Transforming Lives. Building Community Well-Being.



Personal Care Services

For Providers and Trillium Staff





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 <u>Personal Care Services (PCS)</u> 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 <u>Trillium's 3051 Form</u>. The completed form should be emailed to <u>LTSS@trilliumnc.org</u> .

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 <u>Trillium's</u> <u>3051 Form</u>
 - *Non-medical change of status or change of provider requests complete page three only.
- 2. Completed form emailed to <u>LTSS@trilliumnc.org</u> or just click "Submit".





3051 Request for Independent Assessment

A Trillium	MID#:						
HATH HEADING HATH HEADIN HATH H	DMA-3051 ESSMENT FOR F ATION OF MEDICA	PERSONAL	CARE SERVICES				
MEDICAL CHANGE OF STATUS OR NEW REQUESTS, PRA	ACTITIONERS COMPLI	ETE PAGES 1 8	2 ONLY				
REQUEST TYPE: (select one)	DATE OF REQUEST:						
Change of Status: Medical New Request		Expedit	ed Assessment Request				
Questions: Click Here to Submit Questions	Form Submission	Email: LTSS @Trillion	inc.org				
rep 2 SECTION A. BENEFICIARY DEMOGRAPHICS							
Beneficiary's Name: First: MI:Last:		DOB:	1 1				
Medicaid ID#: RSID#(ACH ON)/:		RSID Date:					
Gender: L Male L Female Language: L English	h LISpanish LIOt	her	-				
Address:	City:						
	rione. ()		1.00				
Alternate Contact (Select One): Derent Degal Gu	ardian (required if benefi	olary<18) L	Other				
Relationship to Beneficiary (NON-PCS Provider):			-				
Name:Pho	ne: <u>()</u>						
Active Adult Protective Services Case? Yes No							
Beneficiary currently resides: At home Adult Care Home	Hospitalized/medical fa	cility 🗌 Skilled	Nursing Facility				
Group Home Special Care Unit (SCU) Other	D/C Date (Hospita//SNF):	1 1				
tep 3 SECTION B. BENEFICIARY'S CONDITIONS THAT RESULT IN	NEED FOR ASSISTAN	CE WITH ADLS					
V Identify the current medical diagnoses related to the beneficiary's r (bathing, dressing, mobility, toileting, and eating). List <u>both</u> the diagnose	need for assistance with sis and the COMPLETE I	a qualifying Activi CD-10 Code.	ies of Daily Living				
Medical Diagnosis	Medical Diagnosis ICD-10 Impacts Date of Onset						
1.		□ Yes □ No					
2		□ Yes □ No					
3.		□ Yes □ No					
4.		□Yes □No					
4. 5.		□Yes □No □Yes □No					
4. 5. 6.		Yes No Yes No Yes No Yes No					
4. 5. 6. 7.		Ves No Yes No Yes No Yes No					
4 5. 6. 7. 8. 0		Yes No					
4 6. 7. 6 9. 9. 9. 9. 9. 9. 9. 9. 9. 9.		Yes No					
4 6. 7. 8. 9. 10.		Yes No					
4. 5. 6. 7. 8. 9. 10. 10. 10. 10. 10. 10. 10. 10. 10. 10		Yes No Yes Yes No Yes Yes	Age Appropriste				
4. 5. 6. 7. 8. 8. 10. 10. 10. 10. 10. 10.		Yes No	Age Appropriste				
		Yes No Yes Yes No Yes Yes	Age Appropriate				
4. 5. 6. 7. 8. 9. 10. 10. 10. 10. 10. 10. 10. 10	Montholo Intermediati https://www.automaticality.com/ state/provided/automaticality.com/ state/provided/automaticality.com/ state/provided/automaticality.com/ state/provided/automaticality.com/ state/provided/automaticality.com/ state/provided/automaticality.com/ state/provided/automaticality.com/ state/provided/automaticality.com/ state/provided/automaticality.com/ state/provided/automaticality.com/ state/ state/provided/automaticality.com/ state/ state/ state/ provided/automaticality.com/ state/ state/ provided/ state/ state/ provided/ state/ state/ provided/ state/ state/ state/ provided/ state	Yes No	Age Appropriate				
4. 5. 6. 7. 8. 8. 10. 10. 10. 10. 10. 10. 10. 10. 10. 10	Months) intermediati Provice and stable	Yes No	Age Appropriate				



Request for Independent Assessment: Step 1 – Request Type

	MEDICAL CHANGE OF STATUS OR NEW REQUESTS, PR	ACTITIONERS COMPLETE PAGES 1 & 2 ONLY
Step 1	REQUEST TYPE: (select one)	DATE OF REQUEST:
	Change of Status: Medical New Request	/ / Expedited Assessment Request
	Questions:	Form Submission Email:
	Click Here to Submit Questions	LTSS @Trilliumnc.org



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

			.	•
Step 2	SECTION A. BENEFICIARY DEMO	OGRAPHICS		
	Beneficiary's Name: First:	MI: Last:	DOB:	1
	Medicaid ID#:	RSID#(ACH Only):	RSID Date: /	1
	Gender: 🔲 Male 🗌 Female	Language: 🔲 Eng	lish 🔲 Spanish 🔲 Other	
	Address:		City:	
	County:	Zip:	Phone: ()	
	Alternate Contact (Select One):	Parent Legal	Guardian (required if beneficiary < 18) \Box Other	er
	Relationship to Beneficiary (NON-P	CS Provider):		
	Name:	F	hone: ()	
	Active Adult Protective Services Cas	e? 🗌 Yes 🗌 No		
I	Beneficiary currently resides: 🔲 A	t home 🔲 Adult Care Home	Hospitalized/medical facility Skilled Nursi	ng Facility
	Group Home Special Care	Unit (SCU) Other	D/C Date (Hospital/SNF): 02 / 0	02 / 2024



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

s

	Medical Diagnosis	ICD-10 Code	ADLs	Date of Onset (mm/vvvv)
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 clinica	al judgment, ADL limitations are: 🗌 Short Terr	n (3 Months) 🗌 Intermediat	e (6 Months)	Age Appropriate



Request for Independent Assessment – Page 2

OPTIONAL ATTESTATION: Practitioner should review the following and init	tial only if applicable:	
Panaficiany manufact an increased level of supervision		Initial
Beneficiary requires caregivers with training or experience in caring for indiv generative disease, characterized by interversible memory dysfunction, that atta mpaired memory, thirking, and behavior, including gradual memory loss, impaire	duals who have a cks the brain and results in d judgment, disorientation,	Initial:
rersonanty change, dimouny in learning, and the loss or language skills. leneficiary requires a physical environment, regardless of setting, that inclu measures to safeguard the beneficiary because of the beneficiary's gradual mem lisorientation, personality change, difficulty in learning, and the loss of languages	des modifications and safety ory loss, impaired judgment, kills.	Initial:
Seneficiary has a history of safety concerns related to inappropriate wandering rehavior, and an increased incidence of falls.	, ingestion, aggressive	Initial:
SECTION C. PRACTITIONER INFORMATION		
Attesting Practitioner's Name:Practitio	ner NPI#:	
Select one: Beneficiary's Primary Care Practitioner Outpatient Specialty P Practice Name:	nactitioner Inpatient Practition	er
	Practice Stamp	
Practice Contact Name:		
Address:	•	
Phone: () Fax: ()	-	
Date of last visit to Practitioner: / /**Note: Must be < 90 days 1 Practitioner Signature AND Credentials:	rom Received Date	
Date of field vield to Practitioner,	deceived Date Date d accurate to the beat of my know myseantation may be protected of status request hands and of status request only. Read for hands on assistance (Re	/ / ledge and be also underste d equired):



Request for Independent Assessment: Step 4 – Optional Attestation

Step 4	OPTIONAL ATTESTATION: Practitioner should review the following and initial <u>only</u> if applicable:						
	Beneficiary requires an increased level of supervision.						
	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.						
	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:					
N	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

Attesting Practition	ner's Name:		_Practitioner NPI#:
Select one: 🔲 B	eneficiary's Primary Ca	are Practitioner 🔲 Outpatier	nt Specialty Practitioner 🔲 Inpatient Practitione
Practice Name:			NPI#:
			Practice Stamp
Practice Contact Na	me:		
Address:			
Phone: ()		Fax: ()	

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

	: (select one)		1	DATE OF REQU	EST:		
Change of St	atus: Non-Medic	al 🗌 Change of	Provider .	1	1	Expedited	Assessment Require
Questions:	lick Here to Subm	it Questions		Form Subm	ission Email:	.TSS @Trilliu	imme.org
BENEFICIARY D	EMOGRAPHICS						
Beneficiary's Na	me: First	MI:	_ Last			DOB:	1 1
Medicaid ID#:		Ge	ender: 🗆 M	ale 🗌 Female	Language:	English	Spanish
Address:			City			Other	
County.				ine: 1			
Alternate Contac	t (Select One):	Parent	Legal Gua	rdian (required if	beneficiary < 1	B) ∐Ot	her
Relationship to E	Beneficiary (NON-F	CS Provider):					-
Name:			Phon	e: <u>()</u>			-
Repolicion: outro	athe melidae:		Care Home	Hornitalizadim		Chillod No.	rries Esslitu
			care nome L	- maphalized/m	Contracting L	J DAMES NO	and acouty
Group Home	opecial Care			0/	u Date (Hospit	wonr):	<u> </u>
SECTION E: CH	ANGE OF STATU	S: NON-MEDICA	L	_		-	
(Select One):	LI PCS	Beneficiary	L Legal	Power of	Respon	sible 🖵 Far	nily (Relationship):
(other one)	Provider		Guardian	Attorney (POA) Pany		
Requestor Name:							_
PCS Provider NP	1#:			PCS Provider L	ocator Code#:		-
Facility License #	(if applicable):			Date: /	<u> </u>		
Contact's Name: _			Conta	ct's Position:			
Provider Phone: ()	Provide	r Fax <u>()</u>	Email			
Reason for Chan	ge in Condition F	Requiring Reasse	ssment		_		
(Select One):	L Change in	Days of Need	Change in (Caregiver Status	L Change	in Beneficia	ry location affects
	Li one				ability it	periorini AD	
1 10 11 11	mo onange in conc	ition and its impac				nce (Require	
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Non-Medical Change of Status/Change of Provider Request: Step 1 – Request Type

Transforming Lives. Building	REQUEST TYPE: (select one)	DATE OF REQUEST:
Step 1	Change of Status: Non-Medical 🗌 Change of Provider	/ / Expedited Assessment Required
V	Questions:	Form Submission Email:
	Click Hele to Sublinit Questions	L135 @Thilumite.org



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

Click Here to Sub	mit Questions	LTSS @Trilliummc.org
p 2 BENEFICIARY DEMOGRAPHIC	S	
Beneficiary's Name: First:	MI: Last:	DOB: / /
Medicaid ID#:	Gender: 🗌 Male 🗌 Fe	emale Language: 🗌 English 🔲 Spanish
Address:	City:	Other
County:	Zip: Phone: ()	
Alternate Contact (Select One):	Parent Legal Guardian (requi	ired if beneficiary < 18)
Relationship to Beneficiary (NON	I-PCS Provider):	
Name:	Phone: ()	
Beneficiary currently resides:	At home Adult Care Home Hospitaliz	red/medical facility 🗌 Skilled Nursing Facility
Group Home Special Car	e 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

	Group Home	Special Care U	nit (SCU) 🛄 Of	ther	D/C D	Pate (Hospital/SNF): / /		
Step 3	SECTION E: CHANG	E OF STATUS	: NON-MEDICA	L				
	Requested by (Select One):	PCS Provider	Beneficiary	Legal Guardian	Power of Attorney (POA)	Responsible Family (Relationship): Party		
	Requestor Name:							
	PCS Provider NPI#:				PCS Provider Loca	tor Code#:		
	Facility License # (if a	pplicable):			Date: <u>///</u>			
	Contact's Name:		<u> </u>	Conta	ct's Position:			
	Provider Phone: ()		Provide	r Fax: <u>(</u>)	Email:			
	Reason for Change ir	Condition Re	quiring Reasse	essment				
	(Select One):	Change in D	ays of Need	Change in (Caregiver Status	Change in Beneficiary location affects		
		Other:				ability to perform ADLs		
	Describe the specific of	hange in condit	ion and its impac	t on the benefic	ary's need for hand	s on assistance (Required):		
Ν								



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							
\sim	Requested by (Select One): Care Facility Beneficiary	Other (Relationship):						
	Requestor's Contact Name:	Phone: ()						
	Reason for Provider Change Beneficiary or legal	Current provider unable to Other:						
	(Select One): representative's choice	continue providing services						
	Status of PCS Services (Select One):							
	Discharged/Transferred Scheduled Discharge/Transferred	er 🔲 No Discharge/Transfer Planned.						
Ν	Date: <u>///</u> Date: <u>///</u>	Continue receiving services until established with a new provider.						



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

Ν	Date. / /						
Step 5	BENEFICIARY'S PREFERRED PROVIDER (Select One):						
<u> </u>	Home Care Agency	Family Care Home	Adult Care	Adult Care Bed in Nursing Facility	SLF- 5600a	SLF- 5600c	Special Care
	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 <u>Personal Care Services (PCS)</u>

• 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 <u>Personal Care Services</u> <u>Questions</u>



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
 - <u>HHAeXchange Knowledge Base</u> | HHAeXchange job aids and resources



EVV Resources

- <u>EVV For Providers</u> |Trillium Health Resources
- Information available includes:
 - EVV Terms and Acronyms
 - EVV Q&A
 - EVV Tip Sheet
- To determine services subject to EVV, visit the <u>EVV Service</u> <u>Code List</u>.



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.