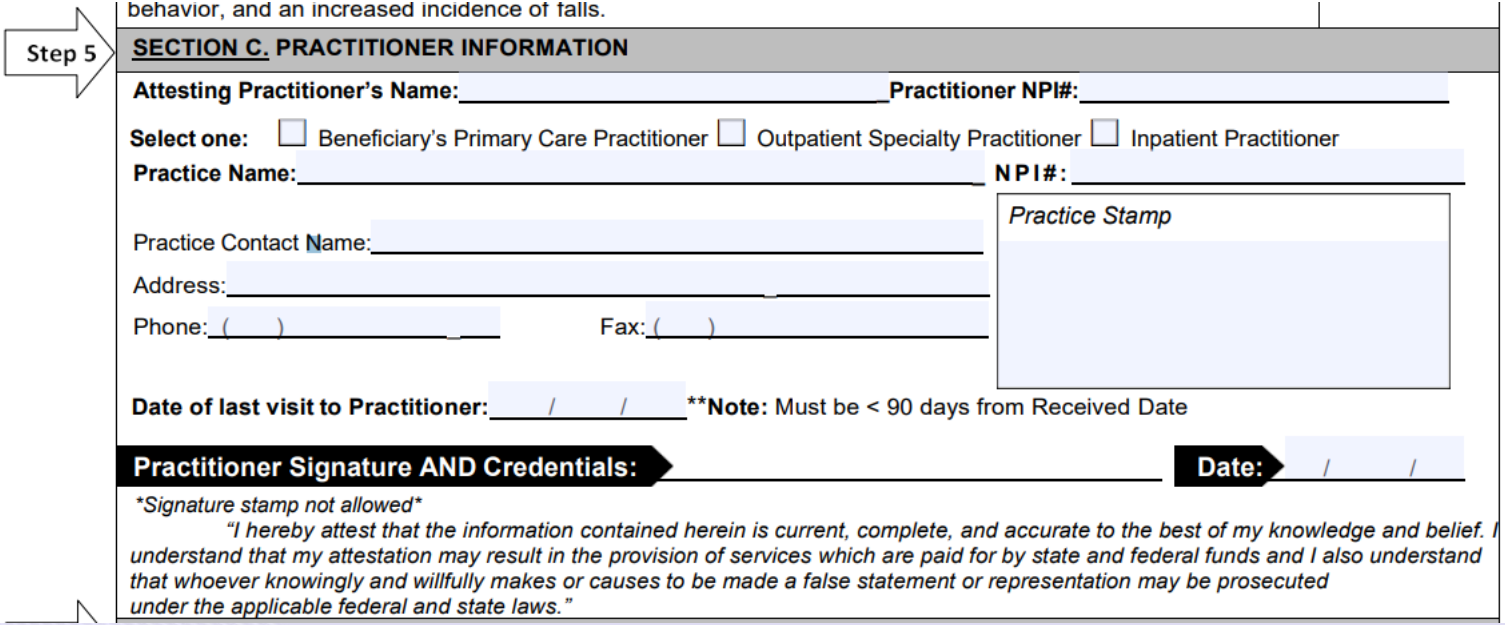
Describe the specific medical change in condition and its impact on the beneficiary's need for hands on assistance (Required):

--- PRACTITIONER FORM ENDS HERE ---

Request for Independent Assessment: Step 4 – Optional Attestation

Step 4	**OPTIONAL ATTESTATION:** ***Practitioner should review the following and initial only if applicable*:**	
	Beneficiary requires an increased level of supervision.	Initial: _____
	Beneficiary requires caregivers with training or experience in caring for individuals who have a degenerative disease, characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.	Initial: _____
	Beneficiary requires a physical environment, regardless of setting, that includes modifications and safety measures to safeguard the beneficiary because of the beneficiary's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.	Initial: _____
	Beneficiary has a history of safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.	Initial: _____

Request for Independent Assessment: Step 5 - Section C Practitioner Information



behavior, and an increased incidence of falls.

Step 5

SECTION C. PRACTITIONER INFORMATION

Attesting Practitioner's Name: _____ **Practitioner NPI#:** _____

Select one: ☐ Beneficiary's Primary Care Practitioner ☐ Outpatient Specialty Practitioner ☐ Inpatient Practitioner

Practice Name: _____ **NPI#:** _____

Practice Contact Name: _____

Address: _____

Phone: ( ) _____ Fax: ( ) _____

Practice Stamp

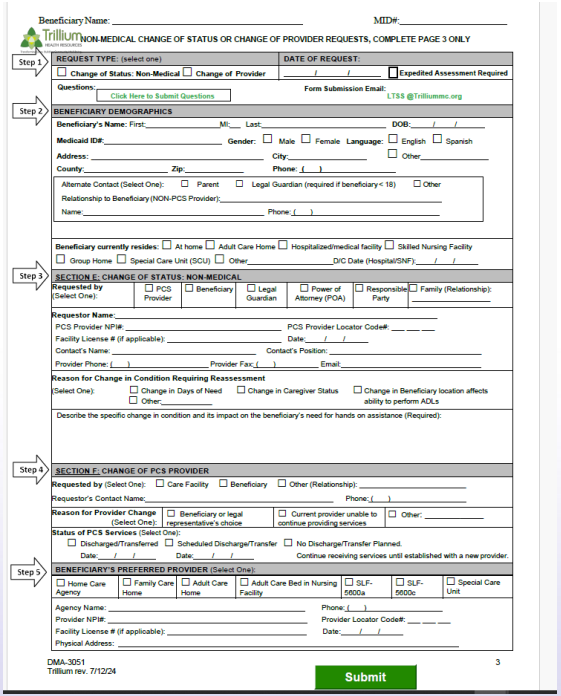
Date of last visit to Practitioner: ____/____/____ ****Note:** Must be < 90 days from Received Date

Practitioner Signature AND Credentials: _____ **Date:** ____/____/____

Signature stamp not allowed

"I hereby attest that the information contained herein is current, complete, and accurate to the best of my knowledge and belief. I understand that my attestation may result in the provision of services which are paid for by state and federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement or representation may be prosecuted under the applicable federal and state laws."

3051 Non-Medical Change of Status or Change of Provider Request



Beneficiary Name: _____ MID#: _____

Trillium — NON-MEDICAL CHANGE OF STATUS OR CHANGE OF PROVIDER REQUESTS, COMPLETE PAGE 3 ONLY

Step 1

REQUEST TYPE: (select one) ☐ Change of Status: Non-Medical ☐ Change of Provider

DATE OF REQUEST: ___/___/___ ☐ Expedited Assessment Required

Questions: Click Here to Submit Questions

Form Submission Email: LTSS @Trilliumme.org

Step 2

BENEFICIARY DEMOGRAPHICS

Beneficiary's Name: First:_____ MI:___ Last:_____ **DOB:**___/___/___

Medicaid ID#:_____ **Gender:** ☐ Male ☐ Female **Language:** ☐ English ☐ Spanish

Address: _____ **City:**_____ ☐ Other_____

County:_____ **Zip:**_____ **Phone:** (___)_____

Alternate Contact (Select One): ☐ Parent ☐ Legal Guardian (required if beneficiary < 18) ☐ Other

Relationship to Beneficiary (NON-PCS Provider):_____

Name:_____ Phone:(___)_____

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 E: CHANGE OF STATUS: NON-MEDICAL

Requested by (Select One):	☐ PCS Provider	☐ Beneficiary	☐ Legal Guardian	☐ Power of Attorney (POA)	☐ Responsible Party	☐ Family (Relationship):

Requestor Name:_____

PCS Provider NPI#: _____ PCS Provider Locator Code#: ___ ___ ___

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

Contact's Name: _____ Contact's Position: _____

Provider Phone: (___)_____ Provider Fax: (___)_____ Email:_____

Reason for Change in Condition Requiring Reassessment

(Select One): ☐ Change in Days of Need ☐ Change in Caregiver Status ☐ Change in Beneficiary location affects ability to perform ADLs ☐ Other:_____

Describe the specific change in condition and its impact on the beneficiary's need for hands on assistance (Required):

Step 4

SECTION F: CHANGE OF PCS PROVIDER

Requested by (Select One): ☐ Care Facility ☐ Beneficiary ☐ Other (Relationship): _____

Requestor's Contact Name:_____ Phone:(___)_____

Reason for Provider Change (Select One):	☐ Beneficiary or legal representative's choice	☐ Current provider unable to continue providing services	☐ Other: _____

Status of PCS Services (Select One):

☐ Discharged/Transferred Date:___/___/___ ☐ Scheduled Discharge/Transfer Date:___/___/___ ☐ No Discharge/Transfer Planned. Continue receiving services until established with a new provider.

Step 5

BENEFICIARY'S PREFERRED PROVIDER (Select One):

☐ Home Care Agency	☐ Family Care Home	☐ Adult Care Home	☐ Adult Care Bed in Nursing Facility	☐ SLF-5600a	☐ SLF-5600c	☐ Special Care Unit

Agency Name: _____ Phone: (___)_____

Provider NPI#: _____ Provider Locator Code#: ___ ___ ___

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

Physical Address: _____

DMA-3051
Trillium rev. 7/12/24

3

Submit

Non-Medical Change of Status/Change of Provider Request: Step 1 – Request Type

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Step 1

REQUEST TYPE: (select one)	DATE OF REQUEST:
☐ Change of Status: Non-Medical ☐ Change of Provider	___/___/___ ☐ Expedited Assessment Required
Questions: Click Here to Submit Questions	Form Submission Email: LTSS @Trilliummc.org

Non-Medical Change of Status/Change of Provider Request: Step 2 – Beneficiary Demographics

Click Here to Submit Questions LTSS @Trilliummc.org

Step 2

BENEFICIARY DEMOGRAPHICS

Beneficiary's Name: First:_____ MI:___ Last:_____ **DOB:**___/___/___

Medicaid ID#:_____ **Gender:** ☐ Male ☐ Female **Language:** ☐ English ☐ Spanish

Address: _____ **City:**_____ ☐ Other_____

County:_____ **Zip:**_____ **Phone:** (___)_____

Alternate Contact (Select One): ☐ Parent ☐ Legal Guardian (required if beneficiary < 18) ☐ Other

Relationship to Beneficiary (NON-PCS Provider):_____

Name:_____ Phone: (___)_____

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):___/___/___

Non-Medical Change of Status/Change of Provider Request: Step 3 – Section E Change of Status: Non-Medical

Step 3

☐ Group Home ☐ Special Care Unit (SCU) ☐ Other_____ D/C Date (Hospital/SNF):___/___/___

SECTION E: CHANGE OF STATUS: NON-MEDICAL

Requested by (Select One):	☐ PCS Provider	☐ Beneficiary	☐ Legal Guardian	☐ Power of Attorney (POA)	☐ Responsible Party	☐ Family (Relationship): _____

Requestor Name: _____

PCS Provider NPI#: _____ PCS Provider Locator Code#: ___ ___ ___

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

Contact's Name: _____ Contact's Position: _____

Provider Phone: (___) _____ Provider Fax: (___) _____ Email: _____

Reason for Change in Condition Requiring Reassessment

(Select One): ☐ Change in Days of Need ☐ Change in Caregiver Status ☐ Change in Beneficiary location affects ability to perform ADLs

☐ Other: _____

Describe the specific change in condition and its impact on the beneficiary's need for hands on assistance (Required):

Non-Medical Change of Status/Change of Provider Request: Step 4 – Section F Change of PCS Provider

Step 4

SECTION F: CHANGE OF PCS PROVIDER

Requested by (Select One): ☐ Care Facility ☐ Beneficiary ☐ Other (Relationship): _____

Requestor's Contact Name: _____ Phone: (___) _____

Reason for Provider Change (Select One):	☐ Beneficiary or legal representative's choice	☐ Current provider unable to continue providing services	☐ Other: _____

Status of PCS Services (Select One):

☐ Discharged/Transferred Date: ___/___/___

☐ Scheduled Discharge/Transfer Date: ___/___/___

☐ No Discharge/Transfer Planned. Continue receiving services until established with a new provider.

Non-Medical Change of Status/Change of Provider Request: Step 5 – Beneficiary's Preferred Provider

Step 5

Date: ____/____/____ Date: ____/____/____ Continue receiving services until established with a new provider.

BENEFICIARY'S PREFERRED PROVIDER (Select One):

☐ Home Care Agency	☐ Family Care Home	☐ Adult Care Home	☐ Adult Care Bed in Nursing Facility	☐ SLF-5600a	☐ SLF-5600c	☐ Special Care Unit

Agency Name: _____ Phone: (___) _____

Provider NPI#: _____ Provider Locator Code#: ___ ___ ___

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

Physical Address: _____

3 Where to Find Assistance.

Where to Find Assistance

- Visit Trillium's Benefit Plans/Service Definitions page and look for Personal Care Services (PCS)
- Call Trillium's Provider Support Service Line Monday through Saturday from 7 a.m. to 6 p.m. at 855-250-1539
- Electronically submit a question at Personal Care Services Questions

4 Electronic Visit Verification's Impact on Personal Care Services.

Electronic Visit Verification (EVV)

- Trillium contracts with HHAeXchange (HHAX) for EVV software.

- Helpful Links:
  - North Carolina Home Health HHAeXchange Provider Enrollment Form |Onboarding Form Link
  - Local Management Entity (LME) Provider Portal Questionnaire
  - HHAeXchange Knowledge Base | HHAeXchange job aids and resources

EVV Resources

- EVV – For Providers |Trillium Health Resources
- Information available includes:
  - EVV Terms and Acronyms
  - EVV Q&A
  - EVV Tip Sheet

- To determine services subject to EVV, visit the EVV Service Code List.

PCS Services – Hard Launch Guidelines – Effective July 1, 2024

- All providers expected to be fully compliant with EVV requirements.
- EVV data must be validated prior to claims adjudication.
- Claims without required EVV criteria will be denied.
- No Prior Authorization (NPA) period: July 1, 2024 through September 30, 2024
  - During this time, no authorization for PCS EVV required.

Home Health Care Services (HHCS) – Soft Launch until January 1, 2025

- HHCS providers encouraged to submit EVV information to HHAX during soft launch period to ensure all systems operating as intended for successful hard launch.
- If experiencing challenges with claims submission during soft launch, providers can submit claims outside of HHAX while working collaboratively with Trillium to resolve barriers.

Summary

- The 3051 form must be completed by the primary care physician or treating physician to request an independent assessment.
- For help, visit Trillium's website, call the provider support line or submit questions electronically.
- Electronic Visit Verification attaches certain criteria to claims for services provided in a member's home.