North Carolina Medicaid

Community Alternatives Program for Children (CAP/C) Manual

The Manual for CAP/C Case Management Agencies

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Community Care Section
N. C. Division of Medical Assistance

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COMMUNITY ALTERNATIVES PROGRAM FOR CHILDREN (CAP/C) MANUAL
CHANGE LIST
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The following lists each section of the manual and notes the significant changes in this combined revision and reprint. In addition to the changes listed below, many sections also have updated examples as well as minor changes in wording, grammar, or sentence structure that do not change the intent or meaning of the material.

In this section….	***The changes to note include…***
1. CAP/C Basics	**1.1** provides definitions for "medically fragile" and "at risk of institutionalization" **1.2** adds the criteria of "medically fragile" and "at risk of institutionalization" to *Who CAP/C Serves.* Clarifies the age at which CAP/C participation terminates. Gives examples of "private and primary residence". Clarifies that Nursing or Nurse Aide (Personal Care) services must include actual interventions which are medically based, continuous, and age-inappropriate. Clarifies that Case Management is to provide assessment, care planning, service authorization, care monitoring, and other activities. Clarifies that Medicaid eligibility includes approval for disability. Points out that there must be no other more conservative or less costly treatments available statewide. Clarifies that approval of level of care does not guarantee approval of CAP/C. **1.3** is revised to update the number of children that can be served by the waiver **1.4** is revised to state that the assessment may be completed by a registered nurse only, or by a registered nurse/social worker team. Clarifies that Case Management and Nursing Services or Nurse Aide (Personal Care) Services must be in the plan of care, and that the other CAP/C services may be considered. **1.5** is a new subsection which explains the limitations of services offered **1.6** is a new subsection which describes the relationship between CAP/C and EPSDT **1.7** is revised to more accurately reflect the role of the client's family

In this section….	***The changes to note include…***
2. The Waiver	**2.0** gives the web address where the waiver can be found on-line. **2.1** is revised to update the dates for which the current waiver is in effect **2.2.4** is revised to update the number of children that can be served by the waiver
3. Program Administration	**3.1** adds "selection of local case management agencies" to DMA responsibilities **3.2** adds "networking, educating", "referring applicants to the program", "documentation", and "advance notice of intent to terminate provider agreement for CAP/C case management services" to local case management agency responsibilities. States that the assessment may be completed by a registered nurse only or by a registered nurse/social worker team. Gives a guideline for a caseload limit. Discourages wait lists, and instructs actions to take if a wait list is unavoidable. Clarifies that case managers must act as patient advocates, but must also respect the limitations of the CAP/C program. Expands the discussion of freedom of choice and addresses potential conflicts of interest. Directs a 15 day turnaround on requests for information from DMA

In this section….	*The changes to note include…*
4. CAP/C Services	**4.1** is revised to include definitions of skilled nursing, continuous, complex, and substantial **4.2** is revised to match Nurse Aide tasks with the Board of Nursing's task lists, clarify the very limited circumstances in which an In-Home-Aide that is not a licensed Nurse Aide I or II may care for a CAP/C client, and addresses the issue of unavailability of Nurse Aide Is and Nurse Aide IIs in staffing cases. **4.3** is revised to state that children under five years of age should obtain their formula primarily through WIC, with CAP/C being the secondary payor **4.4** expands the list of case management responsibilities to include referral intake, explaining the program to clients and providers, ensuring that policies and procedures of the program are upheld, and ensuring that the client does not receive duplicative services. It states that home visits must be done on at least a quarterly basis, although monthly visits are preferred. **4.5** now clarifies that wheelchair ramps must be stationary, not portable **4.6** now includes information regarding the new in-home nurse respite service, and describes when to use respite services versus short-term-intensive services
5. Regular Medicaid Community Services	**5.2** expands the descriptions of skilled nursing services and medical supplies **5.5** differentiates PCS and PCS Plus, and is revised to reflect changes in the PCS and PCS Plus policies **5.8** is a new subsection which briefly describes the Medicaid transportation policy
6. Medicaid Eligibility	There are no substantive changes in this section.

In this section….	***The changes to note include…***
7. Initiating CAP/C	**7.0** Steps for responding to an inquiry is revised to include guiding the inquirer regarding CAP/C as well as other programs. **Illustration 7.1** is revised to include the *Physician's Request Form* **7.2** Now states that the case management agency should complete the referral form, with help from DMA if needed. Case managers can not refuse to submit a referral to DMA. **7.3** deletes the statement that the case manager can direct the referral source to DMA and DMA will gather the information **Illustration 7-2** reflects the new referral form **7.4** is expanded to include the factors which are considered in the prescreening decision by DMA **Illustration 7-4** is new, and shows a sample completed *Physician's Request Form* **7.6** includes a new subsection 7.6.1, which describes parameters for the plan of care, particularly in regards to how many hours will be approved and how those hours are counted.
8. Approval of Level of Care	**8.3** now recommends that the FL-2 be completed by the physician. **8.8** is a new subsection which describes the intermediate level of care as decided by the prior approval agent **8.9** is a new subsection which describes the skilled level of care as decided by the prior approval agent. Included is a note which describes how therapies may affect the level of care, and when a new *FL-2* should be called in. **Illustration 8-1** is new, and describes the various CAP/C levels of care **Illustration 8-2** includes expanded instructions regarding the physician's signature on the *FL-2*

In this section….	***The changes to note include…***
9. Assessment	**9.1** is revised to reflect the change that either an RN alone or an RN/Social Worker team may complete the assessment. **9.2** is expanded to address transfers between counties **Illustration 9-1** is revised to reflect the new *Assessment* form **Illustration 9-2** is revised to show a sample completed new *Assessment* form **Illustration 9-3** is new, and shows a sample completed *FL-2 Discrepancy Resolution Form.*
10. Plan of Care	**10.3** adds case management assessment to the list of items that may be prorated **Illustration 10-1** is revised to reflect the new *Plan of Care* form. **Illustration 10-2** is new. It provides information on how/where things are included on the budget. **Illustration 10-3** is new. It provides information on how to keep your fee schedule information up-to-date. **Illustration 10-4** is new. It shows the monthly budget for each CAP/C level of care. **Illustration 10-5** is updated to reflect the new *Plan of Care* form.
11. Case Management	**11.0** now states that clients are assigned to a case manager based on county of residence, not the county where the child has Medicaid or a legal guardian **11.1** is revised to reflect that the assessment team can either be an RN alone or an RN/Social Worker team **11.4** now addresses having two provider agencies providing Nursing or Nurse Aide (Personal Care) services, and having a service authorization expire prior to DMA being able to approve the CNR **11.10** provides a guideline for maximum monthly billable case management time.
12. Revising the Plan of Care	**12.1** now lists requires actions for changes in goals, changes in informal support. The format has been changed slightly.
13. Continued Need Review	**13.3.4** is a new subsection which lists additional documentation to be submitted with CNRs on hospital-level clients.

In this section….	***The changes to note include…***
14. Plan Approval	**14.3** is amended to include the requirement for the new *Physician's Request for Services* form and additional documentation to be submitted with CNRs
15. Absences	**Illustration 15-1** *CAP/C Update Worksheet*, has been deleted.
16. Case Management Agency Transfers	**16.6** specifies what minimum information must be sent to DMA by the new agency
17. Terminations	**17.1** is amended to state that DMA sends a termination letter to the client, cc's to the Case Manager, when DSS terminates Medicaid eligibility **17.3** clarifies that the last day of CAP/C services is the day before the client's nineteenth birthday, slightly modifies the Case Manager's responsibilities in terminations, expands the information regarding the termination effective date, and slightly modifies the content of DMA's notice to the client.
18. Appeals of CAP/C Decisions	**18.1** is changed in format and in some of the items for which the client has the right to appeal **18.2** now states that DMA sends the *Request for State Appeal* form to DSS, and expands the section on continuation of services pending appeal decision
19. Provider Enrollment	**19.3** now refers you to the provider enrollment web site. It deletes the responsibilities of enrolled providers that are not specific to CAP/C, as they can be found on the web site. **19.7** is expanded and modifies the time frames within which to notify Provider Services of agency changes **19.8** adds criteria for notifying the HCI Unit Supervisor of a provider's intent to terminate enrollment
20. Documentation and Records	**20.2** now addresses HIPAA regulations as they pertain to availability of records.
21.FilingClaims	**21.0** now gives the website for the Community Care Manual **21.3** now gives the web address for the fee schedules **Illustration 21-1** contains some amended instructions for completing the CMS-1500.

In this section….	***The changes to note include…***
22. Tracking Claims **23. Claims Inquiries and Adjustments** **24. Payment Review, Fraud, and Abuse**	These chapters have been deleted from the CAP/C Manual. Please refer to the *Basic Medicaid Billing Guide* for the information that was in these chapters.
Appendix A Glossary	There are several new definitions including *medically fragile, risk of institutionalization, skilled nursing, continuous care, complex care, and substantial care*. Other definitions have been updated.
Appendix B Who to Contact	Names, telephone numbers, fax numbers, addresses, and web sites have been updated.
Appendix C CAP/C Codes and Rates	The codes on the CAP/C fee schedule have been updated.
Appendix D Automated Voice Response (AVR)	This section has been deleted from the CAP/C Manual. Please refer to the *Basic Medicaid Billing Guide* for the information that was in this appendix.

ABOUT THIS MANUAL

This manual provides guidance to local case management agencies for the Community Alternatives Program for Children (CAP/C) and their CAP/C case managers on the operation of the program. The *Medicaid Community Care Manual* provides guidance for other CAP/C providers.

Unless otherwise noted, the content is directed to the CAP/C case manager.

What This Manual Tells You

This manual describes the purpose and background of the program, provides basic Medicaid information, tells who is eligible for CAP/C and how to get them on the program, describes the services, and guides you in your case management responsibilities. It lets you know DMA's policies and procedures for CAP/C as well as providing an overview of related community services (refer to the *Community Care Manual* for greater detail). Provider enrollment, record keeping and payments are also covered.

How to Use the Manual

The Table of Contents guides you to the topics in the manual. Use the Glossary in Appendix A if you need help with the meaning of a word or term.

The first time you read this manual, review the Glossary to learn the terms. Read CAP/C Basics – it provides basic information about the program. Next, review the section about the waiver to help you understand the background of the policies and procedures. Familiarize yourself with the rest of the manual so that you can readily locate needed information.

Keeping It Current

This manual was first published April 1, 1996. Page revisions have been issued periodically. In October 2000, and in August 2006, a reprint of the entire manual was issued that included all changes since the original issue, plus newly revised material.

Each manual page has an issue date at the bottom to help you to know which information is current. Between updates, the information may be changed through articles in the monthly *Medicaid Bulletin,* in *Special Medicaid Bulletins,* and in other DMA publications and memoranda. (Medicaid Bulletins are available on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm.)You are responsible for knowing the information in this manual, plus the information in the publications and memoranda issued since the last revision. Each revision includes all the pertinent information from the previous year's publications.

When You Have Questions

Because a manual cannot cover every situation or problem, there are phone numbers in Appendix B that you may use to call for help.

How to Get Copies

The manual is available on-line at http://www.dhhs.state.nc.us/dma.

CAUTION: *This manual covers Medicaid policies and procedures. Nothing in the manual relieves a provider from meeting licensure, certification and accreditation requirements, or other legal and regulatory requirements.*

TABLE OF CONTENTS

1. CAP/C BASICS

1.0 Why CAP/C Exists 1-1

1.1 CAP/C Basics 1-1

1.2 Who CAP/C Serves 1-2

1.3 The Availability of CAP/C…….....1-3

1.4 What Services Are Offered 1-3

1.5 Limitations of Services Offered……..1-3

1.6 CAP/C and EPSDT 1-4

1.7 Who's Involved……1-5

2. THE WAIVER

2.0 The Waiver……..2-1

2.1 How Long A Waiver Exists.....2-1

2.2 Waiver Requirements 2-1

2.2.1 Target Population 2-1

2.2.2 Waived Medicaid Requirements..... 2-1

2.2.3 Assurances 2-2

2.2.4 Number Of Participants 2-2

2.2.5 Services 2-3

2.3 Federal Monitoring 2-3

3. PROGRAM ADMINISTRATION

3.0 Program Administration……3-1

3.1 DMA Responsibilities 3-1

3.1.1 Selection of Local Case Management Agencies 3-1

3.1.2 Establishing And Administering Policies And Procedures..... 3-1

3.1.3 Providing Manuals And Other Guidelines..... 3-1

3.1.4 Providing Training And Technical Assistance 3-1

3.1.5 Approving CAP Participation And Plans Of Care 3-1

3.1.6 Monitoring Program Operation 3-2

3.1.7 Determining How Many May Participate 3-2

3.1.8 Paying For Services..... 3-2

3.1.9 Completing Reports And Evaluations..... 3-2

3.2 Responsibilities Of The Local Case Management Agencies 3-2

3.2.1 Networking, Educating……3-2

3.2.2 Referring Applicants to the Program……3-2

3.2.3 Assessing Applicants For The Program 3-3

3.2.4 Providing Case Management 3-3

3.2.5 Providing Home Mobility Aids And Waiver Supplies 3-3
3.2.6 Coordinating Services 3-3
3.2.7 Managing Caseloads..... 3-3
3.2.8 Ensuring Quality Services 3-4
3.2.9 Ensuring Client Freedom Of Choice..... 3-4
3.2.10 Cooperating With Monitoring And Reporting Activities 3-4
3.2.11 Documentation 3-4
3.2.12 Advance Notice of Intent to Terminate Provider Agreement for CAP/C Case Management Services……3-5

4. CAP/C SERVICES

4.0 CAP/C Services……..…4-1

4.1 CAP/C Nursing Services (T1000) 4-1

4.2 CAP/C Personal Care (S5125) 4-2

4.3 CAP/C Waiver Supplies 4-7

4.4 Case Management (T1016) 4-8

4.5 Home Mobility Aids (S5165).....4-9

4.6 Respite Care (In-Home Aide S5150; In-Home Nurse T1005; Institutional – H0045) 4-10

5. REGULAR MEDICAID COMMUNITY SERVICES

5.0 Regular Medicaid Community Services…….....5-1

5.1 Durable Medical Equipment (DME).....5-1
5.1.1 What's Covered 5-1
5.1.2 How To Get DME 5-2
5.1.3 Coordinating Care 5-4

5.2 Home Health Services 5-4
5.2.1 Who’s Covered 5-4
5.2.2 What’s Covered 5-4

5.3 Home Infusion Therapy (HIT).....5-7
5.3.1 Who’s Covered 5-7
5.3.2 What’s Covered 5-7

5.4 Hospice 5-8
5.4.1 Who’s Covered 5-8
5.4.2 What’s Covered 5-8
5.4.3 Levels Of Care..... 5-9
5.4.4 Benefit Periods 5-10
5.4.5 Coordination Of Care..... 5-10

5.5 Personal Care Services (PCS).....5-12
5.5.1 Who’s Covered 5-12
5.5.2 When Services Are Covered 5-13

5.5.3 What's Covered……5-14
5.5.4 How To Get PCS 5-14
5.6 Private Duty Nursing (PDN) 5-15
5.6.1 Who's Covered 5-15
5.6.2 What's Covered 5-15
5.6.3 How To Get PDN 5-15
5.7 Health Services For Children 5-15
5.7.1 Health Related Services Provided In Public Schools 5-16
5.7.2 Health Related Services Provided Through Head Start Programs 5-16
5.7.3 Health Related Services Provided By Independent Practitioners 5-16
5.8 Medicaid Transportation Policy……..5-16

6. MEDICAID ELIGIBILITY

6.0 Medicaid Eligibility……..6-1
6.1 Medicaid Basics 6-1
6.1.1 Who's Involved..... 6-1
6.1.2 Who's Eligible For Medicaid 6-2
6.1.3 Applying For Medicaid 6-2
6.1.4 Retroactive Eligibility For Regular Medicaid Services 6-3
6.1.5 Regular Medicaid Deductibles 6-3
6.1.6 Co-Payments 6-4
6.1.7 Prior Approval 6-5
6.2 Medicaid Eligibility And CAP/C 6-5
6.2.1 Waiver Of The Deeming Of Income And Resources..... 6-5
6.2.2 Which Medicaid Categories Are Eligible For CAP/C 6-5
6.2.3 Applying For Medicaid 6-5
6.2.4 Retroactive Coverage 6-6
6.2.5 CAP/C Deductibles 6-6
6.2.6 Co-Payments 6-6
6.2.7 Prior Approval For Other Services..... 6-6
6.3 Verifying Medicaid Eligibility.....6-7
6.3.1 Using The Medicaid ID Card As Verification .....……6-7
6.3.2 Using Automated Voice Response (AVR) 6-10
6.3.3 Using Electronic Data Interchange (EDI)..... 6-10
6.4 Coordinating With DSS Medicaid Staff 6-12

7. INITIATING CAP/C

7.1 Critical Time Limits And Dates 7-1
7.1.1 Time From Physician's Signature On FL-2..... 7-1
7.1.2 Phone FL-2 Approval Time Limit 7-1
7.1.3 Plan Of Care Deadline..... 7-3
7.1.4 CAP Effective Date 7-3

7.2 Inquiries.....7-3
7.3 Referrals.....7-4
7.4 DMA "Prescreening".....7-8
7.5 The Assessment Process 7-9
7.5.1 Informing DSS Of A Potential CAP/C Client 7-9
7.5.2 Prior Approval Of NF Care 7-10
7.5.3 Physician's Request Form..... 7-10
7.5.4 Assessment And Plan Of Care..... 7-10
7.6 DMA's Action On Plan Of Care 7-12
7.6.1 Evaluation..... 7-12
7.6.2 Assessment And Plan Of Care..... 7-13
7.7 Continuing Eligibility.....7-14

8. APPROVAL OF LEVEL OF CARE

8.0 Approval of Level of Care……..8-1
8.1 Critical Time Limits.....8-1
8.1.1 Physician's Signature 8-1
8.1.2 Submitting Phone Approval FL-2's..... 8-1
8.1.3 Submitting The Plan Of Care 8-1
8.2 Effective Date Of FL-2 Approval 8-1
8.3 Completing The FL-2 8-2
8.4 FL-2 Submission 8-2
8.5 FL-2 Response.....8-2
8.6 FL-2 Processing Problems.....8-3
8.7 Denial Of Nursing Facility Level Of Care 8-3
8.8 Intermediate Level of Care.....8-3
8.9 Skilled Level of Care……...8-3
8.10 Hospital Level of Care……8-3

9. ASSESSMENT

9.1 Who Conducts The Assessment.....9-1
9.2 When The Assessment Is Completed.....9-1
9.2.1 New Cases 9-1
9.2.2 Continuing Cases 9-1
9.3 Where The Client Is Assessed.....9-2
9.4 Completing The Assessment 9-2
9.5 Paying For This Activity.....9-2
9.5.1 What May Be Billed 9-3
9.5.2 Who Bills..... 9-3

9.5.3 Date Of Service 9-3
9.5.4 Billing For Non-Participants 9-3

10. PLAN OF CARE

10.0 Plan of Care 10-1
10.1 Purpose Of Plan 10-1
10.2 Critical Time Limits 10-1
10.2.1 Initial Plan 10-1
10.2.2 Continued Need Review (CNR) 10-1
10.2.3 Plan Revisions 10-2
10.3 Plan Preparation 10-2
10.4 Plan Approval 10-3
10.5 Case Manager's Action Upon Notification Of Decision 10-3

11. CASE MANAGEMENT

11.0 Case Management 11-1
11.1 Assessing The Client 11-1
11.2 Planning Care 11-1
11.3 Working With The Physician 11-2
11.4 Authorizing CAP/C Services 11-3
11.5 Coordinating With Other Services On The Plan 11-6
11.6 Coordinating Other Resources 11-8
11.7 Monitoring 11-8
11.7.1 CAP/C Services 11-8
11.7.2 Home Health Skilled Nursing 11-9
11.7.3 Other Services 11-9
11.7.4 Documenting Your Monitoring Activities 11-9
11.8 Changes In Care 11-10
11.9 Providing Case Management To A Client In A Hospital Or NF 11-10
11.10 Billable Case Management 11-12

12. REVISING THE PLAN OF CARE

12.0 Revising the Plan of Care 12-1
12.1 Required Action On Changes 12-1
12.1.1 Change In Goals Or Interventions 12-1
12.1.2 Change In the Unit Rate of a Service or Supply 12-1
12.1.3 Change In Provider Agencies 12-1
12.1.4 Change In Informal Support 12-2
12.1.5 Change In 24 Hour Coverage Schedule 12-2

12.1.6 Change In Amount, Duration, Or Frequency Of A Service Or Supply 12-3
12.2 Time Limit And Effective Date 12-5
12.3 Preparing The Revision 12-5
12.3.1 Deleting A Service 12-6
12.3.2 Adding A Service 12-7
12.3.3 Changing A Service 12-9
12.4 Signature Requirements 12-10
12.5 Getting Approval 12-10
12.6 Case Manager's Actions Upon Notification 12-10

13. CONTINUED NEED REVIEW
13.0 Continued Need Review 13-1
13.1 Due Date 13-1
13.2 Responsibilities 13-1
13.3 Content Of CNR 13-1
13.3.1 Level Of Care Recommendation 13-1
13.3.2 Assessment 13-2
13.3.3 Plan Of Care 13-2
13.3.4 Additional Documentation 13-2
13.4 Getting The CNR Approved 13-3
13.5 Actions If Approved 13-3
13.6 Actions If Denied 13-4
13.7 Paying For The CNR 13-4

14. PLAN APPROVAL
14.0 Plan Approval 14-1
14.1 Approval Authority 14-1
14.2 Applying CAP/C Criteria 14-1
14.3 Getting DMA Approval 14-2

15. ABSENCES
15.0 Absences 15-1
15.1 Hospitalizations 15-1
15.1.1 Anticipated Hospitalization Of 30 Days Or Less 15-1
15.1.2 Hospitalization Over 30 Days 15-2
15.2 Stays In Rehabilitation Centers And Nursing Facilities 15-4
15.3 Temporary Absences From Area 15-6

16. CASE MANAGEMENT AGENCY TRANSFERS
16.0 Case Management Agency Transfers 16-1
16.1 Case Management Agency Transfer Policy 16-1
16.2 Notifying DMA Of Possible Transfers 16-1
16.3 Transfer Basics 16-1
16.4 Client Responsibilities 16-2
16.5 Current Agency Responsibilities 16-2
16.6 New Agency Responsibilities 16-3
16.7 Coordination With Medicaid Eligibility Staff 16-4

17. TERMINATIONS
17.0 Terminations 17-1
17.1 Medicaid Eligibility Terminations 17-1
17.2 Level Of Care Terminations 17-1
17.3 CAP/C Terminations 17-2
17.3.1 Case Manager's Responsibilities 17-2
17.3.2 DMA HCI Unit Responsibilities 17-3
17.3.3 Termination Effective Date 17-3
17.3.4 Notice To The Client 17-4
17.4 Withdrawals Due To Acceptance By Another CAP Program 17-5
17.5 Readmissions 17-5

18. APPEALS OF CAP/C DECISIONS
18.0 Appeals of CAP/C Decisions 18-1
18.1 Client Right To Appeal 18-1
18.1.1 Termination 18-1
18.1.2 Denial 18-2
18.1.3 Other 18-2
18.2 Appeal Procedures 18-3
18.2.1 Time Limit For Requesting A Hearing 18-4
18.2.2 Submitting The State Hearing Request 18-4
18.2.3 Continuing Services Pending The State Hearing Decision On A Termination 18-4
18.2.4 Scheduling The State Hearing 18-4
18.2.5 Preparing For The State Hearing 18-5
18.2.6 Conducting The Hearing 18-5
18.2.7 The Hearing Decision 18-5
18.3 Other Appeals 18-6
18.3.1 Appealing Medicaid Eligibility 18-6
18.3.2 Appealing Level Of Care Decisions 18-6

19. PROVIDER ENROLLMENT

19.0 Provider Enrollment 19-1
19.1 The Purpose Of Enrollment.....19-1
19.2 Who May Be Enrolled 19-1
19.3 Responsibilities Of An Enrolled Provider 19-1
19.4 Requesting Enrollment As A New CAP Provider 19-2
19.5 Changing Services In The Agreement 19-2
19.6 Changing Agency Ownership.....19-3
19.7 Other Agency Changes.....19-3
19.8 Terminating Enrollment 19-3

20. DOCUMENTATION AND RECORDS

20.0 Documentation and Records 20-1
20.1 How Long Records Must Be Kept 20-1
20.2 Availability Of Records 20-1
20.3 What The Case Management Agency Keeps 20-1
20.4 Information Common To All Client Records.....20-2
20.5 CAP/C Records For Case Management Agency Services 20-2
20.6 What Providers Of The Other CAP/C Services Keep 20-3

21. FILING CLAIMS

21.0 Filing Claims…….21-1
21.1 Who's Involved in Claims Processing…….21-1
21.2 Who May File a Claim……...21-2
21.3 What May Be Billed…….…21-2
21.4 What You Will Be Paid…….21-3
21.5 Third Party Coverage……...21-3

21.5.1 Payment Equals or Exceeds Medicaid Rate…….21-4
21.5.2 Payment Less Than Medicaid Rate……..….21-4
21.5.3 Payment Denied By Third Party……...…21-4
21.5.4 Potential Coverage Not Available…….21-5
21.5.5 Insurer Pays Client……..…..21-5
21.5.6 Payment Related to Injuries and Illnesses……..….21-5
21.5.7 Third Party Payment After Medicaid Payment……..….21-5
21.5.8 Medicaid Treatment Plan of Insurance Plan Payments and Denials……...21-6

21.6 Time Limits……...21-6
21.7 How To Prepare A Claim…….21-7
21.8 Electronic Claims…….....21-7

21.9 Signature on File Certification……..21-7

21.10 Submitting Claims……21-7

21.11 When To Expect Payment……..…21-8

21.12 Payment Review, Fraud, and Abuse……...21-14

21.12.1 The Purpose of Prevention and Detection Efforts…….....21-14
21.12.2 Provider Education……21-14
21.12.3 Reporting Fraud, Abuse and Misuse of Funds……...…21-14

APPENDICES

A Glossary
B Who to Contact
C CAP/C Codes

ILLUSTRATIONS

6-1 – Sample Blue Medicaid ID Card for a CAP/C Client 6-8
7-1 – Sample Checklist 7-2
7-2 – Sample Referral Form.....7-6
7-3 – Sample Referral Memo 7-9
7-4-- Sample Physician's Request Form…….....7-11
7-5 – Sample DSS Notification Memo.....7-13
7-6- Referral Algorithm.....7-15
8-1 – CAP/C Levels of Care……..8-5
8-2 – FL-2 Instructions 8-5
8-3 – Sample Completed FL-2 8-7
9-1 – Assessment Form Instructions.....9-5
9-2 – Sample Assessment Form.....9-22
9-3 - Sample FL-2 Discrepancy Resolution Form……..9-33
10-1 – POC Instructions.....10-4
10-2 – Cost Summary Instructions..... ……..…10-11
10-3 – How to Access Fee Schedules and Lifetime Expectancies/
Quantity Limitations for Supplies……10-13
10-4 – CAP/C Budget Limits……10-14
10-5 – Sample Plan of Care.....10-15
11-1 – Sample Service Authorization.....11-5
11-2 – CAP/C Participation Notice.....11-7
12-1 – Sample 24 Hour Coverage Change Documentation 12-3
12-2 – Service Deletion Example.....12-6
12-3 – Service Addition Example 1.....12-7
12-4 – Service Addition Example 2.....12-8
12-5 – Service Change Example 12-9
13-1 – Sample DSS Notification Memo 13-3
17-1 – Termination Guide 17-6
20-1 – Sample Case Management Notes.....20-5
21-1 - CMS 1500 Instructions……...21-9
21-2 – Sample CMS 1500……..…..21-13

1.0 History of CAP/C

Home-based care for children needing long-term medical care was recognized as a viable alternative to institutional care when Katie Beckett's situation became a national issue. Katie Beckett is a child in Iowa who was hospitalized for an extended period. She reached a point where hospitalization was no longer needed, but she could not return home because of the cost of care. Medicaid paid for her hospital care, but her parents' income prevented Katie from being eligible for Medicaid at home. Her situation received national attention, which resulted in home-based care similar to that for disabled adults becoming available for children. North Carolina implemented CAP/C in 1983. In 1995, DMA expanded the program beyond the "Katie Beckett" model to include children who are eligible for Medicaid without applying special rules for the parents' income and resources.

1.1 CAP/C Basics

The Community Alternatives Program for Children (CAP/C) is a special Medicaid-waivered community care program. It is designed to serve a limited number of medically high risk children who would be institutionalized in a nursing facility or hospital without Medicaid payment for the home care available through CAP/C. With good case management, a complete package of services, and support from the parents or substitute parents, some of these children may remain safely at home at a lower Medicaid cost than institutional care. The program is authorized by a Medicaid Home and Community-Based Services Waiver granted by the Centers for Medicare and Medicaid Services (CMS) under Section 1915(c) of the Social Security Act. The current waiver was renewed effective July 1, 2005 for five years. It offers specific services (called "CAP/C services") in the home and community for children up through age 18 who require ICF or SNF level of care or the type of long term care that would ordinarily be provided in a hospital. The program's goal is to allow children needing long-term medical care to return to or remain in the community and live as independently as possible in their homes.

CAP/C is designed to serve children who are medically fragile and who are at risk of institutionalization. Medically fragile refers to children who have:

- A primary diagnosis or diagnoses that are medical – not psychological, behavioral, cognitive, or developmental
- A serious, ongoing illness or chronic condition requiring prolonged hospitalization and ongoing medical treatments and monitoring
- A need for devices or care to compensate for the loss of bodily function
- A need for physician-ordered, continuous in-home care that requires the presence or oversight of a Registered Nurse

Risk of institutionalization refers to children who:

- Are prior-approved through the fiscal agent for nursing facility level of care
- Without in-home nursing care, would need to be institutionalized in a nursing facility or hospital as determined by statement of the parents or responsible party
- Do not have other available resources, formal or informal, including daycare/developmental daycare or family support which can meet their needs.

The following gives you a brief overview of the program. The other sections of this manual provide the details.

1.2 Who CAP/C Serves

A CAP/C child is one who:

- Is under age 19;

  Note: CAP/C eligibility terminates on the day before the nineteenth birthday. The last day of CAP/C services is the day before the client turns 19. No CAP/C services can be provided on the day of the nineteenth birthday.

  - Meets the criteria for medically fragile, as defined in section 1.1;
  - Meets the criteria for risk of institutionalization, as defined in section 1.1;
  - Lives in a private and primary residence while on the program;

    Note: A primary residence is defined as one belonging to a regular caregiver or one court-ordered. Clients residing in group homes, as well as clients residing in residential treatment homes under the mental health system are ineligible for CAP/C services. Clients residing in regular foster care homes are eligible to participate in CAP/C. Clients residing in therapeutic foster homes will be evaluated for CAP/C eligibility on a case-by-case basis. Secondary homes such as vacation homes are excluded. Hotels are excluded except in certain emergency situations which must be discussed with the DMA Consultant. Care may not be provided in the home of the Nurse or Nurse Aide. Care can not be provided during a short visit (e.g., a few hours) at a friend or relative's house as the case manager has not had an opportunity to assess the home environment.

  - At a minimum, requires nursing facility care (ICF or SNF) as determined through the prior approval process of Medicaid's fiscal agent. (DMA may determine that a child approved by the fiscal agent at SNF level of care is at the hospital level for CAP/C care planning – see Section 8);
  - Requires Medicaid coverage of CAP/C Nursing Services or CAP/C Nurse Aide (Personal Care) Services. These services must include actual interventions which are medically based, continuous in nature (occurring at least every two to four hours during the time that the CAP/C staff is provided), and/or not appropriate to the child's age. (See Chapter 4);
  - Requires CAP/C Case Management services to provide assessment, care planning, service authorization, care monitoring, and other case management activities;
  - Desires CAP/C services instead of institutional care, as determined by statement of the parents or responsible party;
  - Meets the Medicaid eligibility criteria for CAP/C as defined in Section 6 including approval for disability by the Social Security Administration; and
  - Can have his or her health, safety, and well being maintained at home

- Can have his or her healthcare needs met within the CAP/C cost limit for his or her level of care, and there is no other more conservative or less costly treatment available statewide.

Note: *To participate in CAP/C, ALL of these criteria must be met. No one criterion, including the fiscal agent's approval for level of care, will qualify a child for the CAP/C program.*

1.3 The Availability of CAP/C

The resources to provide CAP/C Case Management and the other CAP/C services affect its availability in each part of the state. In addition, the number of children that may be served in a waiver year (July through June) is constrained by the statewide limit on the number of participants that is approved in the waiver. Currently (through June 2006), the waiver allows North Carolina to serve up to 874 children. There is no designation as to how many children can be served by each county.

1.4 What Services Are Offered

When a person is considered for CAP/C, the child's strengths and needs are assessed by a registered nurse or a registered nurse/social worker team from the local case management agency. After the assessment, a case manager develops a plan of care that builds on the child's strengths. In addition to the required case management and Nursing Services or Nurse Aide (Personal Care) Services, the CAP/C client may be considered for:

- CAP/C Waiver Supplies (nutritional supplements taken by mouth when ordered by a physician, and reusable incontinence undergarments and the disposable liners for the undergarments for children age 2 and above)

- Home Mobility Aids/Home Modifications (stationary wheelchair ramps, widening of doorways for wheelchair access, safety rails, non-skid surfaces, handheld showers and grab bars)

- Respite Care (In-Home Nursing, In-Home Nurse Aide, or Institutional)

See Section 4 for the definitions, limitations and provider qualifications for the above services.

In addition to the CAP/C services, the client also may receive regular Medicaid services, without co-pay, under the guidelines for those services. The total Medicaid cost of specified services in the home (usually those services that would be provided in a nursing facility) must be within the CAP cost limit. Section 9 gives details of the assessment process. Section 10 tells about developing the plan of care, including how the cost of services is computed.

1.5 Limitations of Services Offered

Medicaid coverage of a CAP/C service is available to the extent that the service is a necessary component of a Plan of Care to prevent institutionalization. The amount and duration of each CAP/C service must not exceed the amount necessary to meet the program's health, safety, and well-being requirements. Convenience items or features are not covered. Services are planned and

authorized to meet the unmet needs of the child, not the needs or preferences of caregivers, provider agencies, or others involved in the child's care.

CAP/C exists to supplement rather than replace the formal and informal services and support already available to the child. It is not the role of CAP/C to assume long-term responsibility for the care of the client, but rather to assist family members. CAP/C services are provided only in cases when assistance is needed by informal caregivers to meet specific unmet needs of the child. The program's goal is to allow children needing long-term institutional care to return to or remain in the community and live as independently as possible in their homes.

An individual is placed on CAP/C because of a need for Medicaid coverage of CAP/C services, in addition to CAP/C Case Management, to avoid institutional care. A child is not placed on CAP/C solely to become eligible for Medicaid or other Medicaid services. CAP/C is not intended to replace other sources of funding, such as private insurance. (See Section 7 about appropriate referrals and Section 14 for details on the applying CAP/C criteria.)

CAP/ C services are not covered when the provider does not comply with all Medicaid guidelines and CAP/C procedures.

CAP/C does not cover services that duplicate another provider's service.

CAP/C does not cover services that are experimental, investigational, or part of a clinical trial.

CAP/C services are not covered when the care involves only monitoring, or being there 'just in case something happens'. Actual, scheduled, hands-on interventions are required.

1.6 CAP/C and EPSDT

Federal Medicaid law requires State Medicaid programs to provide EPSDT (Early Periodic Screening, Diagnosis, and Treatment) for recipients under age 21. Under federal Medicaid law, states are to cover any service that is medically necessary "to correct or ameliorate a defect, physical and mental illness, or a condition identified by screening", whether or not the service is covered under the State Plan. The services required to be provided under EPSDT are limited to services that are within the scope of the services listed in the federal law at 42 U.S.C. § 1396d(a) of the Social Security Act.

If financially eligible for Medicaid and EPSDT, the recipient must also meet the CAP/C program criteria in order to receive CAP/C services. Additionally, the provision of waiver and non-waiver services under the CAP/C program, including EPSDT, must be cost neutral. That is, the projected total cost of the recipient's care per month cannot exceed the established CAP/C monthly budget. If a recipient's needs cannot be met within the budget limitations of the waiver, he/she cannot be served by the waiver.

Care should be taken by representatives of existing and potential CAP/C recipients to select the program that best meets the recipient's needs. A family, whose income makes the recipient eligible for Medicaid State plan and EPSDT services, may in certain instances, be better served by the State plan and EPSDT rather than the waiver because the needed services, when provided under the State Medicaid plan and EPSDT, are not subject to a budget limitation.

Example: *A child needs more in-home therapy services. The increased services do not fit in the CAP/C budget. The increased services can not be obtained through EPSDT, because the CAP/C budget limit still applies. The child would be terminated from CAP/C if a way could not be found to meet all of the child's needs within the budget. If the family was eligible for Medicaid only because of participation in the CAP/C program, the Medicaid would also be terminated. As a result, the child would be ineligible for ESPDT. If, on the other hand, the child's family was financially eligible for Medicaid and CAP/C participation is terminated, the medically needed therapies are provided under the State Medicaid plan and EPSDT.*

1.7. Who's Involved

The key people involved in the care of the CAP/C child, are:

- **The child's family or responsible party**, who help ensure the child's health, safety, and well-being in the home by actively participating , in conjunction with the case manager, provider agencies, and DMA, in planning and providing the child's care.

- **DMA's HCI Unit** who develops the policies and procedures for the program and manages its operation. DMA locates case managers for CAP/C applicants, assures that policies and procedures for CAP/C are followed in assessing and planning for the client's care, and approves referrals and plans of care. It also provides training and guidance to the case managers, publishes and distributes manuals, and handles the responsibilities related to the waiver.

- **The case management agency** that is often a county department of social services, health department, agency for the aged, or hospital within the county. The case management agency is responsible for client assessment and ongoing case management.

- **The enrolled CAP provider agency** that provides quality services according to Medicaid guidelines as well as applicable law, rules, and regulations.

- **The fiscal agent** who approves the nursing facility level of care and processes claims. It provides guidance and training related to these activities.

2.0 THE WAIVER

CAP/C is a Medicaid Home and Community-Based Services (HCBS) Waiver Program. The Centers for Medicare and Medicaid Services (CMS) granted North Carolina a HCBS waiver under Section 1915(c) of the Social Security Act that allows the State to offer the program. The waiver is the basis for program operation. Federal regulations for HCBS waivers are in 42 CFR Part 441 Subpart G.

The North Carolina Division of Medical Assistance CAP/C waiver can be found online at http://www.dhhs.state.nc.us/dma/commaltprog.htm. There are some attachments that were unable to be provided online; hard copies will be provided if requested - call the HCI Unit at 919 855 4380.

2.1 How Long a Waiver Exists

The waiver is approved by CMS for a specified time period and may be renewed. CAP/C currently operates under a waiver that was renewed July 1, 2005, for five years. CMS may terminate the waiver whenever it believes that the waiver is not being properly implemented.

2.2 Waiver Requirements

The requirements for the administration of CAP/C are established by the HCBS waiver. The waiver defines the target population and the related eligibility criteria; requests the waiving of certain Medicaid requirements; gives assurances regarding program operation; lists the services to be provided, including the definitions of those services, provider qualifications, and anticipated utilization; estimates the numbers to be served and the related costs; compares waiver costs to institutional costs to demonstrate cost-effectiveness; and gives other information about program administration. The waiver may be amended with the approval of CMS.

2.2.1 Target Population

The CAP/C services are targeted to children who require the care provided by a nursing facility (ICF or SNF level) or require long term hospital care as described in Section 8, and need Medicaid coverage of CAP/C Nursing Services or CAP/C Nurse Aide (Personal Care) Services in addition to CAP/C Case Management to remain safely at home. Subject to service availability and program requirements, a person who meets the criteria in 1.2 may be considered for CAP/C.

2.2.2 Waived Medicaid Requirements

CMS waived the following requirements in granting the waiver.

- **Comparable Services**: The Act requires a state to provide comparable services in amount, duration, and scope to all Medicaid recipients. This requirement is waived to allow CAP/C services to be offered to only CAP/C recipients.

- **Deeming of Income and Resources**: Medicaid rules require that the income and resources of a spouse/parent be considered in determining Medicaid eligibility for a person who resides with a spouse/parent. This is "deeming" income and resources to the Medicaid recipient. The deeming requirement is waived to allow Medicaid eligibility to be considered similar to the methods used for institutionalized individuals.

2.2.3 Assurances

A state must provide various assurances to CMS to obtain a waiver. North Carolina has provided assurances regarding the following:

- **Health and Welfare of Recipients**: Necessary safeguards are taken to protect the health and welfare of the recipients of the services. These safeguards include provider standards, certification/licensure requirements, specifications on the location of service delivery, and other requirements related to the health, safety, and well-being of the recipients.

- **Financial Accountability**: There is financial accountability for funds expended for CAP/C services. The State will maintain and make available to the Department of Health and Human Services, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits. Records are kept for at least five years.

- **Need for Nursing Facility or Hospital Care**: There is an initial evaluation and periodic reevaluations of the need for nursing facility (ICF or SNF) or hospital care. Written documentation of evaluations and reevaluations is maintained.

- **Recipient Choice**: When a recipient is determined likely to require the level of care provided in a nursing facility or hospital, the recipient or the recipient's legal representative will be informed of any feasible alternatives available under CAP/C; and given the choice of either institutional or CAP/C services.

- **Cost-Effectiveness**: The average per capita waiver year expenditures under the waiver will not exceed the average per capita expenditures that would have been made in the waiver year for nursing facility and hospital care had the waiver not been granted. Also, the total expenditures for home and community-based services ("CAP/C services") and other Medicaid services provided to individuals under the waiver will not, in any year of the waiver period, exceed the amount that would be incurred by Medicaid for these individuals in a nursing facility or hospital in the absence of the waiver.

- **Reports to CMS for Monitoring**: DMA will provide annual reports to CMS about the impact of the waiver on the type, amount, and cost of services provided under the State Plan and on the health and welfare of recipients. The information will be consistent with a data collection plan designed by CMS.

2.2.4 Number of Participants

The CAP/C waiver specifies the maximum number of children to be served each waiver year (July through the following June). Currently (through June 2006) the waiver allows North Carolina to serve up to 874 children. There is no designation of how many children can be served per county.

2.2.5 Services

The CAP/C services approved in the waiver are listed below. These services are sometimes referred to as "waiver services." Please refer to Sections 1 and 4 for service definitions, provider qualifications and limitations.

- Case Management
- CAP/C Nursing Services
- CAP/C Nurse Aide (Personal Care) Services
- CAP/C Waiver Supplies
- Home Mobility Aids/Home Modifications
- Respite (Institutional, In-Home Nursing, or In-Home Nurse Aide)

2.3 Federal Monitoring

CMS monitors the waiver operation through annual reports required of the State and on-site reviews.

3.0 PROGRAM ADMINISTRATION

This section summarizes the major aspects of the administration and operation of CAP/C. It outlines the primary responsibilities of DMA and the local case management agencies. Other sections give the details of the responsibilities.

3.1 DMA Responsibilities

DMA's HCI unit is the lead agency for the CAP/C program. DMA's major responsibilities with regard to CAP/C are described below.

3.1.1 Selection of Local Case Management Agencies

DMA designates the case management agencies that provide and arrange for services for CAP/C participants.

3.1.2 Establishing and Administering Policies and Procedures

DMA develops policies and procedures based on Federal guidelines for operating the program. It also oversees the local case management agencies to ensure that they are operating according to State policies and procedures and Federal guidelines.

3.1.3 Providing Manuals and Other Guidelines

DMA publishes manuals to guide the case managers and CAP provider agencies in providing CAP/C services. In addition to the CAP/C Manual, which is directed toward case managers, DMA publishes the Community Care Manual which is directed towards providers. The Community Care Manual contains DMA policies and procedures for the provision of most of Medicaid's home and community care services, including CAP/C services. The Community Care Manual is available online at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm. For recipients, there is 'A Consumer's Guide to North Carolina Medicaid; Health Insurance Programs for Families and Children'.

3.1.4 Providing Training and Technical Assistance

DMA provides training and technical assistance to the case managers about:

- Completing CAP/C assessments and plans of care.
- Developing and implementing CAP/C services.
- Coordinating CAP/C services with other resources and services in the community.
- Providing case management.

3.1.5 Approving CAP Participation and Plans of Care

DMA is responsible for reviewing and approving CAP/C referrals, assessments, and plans of care for all CAP/C participants.

3.1.6 Monitoring Program Operation

DMA monitors the CAP/C program to ensure that the provision of CAP/C services complies with the intent of the program and with State policies and procedures. There are multiple methods of monitoring, including on-site visits to case management agencies, client home visits, and record reviews.

3.1.7 Determining How Many May Participate

DMA obtains approval from the Federal government of the number of individuals Statewide that may participate in CAP/C.

3.1.8 Paying For Services

DMA is responsible for reimbursement policies and procedures. Reimbursement involves provider enrollment, rate setting, and claims processing. DMA contracts with a fiscal agent to process claims and assist provider agencies with reimbursement issues.

3.1.9 Completing Reports and Evaluations

DMA prepares and submits required Federal reports, and shares information from the reports with the case management agencies. The annual reports include information on the number served, the services used, costs, and health and welfare issues.

3.2 Responsibilities of the Local Case Management Agencies

The local CAP/C case management agency is responsible for managing the CAP/C participant's care on a day-to-day basis and providing certain CAP/C services. The responsibilities of the case management agencies are discussed in more detail below.

3.2.1 Networking, Educating

The case management agency develops and maintains relationships with local physician's offices, hospitals and discharge planners, provider agencies, parent groups, and other program resources. By maintaining these relationships, case managers ensure access to CAP/C for those who need it, and better coordination of care for clients or potential clients. Case managers provide ongoing education and information to clients or their responsible parties regarding the CAP/C program and how CAP/C policies or decisions relate specifically to the client.

3.2.2 Referring Applicants to the Program

When a parent, discharge planner, or other person calls a case management agency to inquire about CAP/C services, the Case Manager has a discussion with the inquirer about the eligibility requirements, services and limitations as well as the needs of the child and their expectations. This discussion is an opportunity to explain what the program can and cannot be expected to provide in relation to the child's needs. The Case Manager then should complete the referral form and submit it to DMA's HCI unit for prescreening.

Note: *The client always has the right to have the referral submitted. The Case Manager may not decide not to submit a referral to DMA because you think the referral is inappropriate and/or it would not be approved.*

3.2.3 Assessing Applicants for the Program

The local case management agencies arrange for a complete assessment of individuals who apply for CAP/C and who have been approved for assessment. The assessment determines the child's strengths and needs and is the basis for determining whether CAP/C is appropriate for the individual. The assessment is completed by a registered nurse or a registered nurse/social worker team who are experienced in home and community long term care assessment and case management.

3.2.4 Providing Case Management

CAP/C Case Management involves developing plans of care and coordinating and overseeing the provision of services to CAP/C clients. The case management agencies arrange for case management to be provided to all CAP/C participants on an ongoing basis. The amount of case management provided is based on the needs of the individual client and may fluctuate from month to month. The case manager is a registered nurse or social worker and is a member of the assessment team.

3.2.5 Providing Home Mobility Aids and Waiver Supplies

CAP/C Case Managers coordinate with local providers to ensure recipients can receive approved home mobility aids and waiver supplies to enhance their safety and functioning in the home that are not available under regular Medicaid. The specific types of mobility aids and supplies that may be provided are listed in Sections 4.3 and 4.5.

3.2.6 Coordinating Services

Case management agencies must coordinate closely with other agencies that work with CAP/C participants, such as health departments, departments of social services, home care agencies, and schools. Close coordination of medical and social services is necessary not only to ensure that the child receives a comprehensive package of services to protect their health, safety, and well-being, but to prevent duplication and make the best use of the home care resources available to children.

3.2.7 Managing Caseloads

Each CAP/C case management agency determines how many cases it has the capacity to manage at any given time. The number that can safely and effectively be served is based on the resources that are available to provide CAP/C services, such as case management staff and agencies that provide personal care and nursing services. As a general guideline, a full-time caseload for a CAP/C Case Manager is approximately 22 children. Caseload limits for case managers should be absolute; in other words, the agency should not make exceptions to the limit. It is important that the health, safety and well-being of participants not be compromised due to lack of staff resources. Agencies should notify their DMA Consultant if there is a child that can not be served because of agency staffing issues or caseload limitations. All efforts should be made to avoid a waiting list.

However, if a wait list is unavoidable, it is the case management agency's responsibility to update DMA monthly on the status of the wait list. Fax a brief statement to 919 715 9025, to the attention of your DMA Consultant, by the fifth of each month.

3.2.8 Ensuring Quality Services

Case managers oversee the provision of CAP/C services and locate and recruit qualified providers of CAP/C services. (See Section 19 for information about provider enrollment.) The case manager monitors the services the client is receiving through direct observation, client report, and review of provider documentation. The Case Manager acts as an advocate for the client and caregivers, within the benefits and limitations of the CAP/C program.

NOTE: *"Quality services" means services that meet the service standards set forth in this manual. Concerns that a provider is violating the standards should be reported to both the DMA CAP/C Consultant at 919 855 4380 and the regulatory body who licenses/certifies the provider.*

3.2.9 Ensuring Client Freedom of Choice

Case management agencies ensure that CAP/C clients are aware of their right to select

- between CAP/C services and institutionalization, and
- among enrolled Medicaid providers for CAP/C and other Medicaid services.

Special care must be taken to avoid a conflict of interest when the case management agency is a home health agency. The client must be given the choice of other nursing agencies to meet the client's needs. Freedom of choice should be explained to the client at the start of care and periodically thereafter, particularly any time a client expresses dissatisfaction with their home health agency services.

3.2.10 Cooperating With Monitoring and Reporting Activities

Case management agencies need to respond promptly to requests by DMA for information required for

- monitoring and quality assurance purposes to meet State and Federal requirements.
- determining CAP/C participation and plan of care approval.

A response is expected within 15 days unless otherwise agreed upon with the DMA CAP/C Consultant or HCI Unit Supervisor.

3.2.11 Documentation

Case management agencies maintain notes and other monitoring requirements as described in chapter 20 of this CAP/C manual.

3.2.12 Advance Notice of Intent to Terminate Provider Agreement for CAP/C Case Management Services

At a minimum, case management agencies must provide a one month advance notice of intent to terminate an agreement to provide direct case management services. Notice should be in writing, to the attention of the HCI Unit Supervisor. In order for DMA to have adequate time to make alternate arrangement, we request at least four months notice.

4.0 CAP/C SERVICES

This section describes the services that are covered in CAP/C. As you review these CAP/C services, remember the following:

- These services are for CAP/C clients.
- How much of each service a client will receive, how often it will be provided, and how long it will be provided must be approved in the CAP/C Plan of Care before Medicaid payment is available.
- A CAP/C service may be provided only by an agency enrolled with Medicaid to provide that specific service. (The agency must have a CAP/C provider number). See Section 19 for provider enrollment information.
- As a Medicaid client, the individual may also receive regular Medicaid services according to Medicaid policies and procedures (see http://www.dhhs.state.nc.us/dma, clinical coverage policies and provider manuals for specific information). The policies may restrict the receipt of some regular Medicaid services by CAP/C participants. For example, a participant may not receive another Medicaid-reimbursed case management service. See Section 5 for information about Medicaid's regular home and community care services.
- Like all Medicaid services, a CAP/C service may not be provided when reimbursement is available from or the responsibility of another payment source.

The HCPCS Procedure Code used to bill for the service is in parentheses. Provider and worker qualifications as well as specific limitations are shown.

***CAUTION**: With the exception of Case Management as described in 11.9, Medicaid will not pay for CAP/C services for a client who is a patient of a hospital, nursing facility, or ICF/MR.*

4.1 CAP/C Nursing Services (T1000)

CAP/C Nursing Services are for clients with medically necessary, continuous, complex and substantial skilled nursing care ordered by the physician. Actual skilled nursing interventions are required; nursing care to monitor for potential complications or to be there 'just in case something happens' is not covered. The service may include performance of specialized procedures, preparation of equipment and material for treatment, assistance in learning appropriate self-care techniques, and other medical tasks performed on an ongoing, daily basis. The nurse may also assist the child with eating or feeding, transfers, ambulation, and other personal care tasks when needed as an integral part of the child's day-to-day treatment plan. In addition to providing care in the home, the nurse may accompany (not transport) a child outside of the home when the child's normal life activities (such as attending school during the day) take the child away from the home during the day. CAP/C Nursing services may not be provided in a preschool or daycare. (See transportation section 5.8). If the care is to be provided in another private residence, such as another relative's home, the setting must be assessed and approved by the case manager prior to the delivery of the service.

Qualifications: An agency providing this service must be a home care agency licensed by the North Carolina Division of Facility Services to provide nursing services. Individuals providing care must be

licensed nurses who are qualified and supervised according to Home Care Licensure rules. These requirements are found in North Carolina Administrative Code Title 10, Chapter 3, Subchapter 3L.

A provider agency may not employ a spouse, parent, grandparent, child or sibling of the client, including step and in-law relationships, to provide the service.

***NOTE**: The home care agency providing the service uses the CMS-485 to document the physician's orders.*

Definitions:

Skilled Nursing,
applied to CAP/C, is defined as assessment, judgment, intervention, and evaluation of interventions that require the education, training, and experience of a nurse licensed by the North Carolina Board of Nursing per G.S. 90-17, Nurse Practice Act Chapter 21 NCAC 36. Skilled nursing excludes tasks which can be delegated to unlicensed personnel (in accordance with program requirements specified in section 3.0 and section 5.0 of the CAP/C policy)

Continuous
is defined as skilled nursing assessment and intervention which is performed at least every two to four hours during the hours that Medicaid-reimbursed nursing service is provided.

Complex
is defined as nursing assessments requiring interventions that can only be performed by a licensed nurse. The purpose of having a licensed nurse with the recipient is not for observation or monitoring in case an intervention is required. 'Just in case something happens' is not covered.

Substantial
is defined as multiple interrelated nursing assessments requiring interventions that can only be performed by a licensed nurse, in accordance with program requirements specified in section 3.0 and 5.0 of the CAP/C policy.

4.2 CAP/C Nurse Aide (Personal Care) Services (S5125)

CAP/C Nurse Aide (Personal Care) Services is assistance for children who need help with eating, bathing, dressing, personal hygiene, ambulation, and activities of daily living due to a medical condition. When specified in the plan of care, Nurse Aide Services may also include help with home management tasks (e.g., meal preparation, bed making, dusting and vacuuming) that are essential, although secondary, to the health and welfare of the individual rather than the individual's family.

Per the North Carolina Board of Nursing, the licensed nurse maintains accountability and responsibility for the delivery of safe and competent care. Decisions regarding the delegation of any Nurse Aide I or II tasks are made by the nurse on a client-by-client basis. A Registered Nurse is responsible for supervision of the Nurse Aide at least every 90 days.

***Caution**: This supervisory visit is not billable.*

Medical transportation, such as transporting a client to a physician's office, a clinic, or a hospital is not paid under CAP/C. Also, an aide accompanying the client during such travel is not paid.

Medicaid covers medical transportation through other sources. The CAP/C Nurse Aide (Personal Care Aide) may function in a supportive role by accompanying (not transporting) the client outside the home and facilitating participation in activities of daily living. Please refer to section 5.8 for details regarding the Medicaid transportation policy.

CAP/C Nurse Aide (Personal Care) services may not be provided to a child during the hours that the child is at school, preschool, or daycare.

Aides may not decide which medication a client needs at a given time. The aide may follow instructions from a mentally competent client or caregiver to assist the client in taking the medication, or can follow specific instructions from the primary caregiver in giving the client pre-filled and labeled medications, including medications via gastrostomy tube. See the Board of Nursing's interpretive statement "Assisting Clients with Self-Administration of Medications: The Role of Unlicensed Assistive Personnel", available at www.ncbon.orgor NCAC 36.0221 section B.

- **Level II - Personal Care**

Due to the medical fragility of CAP/C clients, it is strongly recommended that aides performing any of these tasks meet the NC Board of Nursing's competency requirements and be registered as a Nurse Aide I in the NC Nurse Aide Registry at the Division of Facility Services. However, if a client is receiving only Level II Personal Care Services, the staff may, if necessary, be an In-Home Aide who meets the competency and supervision requirements of the DHHS' In-Home Aide Services Plan.

- Assist ambulatory client with mobility and toileting
- Provide care for normal, unbroken skin
- Assist with personal hygiene (mouth care, hair and scalp grooming, fingernails and bathing: shower, tub, bed and basin)
- Cut and trim hair
- Provide basic first aid
- Shave client (electric and safety razor)
- Assist with applying ace bandages, TED's, binders as stipulated in the service plan, and under the direction of the client
- Assist limited function patient with dressing
- Observe, record and report self-administered medications
- Assist with applying and removing prosthetic devices for stable clients as stipulated in the service plan, and under the direction of the client
- Assist with feeding clients with special conditions (no swallowing difficulties)
- Assist and encourage physical activity and/or prescribed exercise
- Assist client with self-monitoring of temperature, pulse, blood pressure and weight as stipulated in the service plan, and under the direction of the client

- **Nurse Aide I Tasks**

Aides performing any of these tasks must meet the NC Board of Nursing's competency requirements and be registered as a Nurse Aide I in the NC Nurse Aide Registry at the Division of Facility Services.

1. Personal Care

- Bathing (assist, bed bath, tub bath, shower, sitz)
- Side rails/call rails
- Mouth care
- Skin care
- Nail care
- Bedmaking (modified)
- Dressing and undressing

2. Body Mechanics
    - Turn and position
    - Transfer – chair and stretcher
    - Use of lifts
    - Assist with ambulation
    - Range of motion exercises
3. Nutrition
    - Prepare patients for meal time
    - Feed patients
    - Intake and output
    - Force and restrict fluids
4. Elimination
    - Bedpan/urinal
    - Bowel/bladder retraining
    - Collect/test specimens
    - Perineal/catheter care
    - Apply condom catheters
    - Douches
    - Enemas
    - Insert rectal tubes/flatus bags

- Empty drainage devices from cavities/wounds
- Maintain gastric suction

5. Safety
    - Side rails/call rails
    - Mitts and restraints
    - CPR/Heimlich procedure
    - Infection control (handwashing, isolation technique, universal precautions)
6. Special Procedures
    - Vital signs (temperature, pulse, respirations, blood pressure)
    - Height and weight (stand up scales and bed scales)
    - Application of heat and cold
    - Prevent and care for decubitus ulcers
    - Surgical skin preps and scrubs
    - Clean dressing changes
    - Apply ace bandages, TEDS, and binders
    - Apply and remove EKG monitor leads
    - Postmortem care
    - Cough/deep breathing

Nurse Aide II Tasks

Nurse Aide II tasks are performed as part of this service when the tasks are provided according to the NC Board of Nursing rules. Registration with the NC Board of Nursing's Nurse Aide II Registry or special training of Nurse Aide I personnel with Board of Nursing approval is required.

1. Oxygen Therapy
    - Room set-up
    - Monitoring flow rate
2. Suctioning
    - Oropharyngeal

- nasopharyngeal

3. break-up and removal of fecal impaction

4. tracheostomy care

5. sterile dressing change/wound irrigation (over 48 hours old)

6. intravenous fluid – assistive activities

- assemble/flush tubing during set-up
- monitoring flow rate
- site care, dressing changes
- discontinue peripheral IVs

7. elimination procedures (ostomy care/irrigation)

- catheterizations
- irrigation of tubing

8. nutritional activities

- oral, nasogastric infusions after placement verification by licensed nurse
- gastrostomy feedings
- clamping tubes
- removing oral, nasogastric feeding tubes

Other Nurse Aide Tasks

The licensed nurse maintains accountability and responsibility for the delivery of safe and competent care. Decisions regarding delegation of <u>any</u> activities are made by the licensed nurse on a client-by-client basis. The following criteria must be met before delegation of any task may occur:

- task is performed frequently in the daily care of a client or group of clients
- task is performed according to an established sequence of steps
- task may be performed with a predictable outcome
- task does <u>not</u> involve on-going assessment, interpretation or decision-making that cannot be logically separated from the task itself.

As part of accountability, the licensed nurse <u>must validate the competencies of the NA prior to delegating tasks, as well as monitor the client's status and response to care provided on an on-going basis.</u>

The aide may also do the following home management tasks when the task is incidental to the personal care tasks and when the aide is in the home to perform the higher level tasks.

- Clean and care for clothing: ironing, simple mending, laundering
- Do basic housekeeping tasks: sweeping, vacuuming, dusting, dishes in patient care area
- Make unoccupied bed
- Recognize and report changes in health and environment
- Identify medications for client
- Prepare simple meals
- Observe and report symptoms of abuse, neglect, and illness to proper professional
- Assist to find and use community resources
- Perform reading and writing tasks
- Demonstrate appropriate housekeeping practices for cleaning bathroom, kitchen and living areas used by client
- Assist in organizing household routines
- Plan menus using food guide
- Assist with developing a market order
- Demonstrate appropriate food handling, preparation and storage practices

CAUTIONS*: As you consider the tasks to be assigned to the aide, remember: You may not provide home management tasks as a separate service. These tasks are covered only when the aide is in the home to provide Personal Care.*

Qualifications: An agency providing this service must be a home care agency licensed by the North Carolina Division of Facility Services to provide Nurse Aide Services. Individuals who provide Nurse Aide Services must meet the qualifications and supervision requirements for home care agencies. These requirements are found in North Carolina Administrative Code Title 10, Chapter 3, Subchapter 3L. In addition, an aide performing any task deemed by the North Carolina Board of Nursing to require Nurse Aide I registration must be registered as a Nurse Aide I.

A provider agency may not employ a spouse, parent, grandparent, child, or sibling of the client, including step and in-law relationships, to provide the service.

Limitations: CAP/C Nurse Aide (Personal Care) Services may not be provided on the same day as Medicaid Personal Care Services or Home Health Aide Services.

Availability of Nurse Aides: In many instances, Nurse Aide IIs are unavailable, and home care agencies are unwilling to allow Nurse Aide Is to perform all of the tasks permitted by the Division of Facility Services and/or the Board of Nursing. Medicaid will not provide payment for an RN/LPN in these circumstances. It is the provider agency's option to staff the case with an RN/LPN, but that RN or LPN would have to be registered as a Nurse Aide with the Division of Facility Services/Board of Nursing, provide care within the NA scope of practice, and be reimbursed by Medicaid at the NA rate. Note that clients at the skilled level of care do not have a "choice" of nurse or nurse aide; the level of caregiver approved will depend upon the scope of practice that the client requires.

4.3 CAP/C Waiver Supplies

The following items may be provided to a CAP/C participant to promote the health and well being of the individual.

- Nutritional supplements taken by mouth when ordered by a physician.

NOTE: *The physician's orders must be in writing and on file within the recipient's record, and must be renewed every 12 months at minimum.*

NOTE: *For children five years of age or younger, formula should be provided through WIC, with the balance, if any, paid by CAP/C. In the rare instance that a parent refuses WIC, the entire cost may be billed to CAP/C, and the parent's choice should be noted in the comments section on the Plan of Care.*
Formula given via a feeding tube is a regular Medicaid item, not a waiver supply.

- Reusable incontinence undergarments and the disposable liners for the undergarments for children ages 2 and older.

Qualifications: The case management agency bills Medicaid for these items. The supplies must be considered by the case manager to be of sufficient quality to provide for the intended use, and they must be approved in the individual's Plan of Care.

4.4 Case Management (T1016)

CAP/C Case Management is assisting individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case management activities include assessing and reassessing client needs, planning care as well as locating, obtaining, and coordinating services, and ongoing monitoring of the provision of services included in the plan of care, to maintain the client's health, safety, and well-being in the community. The case manager's responsibilities are discussed in Section 11 as well as throughout this manual in regard to specific topics. The principal components of case management are:

- Referral intake and conducting approved assessments for the recipient for the program

- Explaining the benefits and limitations of the CAP/C program to the parents/caregivers and physicians and ensuring understanding of freedom of choice.

- Reviewing client's rights and responsibilities, documenting any deviation from them, and informing DMA of them.

- Developing the Plan of Care, revising the Plan as needed, and following up to secure approval of the Plan and all revisions.

- Locating and coordinating sources of help from within the family and community so that the burden of care is not exclusively borne by formal health and social agencies.

- Monitoring the client's situation to assure quality care as well as the continued appropriateness of the services and CAP/C participation. A home visit should be done at least every 90 days to observe the recipient and the home environment; however, monthly visits are preferred if the situation dictates (e.g., hospital level of care, acute medical or social situations). Visits may also take place in the child's school or the physician office, but those visits do not take the place of a home visit. Telephone contact with the recipient and family should be made at least every 30 days. The monitoring also includes reviewing provider documentation and claims, and obtaining input from the client, family, physician, caregivers, and providers.

- Coordinating with Medicaid income maintenance staff regarding the client's Medicaid eligibility and the meeting of applicable deductibles. This includes planning with the income maintenance caseworkers, clients, and families/primary caregivers on how deductibles will be met. See 6.4 for details.

- Conducting the annual reassessment (Continued Need Review). See Section 13 for details.

- Discharging the client in accordance with CAP/C policies and procedures as directed by DMA, when CAP/C is no longer appropriate.

- Ensuring the policies and procedures of the program are upheld to maintain the health, safety, and well being of the recipient.

- Ensuring that other services offered to a CAP/C recipient (e.g., hospice, respiratory therapy) are not duplicating CAP/C services and they fit within the CAP/C cost limits.

Qualifications: The case manager must be a social worker or registered nurse from an agency that is enrolled by Medicaid to provide case management for CAP/C. The case manager must be experienced in the evaluation and provision of long term community care services. A social worker must meet N.C. Office of State Personnel job specifications for a Social Worker I or II or higher. A registered nurse must meet N.C. Office of State Personnel job specifications for a Public Health Nurse I or II or higher. Please refer to http://ncosp.osp.state.nc.us/CLASS_SPECS/WebPages/ASpecs.htm.

4.5 Home Mobility Aids/Home Modifications (S5165)

Home Mobility Aids are the following items provided to give the client mobility, safety, and independence in the home. They are used to adapt the client's home environment to help overcome functional limitations. These items include:

- Stationary wheelchair ramps.

- Safety rails.

- Grab bars.

- Non-skid surfaces (rough surfaced strips of adhesive material that adhere to non-carpeted areas such as concrete, linoleum, wood, tile, porcelain, or fiberglass).

- Handheld showers.

- Widening of doorways for wheelchair access for the CAP/C client.

Qualifications: The case management agency bills Medicaid for these items. The Home Mobility Aids must be provided by individuals capable of constructing or installing the needed apparatus, with any construction/ installation completed in accordance with State and local building codes. Portable wheelchair ramps do not meet state and local building codes, and will not be approved; wheelchair ramps must be stationary.

Limitations: The total cost of all Home Mobility Aids provided in one fiscal year (July-June) may not exceed $1,500.00. The cost of durable medical equipment and home mobility aids can be prorated over 12 months or the client's expected time of CAP/C participation, whichever is less.

4.6 Respite Care (In-Home Nurse Aide -S5150; In-Home Nurse – T1005; Institutional - H0045)

Respite care provides temporary support to a family caring for a CAP/C child. It may be used as day, evening, or overnight care to meet a range of needs. These include planned absences, such as vacations; relief from the stress of caregiving; shopping; and giving a child respite from his family. Respite care is available as In-Home Respite in which the respite worker goes into the client's home, and as Institutional Respite in which the client goes into a facility that is licensed to provide the appropriate level of care.

Qualifications:

Respite Care: In-Home- Nurse Aide (S5150): An agency providing this service must be a home care agency licensed by the North Carolina Division of Facility Services to provide In-Home Aide services. Individuals who provide In-Home Aide Services must meet the qualifications and supervision requirements for home care agencies according to home care licensure rules. These requirements are found in North Carolina Administrative Code Title 10, Chapter 3, Subchapter 3L.

Respite Care: In-Home Nurse (T1005): An agency providing this service must be a home care agency licensed by the North Carolina Division of Facility Services to provide RN and LPN services. Individuals who provide RN and LPN services must meet the qualifications for home care agencies according to home care licensure rules. These requirements are found in North Carolina Administrative Code Title 10, Chapter 3, Subchapter 3L. The total In-Home Nurse Respite Care a client receives in one fiscal year (July-June) may not exceed 168 hours.

Institutional Respite (H0045): This service is provided in a facility licensed to provide the level of care required by the client - for example, a client who requires ICF care must be placed in a facility licensed to provide ICF care.

Note: therapy services provided during institutionalization are included in the per day cost of the respite.

Limitations: The total Respite Care a client receives in one fiscal year (July-June) may not exceed 720 hours. Each day of Institutional Respite counts as 24 hours against the limit. The 168 hours of in-home nursing respite counts against the limit (so that a child receiving RN/LPN services may receive 168 hours of in-home respite and 552 hours of institutional respite per fiscal year, provided that it fits in the budget).

NOTE: *Respite services are intended to provide leisure time to caregivers. Short-term-intensive services should be used for extra hours that are needed due to acute or post-hospitalization medical needs, family emergencies, or unusual and intermittent work or school obligations.*

NOTE: *Respite services may be billed on either a standing, per-month basis, or on an as- needed basis. There is a worksheet available (for your optional use) on the web at http://www.dhhs.state.nc.us/dma/forms.html#prov that can assist you with tracking the respite hours used and available.*

NOTE: *The hourly limits detailed above are program limits. The amount of respite that any individual caregiver receives is subject to it fitting within the cost limit for that client's level of care.*

5.0 REGULAR MEDICAID COMMUNITY SERVICES

CAP/C clients may receive all of the regular Medicaid services according to Medicaid policies and procedures; however, the policies may restrict the receipt of some regular Medicaid services by CAP/C participants. For example, Medicaid will not pay for another Medicaid-reimbursed case management service in addition to CAP/C case management.

NOTE: Services provided by CDSAs, are often, but not always, duplicative of CAP/C services. Non-duplicative CDSA services may be provided under CAP/C, and are counted on the client's budget as per the CDSA fee schedule. Clients can not, however, receive both CDSA case management and CAP/C case management, even if both services are provided.

Medicaid offers Durable Medical Equipment, Home Health Services, Home Infusion Therapy, Hospice, Personal Care Services, Private Duty Nursing, and special health-related services for children. These services are provided according to Medicaid rules and guidelines. Each service may be supplied only by an agency enrolled as a Medicaid provider for that specific service.

The following summarizes each of these services. More information can be obtained from the *Medicaid Clinical Coverage Policies and Provider Manuals* and the monthly *Medicaid Bulletins*. You will find these publications at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

CAUTION: *This material is only a brief general overview of services and programs. It does not contain all the details about what is covered, when it is covered, who is eligible for the coverage, and the coverage limits.*

REMEMBER: *If Medicaid pays for any of these services for a CAP/C client, the Medicaid cost of the service counts toward the monthly cost limit.*

5.1 Durable Medical Equipment (DME)

DME covers the equipment and related supplies listed on the Durable Medical Equipment Fee Schedule when the item is medically necessary and appropriate for use in a patient's private home. An item is medically necessary if it is needed to maintain or improve a patient's medical, physical or functional level. The patient's physician must verify the need. Convenience items or features are not covered.

Payment for all items includes delivery to the patient's home as well as any required fitting and assembly. Rental payments also include any needed service and repair of the item as well as supplies for use with the equipment during the rental period.

REMEMBER*: DME items including prosthetics and orthotics must be included on the Plan of Care.*

5.1.1 What's Covered

Covered equipment is divided into six categories:

- **Inexpensive or Routinely Purchased** items are purchased for a patient.
- **Capped Rental/Purchased Equipment** that is rented or purchased according to the anticipated need for the item. The item is rented if the physician documents that the

anticipated need is six months or less. The item may be rented or purchased if the physician documents that the anticipated need exceeds six months. Once rental is initiated on an item, a subsequent request for prior approval of purchase of the item will be denied. The item becomes the property of the patient when the accrued rental payments reach Medicaid's allowable purchase price.

- **Equipment Requiring Frequent and Substantial Servicing** is rented.
- **Customized Equipment** is equipment prescribed due to a patient's unique physical needs. Patients who need this type of equipment generally have permanent, severe disabilities and require these items to perform even the most basic functions. These items are purchased for the patient.
- **Oxygen and Oxygen Equipment** includes items dealing with oxygen delivery.
- **Prosthetics and Orthotics** are purchased.

Related medical supplies listed on the DME Fee Schedule are covered when they are provided for use with a DME item owned by the patient.

The service and repair of a DME item owned by a patient is covered over the useful life of the item. The useful life is determined by DMA.

5.1.2 How to Get DME

The following steps outline how a patient receives DME and related supplies. The steps are in the order that they are usually accomplished.

Step 1 the Patient's Physician Prescribes The Item(s)

A physician who has personally examined the patient writes a prescription for the needed DME item(s). The prescription is given to the enrolled DME supplier.

Step 2 The Certificate of Medical Necessity/Prior Approval (CMN/PA) Is Completed

The supplier fills out the appropriate items on the Certificate of Medical Necessity/Prior Approval (CMN/PA) form. The supplier sends the form to the prescribing physician for completion of the items requiring the physician's knowledge and expertise. The physician completes those items, signs and dates the form, and returns it to the supplier.

Step 3 The Supplier Verifies Medicaid Eligibility

The supplier verifies Medicaid eligibility, being sure that the patient has the proper coverage and is eligible on the date of service. The supplier also checks such things as possible Medicare coverage and insurance coverage, as well as possible participation in a Medicaid managed care program, CAP or Hospice. The Case Manager should sign the request for authorization form, signifying that the request will fit into the recipient's budget and is authorized by CAP/C.

Step 4 The Supplier Assesses Appropriateness

Although the patient's physician is responsible for prescribing DME and DME-related supplies, the supplier reviews the available information to see if an item appears appropriate. The supplier resolves any concerns before proceeding. If anything ordered by the physician appears inappropriate or a potential source of problems, the supplier contacts the physician. There are key points to be considered by the supplier. If you are referring a CAP patient for DME, consider the following:

- **Does the patient have a medical necessity for the item?** Look at whether the item is a necessity or a convenience for the patient or his caregivers. For example, a patient may want an electric hospital bed; however, a manual bed meets the patient's need.

- **Is the item required for the patient to function within his home?** Be sure that the patient needs the equipment in order to perform routine daily activities in his place of residence.

- **Is the item appropriate for the patient's situation?** Check to see if the item can be used comfortably and safely in the patient's home. For example, the doors of a patient's home are too small to accommodate the type wheelchair prescribed by his physician.

- **Has Medicaid previously furnished this item to the patient?** If Medicaid has previously purchased the same equipment for a patient, there are specific requirements that must be met before a replacement is allowed. If Medicaid has previously paid rental for the item and it is a capped rental item, there will be payment limitations. Refer to Attachment D of the DME manual: *Lifetime Expectancies and Quantity Limitations for DME.*

- **Is the patient on Hospice?** A patient receiving Hospice under Medicaid or Medicare may not receive DME coverage for items related to the treatment of the terminal illness. A patient who meets the requirements of both services may choose which service he wants to receive. See 5.4 for information on Hospice.

- **Is the patient receiving HIT – Drug Therapy?** A patient receiving drug infusion therapy through Medicaid HIT coverage may not receive DME coverage for items related to the therapy. See 5.3 for information on HIT.

Step 5 The Supplier Requests Prior Approval When Required

Some of the items listed on the DME Fee Schedule have an asterisk (*) beside them. These items require prior approval. In addition, all prosthetics and orthotics require prior approval. If the prescribed item requires prior approval, the supplier initiates the request. For these items, a supplier may want to wait until it receives approval before delivering the item. If a supplier delivers an item before obtaining approval, it does so at its own risk.

NOTE: *Prior approval authorizes payment for a DME item only if the person is Medicaid eligible. It does not ensure that the patient is on Medicaid nor waive other prerequisites to payment, such as billing third party payers. The supplier must verify Medicaid eligibility and follow other reimbursement responsibilities.*

REMEMBER: *DME items that are not covered by Medicaid but needed for a child may be requested through Children's Special Health Services (CSHS). If approved, these items are added to the Plan of Care, in the 'Other' column.*

5.1.3 Coordinating Care

CAP/C case managers work with DME suppliers to ensure good patient care and to be knowledgeable of DME being supplied to CAP clients. Close coordination helps:

- To avoid duplication, overlap, and receipt of unnecessary items.
- To assure that, with DMA approval, covered items are replaced when out of warranty or are no longer cost-effective to repair. Medicaid has established anticipated life expectancies for covered items.
- To keep the total cost for a patient's level of care within the monthly allowable cost limit.

5.2 Home Health Services

Home Health Services are provided by certified home health agencies under a plan of treatment authorized and approved by a physician. Medical supplies available under Home Health also may be provided by the CAP/C case management agency for CAP/C clients.

REMEMBER: *All Home Health Services are included in the Plan of Care.*

5.2.1 Who's Covered

Home Health skilled services (skilled nursing, physical therapy, speech-language pathology and occupational therapy), aide services, and medical supplies are for homebound patients who reside in private residences. Medical supplies are available to patients in private residences regardless of homebound status.

5.2.2 What's Covered

Home Health covers the following services when they are medically necessary to help restore, rehabilitate or maintain a patient in the home:

- **Skilled nursing visits** Skilled nursing is the assessment, judgment, intervention, and evaluation of interventions that require the education, training and experience of a licensed nurse. Skilled nursing services are covered when furnished by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Services must be medically reasonable and necessary for the diagnoses and to the treatment of the recipient's illness or injury. The services include:
  - Observation, assessment and evaluation of the recipient's condition when only the specialized skills and training of a licensed nurse can determine the recipient's medical status
  - Management and evaluation of the recipient's plan of care (POC) to ensure that the care is achieving its purpose

- Teaching and training the recipient, the recipient's family or other caregivers how to manage the recipient's treatment regimen

- Skilled nursing procedures medically reasonable and necessary for the treatment of the recipient's illness or injury

NOTE: *Please note the difference between skilled nursing visits and private duty nursing. A skilled nursing visit is less than two hours in duration and is provided to perform and/or teach a specific nursing skill. Private duty nursing refers to a nurse working several continuous hours; i.e., a "shift", in a client's home.*

CAUTION**:** *It is rare that a child receiving CAP/C Nursing would also require Home Health skilled nursing visits. When a client is receiving home infusion therapy, it is sometimes appropriate for the client to receive Home Infusion Therapy Services and CAP/C Nursing services.*

- **Physical therapy** services are covered when provided by a licensed physical therapist (PT) or a licensed physical therapist assistant under the direction of a licensed PT to help relieve pain, restore maximum body function and prevent disability following disease, injury or loss of a part of the body.

- **Speech-therapy** services are covered when provided by a licensed speech-language pathologist to treat speech and language disorders that result in communication disabilities. The services are also provided to treat swallowing disorders (dysphagia), regardless of the presence of a communication disability.

- **Occupational therapy** services are covered when provided by a licensed occupational therapist (OT) or by a licensed occupational therapy assistant under the direction of a licensed OT to help improve and restore functions impaired by illness or injury. When a recipient's functions are permanently lost or reduced, occupational therapy helps improve the recipient's ability to perform the tasks needed for independent living.

- **Home Health Aide Services** are paraprofessional services provided by a Nurse Aide I or II to support or assist the skilled services (skilled nursing and specialized therapies) being provided. Home health aide services help maintain a recipient's health and facilitate treatment of the recipient's illness or injury. Typical tasks include:

    - Assisting with activities of daily living (bathing, caring for hair and teeth, eating, exercising, elimination assistance, and transferring).

    - Assisting a recipient in taking self-administered medications that do not require the skills of a licensed nurse to be provided safely and effectively.

    - Assisting with home maintenance that is incidental to a recipient's medical care needs, such as light cleaning, meal preparation, taking out trash and grocery shopping.

    - Performing simple medical duties, such as taking a recipient's temperature, pulse, respirations and blood pressure; weighing the recipient; changing dressings that do not require the skills of a licensed nurse; and reporting changes in the recipient's condition and needs to appropriate health care professionals.

CAUTION: *Home health aide services and CAP/C Nurse Aide (Personal Care) Services may not be provided on the same day.*

- **Medical supplies** include those items listed on the Home Health Maximum Reimbursement Rate Schedule. This list is available on DMA'S website at http://www.dhhs.state.nc.us/dma/fee/fee.htm. Medical supplies are covered when the supplies are ordered by a physician, documented in the recipient's plan of care, and are medically necessary as part of the recipient's home health care. The supplies may be furnished to any eligible Medicaid recipient as long as these criteria are met even if no other skilled services are rendered. An item is covered when it meets the following criteria:

  1. The item supplied is medically reasonable and necessary for treatment of a recipient's illness or injury.

  2. The item supplied has a therapeutic or diagnostic purpose for a specific recipient and is not a convenience or comfort item (items that are often used by persons who are not ill or injured, such as soaps, shampoos, lotions and skin conditioners).

  3. The item supplied must be specifically ordered by the physician and included in the POC. The physician's order in itself does not make an item "medically necessary" in the context of Medicaid coverage. The order authorizes you to provide the item but it should be billed to Medicaid only if it meets Medicaid criteria.

  4. The item supplied is not an item routinely furnished as part of recipient care (minor medical and surgical supplies routinely used in recipient care such as alcohol wipes, applicators, lubricants, thermometers, and thermometer covers are not billed individually to Medicaid). These items are considered part of an agency's overhead costs and cannot be reimbursed as separate items.

  5. The item supplied is one considered a home health medical item by Medicaid. Items such as drugs and biologicals, medical equipment, orthotics and prosthetics, and nutritional supplements are examples of items not considered home health medical supplies.

  6. Assessment of the need of the supply, and the appropriateness of the item supplied, is determined by a RN at least every 60 days through an in home assessment.

  NOTE: *This visit is counted on the CAP/C Plan of Care, in the 'Medicaid' column. It is NOT covered if the agency providing the supplies is also providing CAP/C Nursing. In that case, the CAP/C Nurse can do the supply assessment.*

  7. When incontinence supplies are being provided and the only service being rendered involves physical or occupational therapy, the assessment for incontinence supplies can be conducted by the therapist.

  The *Home Health Maximum Reimbursement Rate Schedule* lists the covered medical supplies with the applicable national HCPCS code. The fee schedule is posted on DMA's website (http://www.dhhs.state.nc.us/dma/fee/fee.htm) and lists covered supplies by HCPCS code as mandated under the Health Insurance Portability and Accountability Act (HIPAA). Periodic updates are made to the fee schedule to accommodate coding changes made by the Centers for Medicare and Medicaid Services (CMS). Every effort is made to include the items that are medically necessary and reasonable to treat the illness, diseases or injuries common to the

Medicaid home care population. Provisions are made to allow billing and reimbursement for items that are medically necessary for treatment but not included on the fee schedule through using miscellaneous procedure codes. The miscellaneous code used must be on the fee schedule and the supply must meet Medicaid's coverage criteria. When considering the use of a miscellaneous procedure code:

1. Determine whether the item is not elsewhere classified (listed under another Medicaid program). If the supply is on the Durable Medical Equipment (DME) fee schedule or the Home Infusion Therapy (HIT) fee schedule, but is not listed on the *Home Health Maximum Reimbursement Rate Schedule,* the item is not covered as a home health medical supply
.
2. Determine whether the item meets the medical necessity criteria outlined above.

3. Document the medical reason necessitating the use of this item instead of one listed on the fee schedule. Retain this information in the recipient's medical records.

Note: *If the medical supply item is not listed on the fee schedule but will need to be used on a continuous basis, a request to add the item should be submitted to DMA. The request must be submitted on the* ***Request for Medicaid Coverage – New Home Health Supply form*** *(form A001) with supporting documentation on cost, usage, and efficacy. Refer to* ***Attachment D of the Home Health Services Clinical Coverage Policy, Request for Medicaid Coverage of New Home Health Supply*** *(located at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm, policy 3A) for additional information and a copy of the form.*

5.3 Home Infusion Therapy (HIT)

HIT covers self-administered infusion therapies for a patient when the therapy is medically necessary. Both the drug and nutrition therapies are provided by home infusion therapy agencies that are enrolled with the Division of Medical Assistance as HIT providers. DME suppliers that are enrolled with DMA may also bill the equipment, formulae, and supplies for enteral nutrition therapy to Medicaid.

REMEMBER*: HIT services must be included on the Plan of Care.*

5.3.1 Who's Covered

HIT is for patients who live in a private residence or an adult care home (such as a rest home or family care home). The patient or caregiver is capable, able, and willing to self-administer the therapy following appropriate teaching and with adequate monitoring.

5.3.2 What's Covered

HIT covers the following self-administered infusion therapies when they are medically necessary:

- Total Parenteral Nutrition (TPN)
- Enteral Nutrition (EN)

NOTE: *The enteral formulae listed on the Medicaid list of approved infusion therapies are the formulae a lead agency may provide as a CAP/C Waiver Supply when the formulae are given orally.*

- Chemotherapy (Intravenous)
- Antibiotic Therapy (Intravenous)
- Pain Management Therapy (Subcutaneous, Epidural, Intrathecal and Intravenous)

Drug therapies are paid in a daily fee ("per diem") that includes the equipment, supplies, nursing services and pharmacy services needed for the administration of the drug. The fee also includes delivery to the patient's residence. The package does not pay for the drug - it is paid for through Medicaid's coverage of prescription drugs. The drug is not included on the CAP/C Plan of Care.

Nutrition therapy coverage pays for the equipment, supplies and formulae/solutions ordered by the physician and provided according to standards of practice. The allowance for all items includes delivery to a patient's residence.

5.4 Hospice

Hospice is a package of medical and support services for terminally ill individuals provided by Medicare/Medicaid certified hospice agencies that are enrolled with the Division of Medical Assistance. An individual is considered terminally ill if he or she has a medical prognosis of a six month or less life expectancy. The hospice services are related to the terminal illness. The services are provided in a private residence, an adult care home, a hospice residential care facility, or a hospice inpatient unit. They may also be provided in a hospital or nursing facility under arrangement with the hospice agency.

5.4.1 Who's Covered

A patient must be terminally ill – that is, have a medical prognosis that his life expectancy is six months or less – and choose to participate in Hospice by electing the coverage. The election is for a "benefit period" – a specific period of time for the coverage to be provided. During the time a patient elects Hospice, the patient waives Medicaid coverage of most other services for the treatment of the terminal illness and related conditions as the Hospice package is designed to meet all of the patient's needs. See 5.4.5 for the relationship between CAP/C and Hospice.

5.4.2 What's Covered

The following services are included under Hospice when the service is related to the patient's terminal illness.

- Nursing care.
- Certain physicians' services provided by a licensed doctor of medicine or doctor of osteopathy.
- Medical social services.

- Counseling services, including dietary and bereavement counseling, for the patient, family members and others caring for the patient.
- Home health aide and homemaker services.
- Physical therapy, occupational therapy and speech-language pathology services.
- Short-term inpatient care (general and respite) in a hospice inpatient unit, or a hospital or nursing facility under contractual arrangement with the hospice agency.
- Medical appliances and supplies, including drugs and biologicals. The drugs are those used primarily for pain relief and symptom control related to the terminal illness. Appliances include medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness.
- Ambulance services that are related to the palliation or management of the patient’s terminal illness.

5.4.3 Levels of Care

Each day of a patient's coverage is classified at one of four levels of care. The level is determined by the type and intensity of services the patient needs on that day.

- **Routine Home Care** is the basic level of care that is provided to support a patient. It is provided in a private residence, a hospice residential care facility, or an adult care home. It also may be provided in a nursing facility if the facility has a contractual arrangement with the hospice agency.
- **Continuous Home Care** is provided during a medical crisis - that is, a time when the patient's physician believes that the patient needs continuous care, primarily nursing care, to achieve palliation or management of acute medical symptoms.
    - The patient must need care for at least eight hours of the calendar day (the hours may be split into two or more periods during the day);
    - Nursing services by an RN or LPN must be provided for more than half of the hours of care in a day; and
    - Homemaker and home health aide services may supplement the nursing care.
- **Inpatient Respite Care** is short-term care to relieve family members and other unpaid caregivers caring for a patient in a private residence. Respite may be provided only on an occasional basis for up to five consecutive days at a time. It is provided in a hospice inpatient facility or a hospital or nursing facility under arrangement with the hospice agency. The hospital or nursing facility must meet the special hospice standards for staffing and patient areas.
- **General Inpatient Care** is for the management of symptoms or to perform procedures for pain control that cannot be performed in other settings. The care is provided in a hospice inpatient facility, a hospital or a nursing facility under arrangement with the hospice agency.

The hospital or nursing facility must meet the special hospice standards for staffing and patient areas.

5.4.4 Benefit Periods

A patient or the patient's representative elects Hospice coverage for a "benefit period." The benefit periods are available in the following sequence:

- An initial 90 day period;
- A second 90 day period;
- Followed by an unlimited number of 60 day periods.

5.4.5 Coordination Of Care

When the hospice agency confirms that the patient has a medical prognosis of six months or less to live, it assesses the appropriateness of the patient for hospice and develops a plan of care. If found appropriate, the patient has the opportunity to elect Hospice while waiving other Medicaid coverages for the terminal illness. If the patient is also eligible for Medicare, Hospice coverage under both programs must be elected. If a CAP patient is being considered for Hospice care, it must be determined if Medicare or Medicaid is the primary payer.

- ***If Medicaid is the primary payer and the client is at ICF or SNF level of care,*** you will not be able to offer CAP/C at the same time as Hospice. The cost of Hospice will not fit within the CAP/C cost limit. The client has a choice of which to pursue. The hospice agency's care coordinator, the child's primary caregivers and you can discuss the alternatives.

- ***If Medicaid is the primary payer and the client is at hospital level of care,*** it may be possible to participate in CAP/C at the same time as Hospice. The cost of Hospice will have to fit within the CAP/C cost limit. CAP/C services may be considered that are not included in the Hospice benefit. The hospice agency's care coordinator, and child's primary caregivers and you can discuss the alternatives. In addition to Case Management, you may consider a Medicare Hospice patient for the following services from CAP/C:

  - Home Mobility Aids
  - In-Home Respite (Hospice covers Institutional Respite)
  - Oral Nutritional Supplements under CAP/C Waiver Supplies (the other supplies are a Hospice responsibility)

  You may also include CAP/C Nursing or Nurse Aide (Personal Care) Services to the extent that they do not duplicate what the hospice agency is required to provide under hospice home health aide and homemaker services. When planning CAP/C Nursing or Nurse Aide (Personal Care) Services, carefully coordinate your actions with the hospice agency to avoid duplication. Take the following steps:

  Step 1 Determine the client's need for service - what tasks are required and when they are required.

Step 2 In coordination with the hospice agency, create a plan for meeting the needs. Consider the differences between the hospice nurse or aide coverage and the CAP/C Nursing or Nurse Aide (Personal Care) Services in making this determination.

- The hospice staff will go into the home to complete specific personal care and home management tasks for the client on a visit basis. Determine when the hospice staff will handle these responsibilities. Get a schedule so that you can avoid overlapping with the CAP/C staff.

- The CAP/C staff's duties are broader as they often substitute for family members or caregivers during their absence to provide for the unscheduled personal care needs of the client. The CAP/C staff may spend time supervising the client and assisting with tasks throughout the day, such as toileting, transfer, and ambulation. The staff may also perform medical tasks and monitoring within their scope of practice. Determine the hours that the client needs this support. These are times when the hospice staff will not be with the client.

Step 3 Include the CAP/C Nursing or Nurse Aide (Personal Care) hours in the CAP Cost Summary. Submit the revision to DMA.

Show "Hospice" on the Cost Summary with Medicaid as the payer. If the client's need can be met within the cost limit, the client may be considered for CAP/C participation.

REMEMBER: *Do not offer CAP/C services that duplicate or replace the care that is the responsibility of the hospice agency.*

- ***If Medicare is the primary payer,*** determine the needs of the patient that are not included in the Hospice benefit. In addition to Case Management, you may consider a Medicare Hospice patient for the following services from CAP/C:

  - Home Mobility Aids

  - In-Home Respite (Hospice covers Institutional Respite)

  - Oral Nutritional Supplements under CAP/C Waiver Supplies (the other supplies are a Hospice responsibility)

  You may also include CAP/C Nursing or Nurse Aide (Personal Care) Services to the extent that they do not duplicate what the hospice agency is required to provide under hospice home health aide and homemaker services. When planning CAP/C Nursing or Nurse Aide (Personal Care) Services, carefully coordinate your actions with the hospice agency to avoid duplication. Take the following steps:

  Step 1 Determine the client's need for service - what tasks are required and when they are required.

  Step 2 In coordination with the hospice agency, create a plan for meeting the needs. Consider the differences between the hospice aide coverage and the

CAP/C Nursing or Nurse Aide (Personal Care) Services in making this determination.

- The hospice staff will go into the home to complete specific personal care and home management tasks for the client on a visit basis. Determine when the hospice staff will handle these responsibilities. Get a schedule so that you can avoid overlapping with the CAP/C staff.

- The CAP/C staff's duties are broader as they often substitute for family members or caregivers during their absence to provide for the unscheduled personal care needs of the client. The CAP/C staff may spend time supervising the client and assisting with tasks such as toileting, transfer, ambulation, and medical monitoring that occur throughout a day. Determine the hours that the client needs this support. These are times when the hospice staff will not be with the client.

Step 3 Include the CAP/C Nursing or Nurse Aide (Personal Care) hours in the CAP Cost Summary. Submit the POC revision to DMA.

Show "Hospice" on the Cost Summary with Medicare as the payer. If the client's needs can be met within the cost limit, the client may be considered for CAP/C participation.

REMEMBER: *Do not offer CAP/C services that duplicate or replace the care that is the responsibility of the hospice agency.*

Hospice can provide valuable care and assistance to terminally ill patients and those close to them. In addition to the client electing Hospice, there are other ways to get the benefit of a hospice agency's expertise in assisting terminally ill patients.

- A hospice agency that is licensed to provide in-home aide services as a home care agency may enroll as a CAP/C provider or contract with an enrolled provider of CAP/C Nurse Aide (Personal Care) Services.

- A hospice agency that is licensed to provide nursing services as a home care agency may enroll as a CAP/C provider or contract with an enrolled provider of CAP /C Nursing Services.

- If a home health agency is providing skilled nursing visits, it may contract with a hospice to staff the nursing visit if the hospice is licensed to provide nursing services as a home care agency. The decision on contracting is between the home health agency and the hospice agency.

5.5 Personal Care Services (PCS), Personal Care Services Plus (PCS Plus)

5.5.1 Description of Services

- Personal Care Services

Personal Care Services (PCS) covers the services of an aide in the recipient’s private residence to assist with the recipient’s personal care needs that are directly linked to a medical condition. The services must be authorized by the recipient’s primary care

physician, physician's assistant, or nurse practitioner working under the supervision of the physician (as set forth in the licensing regulations of the North Carolina Boards of Medicine and Nursing). PCS is a paraprofessional service and does not include skilled medical or nursing care.

- Personal Care Services-Plus (PCS-Plus)

Personal Care Services-Plus (PCS-Plus) is an enhancement to the PCS program. PCS-Plus is for recipients who have a qualifying medical condition and personal care needs that exceed the service limit for PCS. Services include assistance with personal care tasks such as bathing, toileting, ambulating, and monitoring vital signs. In addition, services such as housekeeping and home management tasks may be provided if they are essential to the personal care task(s) necessary for maintaining the recipient's health.

NOTE: *When a CAP/C client needs this type of service, it is usually provided through CAP/C Nurse Aide (Personal Care) Services rather than PCS. CAP/C Nurse Aide (Personal Care) Services are under the control of the CAP/C case manager, while PCS is not. If a client wishes to receive PCS, explain to the client/caregiver that similar services are available under CAP/C. In the event the client arranges for PCS, include the cost of PCS as a Medicaid cost in the CAP/C Plan of Care. The cost counts toward the cost limit. The PCS provider is responsible for meeting PCS requirements and service limitations. PCS and CAP/C Nurse Aide (Personal Care) Services may not be provided on the same day.*

5.5.2 When Services are Covered

Coverage Criteria for Infants and Children

PCS for infants and children must be assessed and authorized on an individual basis considering personal care tasks that are directly linked to the medical condition and not needs that are a parental responsibility and/or age appropriate. Refer to Section 2.2 of the PCS policy for further explanation of coverage under EPSDT.

Medicaid covers PCS when:

1. The service is medically necessary.
2. The service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs.
3. The service can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.
4. The service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker or the provider.

Medical Necessity

PCS aide services are covered only when the primary purpose of the visit is to provide personal care. Each of the personal care tasks provided must be directly related to the medical condition, must be medically necessary, and must be authorized on the PCS Physician Authorization for Certification of Treatment (PACT) Form **(**Attachment F in the PCS policy) in accordance with program requirements. For the purpose of this policy and service, medical necessity means that if the plan of care is not implemented, the recipient's medical condition will deteriorate.

Activities of Daily Living

PCS covers aide services rendered in the private residence of a recipient who requires assistance with a minimum of two unmet activities of daily living (ADLs).

The unmet ADLs must be identified on the PCS PACT form and must be addressed in the recipient's plan of care. (See Attachment B of the PCS policy for a listing of ADL activities.)
1. An unmet need exists when the recipient cannot independently perform at least two personal care tasks because of a physical or cognitive impairment; and there is no household member, relative, caregiver or volunteer to meet the need on a regular basis or a third party payer is responsible for covering the service.
2. PCS must be the most cost-effective and appropriate form of care for the recipient. PCS is provided to assist, not replace, the help available from family members and community resources.

Medical Condition
The recipient must have a medical condition that requires the direct and ongoing care of his/her primary physician prescribing PCS and must be medically stable. "Medically stable" means that the recipient does not have a need, pertaining to the PCS plan of care, for continuous monitoring and evaluation by a licensed professional.

PCS Plus
To qualify for PCS-Plus, a client must be eligible for PCS and meet one of the following three criteria:
1. At a minimum, require extensive assistance with four or more ADLs. The identified needs must be met by the plan of care.
2. At a minimum, require extensive assistance in three or more ADLs and need the inhome aide to perform at least one task at the Nurse Aide II (NA II) level. The identified needs must be met by the plan of care.
3. At a minimum, require extensive assistance with three or more ADLs and have a medical or cognitive impairment that requires extended time to perform needed inhome aide tasks. The identified needs must be met by the plan of care.
Refer to Clinical Coverage Policy #3J for additional information on the PCS-Plus program.

5.5.3 What's Covered

Under regular PCS, a client may receive up to 60 hours of PCS each calendar month (maximum of 3.5 hours daily) according to the plan of care authorized by the patient's physician. There is no DMA prior-approval needed.

Under PCS Plus, a client may receive up to 80 hours of PCS each calendar month (no daily limit) according to the plan of care authorized by the patient's physician. Prior-approval must be obtained from DMA.

5.5.4 How to Get PCS

The process begins the patient's physician contacting the home care agency. A registered nurse representing the agency assesses the patient's need for the service. If there appears to be a need, the RN prepares a plan of care. The plan has to be approved by the patient's physician for services to be authorized.

If the RN determines that PCS Plus is needed, a PCS Plus Request Form must be completed and submitted to DMA for approval.

PCS may not be provided on the same day as CAP/C Nurse Aide (Personal Care) Services.

REMEMBER: *The service must be put in the CAP/C Plan of Care and the cost counts towards the cost limit.*

5.6 Private Duty Nursing (PDN)

PDN is medically necessary continuous, substantial and complex nursing services by a licensed nurse (RN or LPN) that is needed by a client for care in the client's home. It is provided by a licensed home care agency enrolled with DMA as a PDN provider.

NOTE: *When a CAP/C client needs this type of service, it is usually provided through CAP/C Skilled Nursing Services rather than PDN. CAP/C Skilled Nursing Services are under the control of the CAP/C case manager, while PDN is not. If a client wishes to receive PDN, explain to the client/caregiver that similar services are available under CAP/C. In the event the client arranges for PDN, include the cost of PDN as a Medicaid cost in the CAP/C Plan of Care. The cost counts toward the cost limit. The PDN provider is responsible for meeting PDN requirements and service limitations. PDN and CAP/C Skilled Nursing may not be provided on the same day.*

5.6.1 Who's Covered

A client must require substantial and complex continuous nursing care by a licensed nurse as documented by the patient's attending physician. This means:

- A patient care task can be done by only a licensed nurse, and
- The tasks must be done so frequently that the need is continuous – these are not tasks that could be reasonably handled by home health skilled nursing visits.

The client must live in a private residence and the need must be for care in that residence.

5.6.2 What's Covered

PDN provides substantial and complex continuous nursing care by a licensed nurse (RN or LPN). It is provided on an hourly basis. The care must be prior approved by DMA's Home Care Initiatives (HCI) Unit

5.6.3 How to Get PDN

This service must be approved by DMA's Home Care Initiatives (HCI) Unit before Medicaid payment is authorized. The referral includes specific medical information from the patient's physician. If the request is approved, the approval will specify the number of hours per day authorized for Medicaid coverage and the length of time of the authorization.

5.7 Health Services for Children

In cooperation with Children's Special Health Services (CSHS) in the Division of Public Health Women's and Children's Health Section, Medicaid offers the following services for children. These services provide additional ways for your clients to get treatment.

If your client is getting any of these services, show the service on the Plan of Care and count the cost towards the cost limit.

5.7.1 Health Related Services Provided In Public Schools

This coverage allows local education agencies (LEA's) to enroll with Medicaid for provision of OT, PT, psychological services, audiology services and speech/language services in the public school setting. Coverage is limited to Medicaid-eligible children who are applying for or receiving special education and related services as part of an IEP (Individualized Education Plan), IHP (Individualized Health Plan), or Individualized Family Services Plan (IFSP). Therapists may be employees of the school or contract with the school for provision of services. The school system bills Medicaid. The services are paid according to the IPP fee schedules.

5.7.2 Health Related Services Provided Through Head Start Programs

Local Head Start Programs may enroll with Medicaid for provision of OT, PT, psychological services, audiological services and speech/language services to children in Head Start Programs. Coverage is limited to Medicaid-eligible children who are applying for or receiving special education and related services as part of an IEP (Individualized Education Plan), IHP (Individualized Health Plan), or IFSP (Individualized Family Services Plan). Therapists may be employees of the Head Start Program or contract with the program for provision of services. The Head Start Program bills Medicaid. The services are paid in 15 minute units. There are individual and group rates.

5.7.3 Health Related Services Provided By Independent Practitioners

Independent practitioners may enroll with Medicaid for provision of OT, PT, RT, audiology and speech/language services. Coverage is limited to Medicaid-eligible children 0-21 years of age. The practitioner bills Medicaid. The services are paid according to the IPP fee schedules.

Note: Special care must be taken to avoid duplication of services. For example, daily or twice daily respiratory therapy visits to perform trach care, nebulizer treatments, chest PT, and suctioning would be unnecessary when the patient receives 18 hours per day of RN services. The RN is capable of providing that care. Intermittent therapy visits for specialized treatments or assessment may be appropriate.

5.8 Medicaid Transportation Policy

Current Medicaid transportation policy allows the use of Title XIX funds to transport a Medicaid recipient to a Medicaid-covered service by the least expensive means appropriate for the recipient and to the nearest provider for the service/recipient. The service provided must be a Medicaid covered service. It does not matter if the particular provider is enrolled in/billing Medicaid, as long as the service received is covered by Medicaid.

To access Medicaid transportation services, the recipient or his/her representative should contact the local DSS. The DSS transportation coordinator will complete an assessment to determine transportation services available to the recipient, the recipient’s need for

transportation, whether the service provided is a Medicaid-covered service, whether (if out of town) the proposed provider is the closest one who can provide the service needed, whether transportation is available for free or is already included in a reimbursement rate for the service, and what will be the least expensive means of providing the transportation that meets the recipient's needs. Each DSS has its own methods/providers of Medicaid transportation.

DSS may pay for an attendant to accompany the recipient to the appointment if it is medically necessary. Maximum reimbursement for the attendant's salary is the current minimum wage, even if the attendant is a nurse or nurse aide.

Note: *If medically necessary, CAP/C will reimburse a RN or LPN for travel time going to and from the appointment. The "wait" time spent in the facility is NOT reimbursable by CAP/C, as the patient is now in the care of another medical provider. Time spent in the facility may, however, be reimbursed at minimum wage by DSS if the transportation is arranged through the local DSS as above with the CAP/C staff considered the attendant, and if the patient is not admitted to the facility. CAP/C requires that a family member accompany the patient to an appointment. DSS will only approve the CAP/C Nurse as an attendant if the recipient needs care during the transportation/appointment that the family can not provide.*

NOTE: *The entire Medicaid transportation policy can be found at:* ***http://info.dhhs.state.nc.us/olm/manauls/dma***.

6.0 MEDICAID ELIGIBILITY

This section gives the case manager general information about Medicaid as well as information specific to CAP/C. Guidance for DSS staff is in the *Aged, Blind & Disabled Medicaid Manual* and the *EIS Manual.*

CAUTION: *The details of Medicaid require considerable expertise to understand. Do not try to be a Medicaid expert. Please do not advise clients or their families/caregivers about Medicaid eligibility. Refer them to the county DSS for this information.*

If you have questions about Medicaid eligibility, contact your county DSS Medicaid staff.

6.1 Medicaid Basics

Medicaid pays medical bills for certain people with limited income. Title XIX of the Social Security Act contains the Federal law for Medicaid. The Centers for Medicare and Medicaid Services carries out the law by writing regulations and overseeing each State's operation of the program. States have some flexibility within the Federal law and regulations to have their own rules. Program costs are paid by Federal, State and county funds.

Many aspects of Medicaid are similar to private health insurance. There are ID cards to show eligibility, deductibles to be met in certain situations, co-payments for some services and prior approval requirements for certain coverages. Just as a private insurer's coverage may not be the same for all policy holders, Medicaid coverage differs across categories of recipients.

The following gives you basic information about Medicaid. See 6.2 for information on how the policies and procedures differ for a CAP/C client.

6.1.1 Who's Involved

The Division of Medical Assistance (DMA), in the Department of Health and Human Services (DHHS), administers Medicaid in North Carolina. It establishes the rules and procedures for the program and directs its operation. DMA's activities must follow Federal guidelines.

As a case manager, you help to assure that care is appropriate, medically necessary and provided according to Medicaid guidelines. Your efforts are needed to get the best care for CAP/C clients as well as the best use of public funds.

Other key players in Medicaid are:

- **Providers, Physicians and other Health Care Professionals** who provide care and confirm that care orders are appropriate to the recipient's needs. These individuals help assure the quality and the cost-effectiveness of care.

- **County Departments of Social Services (DSS)** that use State-issued policies, accept Medicaid applications, and determine Medicaid eligibility.

- **The fiscal agent** that processes Medicaid claims and performs a variety of other administrative tasks, including prior approval of some services. All of this is done through terms of a contract between DMA and the fiscal agent.

In addition, local Social Security Administration offices process applications for Supplemental Security Income (SSI). SSI applications are also applications for Medicaid.

Finally, Medicaid recipients and those who assist them are important to the success of the program. Their mutual cooperation in establishing eligibility and in the delivery and receipt of health care is essential to meeting the goals of Medicaid.

6.1.2 Who's Eligible for Medicaid

Persons who receive Supplemental Security Income (SSI) automatically receive Medicaid in North Carolina.

Other individuals may receive Medicaid if they are in an eligible group or category and meet North Carolina Medicaid income and assets limits. These individuals must apply to and be determined eligible by the DSS in the county in which they live. Eligibility may be based on a variety of factors, including being aged, blind or disabled; receiving assistance from such programs as Special Assistance, Work First, Supplemental Aid to the Blind, and other specific assistance programs; being pregnant; and being under 21 years of age. Medicaid eligibility is linked to the income and, usually, the resources of the individual. Eligibility may also involve the income and resources of parents and spouses.

REMEMBER: *Medicaid eligibility is a separate issue from eligibility for CAP/C and eligibility for a specific service.*

6.1.3 Applying For Medicaid

When an individual applies for SSI, the application is also an application for Medicaid. Individuals apply for SSI at their local Social Security Administration Office.

Individuals who are not eligible for SSI apply for Medicaid at the DSS in the county in which they reside. The county DSS has 45, 60, or 90 days to act on the application, depending upon the type of application and whether disability needs to be established. When applying for Medicaid, the individual should present:

- Birth certificate or other proof of age.
- Social Security Card.
- Proof of income, such as paychecks, wage stubs, and copies of Social Security and VA checks or a letter verifying the benefit amounts.
- Life insurance and medical insurance policies.
- Savings account books and bank statements.
- Information on ownership of real property and motor vehicles.
- Medical bills.

In addition, if the SSI or Medicaid eligibility is to be based on disability and the applicant is not receiving Social Security disability benefits, the applicant will have to provide medical information and have an examination by a physician. The examination will be paid for by the state. The Disability Determination Services Section of the North Carolina Division of Vocational Rehabilitation determines disability.

6.1.4 Retroactive Eligibility for Regular Medicaid Services

Medicaid eligibility usually begins the month of application. A person may apply for coverage for one, two or three months prior to the month of application. Medicaid payment is available for regular Medicaid services provided during this period if all requirements for the service are met. The dates on the Medicaid ID card will show this type of eligibility.

6.1.5 Regular Medicaid Deductibles

A Medicaid deductible (also referred to as a "spenddown") is similar to a private insurance deductible. It is the amount of medical expenses for which the recipient is responsible before Medicaid will pay for covered services. Unlike private insurance, the Medicaid deductible is based on income; therefore, the amount is not the same for each person.

SSI recipients and most persons whose countable income is under the federal poverty level do not have a deductible. However, other persons who meet all other eligibility factors but whose income exceeds the federal poverty level have a deductible. The individuals are responsible for their health care costs until they incur medical bill equal to the amount of their deductible. The deductible is based on how much a person's countable income exceeds what is called "the medically needy income limit." In most situations, this limit is either $242 per month for a single person or $317 for a married person. The amount by which the person's countable income exceeds the monthly income limit is multiplied by the number of months in the eligibility period (usually 6 months). The resulting amount is the deductible. Once the person's incurred medical bills equal the amount of his deductible, Medicaid will pay for covered services for the remainder of the eligibility period. Medicaid may not pay for any expenses used to meet the deductible.

EXAMPLE: *A single man applies for Medicaid on 7/15/05. The six-month eligibility period is July 2005 through December 2005. His income is $825. There is a disregard of $20. His countable income is $805. This countable income level exceeds the current federal poverty level of $798. Because it is in excess, the difference between the countable income and the monthly "medically needy income limit" of $242 is $563. Therefore, the total deductible for July through December that must be met before Medicaid covers anything is $3,378 ($563 x 6). On the date that the incurred medical expenses total $3,378, he is authorized for Medicaid through the end of December.*

The important points to remember about deductibles are:

- Medical expenses that can usually be used to meet a deductible include but are not limited to the following:
  - Hospital charges.

- Clinic and laboratory charges.
- Charges by dentists, physicians, and therapists.
- Prescription drug charges.
- Charges for "over-the-counter" medicines and medical supplies.
- Medically-related transportation costs.
- Charges for dentures, eyeglasses, hearing aids, walkers and other medical equipment.
- Dietary supplements such as "Ensure" if prescribed by a physician.
- Premiums paid by the individual for private health insurance.

- The expense must be incurred by the client to apply to the deductible –bills in advance of the delivery of a service may not be applied.
- The client must be responsible for an expense for the expense to count towards the deductible. There is one exception involving expenses paid with local or State government funds – DSS will apply this exception when appropriate.
- If an expense is partly paid by private insurance, Medicare, or another third party, only the portion that is the client's responsibility counts towards the deductible.
- If the client is billed based on a sliding fee schedule, only the amount for which the client is responsible applies to the deductible.
- A person on a deductible uses bills and receipts to meet the deductible; therefore, it is important that these items are obtained and given to DSS as quickly as possible.
- While a person is meeting a deductible, the individual is not covered by Medicaid and will not have a Medicaid ID card. Medicaid will not pay for services while the person is in a deductible status.
- Usually, only current expenses apply to a deductible; however, there is a provision for an unpaid balance of a medical expense incurred in the 24 months previous to the current certification period to apply. DSS will explain this provision to the client.

6.1.6 Co-Payments

Some Medicaid coverages require a co-payment by the Medical recipient. Visits to physicians, chiropractors, dentists and optometrists, as well as prescriptions, are examples of services that may require a co-payment.

6.1.7 Prior Approval

Some Medicaid services require prior approval before Medicaid will cover the service. Examples include nursing facility care, ICF/MR care, CAP participation, some durable medical equipment, certain dental coverage and private duty nursing.

6.2 Medicaid Eligibility and CAP/C

Medicaid eligibility and coverage differs in some respects for a CAP/C client.

6.2.1 Waiver of the Deeming Of Income and Resources

When a member of a married couple, living together, applies for Medicaid, the spouse's income and resources count towards the applicant's eligibility. Similarly, the income and resources of parents affect the eligibility of any children living with them. This is called the "deeming" of income and resources.

When the spouse or child is in institutional care under specific conditions, deeming may not apply. Because CAP/C is an alternative to nursing facility care and long term hospital care, CMS has allowed North Carolina to waive the deeming requirement and consider the income and resources of a parent similar to a long term care situation.

***NOTE**: The Medicaid staff will ask for the income and resources of the parents when the potential CAP/C client applies for Medicaid. DSS is required to look at all ways that a client may be eligible for Medicaid. In some instances, this is advantageous for the client, as it will allow the client to get on regular Medicaid before the CAP/C Plan of Care is approved. Do not tell parents that they will not be asked about income and resources.*

6.2.2 Which Medicaid Categories Are Eligible For CAP/C

Though there are a variety of categories in Medicaid, only Medicaid recipients in the following coverage groups may receive CAP/C:

- Medicaid to the Blind (MAB)
- Medicaid to the Disabled (MAD)
- Medicaid for children receiving adoption assistance (I-AS)
- Medicaid for children receiving foster care assistance (H-SF)

***REMEMBER:** Not everyone on Medicaid may participate in CAP/C. This is why it is important that a case manager contact DSS when a new client is being considered. See 8.4 for instructions about notifying DSS of CAP/C applicants.*

6.2.3 Applying For Medicaid

Individuals being considered for CAP/C have to apply for Medicaid as outlined in 6.1.3.

6.2.4 Retroactive Coverage

Retroactive coverage is not available for CAP/C services. The effective date that coverage of CAP/C services begins is the latest of:

- The Medicaid application date;
- The FL-2 approval date; or
- The date of deinstitutionalization.

See 11.9 for information about coverage of case management for persons in a hospital or nursing facility prior to the effective date.

NOTE: *If a new CAP/C client is moving from another CAP program, the effective date may be adjusted to avoid an overlap of CAP programs. Contact your CAP/C Consultant in DMA for guidance when this situation occurs.*

6.2.5 CAP/C Deductibles

There are two provisions about deductibles that apply to CAP/C clients.

- The deductible for a CAP/C client is met monthly rather than on a six-month basis.
- In addition to the usual expenses allowed toward a deductible, a CAP/C client may use the cost of CAP/C services approved on the Plan of Care if they are provided during the deductible period.

If you have a client with a deductible, get with the Medicaid worker to learn what expenses may apply and the best method to get the information quickly to the worker. Some case managers collect the bills and receipts to help expedite getting the information to DSS and the person authorized for Medicaid.

REMEMBER: *Medicaid will not pay for services while a client is in deductible status*.

6.2.6 Co-Payments

CAP/C clients are exempt from the co-payment requirements. This helps clients with prescription drugs and physician services. Providers are periodically reminded of the exemption in the *Medicaid Bulletin* and the *Medicaid Pharmacy Newsletter*. If you encounter a provider who is not aware of the exemption, suggest that the provider contact the fiscal agent. The CAP indicator in the CAP block on the Medicaid ID card alerts the provider to the exemption.

6.2.7 Prior Approval for Other Services

CAP/C clients must meet the same requirements as other Medicaid recipients to get the regular Medicaid services. Approval of the CAP/C Plan of Care does not replace the prior approval requirements or other eligibility requirements for services such as DME, Private Duty Nursing, and Home Health Services.

6.3 Verifying Medicaid Eligibility

You need to be sure that your client is authorized for Medicaid and eligible for CAP/C services. The client's Medicaid ID card is your main source of information. A new card is issued each month. If the ID card in not available, Automated Voice Response and Electronic Data Interchange (EDI) can provide much of the same information. After the client is approved for CAP/C, you should verify continuing eligibility for Medicaid and CAP/C each month – either see the card, be sure that a responsible person sees the card, or use AVR/EDI to verify eligibility.

6.3.1 Using the Medicaid ID Card As Verification

The following steps show how to use the ID card as verification. See Illustration 6-1 for a sample blue ID card.

Step 1 Note the Color of the Card

The color of the ID card tells if the client is covered under the regular Medicaid program or under one of two special coverage groups.

Blue: This color indicates regular Medicaid coverage. The CAP/C client must have a **BLUE** card.

Pink: The person is an MPW recipient – covered only for pregnancy-related services. This includes prenatal, delivery, postpartum care and any services required for conditions which complicate the pregnancy. *An MPW client may not be on CAP/C.*

Buff: The person is a Medicare-Aid recipient. Medicaid coverage is limited to the deductible and co-insurance for Medicare covered services. In addition to the distinct color, the card is clearly labeled as a "MEDICARE-AID ID CARD." *A Medicare-Aid client may not be on CAP/C.*

Step 2 Check the Card for CAP/C Coverage

Look at the CAP block on the ID card to see if one of the following codes is there:

- **IC** if the client is at ICF level;
- **SC** if the client is at SNF level; or.
- **HC** if the client is at hospital level

If the block is blank, the entry is incorrect for the client's level of care or there are other letters, contact DSS to correct the CAP indicator code.

REMEMBER: *Your agency and other providers will not be paid for CAP/C services unless the eligibility system shows the client is on CAP/C. Also, the client will not receive the co-payment exemptions mentioned in 6.2.6. The IC, SC or HC on the card shows that the system contains the information needed to process claims and allow the co-payment exemptions.*

Step 3 Check the Card for Carolina Access and HMO Information

Carolina ACCESS participants have "Carolina ACCESS Enrollee" and the primary care provider's name, address, and phone number on the card. Most Medicaid services for Carolina ACCESS participants must be ordered by the primary care provider with an authorization number given to the provider agency. CAP/C services do not require the authorization number.

HMO enrollees have the words "PREPAID HEALTH PLAN ENROLLEE" above the person's name at the bottom right corner of the Medicaid ID card. The card also shows the name and address of the health plan option as well as its member services phone number.

MEDICAID IDENTIFICATION CARD (SEE INSTRUCTIONS ON BACK)

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

VALID

CAP	COUNTY CASE NO.	ISSUANCE	PROGRAM	CLASS
SC	111111	99999R	MAD	C

FROM 09-01-2005 THRU 09-30-2005

RECIPIENT I.D.	ELIGIIBLES FOR MEDICAID	INS. NO.	BIRTH DATE	SEX
111-22-3333-Z	Mary H. Client Dr. Nancy Drew 101 Mystery Lane Happyvalley, NC 29999 910-555-5555 910-555-99991	1	12-18-04	F

INS. NO.	NAME CODE	POLICY NUMBER	TYPE
1	091	998877665544	00

Carolina ACCESS Enrollee
September 2005 MAD 11 10847610 101
Mary H. Client
6 Lucy Lane
Happyvalley, NC 29999

RECIPIENT (Not valid unless signed)

SIGNATURE_____

MISUSE MAY RESULT IN FRAUD PROSECUTION

Illustration 6-1 – Sample Blue Medicaid ID Card for a CAP/C Client

Step 4 Verify the Recipient's Identity

Make sure that the recipient's name is on the ID card under **ELIGIBLES FOR MEDICAID.** Ask to see identification other than the ID card. The recipient's Medicaid ID number (MID), birth date and sex are on the same line as the client's name.

Step 5 Check the Eligibility Period

Under **VALID**, there are **FROM** and **THRU** dates to tell when the recipient is Medicaid-eligible. Medicaid pays only for dates of service in the eligibility period.

Step 6 Look for Insurance Information

Look on the same line as the recipient's name, under the column **INS. NO**. If there is a number in the column look for the same number under **INSURANCE DATA.**

INSURANCE DATA: Any insurance coverage the recipient has – that Medicaid is aware of – is in this block. The information in each column is:

INS. NO: The numbers in this column correspond to the numbers beside the recipient's name. For example, if the client has a 3 beside his name, the related insurance information is listed on the same line as the 3.

NAME CODE: This is a 3 digit code that indicates the name of the recipient's insurance company. You can obtain an Insurance Code Book by contacting DMA's Third Party Recovery Section. The number is listed in Appendix B. It is also available on DMA's website at http://www.dhhs.state.nc.us/dma/tpr.html.

POLICY NUMBER: The policy number of the coverage is shown here.

TYPE: The type of insurance coverage is indicated by one of the following codes:

00-Major Medical Coverage
01-Basic Hospital with Surgical Coverage
02-Basic Hospital only Coverage
03-Dental Only Coverage
04-Cancer Only Coverage
05-Accident Only Coverage
06-Indemnity Only Coverage
07-Nursing Home Only Coverage
08-Basic Medicare Supplement
10-Major Medical & Dental Coverage
11-Major Medical & Nursing Home Coverage
12-Intensive Care Only Coverage
13-Hospital Outpatient Only Coverage
14-Physician Only Coverage
15-Heart Attack Only Coverage
16-Prescription Drugs Only Coverage
17-Vision Care Only Coverage

REMEMBER: *The Medicaid ID card shows only the information known to Medicaid. Ask the recipient about other possible insurance coverage.*

If the insurance information on the card is incorrect, please notify the local DSS.

Step 7 Note the Information in Your Records

Photocopy the ID card or enter the information from the card in your records.

6.3.2 Using Automated Voice Response (AVR)

If you know the client's Medicaid ID number or Social Security number and date of birth, you may use a touch-tone phone to call the EDS Automated Voice Response (AVR) System for eligibility information.

The system can provide you with a variety of eligibility information, including:

- If the client is eligible for Medicaid on a specific date of service.
- If the client is covered under MPW or Medicare-Aid.
- If the client is enrolled in an HMO or Carolina ACCESS.
- If the client is participating in the Community Alternatives Program (CAP).
- If the client is on Medicaid Hospice.
- If the client is covered under Medicare Part A and Medicare Part B.
- Information known by Medicaid concerning other insurance.

Watch the *Medicaid Bulletins* for updates on the information available through Automated Voice Response. See the Medicaid Billing Guide for a brief description of the available information and instructions on the use of Automated Voice Response. Detailed information on the Automated Voice Response System (AVRS) is available in the July 2001 Special Bulletin found on the DMA website at http://www.dhhs.state.nc.us/dma/bulletin.htm.

6.3.3 Using Electronic Data Interchange (EDI)

Providers may obtain Medicaid eligibility information electronically. On-line, interactive eligibility verification is available via EDI vendors (sometimes referred to as clearinghouses). Use of an EDI vendor is voluntary to providers. EDI vendors interface directly with the Medicaid recipient database maintained by the fiscal agent for claims processing. The database is updated every weekday from the state's master eligibility file. The service is available 24 hours per day, 7 days per week, except for when it is down for system maintenance. Scheduled system maintenance occurs on the first, second, fourth and fifth Sundays of each month from 1:00 a.m. to 5:00 a.m., Eastern Standard Time, and on the third Sunday of each month from 1:00 a.m. to 7:00 a.m.

- **Obtaining EDI Service –** DMA approves vendors who have successfully tested their interface with the fiscal agent. Contact an EDI vendor to contract for the software and network access needed to use this option. Any training needed by your staff will be given by the EDI vendor that you select. A list of approved EDI vendors is published periodically in the *Medicaid Bulletin* (including the most current version of the Medicaid Billing Guide – http://www.dhhs.state.nc.us/dma/prov.htm).You may

contact DMA or the fiscal agent at the numbers in Appendix B if you want information on approved vendors.

- **What the Service Costs** – EDI vendors may charge a reasonable cost for their services. Providers will also pay a transaction fee to Medicaid's fiscal agent. Contact the fiscal agent for the current fees. The charges are deducted from the Net Pay Amount on the Medicaid Remittance and Status Report (RA). The Adjusted Net Pay Amount will equal the amount of the payment check.

- **Inquiries** – An eligibility inquiry requires:
  - Your Medicaid provider number
  - The recipient's Medicaid ID number
  - Either:
    - The recipient's Social Security number, or
    - The recipient's date of birth
  - The date of service – either a specific date between the date of inquiry and the prior 12 months, or a span of dates not more than one calendar month

- **Responses** – The response verifying eligibility will include the following data:
  - The recipient's Medicaid identification number
  - The name of the recipient
  - The recipient's date of birth
  - The recipient's Social Security number if it is used to make the inquiry
  - Coverage group for eligibility, such as MPW, MQB, MAA, and other designations
  - Managed care enrollment, if applicable, including
    - HMO plan name and phone number
    - The name of the Carolina ACCESS (CCNC) primary care provider and phone numbers
  - Medicare part A and/or part B information
  - Third party resource coverage (data on up to three policies)

6.4 Coordinating With DSS Medicaid Staff

For your client to get CAP/C benefits and for providers to get paid, you must coordinate activities with the local DSS Medicaid staff. You should establish a contact person at the county DSS. The key areas requiring communication and coordination include:

- **Referring a potential CAP/C client** to DSS is critical so that a Medicaid application can be promptly initiated if the client is not on Medicaid. For a client on Medicaid, it will assure the client is in the proper category. See Section 7 for referral procedures.

- **Promptly processing your assessment and Plan of Care** to get an approval as quickly as possible is important for your client as well as DSS. DSS has strict time limits to act on applications. If the Plan is not approved within the time limit, DSS may have to deny the Medicaid application. This means a client may have to reapply for Medicaid. Getting the Plan approved within **45 days** benefits the client. See Section 7 for information on notifying DSS of the Plan approval.

- **Coordinating deductibles** helps the client and providers. If your client has a deductible, work with the DSS Medicaid staff and the client to be sure that there is a clear understanding of what may be used to meet the deductible, what proof is required for expenses, and who will get the proof to DSS. If the client has a recurring medical expense each month, such as medications, you may be able to develop a plan with DSS for the client to regularly meet the deductible by incurring the expense at the beginning of each month.

- **Notifying DSS about CAP/C changes** is necessary to be sure that your client receives the proper benefits and is given the proper notices about changes in Medicaid eligibility.

  - **If your client has a deductible,** DSS needs a copy of the current Cost Summary from the Plan of Care so it knows what expenses may be used for the deductible.

  - **If you are considering terminating a client**, coordinate the timing of the termination with DSS. DSS has advance notice requirements that it must meet. See Section 17.

  - **If the client is hospitalized, placed in a nursing facility or will be absent for 30 days or more,** notify DSS. See Section 15.

Also you may find it helpful to receive copies of the notices that DSS sends to clients. This will alert you to possible changes in Medicaid eligibility as well as any problems that DSS is having in processing applications and recertifications. DSS requires permission from clients to send copies to the case manager. If you are interested in this possibility, discuss it with DSS.

7.0 INITIATING CAP/C

This Section describes the process for considering a potential CAP/C participant. It is intended to help case managers in handling inquiries and processing referrals. Certain activities must be completed to bring an individual into the program. Some of these activities must be completed at a specific point, while there is leeway in the timing of others.

The process usually begins with an inquiry about the program. If the inquiry results in someone wishing to pursue the program for a child, the key activities to be carried out by the case manager include:

- Taking a referral and gathering information about the needs and expectations. See 7.2.
- Guiding the parent(s)/responsible party on the appropriateness of CAP/C as well as possible other resources. See 7.2.
- Submitting the referral in a timely manner to DMA for pre-screening.
- Arranging for the assessment process to begin, including obtaining FL-2 approval and DSS coordination on Medicaid eligibility. See 7.5.
- Completing the assessment and Plan of Care. See 7.5.4.
- DMA's review and approval action on the Plan of Care and CAP/C participation. See 7.6.

Illustration 7-1 shows a checklist that a case manager may use to track the all of the actions involved in the process.

The following material is directed to the case manager.

CAUTION: *Do not begin a CAP/C assessment unless requested to do so by DMA's HCI Unit. Be sure that a DMA CAP/C consultant evaluates a referral that you receive for CAP/C before the assessment begins. See 7.5.*

7.1 Critical Time Limits and Dates

Keep the following time limits and dates in mind when planning your activities to get someone on CAP/C.

7.1.1 Time from Physician's Signature on FL-2

You must request approval of the level of care on the FL-2 by the fiscal agent within **30 days** of the date that the physician signs the form.

7.1.2 Phone FL-2 Approval Time Limit

If you get telephone prior approval of a FL-2, you must send the FL-2 to reach the fiscal agent within **10 workdays** of the phone approval date.

CAUTION*: If the completed form does not reach the fiscal agent within this time, the prior approval number will be voided. You will have to obtain a new FL-2 and go through the process again. This will delay the start of CAP coverage. Remember to notify the HCI staff if this occurs.*

CAP/C PROCESSING

NAME_____**MID**_____-_____-_____

___/___/____ Date of referral.

___/___/____ Date referral submitted.

___/___/____ Date DMA decision received.

___/___/____ Talk with client/family to explain CAP/C procedures and services and discuss needs. Review Medicaid ID Card (if on Medicaid) to determine if client on another CAP program.

___/___/____ Notify DSS that the client is applying for CAP/C and refer the client/family to DSS (even if they are already on Medicaid)

___/___/____ DMA Provider Enrollment contacted (if not enrolled to provide CAP/C Case Management).

___/___/____ FL-2 (and Physician's Request Form, if needed) forwarded to physician.

___/___/____ Phone approval of FL-2.

___/___/____ FL-2 forwarded to fiscal agent. (Fiscal agent forwards to DSS)

___/___/____ Assessment begun.

___/___/____ DMA CAP consultant contacted to discuss hospital level of care if appropriate.

___/___/____ Assessment and Plan of Care completed with appropriate signatures.

___/___/____ Plan sent to DMA.

___/___/____ Plan approval received from DMA.

___/___/____ DSS notified of approval, Medicaid eligibility confirmed & CAP effective date coordinated.

___/___/____ Client's responsible party notified of approval.

___/___/____ Services started.

___/___/____ Medicaid card seen to confirm eligibility for CAP/C.

___/___/____ Stamped approved FL-2 received.

Illustration 7-1 – Sample Checklist

7.1.3 Plan of Care Deadline

You must submit the completed Assessment and Plan of Care with the required documentation so that it will be received by DMA for approval no later than **60 days** after the FL-2 approval date. If the Plan is not received within the time limit, a new FL-2 will have to be obtained and the process reinitiated. See Section 14 for information about Plan approval.

7.1.4 CAP Effective Date

The effective date for CAP/C participation is the **LATEST** of three dates:

- The date of the Medicaid application.
- The date of the FL-2 approval; and
- The date of deinstitutionalization.

NOTE: *The effective date may be modified to avoid an overlap in waiver program participation when a child moves to CAP/C from another CAP program. In addition, the date may be modified when a child moves from Medicaid HMO coverage to CAP/C. Consult DMA's HCI Unit for guidance when you are processing a referral for a client currently in CAP-MR/DD, CAP/AIDS, CAP/DA or a Medicaid HMO.*

Medicaid payment is available for CAP/C services beginning on the CAP effective date ***IF*** (1) the client is authorized for Medicaid on the date of service; ***AND*** (2) the service is approved on the Plan of Care. This allows a provider agency that is willing to accept the payment risks to begin services before Plan of Care approval. See 11.9 for Case Management provided assessment prior to the effective date.

7.2 Inquiries

An "inquiry" occurs when someone contacts a CAP/C case manager to gather information about CAP/C - such information as eligibility requirements and what the program offers. The information in Section 1 is helpful in responding to an inquiry. As a case manager, you should respond to inquiries and complete the referral forms. If you need help, you may contact DMA's HCI staff.

Please keep in mind that all inquiries regarding CAP/C are not appropriate referrals for the program. It is important help those who wish to make a referral have an understanding of the program's purpose. This can reduce unrealistic expectations by the parent(s)/responsible party. Case managers may not, however, refuse to send in a referral if the responsible party still wants to apply. Denials must be issued by DMA so that the potential recipient/responsible party can receive their due process rights. The following examples may be helpful.

REMEMBER: *The following examples are to help the parent/responsible party and you determine likely candidates for CAP/C. They are brief examples of the application of CAP/C criteria and are not all-inclusive. They may not be used to deny a referral.*

Example 1: *Sara is a 7-year-old child with muscular dystrophy. She is non-ambulatory and requires total assistance with bathing, dressing, toileting, and transfers. She uses a wheelchair that is in the home. Her parents want to care for Sara at home but feel that her personal care needs and other needs are becoming increasingly more stressful to them both physically and emotionally. In addition to personal care needs, the parents are becoming unable to carry Sara in and out of the home, and would benefit from a wheelchair ramp. They are requesting CAP/C services to keep their child safely in the home. Sara appears to be a good candidate for CAP/C as she has extensive needs appropriate for CAP/C services.*

Example 2: *Jim is a 1 year old child with seizure disorder and developmental delay. His seizure disorder is presently under control. He is receiving physical therapy and occupational therapy. His parents are able to provide for his age appropriate personal care needs. They are concerned that their insurance will only provide 15 visits of physical therapy and occupational therapy annually. They are requesting CAP/C to get Jim on Medicaid so that Medicaid can pay for the much needed therapy. Jim does not appear to be a good candidate for CAP/C – there is not a need for CAP/C services.*

Example3: *The mother of a 3-year Medicaid recipient with cystic fibrosis calls to request diapers. The child is incontinent of bowel and bladder. The mother also would like to have three hours per week of personal care assistance. The child's medical needs are handled well by her family; however, the child is unable to perform activities of daily living (ADLs). At present the child has no need for any of the CAP/C services and is not a good candidate for the program. Regular Medicaid services, such as supplies through Home Health and aide services under PCS may be considered to meet the needs of this child.*

Example 4: *A teacher of an eleven-year-old with muscular dystrophy calls to discuss the child's needs for nutritional supplements by mouth. The teacher also reports that the family could use assistance with his personal care needs after school. After receiving the information, the CAP/C consultant contacts the parent who states the family is unwilling to let an aide provide personal care and does not wish any case management assistance in the home. Because of the parent's wishes this is not a good referral for CAP/C.*

Example 5: *A six-week old infant is coming home with a trach, an IV and a G-tube. The parents are concerned with learning the care for the child and coordinating care around their work schedules. The family also needs assistance coordinating DME and supplies so that the child's needs can be met in the home. There is a potential need for hourly nursing services and case management assistance as well as possibly other CAP/C services; therefore, this is a good referral for CAP/C.*

Example 6: *A physician's office calls to discuss the needs of a 6-year-old girl who was recently involved in a motor vehicle accident. The child is paraplegic and needs assistance with personal care tasks. The father and mother both work outside the home and care for three other children. The family is having a difficult time coordinating instructions from the orthopedic and rehab physicians as well as dealing with managing the other care needs of the child. The insurance pays for a limited amount of care. There appears to be a need for CAP/C Personal Care as well as case management. This is an appropriate CAP/C referral.*

Example 7: *A parent calls to request assistance with paying for therapies. The child is 8 years old and has cerebral palsy. The parent reports that the child is going to school and the care needs are met by family. The family wants CAP/C to get the child on Medicaid. The only service that the child currently needs is physical therapy five times per week. The family does not feel that they can afford this expense. As the primary purpose of the CAP/C request is to get the child on Medicaid and there is no need for CAP/C services, this child is not a good candidate for the program.*

Example 8: *A parent calls to request assistance with her six-year-old child who has Down's Syndrome. The child receives some therapies through the school system, and is sometimes incontinent. This is not a good referral for CAP/C, because her needs are not related to a medical diagnosis.*

7.3 Referrals

Referrals are made to CAP/C case managers, or directly to DMA's HCI Unit in the absence of a case management agency. Potential CAP/C clients are identified through referrals from a variety of sources. You may receive referrals from various agencies and organizations that work with children in your community, or the child's family. Establish and maintain contacts with the public and private agencies, interest groups, and service organizations that work with children with special medical needs. Inform the staff of the county department of social services about the program and the referral procedures.

REMEMBER: *DMA's HCI staff needs to evaluate the referral before the assessment process begins. Do not begin an assessment without an approval from DMA.*

The referral process is used to help the parent(s)/responsible party better understand the program as well as to gather information for a "pre-screening" of the client's needs and the family's expectations of the program. DMA's CAP/C consultants use the referral information to determine if the client appears to be a good candidate for CAP/C or if the client should be referred to other programs or services. When you are contacted for a referral:

- Have a discussion with the parent(s)/responsible party about the eligibility requirements, services, and limitations as well as the needs of the child and their expectations. The discussion is an opportunity to explain what the program can and cannot be expected to provide in relation to the child's needs.

- Assemble key information to help the HCI staff determine if the child is a likely candidate for CAP/C. Complete the referral worksheet as shown in Illustration 7-2, and submit it to DMA. The referral form is available at http://www.dhhs.state.nc.us/dma/forms.html#prov.

- ***CAUTIONS:*** *A child who meets the level of care requirements has a right to be assessed for CAP/C. Nothing in the referral process prevents the child from being assessed. The guidance on referrals is to help parents/responsible parties sort out potential care options.*

FOR DMA USE ONLY

Date referral received: _____ **County:** _____ **Consultant Name**_____

☐ **Held for additional information, Date:** _____ ☐ **Additional Information Received, Date**_____

☐ **Referral approved for assessment, Date:** _____ **Letter/Fax sent Date:** _____

☐ **Referral not approved for assessment Date:** _____ **Letter/Fax sent Date:** _____ **Reason code:** _____

☐ **Assessment requested despite denial, Date:** _____ **Letter/Fax sent Date:** _____

DIVISION OF MEDICAL ASSISTANCE
FACILITY AND COMMUNITY CARE SECTION
2501 MAIL SERVICE CENTER, RALEIGH, NORTH CAROLINA 27699-2501
PHONE: (919) 855-4380 FAX: (919) 715-9025

CAP/C REFERRAL FORM

Please submit this form via fax to 919 715-9025.
PLEASE FILL IN ALL INFORMATION COMPLETELY. MISSING INFORMATION WILL DELAY THE PROCESSING OF YOUR REFERRAL.
Properly completed referrals received by 3:00 PM Friday will be reviewed the following week.
Review of incomplete referrals may be delayed until the week following receipt of all of the information.

RECIPIENT DEMOGRAPHIC INFORMATION

Name: Sarah S. Smith **County:** Happy
Address:100 Sunny Lane **Gender:** Female
City: Anywhere **State:** NC **ZIP**27000 **Birth Date:** 2/18/02 **Age:** 4y

MEDICAL INFORMATION

Current Diagnosesspastic CP, trach, reflux/GT, developmentally delayed

Please list the nursing interventions and the *actual* frequency they are performed. Please indicate below if the patient is able to perform interventions without assistance (i.e. self-catheterize):
☐ **None**
☒ **Feeding tube, Type:** GT ☐ **Continuous feed** ☒ **Bolus feeds**
☐ **Ventilator, hours per day** ☐ **CPAP/BIPAP, hours per day**
☒ **Suctioning - tracheal:** 1-2 **Times per** hour ☐ **Suctioning - oropharyngeal Times per**
☐ **Oxygen,** ☐ **Continuous** ☐ **PRN Used or Adjusted: Times per:**
☐ **Catheterization,** ☐ **Indwelling** ☐ **Intermittent, Frequency:**
☐ **Seizure activity requiring skilled intervention (i.e. administration of oxygen for documented desaturation, activation of VNS device, administration of PRN medication), Frequency:**
☐ **Seizure activity requiring safety precautions and monitoring, Frequency:**

If applicable for the patient's age, is the patient:
Continent? ☐ **N/A Bladder** ☐**Yes** ☒ **No** ☐ **Sometimes Bowel** ☐**Yes** ☒ **No** ☐ **Sometimes**
Ambulatory? ☐ **N/A** ☐ **Independent** ☐ **With Assistance** ☒ **Dependent**
Verbal? ☐ **N/A** ☐ **Communicates using words** ☒ **Uses only sounds, or is nonverbal**

Does the patient need *age-inappropriate* help with:
(Check all that are appropriate and describe)
☒ **Bathing?** ☒ **Dressing?** ☒ **Grooming?** ☒ **Eating?**
Describe:

☐ **other actual nursing interventions and frequency they are performed:** pulse ox check Q4H and PRN

Illustration 7-2 Sample Referral Form

CAREGIVER INFORMATION
Please provide a complete and legible address.

Name: Judy Smith
Address: ☒ Same as child's, ☐ Other, specify below
Address:
City: **State:** **ZIP:**

Phone Numbers (W): (919**)** 123-4000 **Hours:** 8-5 M-F
(H): (919**)** 123-4567
Relationship to Patient: mother
Hours and Days Available to Care for Patient: 6P-6A M-F

Name:
Address: ☐ Same as child's, ☐ Other, specify below
Address:
City: **State:** **ZIP:**

Phone Numbers (W): ( ) - Hours:
(H): ( ) -
Relationship to Patient
Hours and Days Available to Care for Patient:

Legal Guardian, if different from above:
Name Title Address Phone ( )- - Fax ( )- - Email

Other sources of informal support: one friend, maternal grandparetns - all provide limited care

PHYSICIAN INFORMATION

Attending Name Samuel Edwards
Phone Number (919**)-**123-5678
Fax Number (919**)-**123-0011

Name of Practice Happy Pediatrics
Address 400 Medical Lane/PO Box 3574
City Anywhere **State** NC **ZIP** 27000

INSURANCE INFORMATION

Medicaid eligible ☒ **No** ☐ **Yes** ☐ **Unknown**
MID# N/A
SSI eligible ☐ **No** ☒ **Yes** ☐ **Unknown**

Private Insurance ☐ **No** ☒ **Yes** ☐ **Unknown**
Type of private insurance BCBS

CURRENT SERVICES

Current Disposition of Child:
☒ **Home** ☐ **Hospital, estimated date of discharge:** ☐ **Other:**

Current Services:
☒ **PDN** 12 **hrs/day,** 7 **days/week** ☐ **PCS** ☐ **PCS Plus**
☐ **Home Health Nurse visits** ☐ **Home Health Nurse Aide visits**
☐ **PT** ☐ **OT** ☐ **ST** ☐ **Early Intervention/CSDA Services**
☐ **Individual Education Plan** ☐ **Individual Health Plan**
☐ **Community Support Services** ☐ **Developmental Therapy Services** ☐ **CAP-MR/DD**
☐ **None** ☐ **Other:**

Reason for requesting change: PDN currently provided by BCBS, but have reached policy limit and will be discontinued

Has patient previously been referred to CAP/C? ☒ **No** ☐ **Yes, date:** **result:**

REQUESTED SERVICES

What service(s) is/are the caregiver requesting? What kind of help does the patient need? needs a nurse to take care of the child while mom works and sleeps, needs a wheelchair ramp, needs in-home therapy, would like some respite care
Will the caregiver accept case management services? ☒ **Yes** ☐ **No**
Will the caregiver accept nursing/aide services? ☒ **Yes** ☐ **No**

Has the patient been considered for the following:
CAP-MR/DD ☐ **Yes** ☒ **No** ☐ **N/A** ☐ **referral made, outcome**
PDN ☒ **Yes** ☐ **No** ☐ **N/A** ☒ **referral made, outcome** not Medicaid eligible
PCS/PCS Plus ☐ **Yes** ☐ **No** ☒ **N/A** ☐ **referral made, outcome**

REFERRAL INFORMATION

Referred by Name D.C. Planner **Title** Ped Pulm Clinician **Agency/Relationship** Hapy Hospital

Phone (919**)-**999-9999 **Email** dp@happy.com **Fax (**919**)** -888-8888 **Address** 1 Hospital Dr., Anywhere, NC 27000

Date Referral Taken 8/30/05 **By Whom** Nancy Nurse **Title** CAP/C Case Manager **Agency** Happy County DSS

Illustration 7-2 Sample Referral Form (continued)

7.4 DMA "Prescreening"

DMA's prescreening of referrals is intended to help parents/responsible parties understand the available care options. It also assists in making the best use of the resources available for CAP/C assessments.

- When the referral comes to the HCI staff, the staff accomplishes the prescreening. Factors considered during the prescreening process, include, but are not limited to:

  - **Is the primary diagnosis medical, as opposed to mental, developmental, behavioral, or cognitive?** For example, children with diagnoses of autism, mental retardation, developmental delay, and Down's syndrome, without any accompanying medical diagnosis, would not be appropriate for CAP/C.

  - **Is there a need (and request) for actual nursing intervention?** CAP/C can not be approved just for monitoring or being there just in case something happens or just to cover a parent's work schedule. There must be a need for regularly scheduled nursing tasks.

  - **Is the need for the actual nursing intervention continuous?**
    Does the scheduled nursing task happen at intervals throughout the shift (e.g., tracheal suctioning, tube feeding)? CAP/C can not be approved only for intermittent or one-time tasks (e.g., wound care) that could be accomplished within a home health visit.

  - **Is there a need (and request) for case management services?**
    There must be a need for a case manager to assess, plan care, monitor, and coordinate services. The family must agree to this service and participate in it.

  - **Is the client at risk of institutionalization?**
    The client's actual nursing care must be of enough frequency and severity that the client could reasonably be expected to be admitted to a nursing home if home care was not available. There must be a lack of other resources such as informal caregivers or formal daycare services that would be able to meet the child's needs.

  - **Are the child's nursing interventions age-appropriate?**
    As a general guideline, children under two years of age whose only nursing need is ADL's will not be approved, as ADLs are a normal developmental need at this age, not a medical need. Children older than two years of age will also be assessed according to the age-appropriateness of the ADL care needed. Children under two years of age with only a colostomy generally will not be approved, as the care is not significantly different than diaper care which is normal at that age.

  - **What resources does the child currently have to meet his/her needs?**
    Existing formal and informal supports are considered. CAP/C can only be approved to supplement, not replace, these resources. Reasons for any change in existing services are considered. CAP/C is approved only to meet unmet medical needs of the child, not for the convenience of the caregivers. If existing resources can meet the child's needs, there is no reason for CAP/C to supplement these resources.

  - **What other potential resources, formal or informal, are available to meet the child's needs?**
    Other programs that could meet the child's needs are considered to ensure that CAP/C is the most appropriate service for the child. If not, DMA will recommend referral to the other program.

The CAP/C consultants review the referral information to determine appropriateness for a CAP/C assessment. As part of the review, a consultant may be in contact with you, the parent(s)/responsible party, the referral source, and those involved in the medical care of the child. Generally, decisions regarding whether a child is or is not appropriate for an assessment are made by the group of CAP/C staff, not any single consultant.

- If the child appears to be a good candidate for CAP/C, the CAP/C consultant contacts a CAP/C case management agency serving the child's area. The consultant also sends a letter to the caregiver informing them of the "approval", and advising the caregiver, in general terms, of the procedure for final approval.

- If the child does not appear to be a good candidate for CAP/C, the CAP/C consultant will notify the parent(s)/responsible party by letter of that determination as well as any known options for care. If the parent(s)/responsible party still wishes to pursue CAP/C, the consultant will refer the child for assessment as outlined above. The parents have 60 days from the date of the letter to request the assessment. After 60 days, a new referral form must be completed, and a new pre-screening done.

7.5 The Assessment Process

When you accept a request from the HCI staff to initiate an assessment for CAP/C, contact the parent(s)/responsible party to schedule the assessment and coordinate other necessary arrangements. You should contact the family within two weeks of the approval for assessment, even if you have to place the child on a waiting list. The contact may be by either telephone or mail.

***REMEMBER**: Your assessment activities, which are billed as Case Management, are not reimbursable unless your agency is enrolled with DMA to as a CAP/C Case Management provider on the date of service.*

7.5.1 Informing DSS of A Potential CAP/C Client

Your action depends upon whether the child is receiving Medicaid.

- **If the child is *NOT* on Medicaid**, refer the child's parents or responsible party to the county DSS Medicaid staff. A sample referral memo is in Illustration 7-3. Give a copy of the memo to whomever will be making the Medicaid application, and send a copy to the Medicaid staff member who is the contact for CAP/C.

- **If the child *RECEIVES* Medicaid**, notify the Medicaid staff that the individual is being considered for CAP/C. There are several types of Medicaid coverage that are not eligible for CAP/C. The Medicaid staff must be aware of the possibility of CAP/C to assure that any changes in coverage are processed. Because changes may affect the child, it is important that the parents/ responsible party have the opportunity to discuss the implications of a change with DSS. (See Section 6 for details about Medicaid eligibility.)

(Date)

MEMORANDUM

TO: (Name of DSS Medicaid Contact)
(County) Department of Social Services

FROM: (Name & Agency of Case Manager)

RE: Referral of Potential CAP/C Participant for Medicaid

I am referring _____ to apply for Medicaid on behalf of _____. The applicant is a potential CAP/C participant.

Thank you for your assistance. If there are any questions or problems please call me at _____.

Illustration 7-3 – Sample Referral Memo

NOTE: *The Medicaid application is open for 90 days. If your waiting list is such that you do not expect to have CAP/C approval within 90 days, defer this step until such time that the client's turn comes up on the waiting list.*

7.5.2 Prior Approval of NF Care

The individual's physician must recommend that the child requires ICF or SNF care and the recommendation must be approved by the fiscal agent for CAP/C to be considered. The recommendation is made on a FL-2 form. The FL-2 prior approval process is described in Section 8.

REMEMBER*: The person must be a Medicaid applicant or recipient for the FL-2 to be processed* ***AND*** *the FL-2 must be approved by the fiscal agent before you begin the assessment and plan of care process.*

7.5.3 Physician's Request Form

The physician's request form must be completed at the time of the initial assessment and each CNR for each patient who receives skilled nursing care. The form does not need to be completed for patients receiving nurse aide care. See Illustration 7-4. The case manager may complete the client's name, address, phone, date of birth, and Medicaid ID number; the remainder of the form should be completed by the physician.

7.5.4 Assessment and Plan of Care

After the FL-2 is approved, initiate the assessment process to determine the child's strengths and needs. If it appears that the child needs hospital level of care, contact the DMA CAP/C consultant for a tentative decision on whether the child qualifies for hospital level. After completing the assessment, develop a Plan of Care. The assessment requirements are in Section 9 and the Plan of Care requirements are in Section 10.

If the required parties agree to the Plan and the child's parents or responsible party accept the Plan, submit the Assessment and Plan of Care for approval. See Section 14 for Plan of Care approval.

North Carolina Division of Medical Assistance
PHYSICIAN'S REQUEST FORM

Medical Necessity for Nursing Services

Community Alternatives Program for Children

Requested Start of Care date: _10-1-05_____ *Complete upon initial referral and annually with CNR, only on patients who do/will receive the care of an RN/LPN.

Name Sarah S. Smith_____ **Medicaid ID#** 900 12 3456 T_____

Address 100 Sunny Lane, Anywhere, NC 27000_____

Telephone Number 919 123 4567_____ **Date of Birth** ___2-18-02_____

Diagnosis ___cerebral palsy, trach, GT, MR_____

Prognosis and expectations of specific disease process _chronic, no significant improvement expected_____

Date of last physician assessment _9-5-05_____

Informal Caregivers availability/Training received:___parent fully trained in all care; grandparents trained for GT feeds
_____

TECHNOLOGY REQUIREMENTS & NURSING CARE NEEDS

1. **Ventilator dependent:** _____ **YES** _____X__ **NO**
   Hours per day on ventilator _____

2. **Oxygen:**__X_____**YES**_____**NO**
   Actual liters per minute and hours per day required ____PRN_____
   Continuous prescribed rate_____ **or adjusted daily/ more often.** __
   Maintain Sats > ___95_____**%** **Frequent need for adjustments and interventions:**__ususally uses only during acute respiratory illness.

3. **Non-ventilator dependent tracheostomy** ____X_____**YES** _____**NO**
   Actual Frequency of Suctioning: ordered Q4H and PRN, actual frequency Q 1-2H_____

4. **Enteral (Tube) feedings** **Sole source of nutrition** ____X_____ **YES** _____**NO**
   Type of nutrition/frequency _Pediasure 1 can/water 30 cc flush Q4H 5x/day via GT____

5. Medical History: note functional/communication limitations/incontinence
   __nonambulatory**,** nonverbal, incontinent_____
   _____
   _____

Physician's Signature ___*Samuel Edwards, MD*_____**DATE**_____*9-5-05*_____

1/2006 CAP C

Illustration 7-4 Sample Physician's Request Form

7.6 DMA's Action on Plan of Care

7.6.1 Evaluation

DMA evaluates the assessment and plan of care according to the criteria outlined in sections 1.2 and 7.4. The following additional guidelines may assist you:

- A child with a full-time informal support system in place will receive a maximum of 10 hours per day of nursing or nurse aide care subject to the limitations of the budget and the level of medical need of the child.
- Up to an additional eight hours per day may be granted on five days of the week to compensate for the absence of an informal support person. This also, is subject to the limitations of the budget and the level of medical need of the child.
- A child may receive 24-hour per day CAP/C care for a maximum of two weeks (usually less) in the event of acute increased medical needs, family emergency, or respite. A plan needs to be in place to ensure the child's safety if formal care services can not be provided.
- If the client's health, safety, and well-being needs can not be met within the above parameters, CAP/C can not serve that client.
- The above parameters (except for provision of 24-hour per day care) exclude respite hours and short-term-intensive services.
- The above parameters include all sources of informal support, including nursing services paid by insurance companies and time spent in school or daycare regardless of whether nursing services are provided during that time.

***NOTE**: Existing CAP/C clients who receive more than the above maximums may continue their present hours until such time as their CNR is reviewed or there is a change in medical need or availability of informal support, whichever comes first. Existing clients who receive more than the maximum may not receive any increase in hours.*

***Example 1**: A patient is approved by CAP/C for 10 hours per day and private insurance for 4 hours per day. The patient does not receive 14 hours per day. The patient receives 10 hours per day, with Medicaid paying for 6 hours and private insurance paying for 4 hours.*
***Example 2**: A patient is approved by CAP/C for 10 hours per day and by the insurance company for 10 hours per day. They are not requesting any other waivered services. Since there is no need for CAP/C services, CAP/C could not be approved for this child*
***Example 3**: A patient currently receives 18 hours per day five days per week and 10 hours per day on weekends. Her parents have now enrolled her in kindergarten for six hours per day on weekdays. The child can not receive 18 hours from CAP/C in addition to 6 hours in school so that she is receiving 24 hour per day care from formal support systems. This client may still receive her TOTAL of 18 hours: six hours in school, and 12 hours of in-home nursing through CAP/C.*

- Additional hours will not be granted to provide a nurse to accompany a child to school.
- The remaining hours of the day that CAP/C has not approved are the responsibility of the informal support system. There is no CAP/C regulation that prohibits the family from paying a caregiver privately during that time. Only formal third party support is counted against the parameters for hours.
- Children at the ICF level of care who need help only with ADLs and who have full-time informal support available will receive no more than 3 hours per day, 5 days per week, of in-home care. This three hours per day is in addition to school or daycare hours. Children with continuous needs or absence of an informal support person will be considered for additional hours. Conversely, children who require less than three hours per day should be evaluated for appropriateness for CAP/C: 1) Are they truly at risk of

institutionalization, and 2) Could their needs be met in a more appropriate way, such as Home Health Visits or PCS?

7.6.2 Actions on Plan of Care Decision

You will be informed by letter of DMA's decision on the Plan of Care and CAP/C participation

- ***If CAP/C participation and the Plan of Care are approved***, do the following:
  - **Notify the parents or responsible party** in writing of CAP/C approval and the services that will be provided. Document the contact in your case management notes.
  - **Notify the DSS Medicaid** worker in writing of CAP/C approval. Send a copy of the Cost Summary (pages 2 and 3 of the Plan of Care) with the notification and a copy of DMA's approval letter. (Your local county DSS may ask for additional items as well.) Illustration 7-4 shows a sample notification memorandum. Follow-up with DSS to assure that the notification was received and the CAP indicator has been entered into the Eligibility Information System. Check the client's Medicaid ID card the next month to see if the CAP indicator (IC for ICF, SC for SNF or HC for Hospital) is in the CAP block on the card.

(Date)

MEMORANDUM

TO: (Name of DSS Medicaid Contact)
(County) Department of Social Services

FM: (Name & Agency of Case Manager)

RE: Approval of CAP/C for (Name and Medicaid ID No. of Client)

I have received approval for the above individual to participate in CAP/C.

Please enter the CAP indicator and the effective date in the Eligibility Information System. The CAP indicator is IC/SC/HC (circle one). The effective date is the latest of the Medicaid application date, the deinstitutionalization date and the FL-2 prior approval date.

FL-2 Approval Date:
Deinstitutionalization Date:

Please let me know the amount of any Medicaid deductible. A copy of the Cost Summary (pages 2 and 3 of the approved Plan of Care) that shows what CAP services are authorized and a copy of the DMA Plan of Care approval letter are attached.

Please call me if you have any questions (case manager's phone number).

Attachments (2)

Illustration 7-5 – Sample DSS Notification Memo

- **Initiate the CAP/C services approved on the Plan of Care** and begin monitoring those services. (See Section 11 for information on the case management activities.) Start services without delay to assure that the child receives the necessary treatment and care. The Plan is approved with the expectation that the services

are going to be provided. If there are delays in starting services, consider alternative sources of care. The client's record must show the reason for any delays and document the actions taken to assure proper care.

***NOTE**: Contact the HCI unit at any point that you recognize that the approved CAP/C services cannot be initiated. If the services cannot be implemented as approved within 30 days of your notification of the Plan approval, a determination will have to be made whether the Plan can be revised and still meet the child's needs, or the child will have to be terminated from the program.*

- ***If CAP/C participation is denied***, the HCI staff will send a written denial to the parent(s)/responsible party. You will be sent a copy of the denial notice and will serve as contact person for the parent(s)/responsible party on the procedures for requesting an appeal. ***Note:*** *Please notify your CAP/C Consultant immediately when a parent contacts you to request an appeal. Immediate contact will ensure that all timelines for the appeal process are adhered to.* (See Section 19 for information about appeals.) The notice will contain the following information:
  - The effective date of the action. This is the date that the notice is prepared and mailed.
  - The applicant's right to request, verbally or in writing, a hearing with the Division of Social Services
  - The time frame for requesting a hearing. This is 60 days from the date of the notice.
  - The time frame for holding a hearing. This is ninety days from the date of the request.
  - The client's right to be represented by someone else and bring others to the hearing.
  - The time-frame for mailing the client a notice containing the hearing decision.
  - The CAP/C consultant's name along with the agency address and telephone number.
  - A clear statement that CAP/C participation is being denied.
  - The reason(s) for the denial.
  - Reference(s) from the CAP/C Manual supporting the denial, including section and sub-section numbers.

7.7 Continuing Eligibility

Provide ongoing Case Management to your client as outlined in Section 11. Remember that eligibility is a continuing process for CAP/C as the client's needs and situation change. There also is a minimum requirement for an annual reassessment and new Plan of Care. Please see Section 12 for Plan of Care revisions, Section 15 for information on absences, and Section 13 for the annual Continued Need Review requirement.

Client **approved** for assessment by DMA after receiving CAP/C Referral.

These steps must be coordinated to happen at the same time

CLIENT

Apply for Disability to qualify for SSI.

Apply for Medicaid.
Done at DSS in the county of residence.

CASE MANAGER

Send out FL-2 (and Physician's request form, if applicable) to physician to complete and sign and date.

Call in FL-2 to fiscal agent within 30 days of physician's signature.
Receive approval and level of care from fiscal agent.

Write verbal approval number on FL-2.
Copy FL-2 for your records.
Mail hard copy of FL-2 to fiscal agent to be received within 10 days of telephone approval.

CAP effective date: Latest of:

1. Medicaid application date
2. FL-2 approval date
3. De-institutionalizaton date

Submit completed & signed assessment and Plan of Care to DMA within 60 days of FL-2 approval date. Completed assessment and plan of care must be approved by DMA within 90 days of Medicaid application date.

IF APPROVED BY HCI UNIT
Send out service authorizations, participation agreements to providers
Notify DSS
Notify parents/responsible party

IF NOT APPROVED BY HCI UNIT
HCI sends out denial letter
Case Manager is contact for parent/responsible party.

Illustration 7-6 Referral Algorithm

Client **not approved** for assessment by DMA after receiving CAP/C Referral

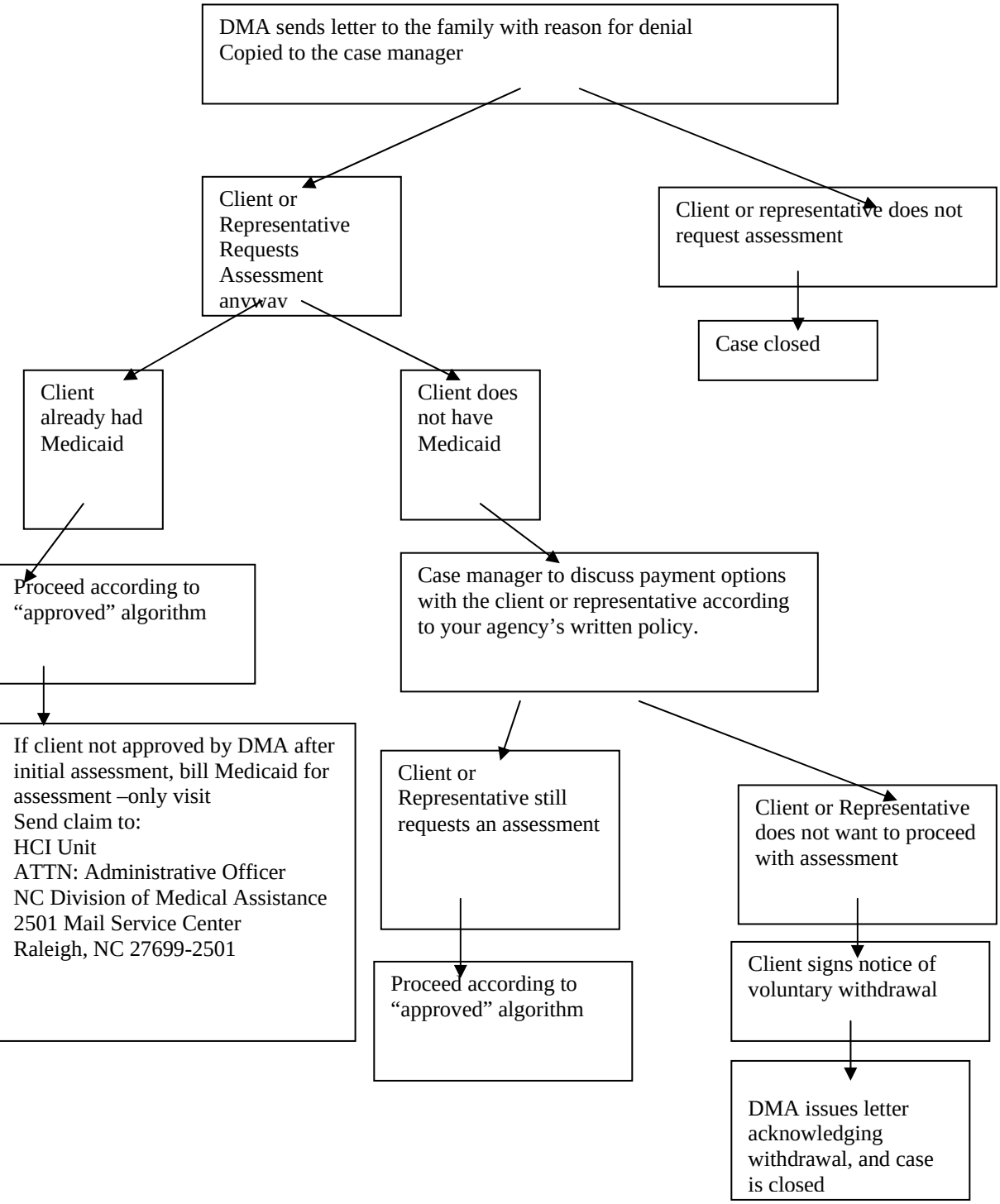

Illustration 7-6 Referral Algorithm (continued)

8.0 APPROVAL OF LEVEL OF CARE

An individual being considered for CAP/C must require the level of care provided by a nursing facility or hospital. The individual's physician begins the level of care process by completing a FL-2 form to recommend nursing facility care at the ICF or SNF level. The recommendation is then sent to the fiscal agent for approval. DMA determines whether hospital level of care is appropriate after the individual has been approved for SNF level. Any time the physician, case manager, or DMA consultant feels the child's level of care has changed, a new FL2 must be submitted. The approval process for nursing facility level of care is described below. See 8.10 for more information on hospital level of care.

***CAUTION**: Nursing facility level of care must be approved by the fiscal agent before the Assessment and Plan of Care process is initiated.*

The following material is directed to the CAP/C case manager.

8.1 Critical Time Limits

There are several critical time limits related to prior approval. Keep the following in mind:

8.1.1 Physician's Signature

Request fiscal agent's prior approval of the FL-2 within ***30 days*** of the date that the physician signs the form.

8.1.2 Submitting A Phone Approved FL-2

Submit a phone approved FL-2 so that it reaches the fiscal agent within ***10 workdays*** of the date of telephone approval. If the completed form does not reach the fiscal agent within this time, the prior approval number will be voided. You will have to obtain a new FL-2 and go through the process again.

8.1.3 Submitting the Plan of Care

Submit the completed Assessment and Plan of Care with the required documentation to the HCI Unit so that it is ***received*** no later than ***60 days*** after the date of FL-2 approval. If the Plan is not received within the time limit, a new FL-2 will have to be obtained and the process reinitiated.

8.2 Effective Date of FL-2 Approval

The effective date of the approval is the date that the fiscal agent gives telephone approval or the date that the fiscal agent enters in item 13 on the FL-2 on mail requests.

***NOTE**: Do not request a retroactive FL-2 approval date from the fiscal agent for CAP/C. If there are processing problems with the FL-2, see 8.6.*

8.3 Completing the FL-2

Instructions for completing the FL-2 are on the back of the form. The information in Illustration 8-2 expands on the instructions in relation to CAP/C. Check "Prior Approval" at the top of the form. A sample form is shown in Illustration 8-3.

The FL-2 should ideally be completed by the physician. The case manager's assessment is found on the assessment form and plan of care; the FL-2 is supposed to reflect the physician's assessment. It also helps to ensure our clients' health, safety, and well-being by noting any discrepancies between the physician's, case managers', and families' information, and resolving those discrepancies.
If, however, the physician will not complete the FL-2, the case manger may complete it and submit it to the physician for review and signature. Please explain to the physician the importance of a complete and accurate FL-2 form and the need for his/her thoughtful consideration of the information and recommendations contained in it.

***CAUTION**: All items must be completed on the form. The physician's signature must be clear and the date of the physician's signature must not be altered. The physician whose name is in block 8 of the FL-2 must be the same physician who signs it.*

8.4 FL-2 Submission

You may request telephone approval from the fiscal agent. For telephone approval:

- After you have received the completed form, signed by the physician, call the fiscal agent's Prior Approval Unit.
- If the fiscal agent gives approval, complete blocks 12 and 13 on the form according to the instructions in Illustration 8-2 and make a copy for the CAP/C record.
- Send the original form to the fiscal agent..

***REMEMBER**: The FL-2 must reach the fiscal agent within **10 workdays** of the date of the phone approval or the approval will be voided.*

Note in your record the date that you sent the form to the fiscal agent.

8.5 FL-2 Response

The fiscal agent will return the processed FL-2 to the DSS. DSS sends the facility copy of the form stamped by the fiscal agent to you. DSS keeps one copy for its income maintenance files.

If you do not receive a stamped copy within 30 days of the date of submission, follow up by:
1. contacting DSS. Make sure they have received it. If they have, ask them to forward you either the stamped pink copy or a photocopy of it. If for some reason, they can not, then
2. call EDS and ask them to fax you a copy. If none of the above work,
3. call your CAP/C consultant. She can provide you with a printout from the MMIS computer system showing the approval.

Attach whatever documentation you receive to your copy of your original FL-2.

***NOTE**: You must have a record of the prior approval in the client's record.*

8.6 FL-2 Processing Problems

If prior approval is delayed or voided due to a processing problem that is beyond the control of the case manager, such as a telephone approved FL-2 being lost between the case manager and the fiscal agent, call DMA's HCI Unit for guidance. A new FL-2 will have to be obtained; however, in some instances, DMA may be able to get approval effective on the original FL-2 approval date.

8.7 Denial of Nursing Facility Level of Care

If the fiscal agent does not approve ICF or SNF care, the physician may request reconsideration by contacting the fiscal agent's Prior Approval Unit. If the reconsideration fails, the client may request a hearing by DMA.

8.8 Intermediate Level of Care (ICF)

Intermediate level of care is approved by the fiscal agent for those children who require some daily licensed nurse aide care, but not continuous skilled nursing care. It is intended to maintain clients at their maximum functional level, prevent regression, and/or return them to a previous level of independence. The following factors frequently indicate the need for intermediate level of care (this list is not all-inclusive): need for assistance with activities of daily living including incontinence care, ambulation assistance, and supervision of special diets; use of preventive measures/devices to prevent or retard the development of contractures (e.g., AFOs, range of motion); therapy services less than five times per week.

8.9 Skilled Level of Care (SNF)

Skilled level of care is approved by the fiscal agent for those children who require continuously available skilled nursing care but not the degree of support available in an acute care hospital. The following factors frequently indicate the need for skilled level of care (this list is not all-inclusive): gastrostomy feedings; tracheostomy care; therapy services at least five times per week.

NOTE: *Frequency of therapy services can affect the patient's level of care. Be alert for this when a client's therapy schedule changes between the school year and the summer vacation. If the change would affect the level of care, you would need to obtain a new FL-2 to submit with the revision.*

8.10 Hospital Level of Care

Hospital level of care is approved by DMA's HCI Unit for children with medical conditions who require continuous, complex and substantial skilled nursing care that could not otherwise be provided in a skilled nursing facility. These children typically have multiple serious illnesses, medical conditions and/or injuries - to the degree that the necessary interventions and supervision can only be met by continuous skilled nursing care rather than intermittent home health nursing. Nursing care to monitor for potential complications will not meet the criteria for this level of care. In most cases, children who are approved for this level of care have continuous skilled nursing needs in one or more of the following areas:

- Dependent on mechanical ventilators

- Require substantial and complex nursing care due to AIDS or AIDS-related conditions, or
- Require a combination of two or more of the following services:
  - Device-based respiratory support requiring on-going intervention including: tracheostomy tube care along with frequent suctioning or tracheostomy care with continuous oxygen therapy for long term respiratory dysfunction;
  - Nutritional management requiring tube feeding;
  - Intravenous administration of drugs, nutritional substances, or fluids over extended periods (greater than four hours daily) secondary to a complex or terminal medical condition;
  - Intensive pain control management through intravenous or epidermal/intrathecal analgesic drug administration;

CAUTION: *Keep in mind that the final decision on hospital level of care is made after the complete package is sent to the HCI Unit and a CAP/C consultant has reviewed all the supporting documentation. Remember to monitor for any changes in the client's care needs and promptly report the changes to the HCI Unit.*

Some examples of children who are likely to meet the Hospital Level of Care criteria are as follows (these examples are provided for guidance and are not intended to be all inclusive):

Situation 1: *Seth is a four-month-old infant who is 24 hour ventilator dependent.*

Situation 2: *Amanda is a three year old who has a tracheostomy and requires suctioning at least once every 30 minutes. She has a gastrostomy tube and requires continuous feeds. Because of her reflux tendencies, her feedings must be monitored and sometimes requires adjusting the rate of the feedings.*

Situation 3: *Kyle is a six year old who receives TPN around the clock and replacement fluids equal to the amount lost. He requires antiemetics for frequent vomiting. On going nursing assessments are necessary to monitor pain management both before and after the intravenous administration of pain medication - the medication often is given every two to three hours.*

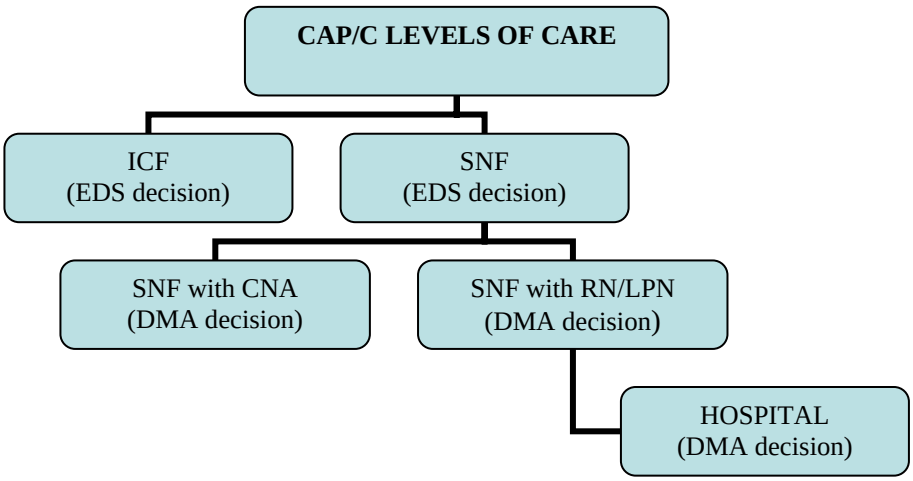

Illustration 8-1 CAP/C Levels of Care

FL-2 Instructions

1. PATIENT NAME	Print last name, first name, and middle initial as the client's name is recorded for Medicaid. If no middle name, indicate **NMN**.
2. BIRTHDATE	Enter month, day, year.
3. SEX	Enter **F** for female or **M** for male.
4. ADMISSION DATE	If the client is in a facility when the FL-2 is completed, enter the admission date - month, day, and year. If the client is at home, enter **N/A**.
5. COUNTY AND MEDICAID NUMBER	Enter 2 digit county number and 9 digit and alpha suffix Medicaid number.
6. FACILITY NAME AND ADDRESS	If currently institutionalized, enter complete name of facility and street address. If the client is at home, enter the case manager's name and address.
7. PROVIDER NUMBER	If currently institutionalized, enter 7-digit number of institution. Enter **N/A** if not institutionalized.
8. ATTENDING PHYSICIAN ADDRESS	Enter complete name and address. The physician's name that appears in this block must be the physician who signs in block 21.
9. RELATIVE	Enter complete name and address of the person responsible for the client.
10. CURRENT LEVEL OF CARE	Enter current level of care provided. If a new CAP/C applicant who lives at home, enter N/A. If the client is on CAP/C, check the current level of care.
11. RECOMMENDED LEVEL OF CARE	Check the block for the recommended level of care. For a child to be eligible for CAP, the recommended level MUST be ICF or SNF. If the child needs hospital level of care, check SNF. DMA will make the determination regarding hospital level of care after SNF level has been approved by the fiscal agent.
12. PRIOR APPROVAL NUMBER	When requesting prior approval by mail, leave blank. If you get phone approval, enter the prior approval number given by the fiscal agent. The fiscal agent must receive the completed FL-2 within 10 workdays of the telephone approval.
13. DATE APPROVED/DENIED	When requesting prior approval by mail, leave blank. If you get telephone prior approval, circle **Approved**, enter the date of phone approval, and enter the initials of the individual in the fiscal agent's Prior Approval unit who granted the approval.

14. DISCHARGE PLAN	Check “Other” and enter CAP/C.
15. ADMITTING DIAGNOSIS	Enter primary and secondary with dates of onset or surgery.
16. PATIENT INFORMATION	Check the blocks applicable to this patient under the designated heading. If may be necessary to check more than one block under a heading or write additional information in blanks. Make information as specific as possible to support recommended level of care.
17. SPECIAL CARE FACTORS	Check those applicable and indicate the frequency for those factors.
18. MEDICATIONS/NAME & STRENGTHS, DOSAGE & ROUTE	List current medications, dosage and route of administration. Include all prescription and over-the-counter medications.
19. X-RAY AND LABORATORY FINDINGS/DATE	Include if available.
20. ADDITIONAL INFORMATION	Use to provide any additional data or information pertinent to the care of the patient and which justifies the type of care requested.
21. PHYSICIAN’S SIGNATURE	The physician must validate by signature the care needs presented on this patient. The signature must be that of the physician indicated in block 8. FL-2s that are signed by a Physician Assistant or Nurse Practitioner must be cosigned and dated by the attending physician, and both names should be in block 8. An FL-2 signed by a physician in the same practice as the physician in block 8 is acceptable as long as the physician writes “in practice with” and his/her name in block 8 next to the first physician’s name. The fiscal agent must receive the form within 30 days of this date.
22. DATE	The FL-2 must be dated by the physician who signs the form.

Illustration 8-2 – FL-2 Instructions

FL-2 (86)
INSTRUCTIONS ON REVERSE SIDE

NORTH CAROLINA MEDICAID PROGRAM
LONG TERM CARE SERVICES

☐ PRIOR APPROVAL ☐ UTILIZATION REVIEW ☐ ON-SITE REVIEW

IDENTIFICATION

1. PATIENT'S LAST NAME / FIRST / MIDDLE: Smith Sarah S.
2. BIRTHDATE (M/D/Y): 2/18/02
3. SEX: F
4. ADMISSION DATE (CURRENT LOCATION): N/A
5. COUNTY AND MEDICAID NUMBER: 92 900-12-3456T
6. FACILITY / ADDRESS: Happy County DSS 1 Happy Rd Anywhere NC 27000
7. PROVIDER NUMBER: N/A
8. ATTENDING PHYSICIAN NAME AND ADDRESS: Samuel Edwards 400 Medical Lane Anywhere, NC 27000
9. RELATIVE NAME AND ADDRESS: Judy Smith 100 Sunny Lane Anywhere, NC 27000
10. CURRENT LEVEL OF CARE: ___ HOME ___ DOMICILIARY ___ SNF ___ (REST HOME) ___ ICF ✓ OTHER ___ HOSPITAL — N/A
11. RECOMMENDED LEVEL OF CARE: ___ HOME ___ DOMICILIARY ✓ SNF ___ (REST HOME) ___ ICF ___ OTHER
12. PRIOR APPROVAL NUMBER: 20057418529 63
13. DATE APPROVED/DENIED: TA 9/5/05 SC WH
14. DISCHARGE PLAN: ___ SNF ___ HOME ___ ICF ___ DOMICILIARY (REST HOME) ✓ OTHER CAP/C

15. ADMITTING DIAGNOSES - PRIMARY, SECONDARY, DATES OF ONSET

1. cerebral palsy 2/02
2. tracheomalacia 2/02
3. gastroesophageal reflux 2/02
4.
5.
6.
7.
8.

16. PATIENT INFORMATION

DISORIENTED		AMBULATORY STATUS		BLADDER		BOWEL	
N/A	CONSTANTLY		AMBULATORY		CONTINENT		CONTINENT
N/A	INTERMITTENTLY		SEMI-AMBULATORY	✓	INCONTINENT	✓	INCONTINENT
INAPPROPRIATE BEHAVIOR		✓	NON-AMBULATORY		INDWELLING CATHETER		COLOSTOMY
	WANDERER	FUNCTIONAL LIMITATIONS			EXTERNAL CATHETER	RESPIRATION	
	VERBALLY ABUSIVE		SIGHT	COMMUNICATION OF NEEDS			NORMAL
	INJURIOUS TO SELF		HEARING		VERBALLY	✓	TRACHEOSTOMY
N/A	INJURIOUS TO OTHERS	✓	SPEECH	✓	NON-VERBALLY		OTHER: Sx 1-2x/hr
	INJURIOUS TO PROPERTY	✓	CONTRACTURES		DOES NOT COMMUNICATE		Q2 PRN CONT.
	OTHER:	ACTIVITIES SOCIAL		SKIN		NUTRITION STATUS	
PERSONAL CARE ASSISTANCE			PASSIVE	✓	NORMAL		DIET Pediasure Icar
	BATHING		ACTIVE		OTHER:		SUPPLEMENTAL H2O 30cc
	FEEDING		GROUP PARTICIPATION		DECUBITI-DESCRIBE:		SPOON T1D via GT
	DRESSING		RE-SOCIALIZATION				PARENTERAL
✓	TOTAL CARE	✓	FAMILY SUPPORTIVE				NASOGASTRIC
PHYSICIAN VISITS		NEUROLOGICAL				✓	GASTROSTOMY
	30 DAYS		CONVULSIONS/SEIZURES				INTAKE AND OUTPUT
✓	60 DAYS	N/A	GRAND MAL		DRESSINGS: trach site		FORCE FLUIDS
	OVER 180 DAYS		PETIT MAL		GT site		WEIGHT 30 lbs
			FREQUENCY				HEIGHT 36 in

17. SPECIAL CARE FACTORS		FREQUENCY	SPECIAL CARE FACTORS		FREQUENCY
	BLOOD PRESSURE			BOWEL AND BLADDER PROGRAM	
	DIABETIC URINE TESTING			RESTORATIVE FEEDING PROGRAM	
✓	PT (BY LICENSED PT)	2 x/week		SPEECH THERAPY	
✓	RANGE OF MOTION EXERCISES	daily		RESTRAINTS	

18. MEDICATIONS - NAME & STRENGTHS, DOSAGE & ROUTE

1. nystatin cream, thin layer TID PRN redness at trach site
2. tylenol 160mg/5ml 5ml GT Q4H PRN pain, fever >101.5
3. MiraLax 1 capful GT QD dissolved in 8oz water
4.
5.
6.
7.
8.
9.
10.
11.
12.

19. X-RAY AND LABORATORY FINDINGS/DATE:

20. ADDITIONAL INFORMATION:

21. PHYSICIAN'S SIGNATURE: Samuel Edwards, MD
22. DATE: 9/4/05

372-124 (12-92) FDS - DMA COPY

Illustration 8-3 – Sample Completed FL-2

9.0 ASSESSMENT

This section tells how to conduct and document the assessment. The assessment determines the feasibility of CAP/C participation. It looks at what is needed to enable the person to attain an optimal level of independence and self-sufficiency. It addresses the well-being of the individual, including the person's health and safety. The process determines the person's abilities; the help the person needs; the support available from and needed by informal caregivers; the help available from other sources; the person's living situation; and the client/responsible party's preferences regarding care. The assessment is the basis for the Plan of Care.

As case manager, you are responsible for coordinating the assessment. Be sure that this is done in a timely and cost-effective manner. The client/responsible party is responsible for cooperating in getting the information required to complete the assessment.

9.1 Who Conducts the Assessment

A registered nurse who meets the case manager qualifications may conduct the entire assessment:

or

A team consisting of a registered nurse and a social worker who both meet the case manager qualifications may each conduct parts of the assessment as identified on the assessment form. The assessment team members may visit the client at the same time or individually.

NOTE: *If the CAP/C case management agency employs only social workers or RNs, it may contract for the other member of the team. The contract may be with a qualified individual or an agency to provide that individual. See 9.5.2 for billing information. To avoid any conflict of interest, the nurse that conducts the assessment should not be the same nurse that regularly provides direct patient care to the client or a supervising nurse from that same agency.*

9.2 When the Assessment Is Completed

Complete the assessment for prospective CAP/C participants as part of the initial consideration for the program. Complete it annually for CAP/C participants.

9.2.1 New Cases

Complete the Assessment after approval of the FL-2 and before you develop the Plan of Care. Submit the Assessment and Plan of Care so that it will be received by DMA for review and approval no later than 60 days after the FL-2 approval date. See 14.3 for instructions.

9.2.2 Continuing Cases

Annually reassess the individual's need for CAP/C. The annual reassessment is called the Continued Need Review (CNR). Complete the CNR during the month of the anniversary date of the original FL-2 approval. The month in which the CNR is due is the "CNR month." Submit the CNR Assessment and Plan of Care so that it will be received by DMA for review and approval no later than the fifth day of the month after the CNR month.

If the client has transferred to you from another county, you may:

- Complete a new CNR, or
- Accept the existing CNR. If you accept the existing CNR, you must update sections 1, 3, 4, and 8 of the assessment (and the POC if necessary) and submit that to DMA.

Whichever you choose, it must be completed within 14 days of the transfer to avoid interruption of the client's services.

EXAMPLE: *If the original FL-2 was approved 7/15/05, complete the CNR during July - the CNR month - and submit the CNR package to the DMA HCI Unit so that it will be received no later than 8/5/06.*

NOTE: *The date the CNR is due is noted in the Plan approval letter. If the date does not correspond with your records, contact the DMA CAP/C consultant.*

9.3 Where the Client Is Assessed

Assessing the client at home is the best way to determine how the client functions in that setting; however, an exception is allowed for initial assessments of hospital/nursing facility patients.

- *For the initial assessment of a child at home*, conduct the assessment where the person resides.
- *For the initial assessment of a hospital/nursing facility patient awaiting discharge*, you may assess the child in the hospital/NF, visit the child's home to gather information about that setting, prepare the Plan of Care and submit it for approval prior to discharge. Confirm your assessment of the client within 30 days of discharge and revise the Plan as needed. Following this procedure will allow you to begin services on discharge, verify how the child functions at home and promptly make any needed adjustments in services.
- *For a CNR*, conduct the assessment at the child's home. If the child is temporarily hospitalized when the CNR is due, contact the DMA HCI Unit for guidance.

9.4 Completing the Assessment

A CAP/C Assessment must be completed by the assessment team for each applicant. The completed form contains basic identifying information and documentation of the assessment. The completion of the assessment interview will not necessarily follow the sequence of the material in the form. Guidance for the assessment interview and specific instructions for the completion of the form are in Illustration 9-1. All fields on the form must be completed unless specifically exempted. The form may be handwritten in ink or typewritten. See Illustration 9-2 for a sample completed CAP/C Assessment.

9.5 Paying For This Activity

File claims for this service according to the following guidance and the instructions in Section 21.

NOTE: *The case management services provided to complete the client assessment may be billed in certain situations for individuals who do not become CAP/C participants. This is the only CAP/C service that may be billed for non-participants. See 9.5.4 for details.*

9.5.1 What May Be Billed

The amount billed may include the CAP/C case manager's time to arrange the assessment activities, the time spent for team members' visit(s) with the client, the time gathering needed information and the time completing the assessment form. The activities have to occur on the dates of service specified in 9.5.3 to be billable. Travel time is not billable.

9.5.2 Who Bills

The case management agency is the only agency that may bill for the assessment activities. If the agency has to arrange for someone not in its employ to be a member of the assessment team, it contracts with that individual (or the agency furnishing that individual) and bills Medicaid for the individual's case management time as part of its CAP/C case management charges.

9.5.3 Date of Service

Assessment activities usually stretch over several days. Document and bill for the time involved each day for assessment activities by showing the date of service as the date that the activities occur. If both members of the team do billable assessment activities on the same date, combine the time of both members and enter it as one line item on the claim.

REMEMBER: *Medicaid payment is available only if the client is authorized for Medicaid in a Medicaid category eligible for CAP coverage on the date of the service. Also, except when conducting an initial assessment for a potential participant in a hospital or nursing facility as outlined in 11.9, the assessment activities must be accomplished on or after the CAP effective date to be billed to Medicaid. Initial assessment activities for a potential participant in a hospital or nursing facility must occur on or after the FL-2 approval date.*

9.5.4 Billing for Non-Participants

You may bill for the assessment of an individual who does not become a CAP/C participant if all of the following conditions are met:

- The client has a properly approved FL-2
- The assessment was completed according to CAP/C policies and procedures.
- The assessment is documented and certified by the RN and, if applicable, by the Social Worker, on the CAP/C assessment form.
- The client is authorized for Medicaid in a Medicaid category eligible for CAP/C coverage on the date of service (see section 6.2.2).

A claim for the assessment of an individual who will not be participating in CAP/C is called an "assessment only" claim. The claim is paid directly by DMA instead of through EDS.

- To submit an "assessment only" claim:
- Prepare a paper claim for the service following the instructions in 21.7.
- Prepare a cover letter that includes:
  - The client's name and Medicaid ID number; and
  - The reason the client will not be participating in CAP/C.
  - Send the claim with the cover letter to:

    HCI Unit
    ATTN.: Administrative Officer
    N. C. Division of Medical Assistance
    2501 Mail Service Center
    Raleigh NC 27699-2501

REMEMBER: *Send "assessment only" claims to DMA's HCI Unit, not to EDS.*

NOTE: *Assessment only claims are an option only for recipients who have Medicaid. Each Case Management agency should have written policies n place regarding payment for assessments for non-Medicaid participants. For instance, the agency may choose to bill the recipient for this time at the full case management rate or at a sliding scale rate, or may choose to provide this service free of charge. Families should be notified of the agency policy before the assessment is performed.*

HOW TO COMPLETE THE ASSESSMENT

The following sections document the assessment of the client's condition and situation. Though the assessment form divides the assessment into specific areas to organize the information, it is not necessary to conduct the assessment interview in any specific order. If more than one assessor conducts the interview, the observations of each assessor should be shared with the other.

The assessment form is located on the DMA web site at http://www.dhhs.state.nc.us/dma/forms.html#prov. The assessment form may be filled out on the computer or printed out and completed by hand. In either case, it must be printed out, signed, and mailed to DMA. We can not accept electronic submissions at this time.

Once you have entered the client's name and Medicaid identification number in section 1 of the form, the form will automatically enter that information onto the top of every page. You do not need to (and will not be able to) type that information in yourself.

CAP/C AGENCY, CASE MANAGER, AND PHONE	***(This portion of the assessment may be completed by the Registered Nurse and/or Social Worker)*** Enter the name of the CAP/C case management agency. Enter the name of the client's CAP/C Case Manager. Enter the Case Manager's phone number, fax number, and email where he/she can be reached by the DMA Nurse Consultant for questions.
INITIAL, CNR, OR REVISION	***(This portion of the assessment may be completed by the Registered Nurse and/or Social Worker)*** Check to indicate whether this is an initial assessment, a Continued Need Review (CNR), or a Plan of Care revision. If it is an initial assessment, indicate the date the client's representative applied for Medicaid. If they already have Medicaid, write "N/A". For a CNR, indicate the date that the CNR is due into DMA. For example, an October CNR would be due to DMA by November 5. Write Nov 5 on the CNR. For a revision, please indicate the date the change is effective. The effective date may be no earlier than 30 days prior to the date received by DMA, as applicable.

Illustration 9-1 – Assessment Form Instructions

1. IDENTIFICATION	***(This portion of the assessment may be completed by the Registered Nurse and/or Social Worker)*** **Name:** Enter the client's name **as it appears on the Medicaid card or application**. **Street Address:** Enter the street/highway/road where the client lives. **Mail Address:** If the client's mailing address is the same as the street address, enter **Same.** If the mail address is different, enter the mail address here. **Town/State/Zip/ County:** Use these entries to complete the client's address. Please indicate the county by name, not number. **Caregiver(s):** Enter the name(s), of the person(s) who is/are responsible for providing most of the client's direct care. **Phone:** Enter the phone numbers of the caregivers. Indicate which caregiver the work or cell phone number is for. If the caregiver does not have a phone, show a phone number through which the caregiver may be contacted and indicate the owner of the phone in parentheses following the number. **Street Address:** Enter the street/highway/road where the caregiver lives. **Mail Address:** If the caregiver's mailing address is the same as the street address, enter **Same.** If the mail address is different, enter the mail address here. **Town/State/Zip/ County:** Use these entries to complete the caregiver's address. Please indicate the county by name, not number. Legal Guardian: Please indicate if the caregivers are the legal guardians. If not, indicate the name, contact information, and relationship of the person or agency responsible for consenting to the client's care. **Sex:** Enter **M** or **F**. **Date of Birth:** Enter month/day/year of birth. Age: Enter the age of the patient on the date the CNR is due. **MID:** Enter the client's Medicaid Identification Number. **Race: Check the box** that describes the observed race of the client. This information is used only for gathering program data that request breakouts by race. **Living Arrangements: Check the box** that applies to the person's living arrangement. Note that clients residing in group homes or facilities are not eligible for participation in CAP/C. Refer to section 1.2 of this manual for specific information regarding living arrangements. **Health Insurance:** Enter **Y** or **N** and the name, policy number, phone number, and contact person of any health insurance policy the client may have. Since Medicaid is the payer of last resort, it is very important to identify all other third party resources. Share this information with the client's DSS income maintenance caseworker. It is also helpful to indicate what the insurance will/will not pay.

Illustration 9-1 – Assessment Form Instructions *(Continued)*

2. PRIOR APPROVAL OF LEVEL OF CARE (FL-2)	***(This portion of the assessment may be completed by the Registered Nurse and/or Social Worker)*** **Prior Approval Number:** Enter the prior approval number received from the fiscal agent. Note that the first four digits of the PA number indicate the year in which the approval was given. If you have a prior approval number that begins with a 7 or 8, it is outdated. Please find out the correct prior approval number. **Approval Date:** Enter the date of the prior approval from the fiscal agent. **Level of Care:** Enter the approved level of care. **Enter IC, SC (with Aide), SC (with Nurse), or SC (HC).**
3. COORDINATING CARE PHYSICIAN	***(This portion of the assessment may be completed by the Registered Nurse and/or Social Worker)*** Enter information about the physician who is primarily responsible for the care of the client. This is usually a local physician and does not have to be the same one who signed the FL-2. If the mailing address is the same as the street address, enter **Same.** If the mail address is different, enter the mail address here. If the physician has no emergency phone, enter 911.
4. EMERGENCY CONTACTS	***(This portion of the assessment may be completed by the Registered Nurse and/or Social Worker)*** Enter at least one emergency contact **outside of the household**. This is the person to be contacted if the parent/primary caregiver is not available. Ideally this is a person who can provide care to the child, but it does not need to be. The contact can be someone out-of-town or out-of-state if that person would know how to reach the primary caregiver and would be available in an emergency. If DSS has custody of the child, enter the appropriate person at DSS as the first contact.

5. PHYSICAL HEALTH: ***(This portion of the assessment must be completed by the registered nurse)***

Use this portion of the assessment to document the onset, extent, control, and complexity of the client's health problems. Compare the health problems and treatments identified by the client and family members with those listed on the FL-2. Discrepancies indicate a need for further evaluation or follow-up to determine the appropriateness of treatment and/or how well the client and family understand the client's condition. Refer discrepancies between FL-2 information and the assessment findings to the client's physician. You may obtain confirmation of the appropriate diagnoses from physician reports, hospital discharge summaries and reports of other service providers. If the diagnoses are obtained from another source, document confirmation that the physician is aware of the diagnoses listed in section 5**A.**

Illustration 9-1 – Assessment Form Instructions *(Continued)*

5. PHYSICAL HEALTH *(Continued)*	
5A. CURRENT DIAGNOSES	List the current diagnoses and the approximate month and year of onset for each. You must comment on the outcome or the current effect of the diagnosis on the client - such as dx: asthma, current effect: poorly controlled, frequent exacerbations, and requires rescue inhaler 1-2 x/day, 3 emergency room visits this year for uncontrolled exacerbations. You may choose to enter the ICD-9 codes for each diagnosis. You will use these codes on the claim form (CMS-1500). See the above instructions regarding correlating your data with the FL-2. Indicate any compliance problems with the prescribed treatment (s). Identify reasons for the non-compliant behavior – such as lack of funds, pain, confusion, or a poor understanding of the reasons for the treatment. Indicate a plan of action for promoting compliance. Use Comments for additional information if needed.
5B. MEDICAL HISTORY	List surgeries, hospitalizations, medical procedures/events, and other diagnoses occurring in the past twelve months or prior to that if they still affect the client (e.g., an arm fracture that was not set properly). Enter the month and year of onset/occurrence and the outcome or current effect on the client's health (e.g., decreased mobility necessitating help with ADLs, pain approximately twice per week treated with PRN ibuprofen.
5C.HOME CARE SERVICES	**Current Services:** Record the home care services currently being provided. Indicate the frequency, the name of the provider agency, and any comments or recommended changes to the services, such as increases, decreases, or cessations. Comments may be left blank for a current service if there is no recommendation for change and no additional information. **New Services:** List any additional services that are recommended. Indicate the recommended frequency and the possible provider agency. Comments may be left blank; however, it is advisable to indicate the reason for the recommendation. **School-**Based Services: Indicate if the client has an Individualized Education Plan (IEP) or an Individualized Health Plan (IHP). Specify what services are provided by this plan. Indicate if the client is in special education classes for all or part of the day. Indicate what special needs the client has during the school day and who meets the need (e.g., client needs help with intermittent catheterization once per day, done by trained teacher's aide.) Also indicate here if the child attends preschool or daycare.

Illustration 9-1 – Assessment Form Instructions *(Continued)*

5. PHYSICAL HEALTH *(Continued)*	
5D. MEDICATIONS	**Name/Dose/Frequency/Route/Comments:** List all prescription and over – the counter medications currently used by the client. Indicate the dosage, frequency, route and any comments, including compliance problems. Have the client/responsible party show each medication, explain its purpose, and state when and how it is taken. If there are compatibility problems (such as medications that interfere with each other or medications that duplicate each other), contact the physician. **Does the Above Agreement with the FL-2? Check** Yes or **No**. Generic equivalents versus brand name medications need not be noted as differences. If No is entered, contact the physician about the discrepancies, and document the contact here. Attach a copy of the letter sent to the physician. Alternately, you may use the client's current CMS-485 form to verify the medications. If you do so, please document that here. **Pharmacy:** Enter the name, location, and phone number of the pharmacy usually used by the client. **Allergic Reactions:** Describe any allergic reactions that the client has encountered with medications. Include the drug name and type of reaction. For example, the client developed a rash as a result of taking penicillin; enter, "Penicillin – Rash." Enter **NKDA** if none known.
5E. NUTRITION	**HT/WT:** Enter the client's height and weight. Indicate if it is an actual height and weight or one that was estimated. If the objective height or weight is several months old, please indicate the date. **Weight Change Past Year:** Enter the amount and indicate if the change is abnormal or if it is expected for the child's normal growth and/or medical condition. If abnormal, indicate the possible reason for the change. All incidences of abnormal weight change or unplanned weight loss should be referred to the physician and documented here. **Food Allergies:** List any food allergies experienced by the client, including the type of reaction. Indicate the type of diet for the client. Be specific (e.g., Pediasure 120 cc with water flush 30 cc Q4H 5 times per day via GT.) Explain if diet does not agree with diet indicated on the FL-2. Specify action taken. **Indicate if** the client and/or caregiver understand and/or comply with the diet. Identify reasons for the lack of understanding or for the non-compliant behavior – such as lack of funds, pain, or lack of formal education regarding special diet. Indicate a plan of action for promoting understanding and compliance. **Comments:** Use Comments for additional information if needed.

Illustration 9-1 – Assessment Form Instructions ***(Continued)***

5. PHYSICAL HEALTH *(Continued)*	
5F. SKIN	Assess the overall skin condition and skin color of the client and check the appropriate box for each. If the client's skin condition and/or skin color is other than "good," check all boxes that apply and describe under Descriptions. Assess any wounds or sites. Specifically include gastrostomy and tracheostomy sites. If the condition is other than "within normal limits," check all boxes that apply and describe under Descriptions. Describe any discrepancies between the assessment and FL-2 information and indicate the action taken to resolve it.
5G. SENSORY AND COMMUNICATION	Rate vision, hearing, and speech and the overall ability to communicate using the codes below. Document your use of age appropriate assessment techniques to evaluate this section. If you are unable to evaluate due to the child's age or diagnoses, leave the code blank and make that note under Explanation**.** Rate the ability with the individual using any assistive devices that are regularly used. If the rating is completed with an assistive device, note under Explanation. Also, enter other needed comments under Explanation. **Vision** No or Minimal Impairment: Infants track objects with their eyes. Child can identify small objects in picture books, discern small objects (such as pills) without difficulty, and handle similar tasks. Moderate Impairment: Child can only discern large objects (e.g., see and identify people, furniture, and other large objects). Can see well enough to move about safely. Give details of this rating under Explanation. Severe Impairment: Infants do not track objects. Child cannot identify large objects and/or tell light from dark. Give details of this rating under Explanation. Cortical visual impairment would be an example of a severe impairment. **Speech** No or Minimal Impairment: Infants cry appropriately. Child can speak clearly and loudly enough to be understood by someone with normal hearing. Moderate Impairment: Child's speech is slurred or occasionally garbled or soft, but can be understood by listening carefully. Give details of this rating under Explanation. Severe Impairment: Cannot speak, or the speech cannot be understood by someone with normal hearing. Give details of this rating under Explanation. **Hearing** No or Minimal Impairment: Infants turn towards voices of parents. Child can hear and understand normal speech without difficulty or can hear with the volume slightly raised. Can hear and understand TV programs even if he/she has to raise the volume somewhat. Moderate Impairment: Infants turn only toward loud sounds. Child can hear if speaker talks in a loud voice and/or speaks slowly. Has to have TV loud enough to hear and understand. Give details of this rating under Explanation. *(Instructions for* I. SENSORY AND COMMUNICATION *continue on next page)*

Illustration 9-1 – Assessment Form Instructions ***(Continued)***

5. PHYSICAL HEALTH *(Continued)*	
5G. SENSORY AND COMMUNICATION (continued)	Severe Impairment: Infants do not respond to any sounds. Child misses many words even when spoken to loudly and slowly, or has no hearing that is useful for communication. Give details of this rating under Explanation. **Overall Communication Ability** No or Minimal Impairment: Can communicate with others with little or no difficulty. Can readily make self understood and can easily understand others. This includes the use of alternate methods of communication such as signing or message writing. Infants startle at sounds and cry appropriately Moderate Impairment: Has some difficulty in understanding others and/or making self understood. If uses alternative methods of communication, is not skilled in their usage. Give details of this rating under Descriptions/Comments. Severe Impairment: In most instances, either cannot understand others and/or cannot make self understood or can never communicate. Give details of this rating under Descriptions/Comments. **Primary Method of Communication:** Indicate the primary method of communication. If the person uses several methods, enter the code for the ones used most often in everyday situations. Describe any discrepancies between the assessment and FL-2 information and indicate the action taken to resolve it. Indicate if there is a language barrier requiring an interpreter.
5H. CONTINENCE	Indicate whether the client is continent or has incontinence problems for both bladder and bowel. If Not Applicable is used, enter the type of catheter and/or ostomy, as appropriate, with the related information. Indicate if the level of continence is appropriate for the child's age. If the child is on a bowel regimen, indicate what it is, and who is responsible for it. If the child is catheterized, please note the frequency. Describe any discrepancies between the assessment and FL-2 information and indicate the action taken to resolve it. Describe any abnormal findings and provide any additional information that may be pertinent.

Illustration 9-1 – Assessment Form Instructions *(Continued)*

5. PHYSICAL HEALTH *(Continued)*	
5I. CARDIAC-RESPIRTATORY	This section is based on observation and caregiver report. You are not required to auscultate the patient. Thoroughly describe any abnormal findings (e.g., apneic spells approximately two times per night during sleep, duration approximately 10 seconds, resolves spontaneously or with repositioning, apnea alarm in use.) Check any assistive or monitoring devices and frequency of their use If fatigue is not due to cardiac or respiratory issues, please indicate reason in comments section.
5J. MUSCULO-SKELETAL	This section is based on observation and caregiver report. Describe any abnormal findings (e.g., contractures of bilateral ankles treated with AFOs). Provide any additional information that may be pertinent., such as braces, assistive devices, etc.
5K. PHYSICAL HEALTH ASSESSMENT SUMMARY AND COMMENTS	Provide as clear a picture as possible of the child's medical needs on an ongoing basis during a typical 24-hour period. Include detailed information on the amount and frequency of medical attention required and who provides it. Discuss the use of any life-sustaining equipment, such as oxygen equipment or ventilators, and give details on the frequency and duration of use. Also describe any special procedures or treatments such as suctioning, and provide information on how often the procedures or treatments are performed and by whom.. Expand on any other areas that need more detail.
5L. PHYSICAL FUNCTION	Function in the context of this assessment refers to impediments to self-care due to physical or medical problems. Check the appropriate box. **Comments:** Use Comments for additional information if needed.

Illustration 9-1 – Assessment Form Instructions *(Continued)*

6. **ACTIVITIES OF DAILY LIVING– *(This portion of the assessment may be completed by the Registered Nurse and/or Social Worker)***

Use this part of the assessment to document the client's performance in activities of daily living (ADL's). Assess the client's ADL functioning through self-reporting by the client/responsible party; observation by the assessor, possibly using performance tests; and/or reports from hospital personnel and others involved in the client's care. The best technique is for the assessor to observe the client performing the specific activities in the home. When that is not possible, use self-report by the client/caregiver and reports from others involved in the client's care.

If there are any apparent differences between the person's performance and capability, give possible reasons for the differences under Additional Comments. ***EXAMPLE:*** *Cindy has a performance rating of 'minor hands on help' needed for eating. She is capable of feeding herself; in other words, she is alert and oriented and has no physical impairment that would prevent her from feeding herself. You suspect, however, that Cindy's primary caregiver continues to provide more assistance than is actually needed. Document this under Additional Comments.*

Assess each ADL listed on the assessment form. **Grooming** includes combing hair, brushing teeth, and similar tasks. **Toilet Use** does not apply if the client has an indwelling catheter and a colostomy. **Transfer** applies to assistance in/out of bed, wheelchairs, etc. The other ADLs are self-explanatory.

For each ADL and IADL, indicate the following:

PERFORMANCE CODE	Check the appropriate box for each activity with the client using any assistive devices that he/she normally uses. Note the type of device used. If the client has a device, but does not use it, do not rate with the use of the device. Independent: Can perform activity without help or supervision from someone else. Only Verbal Prompting Needed: Can only perform activity when someone gives verbal or written supervision, guidance, or prompting. Use this code only if no hands-on assistance is needed. Describe the help needed under Additional Comments. Minor Hands-On Help Needed: Can only perform activity when someone provides minor physical assistance, such as physically guiding the client or buttoning clothing. Describe the type and amount of help needed in Additional Comments. Totally Dependent: Someone else must complete the task for the client. For example, a client must be totally dressed as opposed to needing only some help with buttoning clothing. Describe the type of help needed with ADLs under Additional Comments. Activity Does Not Occur: Use this code for activities that are not applicable to the client. For example, for "Wheelchair Use" if the client is ambulatory. Also use this code if the activity is not appropriate for the child's age.
HELP CODE	If the client needs assistance with any of the activities, check the appropriate box to show who is providing help. Check as many boxes as needed. If the client performs the activity independently, or the activity does not occur, do not enter a Help Code Household Members: Anyone who lives in the same household as the client. *(Instructions for* ACTIVITIES OF DAILY LIVING *continue on next page)*

Illustration 9-1 – Assessment Form Instructions *(Continued)*

6. ACTIVITIES OF DAILY LIVING *(Continued)*	
HELP CODE ***continued***	Other Family: A family member who lives outside the household. Neighbor/Friend: A neighbor or friend, not a family member, who lives outside the household. Agency: A formal service provider who gives assistance to the client. The term "agency" includes paid workers (whether paid as an individual contractor or provided by an agency or organization), and volunteer workers arranged by an agency or organization. Use this code regardless of whether the client has to pay for the service. Activity Does Not Occur: Use this code for activities that are not applicable to the client. For example, for "Wheelchair Use" if the client is ambulatory. Also use this code if the activity is not appropriate for the child's age.
NEED MET?	Check one of the boxes for every ADL . Totally Met: The need is met and will continue to be met. Also, use this if the client is independent in the activity. Met Now, But Will Need Help: The client's need is met, but the help will diminish or cease in the near future. For example, the client's parent must return to work. Need Not Met: There is no help or the help is insufficient to meet the client's need. Suggest the type of help needed under Additional Comments. Activity Does Not Occur: Use this for activities that are not applicable to the client. For example, for "Wheelchair Use" if the client is ambulatory. Also use this if the activity is not appropriate for the child's age.
DME	List all of the DME/assistive devices used by the client. Indicate with an asterisk which pieces of equipment are owned by the client (e.g., capped off, purchased before CAP/C participation). All other DME, rented or purchased, paid by Medicaid or another source, should be listed on your Plan of Care Cost Summary. List any devices that may be needed. Explain the need and the plan for obtaining the equipment/meeting the need.

7. SOCIAL SUPPORT (*This portion of the assessment may be completed by the registered nurse and/or social worker.)*

This area describes the type and amount of the informal support available to the child and gives caregivers an opportunity to express their concerns and identify unmet needs. It also documents family/household dynamics, and the relationships between the child and members of his/her social support network.

NOTE: *This portion of the assessment gives details on the informal assistance provided by family and friends that is indicated in 6. ADLs. Information in section 6 of the Assessment should correlate with the information in section 7.*

(Instructions for SOCIAL SUPPORT *continue on next page)*

Illustration 9-1 – Assessment Form Instructions ***(Continued)***

7. SOCIAL SUPPORT *(Continued)*	
7A. CLIENT'S CONCERNS	Enter **Yes** or **No** to indicate whether the client shows any concern about family/informal support. Describe any concerns, using the client's words as much as possible. Specify what help the client believes is needed, using the client's words as much as possible.
7B. FAMILY/ HOUSEHOLD DYNAMICS	During the assessment process, note the apparent relationships and interactions between the client and household members. Briefly describe what is observed in terms of support, indifference, hostility, tension, or other factors that could influence the success of care in the home. In observing household members in their interactions with the child, look at the informal caregivers' motivation and capacity to learn special techniques to care for the child. Note whether they are interested in and receptive to teaching and guidance from professionals, such as nurses or therapists, who are involved in the child's care.
7C. ASSESSOR'S EVALUATION OF INFORMAL SUPPORT	After considering all of the input from the client, family, friends and other significant persons, evaluate the status of the informal support using the following definitions. Intact and could expand if needed: There is solid support and the informal caregivers can and are willing to do more. Note in Comments the additional help that may be available. Intact, but at limit: There is solid support, but no additional support may be expected from the informal caregivers. No Comments are required. Stressed, meeting with difficulty: The informal support is struggling to meet the client's minimum needs. There is obvious stress in the situation. This includes situations in which the needs are currently being met, but it is doubtful if the support can continue to be provided due to the stress on the caregivers. Specify the areas of support most endangered and add any other explanation of this rating in Comments. Inadequate: The informal support is not meeting the client's minimum needs. Identify in Comments the areas in which support is needed. No informal support in place: There is no informal support provided to the client. This includes situations in which there are persons who could possibly help, but for whatever reason, do not help. Note in Comments if it is possible to develop informal support, and, if known, who might be willing to help.
7D. ADVANCE DIRECTIVES	Indicate the code status of the client. Document it as ordered by the physician and written on the Plan of Care. Also, document other pertinent information, such as religious beliefs that affect medical care (e.g., Jehova's Witness), or attitudes of the family that affect medical care (e.g., the physician recommends a GT but the parents refuse, considering it too invasive). *Section 7 Safety and Welfare, continued on next page.*

Illustration 9-1 – Assessment Form Instructions ***(Continued)***

7. Safety and Welfare (Continued)	
7E. SAFETY AND WELFARE	Concerns regarding the client's safety and welfare can arise from any source, including concerns from the caregivers, other sources of informal support, or your own observations. Include any history of involvement with Child Protective Services, if known. Include any history of household members with drug or alcohol abuse, if known. If issues are identified, document your plan for ensuring the child's safety and well-being.
7F. ADDITIONAL COMMENTS	Use this space to expand on any information provided in Sections 6 or 7 of the assessment.
8. HOME ENVIRONMENT *(This portion of the assessment may be completed by the registered nurse and/or social worker)* Use this part of the Assessment to document information about the client's living environment. If the client receives services in more than one primary residence, this section must be completed for EACH residence. ***CAUTION:*** *The home environment must support the client's health, safety, and well-being. Clients with an unsafe and/or inadequate home environment may not be approved for CAP participation.*	
Location	Check the box that best describes the location of the client's home. City/Town: The client lives in a city, town, or the suburbs of either. Rural Community: The client lives in a small rural community, including farm communities and other areas where several dwellings are near each other, possibly centered around a church or store. Isolated: The client lives in an area with few dwellings. While a few dwellings may be near each other, there is a significant distance to other dwellings, stores, and the usual community services. Other: Please specify
Client's Living Area is On	Check the box to indicate where the client lives in the dwelling. If 'other', please specify. Provide an explanation under 'Comments' of any apparent discrepancies (e.g., a client in a wheelchair lives on multiple levels; document that the family carries the patient up and down the stairs).
Dwelling Is	Check the box that describes the ownership of the dwelling. If 'other', please specify. *Instructions for* Home Environment *are continued on next page*

Illustration 9-1 – Assessment Form Instructions *(Continued)*

8. HOME ENVIRONMENT (Continued)	
ASSESSMENT AREAS: In assessing each area, consider the client's abilities, conditions, needs, and support. View the home environment in relation to the client's ability to perform home care and self-care tasks safely. The client's mental and physical condition, as well as support, affects decisions in this area. Be sure that your ratings here correlate with the other areas of the assessment. Overall, the environment must support an acceptable level of safety, care, and independence for the client. Identify apparent barriers to adequate care and threats to the client's health and safety. Base ratings on your observations and common sense. You may seek professional advice. Use the definitions below to rate each area: Adequate for Client's Needs/Safety. Not a Threat to Health, Safety, and Well-being: The area meets the client's needs and does not present a health or safety hazard, given the client's condition and support. Comments are not required. Minor Problem Area for Which Improvement Would Benefit Client, However It Is Not a Threat to Client: The area does not threaten the client; however, a repair or correction could benefit the client. Describe the type of problem and possible solutions under Comments. Inadequate-Doesn't Provide for Client's Needs/Safety – Must Be Resolved Before Well-Being Can Be Assured: This is a problem that must be resolved before a client may be approved for CAP. Describe the problem and indicate whether a solution is feasible under COMMENTS. Most of the areas listed on the form are self-explanatory. There are a variety of questions that may be asked in each area, depending upon the specific situation. Look at any area or system that is not readily observable and is essential to the client's health, safety, and well-being. The following questions, though not all-inclusive, may help guide you in your assessment of the environment:	
Exterior Access	Can the client enter and exit the home safely, especially in an emergency? For immobile clients, is the access adequate for someone to get the client out of the home?
Interior Access	Does the client have safe access to all essential areas within the home? For example, can a wheelchair bound client get through all needed doorways? Are there areas contributing to frequent falls? Are there necessary safety rails or grab bars? Are there potentially dangerous items, such as throw rugs, that could hinder safe access?
Heating	Is the heating adequate to maintain the client's living area at a comfortable temperature? Does the source of heat appear safe and reliable? Do special precautions need to be taken in extreme weather, such as alertness to freezing lines or overheating of the appliance?
Cooling	Is there a method to adequately cool the client? Does it appear to be safe?
Cleanliness of Home	Is the client's living area relatively neat and clean? Are there piles of litter that could attract and/or hide pests? Is there clutter that could make it difficult for the client to walk? Are there obvious unsanitary conditions?
Trash Disposal	Is there a sanitary way to dispose of garbage and trash? Is it being used? *(Instructions for* HOME ENVIRONMENT are *continued on next page)*

Illustration 9-1 – Assessment Form Instructions *(Continued)*

8. HOME ENVIRONMENT *(Continued)*	
Clean Water Source	Is there an adequate, reliable source of clean water to use for bathing and cooking? Are there potential problems in very cold or dry weather that need to be recognized?
Hot Water	Is there a safe and reliable source of hot water, whatever the means obtained (boiling on stove, water heater, or other means)?
Body Waste Disposal	If there is indoor plumbing, are there indications that it is not functional? Is the method of disposal sanitary and accessible?
Laundry	Is there an adequate and sanitary method to clean clothes and bed linen?
Cooking Appliance	Is there a safe and adequate method to prepare food? Does the appliance present any particular hazards to the client?
Refrigerator	Is there a functioning refrigerator in the home? If not, is there another means of keeping foods as well as medications that may require refrigeration?
Lighting	Is there adequate lighting for the client and caregivers to function? Does it appear safe?
Other Electrical	Are there obvious signs of electrical hazards, such as bare wires? Does the wiring appear adequate to support any life sustaining equipment in the home? If life-sustaining equipment is in use, has the power company been notified?
Structure Integrity	Does the home appear to be in good repair? Are there holes in the roof or floors in the client's living area? Are there unsafe steps? Is the living area drafty? Does rain come in through the windows, roof or doorways? Can the floor support equipment used by the client, such as a heavy wheelchair? Are windows or doors broken?
Telephone	Is there a phone in the client's living area for his/her use? Is it accessible to the client's caregivers? If there is not a phone in the client's living area, is there one in the immediate area?
Pest/Vermin Control	Are there any signs of infestation of any types of pests or vermin rats, mice, snakes, bugs, or other creatures? Are past infestations under control? Are there active measures to control infestations that may be likely?
Fire Safety	Are there obvious fire hazards in the home, such as piles of newspapers, frayed electrical cords, faulty heating appliances, or unsafe storage of flammables? Are there smoke detectors? Are local fire officials aware of a bedfast or wheelchair bound client? Are there safe exits in the event of a fire? *(Instructions for* HOME ENVIRONMENT *are continued on next page)*

Illustration 9-1 – Assessment Form Instructions *(Continued)*

8. HOME ENVIRONMENT *(Continued)*	
Security	Are there obvious security hazards for the client? If the client is alone, are there functioning and seemingly adequate locks?
ADDITIONAL COMMENTS: Use this space, if needed, to expand on any comments.	
9. ECONOMIC STATUS*(This portion of the assessment may be completed by the registered nurse and/or social worker)* Use this part of the Assessment to document whether the client's basic financial needs are met or will be met if approved for CAP/C. ***NOTE:*** *It is not the role of the screening team or case managers to attempt to determine Medicaid eligibility. Refer the client to the Medicaid caseworker at the county DSS for answers to questions about Medicaid eligibility.*	
9A. FINANCIAL MANAGER	Check the appropriate box to show who handles the client's/family's money. If the individual is other than the client's parent, give the name and address of the person. If this person has a formal designation, such as Power of Attorney or Guardian, note it in the space provided.
9B. FINANCIAL MANAGEMENT	Indicate if there seems to be any mismanagement of funds by checking the appropriate box. If a **Yes** is entered, refer to the appropriate agency and note the detail of the referral here (who took the referral, what agency, and the date of the referral). Example: Utilities cut off because of non-payment of bills. Refer to agency or church to assist with payment, or refer to credit counseling agency to assist with making timely payments.
9C. FINANCIAL NEED	Indicate if the monthly expenses exceed the monthly income. If so, describe how the client's needs are met or unmet (e.g., the formula prescribed for the client is too expensive so the family waters it down or substitutes a cheaper formula).
10. MENTAL HEALTH *(This portion of the assessment may be completed by the registered nurse and/or social worker)* Use this portion of the assessment form to document findings on the client's mental status that may affect his/her capacity for self-care and the provision of care by others. Document your observations during the interview, while drawing upon other reliable information that is available to you. Examples of such information are medical reports, psychological evaluations and reports from the child's parents or other individuals who are familiar with the child's mental health status.	
10 A. ORIENTATION	Check **Yes, No, or Sometimes** on the form to indicate the client's alertness and orientation to person, place, and time. Describe some of the client's favorite activities to help clarify the patient's level of interaction and developmental status. *Instructions for* Mental Health *are continued on next page.*

Illustration 9-1 – Assessment Form Instructions *(Continued)*

10. MENTAL HEALTH *(Continued)*	
10B. EMOTIONAL STATE	Assess the client's affect and consider the appropriateness of the client's emotional state for the client's situation. Check the box that most nearly describes the client most of the time. Explain abnormal findings. ***NOTE:*** *If there is inappropriate depression or grandiosity, unreasonable or inappropriate ideas, delusions, hallucinations, or suicidal indications, make a referral to the appropriate person (client's physician or mental health specialist). Document the details of the referral under* Comments*.*
10C JUDGMENT	Describe a variety of routine and emergency situations to the client during the course of the interview, and evaluate the client's responses. Many situations fit naturally into the interview process during discussions of other assessment areas. Use the definitions below to rate each area. Explain mild deficit, moderate to severe deficit, and unable to determine under 'Comments'. Comments may also be used for additional information. Age-appropriate decisions and problem solving: The client responds appropriately, for his/her developmental stage, to real life problems and situations. Mild deficit-usually handles simple issues; not good with complex issues: **Check this box** to describe a client that appears to handle simple decisions that involve only one or a few steps, but has difficulty when several steps are needed. For example, an adolescent client may know to call someone when the power goes off, but might not think through all of the other actions needed, such as handling medicine that relies on power for refrigeration. Describe the limitations and any implications on care requirements. Moderate to severe deficit-difficulty with simple issues-cannot make decisions or solve problems: The client's judgment limitations are such that he/she cannot reliably deal with simple issues. The client does not show a consistent ability to make sound decisions on basic, everyday issues. Note under Comments the implications for care – this may be a simple statement such as, "the client cannot be left alone." Non-Responsive/Unable to Determine: Client's judgment cannot be determined as he/she is not responsive during the assessment. Also use this code if you are unable to assess because of the client's age. *Instructions for* Mental Health *are continued on next page.*

Illustration 9-1 – Assessment Form Instructions *(Continued)*

10. MENTAL HEALTH (Continued)	
10D. BEHAVIOR	This item refers to the social behavior of the client, primarily with those outside of the home and outside of the immediate family. Because negative behavior may impede the ability to provide care in the home, it is important that it be noted. Base your evaluation on your observations as well as information from reliable sources. Check all of the boxes that apply. Give explanations of abnormal findings.
10E. FUNCTION	Function in the context of this assessment refers to impediments to self-care due to mental status. Check the appropriate box as described on the form.
10F. MENTAL HEALTH ASSESSMENT SUMMARY	Briefly summarize the client's mental status. Highlight any information that is significant to the development of the Plan of Care or to the feasibility of CAP/C participation. If the client has been diagnosed with mental retardation or developmental delays, note this information and discuss the degree or level of cognitive impairment if known.
11. ADDITIONAL INFORMATION *(This portion of the assessment may be completed by the registered nurse and/or social worker)* **Use this section to expand on any areas of the assessment in which you did not have enough room to include all information, or to provide additional pertinent information.**	
12. ASSESSMENT CERTIFICATION*(This portion of the assessment must be completed by the registered nurse and/or social worker as appropriate)* The assessor's signatures certify that they have been involved in the assessment and completed those areas that require the individual's professional expertise as indicated on the form. The assessment should be signed and dated on the day it is completed by each assessor. Enter the name of the agency that employs the assessor, and the assessor's phone number. Indicate which sections of the form were completed by each assessor.	

Illustration 9-1 – Assessment Form Instructions *(Continued)*

CAP/C Assessment **Client: Sarah** S. Smith **MID:** Error! Reference source not found.

Community Alternatives Program for Children (CAP/C) Assessment
North Carolina Division of Medical Assistance

CAP/C CASE MANAGEMENT AGENCY Happy County DSS			
CASE MANAGER/TITLE Nancy Nurse, RN		**PHONE NUMBER**	**(**919**)** 857 - 2345
CASE MANAGER E-MAIL nnurse@happycountydss.com		**FAX NUMBER**	**(**919**)** 857 - 2346
☒ **INITIAL, Medicaid application date** 9/1/2005 **deadline date** 12/1/05			
☐ **CNR, due date**	☐ **REVISION, effective date**		

1. IDENTIFICATION (May be completed by RN or Social Worker)

Client's (Child's) Name (as it appears on Medicaid application/card) Sarah S. Smith			
Street Address 100 Sunny Lane	**Mailing Address** 100 Sunny Lane		
City Anywhere	**NC**	**ZIP code** 27000	**County** Happy
Caregiver(s) Judy Smith (mother)			
(For work and cell numbers, please indicate which caregiver the number belongs to.)			
Phone (home) (919**)** 123-4567 **Phone (work) (**919**)** 123-4000 mom **Phone (cell) (**919**)** 123-4567 mom			
Street Address 100 Sunny Lane	**Mailing Address** 100 Sunny Lane		
City Anywhere	**NC**	**ZIP code** 270000	**County** Happy
Is the caregiver the legal guardian? ☒ **Yes** ☐ **No If not, please specify**			
Sex ☐ **M** ☒ **F** **Date of Birth** 2/18/2002 **Age** 4y		**Medicaid ID No** 999-99-9999 A	
Race ☐ **American Indian/Alaskan Native** ☐ **Asian/Pacific Islander** ☐ **Black (not Hispanic)** ☐ **Hispanic** ☒ **White (not Hispanic)**			
Living Arrangement ☒ **with parent(s)** ☐ **with other relatives** ☐ **foster care** ☐ **with others (private residence)** ☐ **group home or other facility**			
Health Insurance ☒ **Yes** ☐ **No. If yes, please specify** ABC Insurance, 1 800 987 6543 Casey Manager, 80% DME, no nursing, 15 therapy visits each discipline per year			

2. PRIOR APPROVAL OF LEVEL OF CARE (May be completed by RN or Social Worker)

Service Review No. 2005 741 852 963	**Approval Date** 9/5/2005	**Level of Care** SC (HC)

3. COORDINATING CARE PHYSICIAN (May be completed by RN or Social Worker)

Name Samuel Edwards	**Name of Practice** Happy Pediatrics	
Street Address 400 Medical Lane	**Mailing Address** PO Box 3574	
City Anywhere	**NC** **ZIP code** 27000	
Emergency Phone (**)** 911-	**Office Phone (**919**)** 123-5678	**Fax (**919**)** 123-0011

4. EMERGENCY CONTACTS (May be completed by RN or Social Worker)

At least one emergency contact should be a non-household member. It does not need to be someone capable of providing medical care to the client.

Name James Jones	**Street Address** 102 Cloudy Lane	
Relationship friend	**Mailing Address** 102 Cloudy Lane	
Phone (home) (919**)** 124-7890	**City** Anywhere	**State** NC
(cell) (919**)** 135-7913 **(work) (**919**)** 146-8901	**Zip Code** 27000	
Name Joyce and John Smith	**Street Address** 103 Rainy Road	
Relationship grandparents	**Mailing Address** 103 Rainy Road	
Phone (home) (919**)** 246-8024	**City** Anywhere	**State** NC
(cell) (N/A**)** - **(work) (**N/A**)** -	**Zip Code 27**000	

Illustration 9-2 Sample CAP/C Assessment Form

CAP/C Assessment **Client:** Sarah S. Smith **MID: 999-99-9999 A**

5. PHYSICAL HEALTH (Must be completed by RN)

A. CURRENT DIAGNOSES – Please indicate how the diagnosis affects the client's abilities or care.

DIAGNOSIS	ONSET DATE	OUTCOME/CURRENT EFFECT	ICD-9 (optional)
cerebral palsy	2/18/2002	spastic, profound MR, seizures	123.4
tracheomalacia	2/18/2002	trach, room air, requires sx 1-2X/h	567.8
gastroesophageal reflux	2/18/2002	GT/Nissen done 3/00, all nutrition via GT, reflux resolved with Nissen	901.2

Does above agree with FL-2? ☒ **Yes** ☐ **No. If not, please specify action taken:**

Are there compliance problems? ☐ **Yes** ☒ **No If yes, describe:**

Comments:

B. MEDICAL HISTORY – List surgeries, hospitalizations, and major treatments that occurred within the last year or that still have an effect on the client.

EVENT	DATE	OUTCOME/CURRENT EFFECT
hospitalization for pneumonia	1/5/2005	resolved

C. SERVICES

CURRENT SERVICES	FREQUENCY	PROVIDER AGENCY	COMMENTS/ RECOMMENDED CHANGES
hourly nursing	8h/d, 7d/w	Happy Home Care	increase to 18 h/d weekdays and 10h/d weekends so caregiver can work
NEW SERVICES	**FREQUENCY**	**PROVIDER AGENCY**	**COMMENTS/ REASON FOR NEW SERVICE**
case management	5h/y plus 4h/m	Happy County DSS	for coordination of care
physical therapy	2 visits per week	Happy Home Care	for spasticity and developmental delay

SCHOOL-BASED SERVICES

☒ **Client is not school-age**

☐ **Individualized Education Plan** ☐ **Individualized Health Plan Specify services provided:**

Is client mainstreamed? ☐ **Yes, completely** ☐ **Yes, for some classes** ☐ **Not at all**

Does client require 1:1 care during school?
☐ **Yes, continuously** ☐ **Yes, for specific tasks/times** ☐ **No**
If yes, from whom? ☐ **teacher** ☐ **teacher's aide** ☐ **other trained school personnel** ☐ **school nurse**
☐ **private duty nurse** ☐ **nurse's aide** ☐ **parent/primary caregiver**

Illustration 9-2 Sample CAP/C Assessment Form, *(continued)*

CAP/C Assessment **Client:** Sarah S. Smith **MID:** 999-99-999 A

D. MEDICATIONS (Prescription and over the counter)

NAME	DOSE	FREQUENCY	ROUTE	COMMENTS/PROBLEMS
Nystatin Cream	thin layer	TID PRN	topical	for redness at trach site
Tylenol 160 mg/5 ml	1 teaspoon	Q4H PRN	GT	pain or fever > 101.5
MiraLax	1 capful	QD	GT	dissolve in 8 ounces water

Does above agree with FL-2? ☐ **Yes** ☒ **No** **If not, indicate action taken:** see FL-2 discrepancy resolution form; Tylenol was inadvertently left off of FL-2, Septra has been discontinued.

Pharmacy Happy Pharmacy **City** Anywhere, NC **Phone (**919**)** 123-1112

Allergic Reactions (specify medication and type of reaction): penicillin causes hives

E. NUTRITION

Height 36 in ☒ **objective** ☐ **estimated** **Weight** 30 lbs ☒ **objective** ☐ **estimated**

Weight change past year amount +/- + 3 lbs ☒ **objective** ☐ **estimated**

Is weight change appropriate for client's age and medical condition? ☐ **Yes** ☒ **No**

If not, explain: Less than needed for growth. Contacted MD, GT feeds increased.

Is MD aware? ☒ **Yes** ☐ **No**

Food Allergies (specify food and type of reaction): None known

☐ **Oral feeds, type/amount/frequency:**

☒ **Enteral feeds, type/amount/frequency:** Pediasure 1 can and water 30 cc flush TID via GT

☐ **Parenteral feeds, type/amount/frequency:**

Does above agree with FL-2? ☐ **Yes** ☒ **No** **If not, indicate action taken:** see FL2 discrepancy resolution form - MD order changed after FL-2 was completed

Are patient and/or caregiver compliant with diet? ☒ **Yes** ☐ **No** **If not, explain:**

Additional Comments:

Illustration 9-2 Sample CAP/C Assessment Form, (*continued)*

CAP/C Assessment **Client:** Sarah S. Smith **MID: 999-99-9999 A**

F. SKIN (Check as many items as apply)

Skin condition: ☒ **Good** ☐ **Pressure Areas** ☐ **Decubitus** ☐ **Rash** ☐ **Other**
Skin color: ☒ **Good** ☐ **Jaundiced** ☐ **Pale** ☐ **Cyanotic** ☐ **Other**

Trach site: ☐ **N/A** ☒ **Within Normal Limits**
☐ **Signs/Symptoms infection** ☐ **Signs/Symptoms skin breakdown** ☐ **Other**
GT site: ☐ **N/A** ☒ **Within Normal Limits**
☐ **Signs/Symptoms infection** ☐ **Signs/Symptoms skin breakdown** ☐ **Other**
Other site: ☒ **N/A** ☐ **Within Normal Limits**
Specify: ☐ **Signs/Symptoms infection** ☐ **Signs/Symptoms skin breakdown** ☐ **Other**

Does above agree with FL-2? ☒ **Yes** ☐ **No If not, indicate action taken:**

Descriptions of abnormal findings and other comments: 8FR Mic-Key GT, turn QD, changed Q 3 mos by nurse or MD

G. SENSORY AND COMMUNICATION

SENSE	DEGREE OF IMPAIRMENT (see CAP/C manual for definitions of minimal, moderate, and severe)	EXPLANATION OF MODERATE OR SEVERE IMPAIRMENT/OTHER COMMENTS (List any assistive devices that are used or needed.)
VISION	☒ No/Minimal ☐ Moderate ☐ Severe	appears normal, teracks, responds to visual stimuli near and far
SPEECH	☐ No/Minimal ☐ Moderate ☒ Severe	nonverbal due to trach, does not tolerate Passey-Muir
HEARING	☒ No/Minimal ☐ Moderate ☐ Severe	hearing eval 6/05 within normallimits

Overall Communication Impairment ☐ **No/Minimal** ☐ **Moderate** ☒ **Severe**

Primary Method of Communication (If none, please indicate how client's needs are met.)
☐ **Speech** ☒ **Gestures** ☐ **Writing** ☐ **Communication Device** ☐ **None:**

Does above agree with FL-2? ☐ **Yes** ☐ **No If not, indicate action taken:**

Descriptions of abnormal findings and other comments: caregivers interpret facial expressions and anticipate client's needs

Is an English-speaking interpreter needed? ☐ **Yes, specify language** ☒ **No**

H. CONTINENCE

Bladder:
☐ **Continent** ☐ **Occasionally Incontinent** (more than once per week) ☐ **Frequently Incontinent** (more than once per day) ☒ **Totally Incontinent** ☐ **N/A** (cath/ostomy)
Age-appropriate? ☐ **Yes** ☒ **No**
Catheterizations: ☐ **intermittent** ☐ **indwelling** **Frequency (if applicable)**

Bowel:
☐ **Continent** ☐ **Occasionally Incontinent** (more than once per week) ☐ **Frequently Incontinent** (more than once per day) ☒ **Totally Incontinent** ☐ **N/A** (ostomy)
Age-appropriate? ☐ **Yes** ☒ **No**
Bowel regimen: MiraLax QD administered by nurse or pt's mother to prevent constipation

Diapers: type/amount per day 8

Does above agree with FL-2? ☒ **Yes** ☐ **No If not, indicate action taken:**

Descriptions of abnormal findings and other comments:

Illustration 9-2 Sample CAP/C Assessment Form, *(continued)*

CAP/C Assessment **Client:** Sarah S. Smith **MID: 99-99-9999 A**

I. CARDIAC-RESPIRATORY – Check all that apply.
This section is based only on observation and caregiver report. The Case Manager is not required to auscultate the patient.

Respirations: ☒ **Regular** ☐ **Irregular** ☐ **Tachypneic** ☐ **Bradypneic** ☐ **Apneic**
☐ **Unlabored** ☐ **Dyspnea** ☐ **Dyspnea with exertion** ☒ **Upper airway congestion**
☐ **Cough** ☐ **Stridor** ☐ **Wheezing** ☐ **Retractions** ☐ **Other**

☒ **Trach:** **Type** Shiley **Size** 4.0 **Actual frequency of suctioning** 1-2x/hr awake, Q1-2 hrs while asleep

Pulse oximetry: ☐ **continuous always** ☐ **continuous at night** ☐ **spot checks, frequency** ☐ **PRN**

☐ **Oxygen: Amount Route Actual frequency of use**

☐ **CPAP** ☐ **BIPAP** ☐ **ventilator Actual frequency of use**

Endurance:
☒ **Within normal limits** ☐ **Fatigues with exertion** ☐ **Easily fatigued** ☐ **Unable to participate in ADLs**

Descriptions of abnormal findings and other comments: RA mist collar or thermovent. UAC cleared by sx.

J. MUSCULOSKELETAL – Check all that apply

Ambulatory Status: ☐ **Independent** ☐ **Person-assist** ☐ **Device-assist, specify** ☒ **Non-ambulatory**

Appearance: ☐ **Within normal limits** ☐ **Scoliosis** ☒ **Contractures** ☐ **Other**
☐ **AFOs** ☐ **TLSO** ☐ **Other braces/devices, specify**

Tone: ☒ **Rigid** ☐ **Normal** ☐ **Flaccid** **Location** throughout
☐ **Rigid** ☐ **Normal** ☐ **Flaccid** **Location**

Strength:
☐ **Normal (active range of motion against full resistance)**
☐ **Mild weakness (active range of motion against gravity alone or light resistance)**
☒ **Moderate weakness (passive range of motion when gravity removed)**
☐ **Paresis/severe weakness**
☐ **Paralysis**

Descriptions of abnormal findings and other comments: Limited spont. movement, able to grasp favorite toy

K. PHYSICAL HEALTH ASSESSMENT SUMMARY AND COMMENTS – Give a clear picture of the client's needs during a typical 24 hour period.

Day:
Bolus tube feeding at 9A and 1P. Incontinence care Q 2H Sometimes naps 11A-12N.
Suctioning of trach 1-2 x/hr. Range of motion exercises.
Personal care including trach care and GT care. Trach changed Q Monday.

Evening:
Bolus tube feeding at 5P. Continuous tube feed started at 8P.
Trach care. Night-time ADLs, pt to bed at 8P.
Suctioning of trach 1-2 x/h until 8P, then Q 1-2 H.
Incontinence care every 2 hours until 8P, then every 4 hours.

Night:
Incontinence care once or twice during the night. Pt wakes up at 6A.
Suction trach once every one to two hours. Continuous feeding stopped at 6A.

L. PHYSICAL FUNCTION

The previous areas of this assessment provide the basis for determining if there are impediments to self-care for physical reasons. Select a statement below to rate physical function.
☐ **Physical/medical status is adequate; no in-home supervision needed.**
☐ **Physical/medical status is adequate; supervision required due to age of child**
☐ **Physical health impairment requiring supervision for specific tasks or at specific times**
☒ **Physical health impairment requiring 24 hour supervision.**
Comments:

Illustration 9-2 Sample CAP/C Assessment Form, *(continued)*

CAP/C Assessment **Client:** Sarah S. Smith **MID: 999-99-9999 A**

6. ACTIVITIES OF DAILY LIVING (May be completed by RN or Social Worker)

ACTIVITIES OF DAILY LIVING	PERFORMANCE CODE	HELP CODE	NEED MET?
Grooming	☐ independent ☐ verbal prompting ☐ minor hands-on help ☒ totally dependent ☐ activity does not occur	☒ household member ☐ other family ☐ neighbor/friend ☐ agency ☐ activity does not occur	☐ totally ☒ met now, but will need help ☐ need not met ☐ activity does not occur
Bathing	☐ independent ☐ verbal prompting ☐ minor hands-on help ☒ totally dependent ☐ activity does not occur	☒ household member ☐ other family ☐ neighbor/friend ☐ agency ☐ activity does not occur	☐ totally ☒ met now, but will need help ☐ need not met ☐ activity does not occur
Dressing	☐ independent ☐ verbal prompting ☐ minor hands-on help ☒ totally dependent ☐ activity does not occur	☒ household member ☐ other family ☐ neighbor/friend ☐ agency ☐ activity does not occur	☐ totally ☒ met now, but will need help ☐ need not met ☐ activity does not occur
Elimination	☐ independent ☐ verbal prompting ☐ minor hands-on help ☒ totally dependent ☐ activity does not occur	☒ household member ☐ other family ☐ neighbor/friend ☐ agency ☐ activity does not occur	☐ totally ☒ met now, but will need help ☐ need not met ☐ activity does not occur
Transfer	☐ independent ☐ verbal prompting ☐ minor hands-on help ☒ totally dependent ☐ activity does not occur	☒ household member ☐ other family ☐ neighbor/friend ☐ agency ☐ activity does not occur	☐ totally ☒ met now, but will need help ☐ need not met ☐ activity does not occur
Walking	☐ independent ☐ verbal prompting ☐ minor hands-on help ☐ totally dependent ☒ activity does not occur	☐ household member ☐ other family ☐ neighbor/friend ☐ agency ☒ activity does not occur	☐ totally ☐ met now, but will need help ☐ need not met ☒ activity does not occur
Wheelchair use	☐ independent ☐ verbal prompting ☐ minor hands-on help ☐ totally dependent ☒ activity does not occur	☐ household member ☐ other family ☐ neighbor/friend ☐ agency ☒ activity does not occur	☐ totally ☐ met now, but will need help ☐ need not met ☒ activity does not occur
Eating	☐ independent ☐ verbal prompting ☐ minor hands-on help ☒ totally dependent ☐ activity does not occur	☒ household member ☐ other family ☐ neighbor/friend ☐ agency ☐ activity does not occur	☐ totally ☒ met now, but will need help ☐ need not met ☐ activity does not occur
Medication Administration	☐ independent ☐ verbal prompting ☐ minor hands-on help ☒ totally dependent ☐ activity does not occur	☒ household member ☐ other family ☐ neighbor/friend ☐ agency ☐ activity does not occur	☐ totally ☒ met now, but will need help ☐ need not met ☐ activity does not occur

Please list all assistive devices/DME used:
(Please indicate with a * which, if any, equipment is owned by the client. All other equipment should be indicated on the Plan of Care Cost Summary.)
*feeding pump, *IV pole, suction machine, humidifier, trach and feeding supplies

What assistive devices/DME may be needed? wheelchair - currently using stroller but will soon outgrow
What is the plan for meeting these needs? Have contacted PT to evaluate, will submit revision

Illustration 9-2 Sample CAP/C Assessment Form, *(continued)*

CAP/C Assessment **Client:** Sarah S. Smith **MID: 999-99-9999 A**

7. SOCIAL SUPPORT (May be completed by RN or Social Worker)

A. CLIENT'S CONCERNS

Does client show any concern about family/informal support and care at home?
☐ **Yes** ☐ **No** ☒ **Unable to communicate concerns**
If yes, please describe: Communication ability severely impaired but client appears content and seems to have needs met.

B. FAMILY/HOUSEHOLD DYNAMICS

Briefly describe the apparent relationships and interactions between the client, household members, and immediate family members. This is primarily based on observations during the assessment interview. Note whether there appears to be a supportive relationship, hostility, or other factor that would contribute to or detract from care in the home. Client's mother is very attentive and loving to Sarah, but she is visibly stressed by recent divirce, recent move, financial situatiuon due to current lack of employment, and demands of caring for Sarah.Receives emotional support from extended family, and they sometimes help with Sarah so Mom caqn seek employment during the day. Extended family very happy to have Sarah and her Mom nearby again, and interact happily and affectionately with Sarah. Sarah's father uninvolved.

Describe any concerns of the family regarding care. What help do they believe is needed? More hours of in-home nursing so mother can work outside of home - currently uses her 8 hours at night to sleep.

C. ASSESSOR'S EVALUATION OF INFORMAL SUPPORT

After considering all of the input from the client, family, and other significant individuals, the assessor needs to evaluate the status of informal support. If informal support is insufficient, explain.
☐ **Intact and could expand if needed** ☒ **Intact, but at limit**
☐ **Stressed, meeting with difficulty** ☐ **Inadequate**
Comment Client/mother just moved to area to be closer to client's uncle and grandparents. They have not had a chance to develop other relationships or support networks.

Describe any concerns of the informal support persons regarding care. What help do they believe is needed? They believe more in-home nursing is needed. Not sure how long mother can keep up with Sarah's care needs, concerned that Sarah's and her mother's heal;th will decline if they do not receive more help.

D. ADVANCE DIRECTIVES

Does the client have any type of advance directive, such as a Do Not Resuscitate order? ☐ **Yes** ☒ **No**
Please describe: DNR has been discussed and declined.

E. SAFETY AND WELFARE

Do any concerns exist regarding the child's safety or well-being? ☐ **Yes** ☒ **No**
If yes, please describe:

Illustration 9-2 Sample CAP/C Assessment Form, *(continued)*

CAP/C Assessment **Client:** Sarah S. Smith **MID: 999-99-9999 A**

8. HOME ENVIRONMENT (May be completed by RN or Social Worker)

If client receives services in more than one primary residence (i.e. lives part-time with mother, part-time with father), this section must be completed for EACH residence.
Rate each component of the home environment according to the following definitions:
Adequate for client's needs/safety. Not a threat to health, safety, and well-being.
Minor problem area for which improvement would benefit client, however is not a threat to client
Inadequate – doesn't provide for client's needs/ safety, must be resolved before well-being can be assured.

Street Address: ☐ **same address as listed for client on page 1** ☐ **other, specified below**
100 Sunny Lane, Anywhere, NC 27000

Location	Client's Living Area	Dwelling
☒ city/town	☒ one floor/ground level	☒ owned by caregivers
☐ isolated	☐ one floor/upper level	☐ owned by others
☐ rural	☐ multiple levels	☐ rented by caregivers
☐ other	☐ other	☐ rented by others
		☐ other

	ADEQUATE	MINOR PROBLEM	INADEQUATE
Exterior Access	☒	☐	☐
Interior Access	☒	☐	☐
Heating	☒	☐	☐
Cooling	☒	☐	☐
Cleanliness of Home	☒	☐	☐
Trash Disposal	☒	☐	☐
Clean Water Source	☒	☐	☐
Hot Water	☒	☐	☐
Body Waste Disposal	☒	☐	☐
Laundry	☒	☐	☐
Cooking Appliance	☒	☐	☐
Refrigerator	☒	☐	☐
Lighting	☒	☐	☐
Other Electrical	☒	☐	☐
Structural Integrity	☒	☐	☐
Telephone	☒	☐	☐
Pest/Vermin Control	☒	☐	☐
Fire Safety	☒	☐	☐
Security	☒	☐	☐

Comments: Client will need wheelchair ramp in future; at this time, Mom still able t carry Sarah in and out of house.

Illustration 9-2 Sample CAP/C Assessment Form, *(continued)*

CAP/C Assessment **Client:** Sarah S. Smith **MID: 999-99-9999 A**

9. ECONOMIC STATUS (May be completed by RN or Social Worker)

A. Financial Manager	
Who manages the client's finances? ☒ **Parent** ☐ **Other** **If not the parent, give name and address of person as well as any formal designation (such as guardian, trustee, power of attorney) below:**	
Name	**Formal Designation**
Address	

B. Financial Management
Is there any indication of mismanagement of the client's funds? ☐ **Yes** ☒ **No** **If yes, give details of referral to appropriate agency:**

C. Financial Need
Are there items or services that the client does without each month due to lack of funds? ☐ **Yes** ☒ **No** **If yes, please explain:**

10. MENTAL HEALTH (May be completed by RN or Social Worker)

This part of the assessment looks at a variety of mental health areas that relate to the client's ability for self-care and behaviors that may affect the provision of care. Many of these areas are difficult to measure objectively. When ratings are requested, enter the one that best describes the client most of the time. Many of the ratings may come from observations of the client's actions/responses during the assessment. Note that this is not a formal mental health evaluation, though it may show the need for a formal evaluation or referral.

A. ORIENTATION
Is the client alert? ☒ **Yes** ☐ **No** ☐ **Sometimes** **Is the client oriented to person, as appropriate for age?** ☒ **Yes** ☐ **No** ☐ **Sometimes** **Is the client oriented to place, as appropriate for age?** ☒ **Yes** ☐ **No** ☐ **Sometimes** **Is the client oriented to time, as appropriate for age?** ☒ **Yes** ☐ **No** ☐ **Sometimes**
Describe activities the client engages in with family members, others, or self, and their reactions to these activities. (Favorite toys, videos, reading, sensory stimulation activities): Client recognizes and respons to regular caregivers. Cries when she goes to MD office. Seems to enjoy being outdoors. Sensitive to changes in her routine. Spends most of time in stroller or on mat on floor. Has small stuffed Elmo that she likes to hold. Seems to enjoy being held and read to. Mesmerized by lava lamp.

Illustration 9-2 Sample CAP/C Assessment Form, *(continued)*

CAP/C Assessment **Client:** Sarah S. Smith **MID: 999-99-9999 A**

B. EMOTIONAL STATE

Assess the client's overall emotional state – the client's affect, satisfaction with life, and activity level using the statements below.

☒ **Contented, shows interest**
☐ **Unhappy/depressed for short periods, interest in activity has waned**
☐ **Feelings of helplessness and hopelessness, dissatisfied with life, declining participation in ADLs**
☐ **Non-responsive/unable to determine**

Expand on abnormal findings:

C. JUDGMENT

Assess the client's ability to discern unsafe/threatening situations, and respond to emergency situations. Use the statements below to indicate the rating.

ROUTINE – Describe several routine situations that may occur (e.g.; stranger knocks at door, dressing appropriately for weather/situation, recognizing soiled/wet diaper)

EMERGENCY – Does client know how to access 911? ☐ **Yes** ☐ **No**

☐ **Age-appropriate decisions and problem solving**
☐ **Mild deficit; can handle simple issues, difficulty with more complex issues**
☐ **Moderate to severe deficit; difficulty with simple issues, can not make decisions or solve problems**
☒ **Non-responsive/unable to determine**

Give details of deficits: Nonverbal and developmentally delayed, and not an age-appropriate task.

D. BEHAVIOR

Based on the assessor's observations and available information from reliable sources, rate the client's usual behavior toward persons outside the household/immediate family.

☐ **cooperative** ☒ **passive** ☐ **argumentative/suspicious/hostile** ☐ **verbally abusive**
☐ **physically abusive** ☐ **other**

Explain abnormal findings: Client with physical and developmetnal delays unable to actively cooperate.

E. MENTAL FUNCTION

The previous areas of this assessment provide the basis for determining if there are impediments to self-care for mental reasons. Select a statement below to rate mental function.

☐ **Mental status is adequate; no in-home supervision needed.**
☐ **Mental status is adequate; supervision required due to age of child**
☐ **Mental health impairment requiring supervision for specific tasks or at specific times**
☒ **Mental health impairment requiring 24 hour supervision.**
☐ **Unable to determine**

Comments:

Illustration 9-2 Sample CAP/C Assessment Form, *(continued)*

CAP/C Assessment **Client:** Sarah S. Smith **MID: 999-99-9999 A**

F. MENTAL HEALTH ASSESSMENT SUMMARY

Expand on any areas that need more detail. Describe the client's overall level of psychosocial development and how it influences the client's care. Include results of any formal developmental evaluations.

Severely developmentally delayed, unable to participate in care, requires constant supervision, no formal developmental evaluations done.

11. ADDITIONAL INFORMATION (May be completed by RN or Social Worker) – This section is optional.

Use the space below to expand on any of the previous sections in which you did not have enough room to include all information. Please refer to the section number and/or letter.

No additional information.

12. ASSESSMENT CERTIFICATION (To be completed by both assessors as appropriate)

The signature of each member of the assessment team below certifies that each person has been involved in the assessment and completed the specific areas that require that member's professional expertise. An individual who certifies a material and false statement in this assessment will be subject to investigation for Medicaid fraud and will be referred to the appropriate professional licensing agency for investigation. Along with the signature, enter the assessor's title and the name and phone number of the agency that the assessor represents.

REGISTERED NURSE

Name Nancy Nurse, RN **Signature**__*Nancy Nurse, RN*_____

Agency Happy County DSS **Phone** 919 857 2345 **Date** 9/10/2005

Sections Completed: ☒ **1** ☒ **2** ☒ **3** ☒ **4** ☒ **5** ☒ **6** ☐ **7** ☐ **8** ☐ **9** ☒ **10** ☒ **11** ☐ **All**

SOCIAL WORKER

Name Sally S. Worker, SW **Signature**__*Sally S. Worker, SW*_____

Agency Happy County DSS **Phone** 919 857 2346 **Date** 9/10/2005

Sections Completed: ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **6** ☒ **7** ☒ **8** ☒ **9** ☐ **10** ☐ **11**

Illustration 9-2 Sample CAP/C Assessment Form, *(continued)*

Date: 9/09/2005

Re: Patient's Name Cap C. Kid Patient's Date of Birth 2/18/02
Patient's Medicaid Number 999 99 9999 A Patient's SSN

Dear Dr.Pepper:

During our recent assessment of the above-named patient for services through the Community Alternatives Program for Children (CAP/C), it was discovered that some of the information on the FL-2 (North Carolina Medicaid Program Long Term Care Services) form did not match the information given to us by the patient's family. Below is a list of the discrepancies. Please review and clarify this information, and fax it back to 857 2345, attention Nancy Nurse.

The following diagnoses were not listed on the FL-2, but were identified by the family:

DIAGNOSIS	CORRECT	INCORRECT

The following diagnoses were indicated on the FL-2, but were not identified by the family:

DIAGNOSIS	CORRECT	INCORRECT

The FL-2 indicated the patient's diet to be:

DIET	CORRECT	INCORRECT
Pediasure 1 can GT TID		X

The patient's family indicated the patient's diet to be:

DIET	CORRECT	INCORRECT
Pediasure 1 can GT QID	X	

The following medication discrepancies were found:
Identified on FL-2, but not by patient's family:

MEDICATION	DOSE	FREQUENCY	ROUTE	CORRECT	INCORRECT – SHOULD BE:

Identified by patient's family, but not on FL-2:

MEDICATION	DOSE	FREQUENCY	ROUTE	CORRECT	INCORRECT – SHOULD BE:

Discrepancy in medication concentration, dose, frequency, or route:

MEDICATION	DOSE(S)	FREQUENCY(IES)	ROUTE(S)	SHOULD BE:
Albuterol 0.083%	I vial	Q4h or Q4H PRN	nebulizer	Q4H PRN

Other discrepancies:

Physician's Signature: ____*Doctor Pepper, MD*_____, MD Date___*9/12/05*_____

Thank you very much. Your prompt attention to this matter ensures that we can safely and accurately care for this patient, and is required for this patient to receive home care services through CAP/C.

Sincerely,
Nancy Nurse, RN
Nancy Nurse, CAP/C Case Manager
Happy County DSS

Illustration 9-3 Sample FL-2 Discrepancy Resolution Form

10.0 PLAN OF CARE

This section tells you how to complete the Plan of Care. Section 9 discusses the assessment activities that serve as its basis. Sections 7 and 13 respectively cover the overall processes for new applicants and continuing participants. After a client is assessed, the case manager develops a Plan of Care and submits it for approval. The case manager revises the Plan as the client's needs change - the instructions are in Section 12. The Plan must be approved before an individual may participate in the program. Only the CAP/C services approved in the Plan may be provided to the client.

NOTE: *Medicaid coverage for CAP/C services approved in the Plan of Care is available beginning on the CAP effective date* ***IF*** *the client is authorized for Medicaid on that date. Providers may begin services before the Plan is approved if they are willing to risk that Medicaid may not pay. If the client is not eligible for Medicaid on the date of service, the client is not approved for CAP/C, or the service is not approved in the Plan, Medicaid will not pay for the service.*

The following material is directed to the case manager unless otherwise indicated.

10.1 Purpose of Plan

This information contained in the Plan of Care is the basis to determine client eligibility for CAP/C services. Use the Plan to:

- Summarize the evaluation and assessment information to highlight the client's strengths and needs.
- Outline goals and objectives based on the assessment and identified needs.
- Provide a plan for the provision of services.

The services listed in the Plan of Care, including both formal and informal services, must effectively meet the needs identified in the assessment.

10.2 Critical Time Limits

There are time limits for getting the Plan approved. The limit depends upon the type of action.

10.2.1 Initial Plan

Submit the Assessment and Plan of Care so that it will be received by DMA no later than 60 days after the FL-2 approval date.

CAUTION: *Remember that the DSS may be working within shorter time frames to determine eligibility for Medicaid, so it is important that you coordinate the assessment and care planning activities with the DSS Medicaid case worker. Remember, you must follow up with the DSS Medicaid caseworker to make sure the patient meets a Medicaid Category that allows them to participate in CAP/C. In scheduling your activities, also keep in mind that DMA needs sufficient time to carefully review the material before making a decision.*

10.2.2 Continued Need Review (CNR)

As part of the annual reassessment of the individual's need for CAP/C, prepare a new Plan. Complete the CNR Plan during the month of the anniversary date of the original FL-2 approval. The month in which the CNR is due is the "CNR month." The CNR assessment and Plan of Care must be received by DMA no later than the fifth day of the month after the CNR month.

NOTE: *The date the CNR is due is noted on the DMA Plan approval letter. If the date does not correspond with your records, contact the DMA CAP consultant.*

10.2.3 Plan Revisions

Plan revisions should be done when there is a change in the client's medical condition, care, or treatment. The revised Plan of Care should be approved before a change is made; however, changes may be approved retroactively for up to 30 days. There also is a provision for emergency approval of Plan revisions. See Section 12 for the details about Plan of Care revisions.

10.3 Plan Preparation

Prepare the Plan in consultation with those involved in the client's care, including the client's family and other appropriate parties.

As you develop the Plan, keep the following in mind:

- The formal and informal services on the Plan must meet the needs identified through the assessment.

  REMEMBER: *As you develop the Plan, be sure to address the need for a back-up plan when caregivers are not available. See 11.2 for additional guidance.*

- The parent(s)/responsible party has freedom of choice of enrolled CAP/C providers. Document that the parent(s)/responsible party has been informed of the available CAP/C providers. The signature on the Plan of Care documents their selection of the providers.

- The Plan must include:

  - Case Management services for assessment activities;

  - Case Management services for ongoing monitoring and coordinating activities;

  Remember: *Medicaid will not pay for another Medicaid-reimbursed case management service in addition to CAP/C Case Management.*

- If the client will receive Home Health skilled nursing visits, include the service cost, and monitor the provision of the nursing care by monthly contacts with the home health nurse. Refer to Section 11.7.2 for guidance on the contacts.

  NOTE: *Receiving Home Health skilled nursing visits is not a requirement to participate in CAP/C. There are some CAP/C clients who do not meet the requirements for Home Health. Participation in CAP/C does not exempt the client from meeting those requirements.*

- You are able to spread out the costs of Home Mobility Aids/Home Modifications and purchased DME so that a purchase does not heavily impact the client's care in the month of purchase. On the Cost Summary, you will prorate the cost over 12 months or the client's expected time of CAP/C participation, whichever is less. See the instructions for computing the AVERAGE MONTHLY COST for details and an example.

- You also are able to spread out the cost of short term, intensive services or respite services provided over a period of 60 days or less. This provision allows clients with heavy service use for a short time - such as after a hospital stay - to participate in CAP/C. Use the same proration procedure that is used for Home Mobility Aids and DME. See the instructions for computing the AVERAGE MONTHLY COST for details and an example.

- The time you spend doing your annual CAP/C assessment may also be prorated, using the same procedure that is used for Home Mobility Aids/Home Modifications and purchased DME.

Complete the Plan of Care according to the instructions in Illustration 10-1. The instructions are the same for an initial Plan and a CNR Plan unless otherwise indicated. See Illustration 10-5 for a sample completed Plan of Care.

10.4 Plan Approval

Follow the instructions in Section 14 to get Plan approval.

10.5 Case Manager's Action Upon Notification Of Decision

Depending on whether the decision involves an initial or CNR Plan, follow the instructions in Section 7, Initiating CAP/C, or Section 13, Continued Need Review.

HOW TO COMPLETE THE CAP/C PLAN OF CARE

The Plan of Care form is located on the DMA web site at http://www.dhhs.state.nc.us/dma/forms.html#prov. You will need both the "CAP/C Plan of Care Form" and the "CAP/C Cost Summary Form". They can be filled out on the computer or printed out and completed by hand. Both forms must be printed out, signed, and mailed to DMA. We can not accept electronic submissions at this time.

CAP/C AGENCY, CASE MANAGER, AND PHONE	Enter the name of the CAP/C case management agency. Enter the name of the client's CAP/C Case Manager. Enter the Case Manager's phone number and email where he/she can be reached by the DMA Nurse Consultant for questions.
INITIAL, CNR, OR REVISION	Check to indicate whether this is an initial assessment, a Continued Need Review (CNR), or a Plan of Care revision. If it is an initial assessment, indicate the date the client's representative applied for Medicaid. If they already have Medicaid, write "N/A". For a CNR, indicate the date that the CNR is due into DMA. For a revision, please indicate the date the change is effective. Indicate the client's level of care as IC, SC (with Aide), SC (with Nurse), or SC (Hospital).

A. <u>GOALS AND OBJECTIVES</u>	Check all appropriate interventions for Goal number 1. Use the space under "Comments" to individualize the intervention to the specific client. You may add additional goals related to the client's care under CAP/C. Use section F and additional sheets if needed. CAP/C goals usually involve maintaining and/or improving the client's health, safety, functioning, and independence. For each goal, list the interventions to meet that goal; the services and support needed for the intervention; and any comments. There is space to enter progress notes, if desired.

B. <u>COST SUMMARY</u>

Show all CAP/C services and other formal home and community care services needed by the client. In addition to the CAP/C services, this includes Medicaid services such as Home Health, Home Infusion Therapy, Durable Medical Equipment, IPP, and Hospice as well as similar services provided by other funding sources. Provide the details about the service, including how often it is provided, how long it will be provided, who provides it, which pays for it and what it costs.

Please refer to applicable DMA fee schedules for the codes, maximum charges, billing units, and the units to be used on the Plan for each service. Complete information on CAP/C services is in Section 4. Section 5 covers other community services, and Sections 21 through 24 cover claims information.

Please use one line for each service or supply; do not put two items on the same line.

REMEMBER: *When preparing the plan:*

- *Include case management for assessment, reassessment, and required monthly activities*
- *Be alert to potential duplications of services and various restrictions on services when developing the Plan – like the relationships between similar services such as CAP/C Personal Care, Home Health Aide, and Medicaid Personal Care.*

Complete each column of the Cost Summary as follows – see the sample plan, Illustration 10-5 for an example.

Illustration 10-1 – POC Instructions

COST SUMMARY *(Continued)*	
SERVICE	Enter the services needed by the client as follows: • On the first line, enter "CM Assessment". This is where you will enter the case management time for the assessment. On revisions, remember to include the prorated case management cost. • Use the second line to enter the estimated monthly amount of ongoing case management that you will provide. • Use a separate line to enter ongoing Nursing or Aide services. • Use a separate line for respite Nursing or Aide services. • Use a separate line for each item of DME. Revisions and CNR plans continue to include purchased DME items still in the proration period. • Use a separate line for each Home Mobility Aid. On revisions and CNR Plans, Home Mobility Aids are included if still in the proration period. • Use a separate line for each CAP/C Waiver Supply. • Use a separate line for each short-term intensive service. On revisions and CNR plans, remember to include a short-term intensive service that is still in the proration period. It is a good idea to plan all your school-related short-term-intensive services for the year at the time of the CNR. • Use one line to show each item provided by CSHS. If they were paid in full by CSHS, put "CSHS" as the code, and the price they quoted you as the unit rate. • All equipment should be placed on the Cost Summary effective the date that it was delivered to the client. • Use one line to show each special programs service billed to Medicaid through the county school system (PT, ST, OT). • Use one line to show each type of Independent Practitioner service (PT, OT, ST, RT). • Use a separate line for each of the other services. *Remember: Do not put two items on one line of the cost summary. Use a separate line for each item.*
CODE	Enter the procedure code for each CAP/C service, the revenue code for each Home Health Service, and the applicable codes for the other Medicaid services. (See illustration 10-3 for how to find up-to-date codes.)
PROVIDER AGENCY	List the agency that will provide and bill for the service. If the service is to be reimbursed by Medicaid, the agency must be enrolled by DMA to provide the specific service. For CAP/C services, the agency must be enrolled by DMA as a CAP provider for the specific service. If the service is to be paid for completely by insurance or another third party, enter the name of the provider agency.
FREQUENCY	List the anticipated frequency of the service. Abbreviate visits with a **V**; hours with an **H**; days with a **D**; weeks with a **W**; months with an **M**; and year with a **Y**. **For CM Assessment,** enter the total hours for the Case Management time (of both assessors if applicable. **For ongoing Case Management,** show the average number of hours expected to be used per month. This amount is expected to be an ***estimate***. If the experience with the case shows the estimate is high or low, revise the Plan of Care. **For In-Home respite hours,** show the hours per month. **For Institutional respite hours,** show the days per month.

Illustration 10-1 – POC Instructions (Continued)

COST SUMMARY *(Continued)*	
FREQUENCY ***(continued)***	**For all other services billed on a time basis,** show the hours per day and the number of days per week. **For services billed on a visit basis,** show the number of visits per week or month. Note that a home health agency providing supplies may bill for a nurse visit every 60 days, except when that home health agency is also providing the LPN or RN care for that same patient. **For one-time purchases of DME or Home Mobility Aids,** enter "one time purchase" **For medical supplies,** enter "N/A." **For CAP/C Waiver Supplies,** show the number of units per month. **For DME rental,** enter the time period related to reimbursement. Most items are rented on a monthly basis, in which case the entry is "1/M." Indicate whether the rental is capped or ongoing.
FROM/TO	Complete this block for purchased and rental DME, Home Mobility Aids, short-term intensive services, and respite. **LEAVE BLANK FOR ALL OTHER SERVICES.** **For purchased DME and Home Mobility Aids**, enter the first and last month/year of the proration period (e.g. "3/98-2/99"). The first month of the period is the month in which the item is delivered to the client. **For capped rental DME,** enter the anticipated start and end dates of the rental. **For short -term intensive services,** enter the anticipated starting and ending dates of the service using a month/day/year entry (e.g. "6/1/98-7/30/98") is entered. ***REMEMBER:*** *The total number of days from the first day to the last day of each short-term intensive service provided may not exceed 60 calendar days.*
UNIT RATE	Show the unit rate that will be reimbursed by Medicaid in direct relationship to what is shown in the Frequency column. For example, if the Frequency column lists "hours," show the unit cost in cost per hour. The amount shown in this column is either the amount charged by the provider or the maximum Medicaid allowable charge, whichever is less. See Illustration 10-3 for how to find up-to-date unit rates.

Illustration 10-1 – POC Instructions (Continued)

B. COST SUMMARY (*Continued)*	
AVERAGE MONTHLY COST	Use the following guidelines to calculate the average monthly cost to Medicaid and the average monthly cost to other sources: • **Daily to monthly** costs are converted by multiplying daily cost by 30. • **Weekly to monthly** costs are converted by multiplying weekly costs by 4.3. • To **"prorate"** a cost means to spread out the cost of an item or service over 12 months or the anticipated length of participation in CAP/C, whichever is less. Assume the client will participate for 12 months unless you have information to the contrary (e.g., a client will turn 19 in six months). The prorated cost is shown as the average monthly cost. ***NOTE:*** *The proration procedure is used to calculate the average cost on the Cost Summary. It does not affect how services are billed. Providers bill for services as they are provided. For example, if a piece of purchased DME costs $600, the cost is prorated as $50; however, the entire $600 charge is billed when the item is delivered to the client.* • **For CM Assessment,** prorate the cost over 12 months or the anticipated length of participation in CAP/C, whichever is less, and show the monthly prorated cost in this column.. • **For purchased DME or Home Modifications,** prorate the purchase price over 12 months or the anticipated length of participation in CAP/C, whichever is less, and show the monthly prorated cost in this column. Purchased DME and home mobility aids must be included on all Plan revisions through the 12-month proration period. ***EXAMPLE:*** *A set of full-length bed rails is purchased for $161.62 in a plan-dated 10/05; the pro-rated amount $13.47 ($161.62 divided by 12 months) is the monthly cost to be shown in the plan through 9/06. Any plan revisions through 9/06 will show the bed rails with the $13.47 monthly pro-rated cost. Plan revisions after 9/06,, including a CNR conducted after that month, will not include the bed rails on the Cost Summary.* ***NOTE:*** *A Plan revision for the sole purpose of deleting the DME monthly prorated cost at the end of the proration period is not necessary. The costs can be deleted in the next revision after the end of the period.* • **For short -term intensive services,** prorate the total cost of the service over a one-year period or the anticipated length of participation in CAP, whichever is less. ***EXAMPLE:*** *Physical therapy will be provided 2 times per week for 8 weeks, at a cost of $99.94 per visit, for a total of $1599.04. The $1599.04 is prorated over 12 months. A monthly cost of $133.25 is entered in this column. The cost is included in all Plan revisions prepared during the 12-month proration period, and deleted in the first revision after the period.* • **For Waiver Supplies,** refer to Section 21.4 in computing the total monthly cost of an item to include taxes, delivery, and overhead charges if applicable. List the average monthly cost of each service under the appropriate column.

Illustration 10-1 – POC Instructions (Continued*)*

B. COST SUMMARY (*Continued*)	
AVERAGE MONTHLY COST *(Continued)*	**MEDICAID:** List the amount to be paid by Medicaid. Keep in mind that Medicaid is the payer of last resort. Services, which may be paid by another party, such as a private insurer, must be billed to that party before billing Medicaid. When there is a third party involved in payment, Medicaid may only be billed the difference between the amount reimbursed by the third party and the maximum Medicaid allowable charge. See 21.5 for third party liability information. ***EXAMPLE:*** *An agency charges $125.00 for a purchased piece of DME for which the Medicaid maximum is $110, and private insurance pays $100; only $10 (the difference between the insurer's reimbursement and the Medicaid maximum) may be billed to Medicaid. The Medicaid recipient cannot be billed for the amount not reimbursed by Medicaid and the insurer* **OTHER/S:** List the amount to be paid by other funding sources. Enter the code for the source of payment in the column headed with an **S.** Use the codes on the form. If a source is not listed, use 5**,** or 6, and identify the source next to the code. If there are multiple sources, list the source that will pay the larger portion.
TOTALS	Enter in the appropriate columns the total monthly cost to Medicaid and the total monthly cost to other sources. Make sure the total cost to Medicaid is within the budget limit for the client's level of care. Budget limits can be found in Illustration 10-4.

B. COST SUMMARY – MEDICAL SUPPLIES

Use this part to itemize all regular Medicaid medical supplies. Under the appropriate column, enter a description of the item; the procedure code; the provider agency, the estimated number of units to be provided per month; the billing unit (e.g., each, case, dozen, or other applicable unit); the unit cost, the from/to dates, if applicable, and the average monthly cost (see above instructions). An item covered by a source other than Medicaid would be shown in Column S, using the codes at the top of the page. Show your calculation for formula in the "Comments" section. Transfer the totals from this part to Part B of the Cost Summary.

C. INFORMAL SUPPORT

Enter information on the informal support that will be provided. This includes assistance from family, neighbors, friends, community organizations, church groups, and other informal sources of help. Show the following:

- The name of the individual or organization.
- If the source of help is an individual,
  - Place a check or **X** in the column after the person's name if the person lives in the same household as the client; and
  - Enter the approximate age of the individual.

Illustration 10-1 – POC Instructions (Continued*)*

C. INFORMAL SUPPORT *(continued)*

- Check the appropriate box to indicate the relationship of the source to the client (the "Volunteer Group" code includes all organizations that may provide informal support, such as church groups, service organizations, and other similar entries).
- Check the appropriate boxes for the specific tasks performed or type of support provided.
- When help is available. Be sure to document specific hours of availability/work hours for in-home caregivers. Stating "before and after work, and weekends" is not acceptable.

D. 24-HOUR COVERAGE

Complete this item for all CAP/C Plans of Care. The entries are for a 24 hour day beginning following midnight. The entries must correlate to the entries for the formal and informal services listed above. If the child attends school or a day care program, include the schedule and indicate who is responsible for him/her while at school/day care. The total number of CAP/C hours should match what is requested on the cost summary, and should correlate with the caregiver availability as noted above.

E. REASON FOR REVISION

Only complete for Plan Revisions Briefly explain the reason for the Plan revision here. Do not simply restate the revision that was made; please give the reason the revision was made. For example, "Increase nursing hours." is not acceptable. Instead, state "Increase nursing hours because pt has acute respiratory illness and is now requiring suctioning while asleep as well as while awake." See the sample plan for an example. Check "N/A" for Initial plans of care and Continued Needs Reviews.

F. ADDITIONAL INFORMATION Use this space for additional goals, support persons, financial information, or anything else you did not have enough room on the form to address completely.

G. CLIENT STATEMENT OF UNDERSTANDING

The statement on the form must be reviewed and signed by the client's representative before initial CAP/C participation and continuing CAP/C participation at the time of the CNR may be approved. If the representative signs by a mark, it must be witnessed. A family member or another individual chosen by the representative is preferred to be the witness. The case manager may not witness the representative's mark. The representative's signature indicates that he or she has been given the option of nursing home placement; has chosen CAP participation; agrees to the Plan of Care; understands the statements regarding CAP/C eligibility, changes in the plan of care, and terminations, has been informed of the right to appeal, and agrees to be an active participant in the plan of care. In the case where the primary caregiver and the legal guardian are not the same person, both signatures need to be obtained.

NOTE: *CAP/C clients who are 18 to 19 years of age and who have the primary responsibility for making decisions about their care may sign the client choice statement.*

Illustration 10-1 – POC Instructions (Continued*)*

H. AGREEMENTS

This item is completed to indicate that the signers have reviewed and agreed to the Plan. **The caregiver/legal guardian must never be given a blank plan of care to sign.** The case manager must sign all Plans of Care and may request the signature of the client's physician. The decision to request the physician's signature is made by the local case management agency. In the case where the primary caregiver and the legal guardian are not the same person, both signatures need to be obtained.

CAUTION: *Although the physician's signature on the Plan of Care is not required, orders from the client's physician are needed to provide three services. The case manager must get the signed physician's orders for Medicaid Medical Supplies provided by the case management agency and for nutritional supplements (a component of waiver supplies). Home care agencies providing CAP/C Nursing must have physician's orders to provide the service.*

NOTE: *See 12.4 for information on signature requirements for revisions.*

Illustration 10-1 – POC Instructions (Continued*)*

GUIDELINES FOR COMPLETING THE COST SUMMARY

The following table excludes the use of private insurance. If private insurance is paying in whole or in part for a particular service or supply, the portion paid by the insurance is included in "Other", with the remainder included in Medicaid. Please indicate the percentage or amount of insurance copayment in the "Comments" section of the Plan of Care.

SERVICE	DO NOT COUNT	MEDICAID	OTHER	FEE SCHEDULE	COMMENTS
In-home therapy provided by a home health agency		X		Home Health	
In-home therapy not provided by a home health agency		X		IPP	If IPP codes are unknown or frequently change, you may use an estimated unit rate of $53.81 per visit. Please indicate which unit rate you are using – IPP actual or IPP estimate.
In-school therapy, when the county bills Medicaid for the service		X		IPP	If IPP codes are unknown or frequently change, you may use an estimated unit rate of $53.81 per visit. Please indicate which unit rate you are using – IPP actual or IPP estimate.
In-school therapy, when the county pays out of its own school budget			X	IPP or actual price paid by school if known	If IPP codes are unknown or frequently change, you may use an estimated unit rate of $53.81 per visit. Please indicate which unit rate you are using – IPP actual, IPP estimate, or school
Outpatient therapy			X	IPP	If IPP codes are unknown or frequently change, you may use an estimated unit rate of $53.81 per visit. Please indicate which unit rate you are using – IPP actual or IPP estimate.
In-school nursing services, when the county bills Medicaid for the service		X		CAP/C	
In-school nursing services , when the county pays out of its own school budget			X	CAP/C or actual price paid by school if known	Please indicate which unit rate you are using – CAP/C or school
Nurse or Nurse Aide services in a preschool or daycare	This is not covered service under CAP/C				
Nurse to accompany client to college classes		X	X		Vocational Rehabilitation Services should be the primary payor. If they do not pay, Medicaid will cover or supplement.
Formula obtained through WIC			X	DME or actual price paid by WIC if known	Please indicate which unit rate you are using – DME or WIC
Tape	X				Recipients may still receive tape, and the provider agency may still bill for it, but it does not need to be indicated on the Cost Summary.
TPN		X		Home Infusion	Generally does not fit within cost limitations of CAP/C budget unless there is a third party payor.

Illustration 10-2 Cost Summary Instructions

GUIDELINES FOR COMPLETING THE COST SUMMARY *(continued)*

SERVICE	DO NOT COUNT	MEDICAID	OTHER	FEE SCHEDULE	COMMENTS
Items provided by CSHS, when that item is on the DMA fee schedule		X		DME or Orthotics and Prosthetics, as applicable	Also includes therapy vests.
Items provided by CSHS, when that item is not on the DMA fee schedule			X	Price quoted to you by CSHS	For code, write CSHS. Includes car seats. Attach quote to cost summary.
Wheelchairs*	Follow the guidelines for CSHS items. Wheelchairs are the sum of many different components. If a component is on the DME fee schedule, count it under Medicaid. If it is not, count it as "Other", with the payer source being CSHS. The list of components and their codes is available from the provider agency. Be sure to get the state codes (e.g., K0108 is a miscellaneous code for many different wheelchair parts. You need to get the more specific "W" code that goes with it in order to determine what the Medicaid payment will be.)				
Early Intervention Services not billed to Medicaid			X	CDSA	Be sure that services are not duplicative. Case Management services for Early Intervention and CAP/C can not both be billed on the same client.
Early Intervention Services billed to Medicaid		X		CDSA	
Hospice Services		X			Be careful not to double bill - any services/supplies related to the terminal illness are covered under the per diem rate for the hospice, and would not be a separate item on your cost summary.
Home Infusion Therapy Services		X		Home Infusion	
Community Support Services		X		MH/DD/SA Attachment B	
Developmental Therapy Services			X	MH/DD/SA Attachment C	

* If the cost of a wheelchair or other equipment causes a recipient to lose services as a result of being over-budget, that cost will still be considered on the budget if the recipient reapplies for CAP/C within the one-year proration period.

Illustration 10-2 Cost Summary Instructions (continued)

HOW TO ACCESS FEE SCHEDULES AND LIFETIME EXPECTANCIES/QUANTITY LIMITATIONS FOR SUPPLIES

To access fee schedules for
CAP/C DME Home Health Home Infusion Therapy Hospice Orthotics and Prosthetics Independent Practitioners (IPP):
Go to http://www.dhhs.state.nc.us/dma
Click "Provider Links"
Scroll down to "Publications". Click on "Fee Schedules".
Scroll down and click "Accept".
Click on the desired fee schedule.

To access the mental health fee schedule, which includes the codes for Community Support Services and Developmental Therapy Services, go to http://www.dhhs.state.nc.us/dma/fee/mhfee1.pdf.

A copy of the fee schedule for Children's Developmental Services Agencies (CDSA) may be obtained from the Division of medical Assistance Financial Operations Section using the Fee Schedule Request Form. The form is available on DMA's website at http://www.dhhs.state.nc.us/dma/forms.html.

To access the "Lifetime Expectancies and Quantity Limitations for DME":
Go to http://www.dhhs.state.nc.us/dma
Click "Provider Links"
Click on "Clinical Coverage Policies and Provider Manuals"
Scroll down to Number 5A, "Durable Medical Equipment"
Scroll down to "Attachment D" (towards the end of the manual)

To access the "Lifetime Expectancies and Quantity Limitations for O&P (Orthotics and Prosthetics)":
Go to http://www.dhhs.state.nc.us/dma
Click "Provider Links"
Click on "Clinical Coverage Policies and Provider Manuals"
Scroll down to Number 5B, "Orthotics and Prosthetics"
Scroll down to "Attachment D" (towards the end of the manual)

To access the "Enteral Nutrition Product Classification List":
Go to http://www.palmettogba.com/classifications/enteral%20nutrition.pdf

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FEE SCHEDULES ARE UPDATED FREQUENTLY. YOU WILL BE ADVISED OF UPCOMING CHANGES VIA THE MEDICAID BULLETINS, AND MAY ACCESS THE UPDATED FEE SCHEDULES AS ABOVE.

Illustration 10-3 Fee Schedule/Quantity Limitations

CAP/C BUDGET LIMITS
(as of May 1, 2006)

IC (Intermediate Care)	$2680 per month
SC (Skilled Care)	$3487 per month
HC (Hospital level)	$28,729 per month

Illustration 10-4 CAP/C Budget Limits

Note: *This sample, particularly the cost summary, is designed to give you as many different situations and calculations as possible. It is not intended to completely correlate with the assessment, nor is it intended to be appropriate for any one client.*

CAP/C Plan of Care **Client:** Sarah S. Smith **MID:** 999-99-9999 A

Community Alternatives Program for Children (CAP/C) Plan of Care
North Carolina Division of Medical Assistance

CAP/C CASE MANAGEMENT AGENCY Happy County DSS
CASE MANAGER/TITLE Nancy Nurse, RN PHONE NUMBER 919 857 2345 EMAIL nnurse@happycoutnydss.com

☒INITIAL, Medicaid application date 09/01/2005 ☐CNR, due date
☐REVISION, effective date LEVEL OF CARE HC

The Plan of Care is to document formal and informal services to be provided to the client. It is also used to outline the goals and interventions for the client and staff, and to record the client's acceptance of CAP/C as an alternative to institutional placement. The Plan must be revised as needed according to changes in the client's situation. Each Plan and each revision must be approved according to CAP/C policies and procedures.

A. GOALS & INTERVENTIONS

Use this space to list goals and the interventions related to accomplishing these goals. Select as many interventions as apply. Use the comments space to individualize the plan of care. You may also add additional goals or interventions as applicable. If you need additional space, please continue in section F.

1. **Goal:** The client will be able to maintain his/her health, safety, and well-being in the home environment rather than in an institution.

1**. Interventions:**

☒ CAP/C Nursing Services will supplement and support the client's informal support system by providing direct care to the client and education to caregivers in accordance with the RN and/or LPN scope of practice and a nursing careplan written by the provider agency that is designed to maintain or improve the client's current health status.	**Comments/Progress Notes**
☐ CAP/C Nurse Aide Services will supplement and support the client's informal support system by providing help with personal hygiene, ambulation, feeding, and home management in accordance with the CNA I or CNA II scope of practice and a careplan developed by the provider agency and overseen by a Registered Nurse.	**Comments/Progress Notes**
☒ CAP/C Case Management Services will assess the needs of the client and caregivers; plan care; and locate, coordinate, and monitor services and supplies, including the provision of CAP/C Waiver Supplies and Home Modifications in accordance with the regulations of the CAP/C program.	**Comments/Progress Notes**
☒ CAP/C Respite Services, whether institutional or in-home, will provide temporary support to informal caregivers for a range of needs, and will be provided in accordance with the client's level of care, licensing requirements of the provider agency, and regulations of the CAP/C program.	**Comments/Progress Notes**
☒ Therapy services, whether Physical Therapy, Occupational Therapy, Speech Therapy, or some combination of the above, will provide direct care to the client and education to caregivers in accordance with licensing requirements and a careplan written by the provider agency that is designed to maintain or improve the client's current health and functional status.	**Comments/Progress Notes**

2**. Goal:**

2**. Interventions:**

☐	**Comments/Progress Notes**

Page 1

Illustration 10-5 Sample CAP/C Plan of Care

CAP/C PLAN OF CARE

CLIENT Sarah S. Smith
MID 999 99 9999 A
DATE 09/01/05 LOC HC

B. COST SUMMARY

Total Services and Supplies

Please put only ONE service or supply in each box.
P=Purchase C=Capped Rental R= Ongoing Rental <MMA=Less Than Maximum Medicaid Allowable
List all services to be provided. When payer is not Medicaid, enter one of the following codes in Column S:
1=Insurance 2=Family/Friends 3=School System 4=WIC 5=CSHS 6=Outpatient 7=_____
Medical Supplies must be itemized on Page 3, with the total brought forward below. Regularly scheduled services should be listed first. List short-term intensive services below. Short-Term Intensive services, Case Management Assessment (if applicable), Home Modifications, and Respite Services may be prorated over 12 months.

SERVICE	CODE	PROVIDER AGENCY	FREQUENCY/ DATE(S) OF SERVICE	P C R	ON BUDGET FROM/TO	COST/UNIT SOURCE	AVERAGE MONTHLY COST MEDICAID	OTHER	S
Case Management	**T1016**	Happy Co DSS	5 h/yr			55.28/hr □<MMA □Other	23.03		
Case Management	**T1016**	Happy Co DSS	4 h/mo			55.28/hr □<MMA □Other	221.12		
Hourly Nursing scheduled	**T1000**	Happy Home Care	18 h/d, 5 d/w 10 h/d, 2 d/w			36.44/hr □<MMA □Other	17,236.12		
Hourly Nursing respite	**T1005**	Happy Home Care	6 h/d, 2 d Nov 1-2, 2005		11/05 - 10/06	36.44/hr □<MMA □Other	36.44		
Institutional respite	**H0045**	Happy Nsg Home	1 day Nov 3, 2005		11/05 - 10/06	941.80/day □<MMA □Other	78.48		
Nurse Aide scheduled	**S5125**	Happy Home Care	3 h/d, 5 d/w			14.40/hr □<MMA □Other	928.80		
Nurse Aide respite	**S5150**	Happy Home Care	10 hrs/month			14.40/hr □<MMA □Other	144.00		
Nursing Visits	**550**	Glad Home Care	1 visit Q 60 d			101.41 /visit □<MMA □Other	50.71		
Physical Therapy	**420**	Happy Home Care	1 visit per week			99.94/visit □<MMA □Other	429.74		
Occupational Therapy	**IPP 97110**	Happy Therapy	30 mins/visit 1 visit/wk			25.65/15 mins □<MMA □Other	220.59		
Speech Therapy	**IPP est**	Happy Speech	2 visits/week			53.81/visit □<MMA □Other		462.77	6
Home Modifications	**S5165**	Happy Mobility Co	w/c ramp 9/1/2005	P	9/1/2005 8/31/06	1200.00/ea see quote	100.00		
Medical Supplies							768.62	854.69	
GRAND TOTAL ALL SERVICES AND SUPPLIES							20,237.65	1,317.46	

COMMENTS Home modifications $400 remaining for fiscal year ending June 30, 2006. Nursing respite 684 total hours/156 in-home hours remaining for fiscal year ending June 30, 2006. In-home-aide respite 600 hours remaining for fiscal year ending June 30, 2006.

Page 2

Illustration 10-5 Sample CAP/C Plan of Care (continued)

CAP/C PLAN OF CARE

CLIENT: Sarah S. Smith
MID: 999 99 9999 A
DATE 9/1/2005 LOC HC

B. COST SUMMARY

Itemized Medical Supplies

Please put only ONE service or supply in each box
P=Purchase C=Capped Rental R= Ongoing Rental <MMA=Less Than Maximum Medicaid Allowable
Itemize medical supplies here and transfer the Total Average Monthly Cost to Page 2. When the payer is not Medicaid, enter one of the following codes under Column S.
1=Insurance 2=Family/Friends 3=School System 4=WIC 5=CSHS 6=Outpatient 7=_____
The total for Medical Supplies must be brought forward to Page 2, above. Purchased medical equipment may be prorated over 12 months. For all prorated purchases and capped rentals, indicate from/to dates.

MEDICAL SUPPLIES	CODE	PROVIDER AGENCY	FREQUENCY OR AMOUNT PER MONTH	P C R	ON BUDGET FROM/TO	COST/UNIT SOURCE	AVERAGE MONTHLY COST MEDICAID	OTHER	S
Pediasure	B4160	Happy DME Company	90 cans	P		0.53/100 cals □<MMA □Other	37.68	75.37	4
Mic-Key button	B9998 W4210	Happy DME Company	4 per year	P		131.44 ea □<MMA □Other	8.76	35.05	1
Mic-Key ext. tubing bolus	B9998 W4212	Happy DME Company	2	P		9.32 ea □<MMA □Other	18.64		
enteral fdg kit syringe	B4034	Happy DME Company	30	P		5.78 ea □<MMA □Other	2.89	11.56	1
pulse oximeter	E0445	Happy DME Company	1	R		181.04 ea/mo □<MMA □Other	66.21	114.83	1
suction pump	E0600	Happy DME Company	1	C	10/05 - 7/06	43.50 ea/mo □<MMA □Other	43.50		
humidifier	E0550	Happy DME Company	1	C	10/05 - 7/06	49.15 ea/mo □<MMA □Other	9.83	39.32	1
oxygen	E0431	Happy DME Company	1	R		30.57 ea/mo □<MMA □Other	6.11	24.46	1
trach	A7520	Happy DME Company	4	P		45.00 ea X<MMA □Other	9.00	36.00	1
trach care kit	A4629	Happy DME Company	30	P		4.63 ea □<MMA □Other	27.78	111.12	1
suction catheters	A4624	Happy DME Company	90	P		2.10 ea □<MMA □Other	37.80	151.20	1
suction tubing	A7002	Happy DME Company	1	P		3.09 ea □<MMA □Other	0.62	2.47	1
suction canister	A7000	Happy DME Company	1	P		8.90 ea □<MMA □Other	1.78	7.12	1
saline bullets	A9900 W4670	Happy DME Company	150	P		0.32 ea □<MMA □Other	9.60	38.40	1
						TOTAL THIS PAGE	280.20	646.90	

COMMENTS
formula: 237 **calories per can / 100 calories =** 2.37 **units per can X** 30 **cans per month X $** 0.53 **per unit**
Indicate percent covered by private insurance, if applicable. Explain any irregularities in the type or amount of supplies used.
60 cans form

Page 3A

Illustration 10-5 Sample CAP/C Plan of Care (continued)

CAP/C PLAN OF CARE

CLIENT Sarah S. Smith
MID 999 99 9999 A
B. COST SUMMARY DATE 9/1/2005 LOC HC

Itemized Medical Supplies

Please put only ONE service or supply in each box
P=Purchase C=Capped Rental R= Ongoing Rental <MMA=Less Than Maximum Medicaid Allowable
Itemize medical supplies here and transfer the Total Average Monthly Cost to Page 2. When the payer is not Medicaid, enter one of the following codes under Column S.
1=Insurance 2=Family/Friends 3=School System 4=WIC 5=CSHS 6=Outpatient 7=_____
The total for Medical Supplies must be brought forward to Page 2, above. Purchased medical equipment may be prorated over 12 months.For all prorated purchases and capped rentals, indicate from/to dates.

MEDICAL SUPPLIES	CODE	PROVIDER AGENCY	FREQUENCY OR AMOUNT PER MONTH	P C R	ON BUDGET FROM/TO	COST/UNIT SOURCE	AVERAGE MONTHLY COST MEDICAID	OTHER	S
thermovents	A4483	Happy DME Company	30	P		6.06 ea □<MMA □Other	36.36	145.44	1
trach holder	A7526	Happy DME Company	12	P		3.37 ea □<MMA □Other	8.09	32.35	1
specialized car seat	CSHS	Happy DME Company	1	P	10/05 - 9/06	360.00 ea □<MMA XOther		30.00	5
manual wheelchair	E1233	Chesapeake Rehab Equip	1	P	10/05 - 9/06	2215.73 ea □<MMA □Other	$184.64		
seat support	E2618	Chesapeake Rehab Equip	1	P	10/05 - 9/06	148.75 ea □<MMA □Other	12.40		
armrests	E0973	Chesapeake Rehab Equip	2	P	10/05 - 9/06	109.22 ea □<MMA □Other	18.20		
caster tire	E2217	Chesapeake Rehab Equip	2	P	10/05 - 9/06	39.75 ea □<MMA □Other	6.63		
footrest extension tube	K0043	Chesapeake Rehab Equip	2	P	10/05 - 9/06	18.56 ea □<MMA □Other	3.09		
footplate	K0040	Chesapeake Rehab Equip	1	P	10/05 - 9/06	70.94 ea □<MMA □Other	5.91		
tires	E2216	Chesapeake Rehab Equip	2	P	10/05 - 9/06	28.89 ea □<MMA □Other	4.82		
anti-tip device	E0971	Chesapeake Rehab Equip	2	P	10/05 - 9/06	30.72 ea □<MMA □Other	5.12		
oxygen holder	E2208	Chesapeake Rehab Equip	1	P	10/05 - 9/06	118.78 ea □<MMA □Other	9.90		
seat cushion	E2605	Chesapeake Rehab Equip	1	P	10/05 - 9/06	321.69 ea □<MMA □Other	26.81		
back cushion	E2617	Chesapeake Rehab Equip	1	P	10/05 - 9/06	manually priced □<MMA XOther	69.07		
trunk support	E0956	Chesapeake Rehab Equip	2	P	10/05 - 9/06	98.58 ea □<MMA □Other	16.43		
						TOTAL THIS PAGE	407.47	207.79	
(TOTAL PAGE 3A + PAGE 3B)						**TOTAL SUPPLIES**	687.67	854.69	

COMMENTS
<u>Indicate percent covered by private insurance, if applicable.</u> Explain any irregularities in the type or amount of supplies used.

Page 3B

Illustration 10-5 Sample CAP/C Plan of Care (continued)

CAP/C PLAN OF CARE

CLIENT Sarah S. Smith
MID 999 99 9999 A
B. COST SUMMARY DATE 9/1/2005 LOC HC

Itemized Medical Supplies

Please put only ONE service or supply in each box
P=Purchase C=Capped Rental R= Ongoing Rental <MMA=Less Than Maximum Medicaid Allowable
Itemize medical supplies here and transfer the Total Average Monthly Cost to Page 2. When the payer is not Medicaid, enter one of the following codes under Column S.
1=Insurance 2=Family/Friends 3=School System 4=WIC 5=CSHS 6=Outpatient 7=_____
The total for Medical Supplies must be brought forward to Page 2, above. Purchased medical equipment may be prorated over 12 months.For all prorated purchases and capped rentals, indicate from/to dates.

MEDICAL SUPPLIES	CODE	PROVIDER AGENCY	FREQUENCY OR AMOUNT PER MONTH	P C R	ON BUDGET FROM/TO	COST/UNIT SOURCE	AVERAGE MONTHLY COST MEDICAID	OTHER	S
thigh support	E0957	Chesapeake Rehab Equip	2	P	10/05 - 9/06	137.93 ea □<MMA □Other	22.99		
seat belt	E0978	Chesapeake Rehab Equip	1	P	10/05 - 9/06	39.39 ea □<MMA □Other	3.28		
shoulder support	E0960	Chesapeake Rehab Equip	1	P	10/05 - 9/06	90.98 ea □<MMA XOther	7.58		
ankle huggers	K0108 W4143	Chesapeake Rehab Equip	2	P	10/05 - 9/06	139.84 per pair □<MMA □Other	11.65		
pad mounting bracke	K0108 W4132	Chesapeake Rehab Equip	1	P	10/05 - 9/06	326.63 ea □<MMA □Other	27.22		
tray	E0950	Chesapeake Rehab Equip	1	P	10/05 - 9/06	98.76 ea □<MMA □Other	8.23		
					TOTAL THIS PAGE		80.95	0.00	
(TOTAL PAGE 3A + PAGE 3B + 3C)					**TOTAL SUPPLIES**		768.62	854.69	

COMMENTS
Indicate percent covered by private insurance, if applicable. Explain any irregularities in the type or amount of supplies used.

Page 3C

Illustration 10-5 Sample CAP/C Plan of Care (continued)

CAP/C Plan of Care **Client:** Sarah S. Smith **MID:** Joyce Smith999 99 9999 A

C. INFORMAL SUPPORT

Include information about the support to be provided by unpaid caregivers. Enter the name; a check if living in the client's household; the approximate age; the relationship, the tasks performed/support provided; and when the tasks will be performed. **Please provide SPECIFIC hours for availability.**

Name	✓	Age	Relationship	Tasks Performed/Support Provided	Availability work hours, days commute time
Judy Smith	☒	30	☒ Mother ☐Father ☐ Brother ☐ Sister ☐ G-father ☐G-mother ☐ Other relative ☐ Foster parent ☐ Friend ☐ Neighbor ☐ Volunteer ☐ Other,	☒Grooming ☒Bathing ☒Dressing ☒Elimination ☒Transfer ☐Walking ☒Wheelchair use ☒Eating ☒Medication Administration ☒Socialization ☐Other, please specify: ☐ All	works/commutes 7:30 AM to 4:30 PM Monday thtrough Friday, available 24/7 on weekends
James Jones	☐	32	☐ Mother ☐Father ☐ Brother ☐ Sister ☐ G-father ☐G-mother ☐ Other relative ☐ Foster parent ☒ Friend ☐ Neighbor ☐ Volunteer ☐ Other,	☐Grooming ☐Bathing ☐Dressing ☐Elimination ☒Transfer ☐Walking ☒Wheelchair use ☐Eating ☐Medication Administration ☒Socialization ☐Other, please specify: ☐ All	works/commutes 7:30 AM to 6:00 PM Monday through Friday, available PRN evenings and weekends
Joyce Smith	☐	60	☐ Mother ☐Father ☐ Brother ☐ Sister ☐ G-father ☒G-mother ☐ Other relative ☐ Foster parent ☐ Friend ☐ Neighbor ☐ Volunteer ☐ Other,	☒Grooming ☒Bathing ☒Dressing ☒Elimination ☒Transfer ☐Walking ☒Wheelchair use ☒Eating ☒Medication Administration ☒Socialization ☐Other, please specify: ☐ All	not employed, available as needed 24/7
John Smith	☐	60	☐ Mother ☐Father ☐ Brother ☐ Sister ☒ G-father ☐G-mother ☐ Other relative ☐ Foster parent ☐ Friend ☐ Neighbor ☐ Volunteer ☐ Other,	☐Grooming ☐Bathing ☐Dressing ☐Elimination ☒Transfer ☐Walking ☒Wheelchair use ☒Eating ☒Medication Administration ☒Socialization ☐Other, please specify: ☐ All	works/commutes 8:00 AM to 5:30 PM Monday through Frday, available PRN evenings and weekends

D. 24-HOUR COVERAGE

Use this calendar to show coverage plans, including paid and unpaid caregivers. Write the hours covered each day, beginning after midnight, and who is covering (e.g., "12 - 8 a.m. – Sam Jones"). For nurse/aide coverage, assume that your plan of care is approved as written.

	Time Covered/Name of Person Covering
Monday	MN to 5:00 PM CAP/C Nurse; 5:00 PM to 11:00 PM Judy Smith; 11:00 PM to MN CAP/C Nurse
Tuesday	same as Monday
Wednesday	same as Monday
Thursday	same as Monday
Friday	same as Monday
Saturday	MN to 7:00 AM CAP/C nurse; 7:00 AM to 9:00 PM Judy Smith; 9:00 PM to MN CAP/C Nurse
Sunday	same as Saturday

CAP/C Plan of Care **Client:** Sarah S. Smith **MID:** 999 99 9999 A

D. 24-HOUR COVERAGE – ALTERNATE SCHEDULE (i.e., summer, short-term-intensive, alternate caregiver work schedule)
Use this calendar to show coverage plans, including paid and unpaid caregivers. Write the hours covered each day, beginning after midnight, and who is covering (e.g., "12 - 8 a.m. – Sam Jones"). For nurse/aide coverage, assume that your plan of care is approved as written.

	Time Covered/Name of Person Covering
Monday	N/A
Tuesday	N/A
Wednesday	N/A
Thursday	N/A
Friday	N/A
Saturday	N/A
Sunday	N/A

Page 4

C. REASON FOR REVISION - Please be specific. Do not simply state what was revised; explain the reason that it needed to be revised.
☒ Initial ☐ CNR
☐ Revision, reason:

F. ADDITIONAL INFORMATION - Use the space below to expand on any of the previous sections in which you did not have enough room to include all information. Please refer to the section title.
None

Page 5

Illustration 10-5 Sample CAP/C Plan of Care (continued)

CAP/C Plan of Care **Client:** Sarah S. Smith **MID:** 999 99 9999 A

G. AGREEMENTS – This must be signed by the case manager with each and every plan of care submission. It must be signed by the caregiver (and legal guardian, if applicable) whenever the revision involves a change in a waiver service or supply. See chapters 10 and 12 of the CAP/C manual for more detailed instructions.

The following persons have reviewed the Plan of Care and agree to participate in the Plan.

CASE MANAGER

Nancy Nurse, RN

10/07/05

Signature/Title Date

mother

CAREGIVER (SPECIFY RELATIONSHIP)

Judy Smith

Signature

10/07/05

Date

Witness Signature for mark

LEGAL GUARDIAN (SPECIFY RELATIONSHIP/TITLE)

Signature

Date

Witness signature formark

OTHER (SPECIFY RELATIONSHIP)

Signature

Date

Witness signature for mark

PAGE 6

Illustration 10-5 Sample CAP/C Plan of Care (continued)

CAP/C Plan of Care **Client:** Sarah S. Smith **MID:** 999 99 9999 A

H. Client Statement of Understanding – This should be signed by the case manager, the caregiver, and the legal guardian if not the caregiver, at the time of the initial plan of care, with each CNR, and any other time that one of the above parties deem appropriate.

By signing this Plan of Care, I, as the primary caregiver (parent or guardian) for Sarah S. Smith, acknowledge my understanding of the Community Alternatives Program for Children (CAP/C).

I understand that:

1. My child has the choice of seeking nursing facility care instead of participating in the Community Alternatives Program.
2. My child has the choice of enrolled Medicaid providers: for example, nursing agencies.
3. My child, the recipient, will receive the services shown in the Plan of Care, and these services may be changed as needed.
4. I have been informed of my right to appeal the denial of participation in the Community Alternatives Program, as well as the right to appeal any change in, or denial of, services provided through CAP/C.
5. My child, the recipient, must require Skilled Care equivalent to care received in an institutional setting to be eligible for this program.
6. CAP/C is designed to supplement, not replace the formal and informal services, including the parent's/guardian's responsibility, already available to my child.
7. As the primary caregiver, I will actively participate in planning for my child's care.
8. Skilled nursing hours and other services may be changed over time, resulting in an increase or decrease in services, based on the medical needs of my child.
9. The level of care needs of my child may change over time, thus requiring a new monthly budget.
10. CAP/C services will be terminated when my child meets any of the following criteria:
    - no longer lives in a private, primary residence;
    - at a minimum, no longer requires nursing facility care as determined through the Medicaid prior approval process;
    - no longer requires Medicaid coverage of CAP/C services in addition to CAP/C case management to remain safely at home;
    - CAP/C services are no longer desired;
    - no longer eligible for Medicaid under CAP/C;
    - my child (the recipient) reaches 19 years of age;
    - the safety, health, and well being cannot be maintained at home
    - needs cannot be met within the Medicaid cost limit.
11. The provider (nursing agency) I choose may have certain requirements regarding my participation in my child's treatment and enrollment with their agency.
12. The Case Manager is responsible for coordinating the assessment, plan of care, and authorizing and monitoring CAP/C services to ensure the client's needs are met within program guidelines. I understand that I must maintain communication with my case manager by returning his/her telephone calls, being available for home visits, and informing him/her of changes in my child's condition, hospitalizations, absences from the county, and new equipment.
13. The Division of Medical Assistance has final approval authority over the plan of care. My case manager is unable to approve or deny any services or supplies.

Sarah S. Smith
NAME OF CLIENT

Judy Smith		10/07/05
SIGNATURE OF CAREGIVER	WITNESS SIGNATURE FOR MARK	DATE
SIGNATURE OF LEGAL GUARDIAN IF NOT CAREGIVER	WITNESS SIGNATURE FOR MARK	DATE
Nancy Nurse, RN		10/07/05
SIGNATURE OF CASE MANAGER		DATE

Illustration 10-5 Sample CAP/C Plan of Care (continued)

Quote

-A

Date
Client
File# Order #
Does Of Birth
Date Of Injury
Subscriber Name
ID #
Policy #
Group#
Contract#
Case#
Case Mgr
Case Mgr Fax
Plan#
Physician
Physician Phone
Therapist
Therapist Phone
Therapist Fax

TaxID# Provider #
Attn:

Diagnosis

781.0 ABN INVOLUN MOVEMENT NEC

Vendor	Part #	Description	Code	Unit	Qty	MSRP	Allowable	Charge	Total
Quickie	162wm47	-Zippie Iris Tilt-in-Space Standard Base and Seat Frame Manual Wheelchair	E1233	Ea	1	$2865.00	$2,109.94	$4584.0 0	$4584.00
Quickie	162C 1	Blue Frame Color		Ea	1				
Quickie	162W5	14" Frame Width		Ea	1				
Quickie	162FD7	16” Frame Depth		Ea	1				
Quickie	162ST35	Standard Seat Pan	E2618	Ea	1	$105.00		$168.00	$168.00
Quickie	1 62TA7	+6 To 60 Degree		Ea	1				
Quickie	162BP10	Medium Similar Backpost		Ea	I				
Quickie	162AA7	Length Adjustable, Locking Flip-Up Armrest	E0973	Ea	2	$117.50	$109.22	$188.00	$376.00
Quickie	162AM1	Desk Length (10") Armpad		Ea	2				
Quickie	162CW35	6" X 1.5 Semi Pneumatic Caster	E2217	Ea	2	$42.60		$68.00	$136.00
Quickie	162CS5	3/4" Longer Fork Stem bolt		Ea	2				
Qulckie	162H7	70' Swing Away Front Mount Footrest Hanger		Ea	2				
Quickie	162E23	Extension Tube 2"	K0043	Ea	2	$1 5.00	$15.00	$24.00	$48.00
Quickie	162F4	Kids Angle Adjustable Footplate with Leg Strap	K0040	Ea	1	$75.00	$70.94	$120.00	$120,00
Quickie	162AL33	Standard Axle Plate		Ea	1				

PAGE 03

Quote

Date
Client
File#

Order #

Vendor	Part #	Description	Code	Unit	Oty	MSRP	Allowable	Charge	total
Quickie	162AX1	QuickRelease Axles		Ea	1				
Quickie	182RW13	f2' Meg Rear Wheel		Ea	2				
Quickie	162RT2	Pneumatic Airless Insert	E2216	Ea	2	$72.50	$28.69	$116.00	$232.O0
Quickie	11132WL25	Atterlident Wheellock		Ea	2				
Quickie	162AT	Rear Anti-Tip	E0971	Ea	2	$67.50	$30.72	$108.00	$216.00
Tag	629052	Oxygen Holder. High Mount,E Tank(Speclty, if For D Tank). To Fit Most	E2208	Ea	1	$110.00	$112.84	$176.00	$176.00
Aef	334415-70+62	Seat Cushion, Contour-One Foam	E2605	Ea	1	$346.00	$305.61	$553.60	$553.60
Aef	33022	Velcro Loop On Bottom of Cushion		Ea	1				
Aef	403-415-21+62	Drop-In Curved R-Backs, 1-1/2” SSM	E2617	Ea	1	$518.00	$373.39	$628.80	$828.80
Aef	51868+08	80' Forward Adjustment Kit 6 Hole L Bracket 1” Diameter Tubing, Versalock		Ea	1				
Aef	47000	Embroidery Mod (N/C For Full Statems)		Ea	1				
Aef		paul - block - blue		Ea	1				
Aef	25156+62	Trunk Pad Curved 5"h x 6"d	E0956	Ea	2	$228.00	$84.48	$364.80	$729.60
Aef	15721	Quick Plus Lateral Brkt Z-Style 1" Slot		Ea	2				
Acf	25346+62	Hip Pad Flared 4"h x 6"d	E0957	Ea	2	$117.00		$187.20	$374.40
Aef	15326	Lat Bracket 100" 2"H x 6"L		Ea	2				
Bodypoint Designs	HB504-A1	Hip belt, medial Four-Point, Dual~ Pull, SR, Small. Flat-Mount	E0978	Ea	1	$76.00	$39.39	$121.60	$121.60
Bodypoint Designs	SH310S	Stayflex Anterior Trunk Support, Standard, Small	E0950	Ea	1	$140.00	$86.43	$224.00	$224.00
Bodypoint Designs	FT206SR	Ankle Huggers, Small, Side Release Buckle, with Adjustable Mounting	K0108 W4143	Ea	2	$60.00	$76.80	$96.00	$192.00
Whitmyer Biomechanix	ONYX-P3	8" Plush Pad with Onyx Vertical/Horizontal mount	K0108 W4132	Ea	1	$290.00	$192.07	$464.00	$464.00
Whitmyer Biomechanix	M2100	Onyx Detachable Mounting Bracket		Ea	1				
Therafin Corporation	33000	V-Ilne~ Tray (no rim) With Pre-inst E-z Lock Clamps Child	E0950	Ea	1	$242.35	$96.75	$387.76	$387.76

PAGE 04

Quote

Date
Client
File # Order #

Vendor	Part #	Description	Code	Unit	Quantity	MRSP	Allowable	Charge	Total
			TOTAL ALLOWABLES			$4,074.58	Subtotal		$9,931.76

If you have any questions, please call me
Sincerely,

Total	$9,931.76
Tax	
Grand Total	$9,931.76

11. 0 CASE MANAGEMENT

CAP/C Case Management is a requirement to participate in CAP/C. The provision of good case management is critical for the client to benefit from the program. This section discusses the components of CAP/C Case Management and the responsibilities of the case manager. The material is directed to the case manager. See Section 20 for documentation requirements.

A Case Management agency is assigned to a client based on the client's current county of residence, even if the client's Medicaid or the client's legal guardian is in a different county.

11.1 Assessing the Client

When your agency accepts an individual as a potential CAP/C participant, it provides a complete assessment of the client according to the guidance in Section 9. A registered nurse or a team consisting of a Registered Nurse and a social worker complete the assessment. In the latter case, both members of the assessment team must meet the case manager qualifications in 4.4.

Annually, the formal assessment is repeated to determine if the individual is still appropriate for the program and the Plan of Care adequate to meet the individual's needs. The assessment is part of the Continued Need Review process. See Section 13.

In addition to the formal assessments, you are continually informally assessing the client's situation. The information that you gather enables you to adjust services, develop resources and perform other case management activities to support the client. It also helps you know when a client is no longer appropriate for the program.

11.2 Planning Care

The Plan of Care that you complete according to the guidance in Section 10 is the basis for providing services and coordinating of other resources. When planning services, keep in mind the goals and objectives for the client, when the client is available for care and treatment, how the scheduling will affect the client and other significant parties, and how the services link with other services and resources. Arrange services to get the maximum benefit for the client. Get the client/responsible party and the provider to agree on how services will be provided.

When scheduling services, be aware of the limitations in Section 4. Remember that:

- Some services may not be provided on the same day as other services, such as Medicaid Personal Care and CAP/C Nurse Aide (Personal Care) services.

- It will be rare for a client to need additional home nursing services (such as home health nursing) when the client is receiving CAP/C Nursing services. When a client is receiving home infusion therapy, it is sometimes appropriate for the client to receive both Home Infusion Therapy services and CAP/C Nursing Services.

Help the client/responsible party develop back-up and emergency plans in conjunction with the formal and informal caregivers. The plans will differ according to the client's location, support system and needs. Some of the typical activities are listed below. Carefully document all of your activities in the client's record.

- In regard to CAP/C Nurse Aide (Personal Care) services and CAP/C Nursing services, be sure that the client/responsible party knows how the provider agency arranges for substitute staff and who to call at the provider agency in emergencies. Include a copy of any information from the provider agency in the client's record. Document the date information was provided and to whom it was provided. Go over any provider agency information with the client/responsible party to help assure a common understanding of the information. Also, document any instances of when the information changes.

- Help the client/responsible party understand their responsibility for a backup plan for when caregivers are not available and assist in developing such a plan. Document the discussions and the plan in the client's file.

- Assist the client/responsible party in planning for emergencies such as power outages, storms, and fires. Though the contacts with power companies, local fire and rescue squads, and emergency management officials are usually best made by the client/responsible party, help them understand who to contact and the importance of such contacts. Some case managers find it helpful to have a checklist of needed contacts with names, phone numbers and a space to enter the date of contact. Again, carefully document your efforts in the client's record.

11.3 Working with the Physician

A good working relationship with the client's physician and the physician's staff benefits all involved with the client's care. Some of the things you may do to develop and maintain such a relationship include:

- Help the physician understand how CAP/C will support the client as well as the physician's efforts to provide the best care for the client. Note that CAP/C may help reduce hospitalizations, allow earlier discharges, and permit clients to live at home. Briefly and clearly let the physician know what CAP/C offers the client.

- Keep the physician informed about the client's CAP/C plan of care. Provide the physician with a summary of the services the client is receiving or a copy of the current plan of care.

  EXAMPLE: *A note to the physician describing the services that the client will receive as a participant in CAP/C might say, "Sarah Jones has been approved to participate in CAP/C. The services authorized include eight hours of CAP/C Nursing daily, construction of a wheelchair ramp, three cans of Ensure daily and Case Management. Please let me know if you would like more information or have questions about the plan of care. My telephone number is (012) 345-6789."*

- Let the physician know and periodically remind the physician of your role. As a case manager who knows what is available in the community, you will often be a "problem-solver" for the physician.

- Communicate in a clear and straightforward manner. Use short narratives with short sentences or phrases - something the physician can quickly and easily comprehend.

- Establish yourself as a provider of information and a source of help, not a sender of forms to sign. When you have to get a form signed, include a brief note that lets the physician know why you are making the request in terms of how it relates to the client. For example, when

sending an FL-2 for the Continued Need Review, let the physician know why you need to have it completed.

11.4 Authorizing CAP/C Services

Get the CAP/C services approved on the Plan of Care started by using a service authorization sent to the provider agency identified on the Plan. Promptly arrange services after they are approved. The services received by the client are expected to match the Plan of Care. If services cannot be promptly implemented, consider if a revised service package will meet the client's needs. Either submit a Plan revision for approval or act to terminate CAP/C participation. See Section 12 for Plan revisions and Section 17 for terminations.

When authorizing CAP/C Nurse Aide (Personal Care), CAP/C Nursing and Respite, send an authorization to the provider agency that contains:

- The client's name (as on Medicaid records), Medicaid ID number, date of birth, sex, ICD-9 code diagnoses and FL-2 prior approval number.
- The name of the insurance company and policy number, if applicable.
- The client's address, phone number and, if needed, directions to the home.
- The name, address and phone number of the parent(s) or responsible party.
- Your name, agency address and phone number.
- The name of the service and HCPCS billing code for the service.
- The date the service is to start, plus instructions for its delivery, including:
  - For CAP/C Nursing, the days of the week, the times of the day and the tasks to be accomplished each day. Indicate that the schedule may not be changed without your approval.
    Note: When there are issues with staffing, you may use two provider agencies. The service authorization must clearly delineate which agency provides service at which times. The agencies may not interchange without approval and a service authorization from you. When reviewing claims, be alert for duplicate billing.
  - For CAP/C Nurse Aide (Personal Care) services, the days of the week, the times of the day and the tasks to be accomplished each day. (You may use DMA's PCS Plan of Care for this purpose, available at http://www.dhhs.state.nc.us/dma/forms.html#prov or from the nurse aide agency). Indicate that the schedule may not be changed without your approval.
    Note: When there are issues with staffing, you may use two provider agencies. The service authorization must clearly delineate which agency provides service at which times. The agencies may not interchange without approval and a service authorization from you. When reviewing claims, be alert for duplicate billing.
  - For In-Home respite, the hours per month to be provided.
  - For Institutional respite, the days per month to be provided.

- The date the service is expected to end. Unless you know a specific date that the service will end, use the date of the next CNR as the projected end date. Always note that the end date is subject to change. If the service authorization expires prior to DMA being able to approve the CNR, you may send the agency a new service authorization for one additional month at a time if they request it. The service authorization should be for the current services. Please do not authorize any new services without approval from DMA.

- Any special instructions for the delivery of the services, such as special feeding instructions or diet information.

- The Medicaid maximum allowable payment for the service. Except for Institutional Respite, provider agencies bill their usual and customary charges for these services. If the agency's usual charge for these services is more than the Medicaid maximum, also show the agency's usual charge on the authorization. See 21.3 for details about what a provider may bill.

- Medicaid deductible information, if appropriate.

- A statement that you are authorizing care for the client subject to the client being authorized for Medicaid coverage. Your authorization does not guarantee Medicaid eligibility.

- A reminder to send claims to you prior to submitting to the fiscal agent.

Keep a copy of the authorization in the client's record. See Illustration 11-1 for a sample authorization.

REMEMBER: *Send service authorizations only for CAP/C services. Do not send service authorizations for regular Medicaid home and community care services. CAP/C Case Managers do not authorize regular Medicaid home and community care services. See Section 5 for an explanation of these services. Remember that the cost of these services is included in the client's CAP budget.*

When arranging the services that may be provided only by the case management agency - that is, Home Mobility Aids and CAP/C Waiver Supplies, you do not have to complete a service authorization as outlined above. See 20.6 for the records needed to document the provision of these services.

CAP/C SERVICE AUTHORIZATION
April 11, 2005

TO: Happy Co. Home Health
123 Smiley Lane
Anywhere, NC 27000

FM: Nancy Nurse, Case Manager
Happy Co. DSS
Anywhere, NC 270000
555-5555 Ext 456

CLIENT'S NAME: Sarah Smith **PHONE:** 123-4567
ADDRESS: 100 Sunny Lane, Anywhere, NC 27000
DIRECTIONS: Go out of town west on Main Street to Joe's Burgers. Turn left onto Smith Street. Go 3 blocks and turn right onto Sunny Lane. Third house on left.

DOB: 2/18/02 **SEX:** Female **FL-2 PA#:** 2005 741 852 963
MID: 999-99-9999 A **INSURANCE:** Expired 3/01.
DIAGNOSES: cerebral palsy, tracheomalacia, gastroesophageal reflux

PARENTS/RESP. PARTY: Judy Smith **PHONE:** 123-4567
ADDRESS: Same as client's.

Please provide **CAP/C Nursing Services** to the above named CAP/C participant. The billing code is **T1000**.

Begin the service on **4/15/05** and continue it until **3/5/06** unless otherwise notified. Please contact me if you have problems delivering the service or if you believe the service needs to be stopped or changed.

The Medicaid maximum for this service is **$ 9.11** per 15-minute unit. I understand that your usual customary charge is **$10.00** per 15-minute unit.

ADDITIONAL INFORMATION: Provide CAP/C Nursing Services from 7:00 am to 7:00 pm (48 units per day), Monday through Friday of each week. See attached for tasks to be performed each day. Do not change this schedule without my approval. This client does not have a monthly deductible that has to be met before being authorized for Medicaid coverage.

This authorization allows payment only if the client is Medicaid eligible on the date of service. You must verify Medicaid eligibility and meet other Medicaid reimbursement requirements.

Remember that I must approve your claims before they are sent to the fiscal agent.

THANK YOU.

Nancy Nurse, Case Manager

Illustration 11-1 – Sample Service Authorization

11.5 Coordinating With Other Services on the Plan of Care

Most of the coordination of the other services occurs as you develop the Plan of Care and arrange care. Plan services to provide a workable package for the care and treatment of the client. Continue this process as the client participates in the program. Work with the client, family, provider agencies and others involved with the client's care to avoid/resolve scheduling conflicts, duplication of effort and other problems that hinder effective care. The monitoring activities described in 11.7 will help you in this process. Remain accessible to all of the parties and encourage the sharing of information for the benefit of your client.

Although CAP/C approval is for CAP/C participation and services only, the cost of all Medicaid services on the Plan of Care is included in the CAP budget. You need to be aware of all Home Health services and medical supplies, DME, home infusion therapy and hospice services the client is receiving. When the CAP/C Plan is approved, send written notification to the agency or agencies providing these services to let them know that CAP/C participation has been approved or is continuing. The notice documents and verifies the non-CAP/C home and community care services the client is receiving (or will be receiving pending Medicaid approval) and reminds the provider to coordinate any changes with you. See Illustration 11-2.

At a minimum, include the following in your notification:

- The client's name (as on Medicaid records), MID number, sex and date of birth;
- Your name, agency address and phone number;
- Type, frequency and cost of services the agency is/will be providing;
- CAP/C start date;
- Medicaid deductible information, if appropriate;
- A request to be notified of changes in the type, frequency and/or funding source of services;
- A reminder that this is not an authorization or approval for regular Medicaid home and community services.

If this is a new client to the provider agency and this notice is also a referral to evaluate the client for their services, include the following information in addition to that listed above:

- The client's address, phone number and, if needed, directions to the client's home.
- The name, address and phone number of the responsible party;
- Insurance name and policy number, if applicable;
- Diagnoses.

CAP/C PARTICIPATION NOTICE

April 11, 2005

TO: Good Health Medical Supply
799 Harmony Court
Anywhere, NC 27000

FM: Nancy Nurse, Case Manager
Happy Co. DSS
Anywhere, NC 27000
555-5555 Ext 456

CLIENT'S NAME: Sarah Smith **PHONE:** 123-4567
ADDRESS: 100 Sunny Lane, Anywhere, NC 27000
DIRECTIONS: Go out of town west on Main Street to Joe's Burgers. Turn left onto Smith Street. Go 3 blocks and turn right onto Sunny Lane. Third house on left.

DOB: 2/18/02 **SEX:** Female
MID: 999-99-9999 A **INSURANCE:** Expired 3/01
DIAGNOSES: cerebral palsy, tracheomalacia, gastroesophageal reflux

PARENTS/RESPONIBLE PARTY: Judy Smith **PHONE:** 123-4567
ADDRESS: Same as client's.

The client is authorized for CAP/C participation beginning 4/20/05. The following services from your agency are included in the CAP/C Plan of Care:

CODE	SERVICE	AMOUNT & FREQUENCY	COST	PAYER

(See attached listing of medical equipment and supplies.)

If there are any changes in the amount, type, frequency or funding source of any of these services, please call me.

ADDITIONAL INFORMATION: This client does not have a monthly Medicaid deductible.

IMPORTANT: *This is not an authorization for or approval of services from your agency. The purpose of this notice is to coordinate the client's home and community care services and ensure that their cost to Medicaid does not exceed the cost of nursing home care. Your services are provided and paid according to Medicaid policies and procedures. You are responsible for verifying Medicaid eligibility and the client's eligibility for the service*.

Thank you for helping coordinate care for this client.

Nancy Nurse, Case Manager

Illustration 11-2 – CAP/C Participation Notice

11.6 Coordinating Other Resources

CAP/C is not intended to replace or duplicate services and resources, such as health insurance benefits or services available through the schools, which are available to the client. Help assure that the client gets the best available treatment and care by carefully coordinating the CAP/C services with the resources available in the community. For those clients with a broader array of needs than can be met with CAP/C, it is essential that you fully utilize all resources to allow the individual to stay in the community. Explore what the community has to offer, such as assistance from community groups, private individuals, public agencies and other entities. If the child has an IEP or IFSP, be sure to know what is included in the plan and coordinate services with the plan services.

11.7 Monitoring

You are responsible for monitoring the CAP/C services provided to the client as well as the overall care of the client. This activity enables you to continually evaluate the client's need to participate in CAP/C.

11.7.1 CAP/C Services

After a child begins participating in CAP/C, monitor the care and treatment and make needed changes. Look at the need for specific services as well as for CAP/C participation. Your close contact with the client, provider agencies and others involved with the client should provide prompt indications of any need to change the client's care or treatment. When you find that changes are needed, determine if the Plan of Care needs to be revised or if you should consider termination.

Plan monitoring activities in relation to a client's situation. Some clients may require more monitoring than others because of the intensity of needs, the support available from responsible parties, or other factors. Review whether services are being provided as authorized and whether they are meeting their intended purpose. Look at the provider's performance and the client's response to the service to determine the need for adjustments in the service. Document the monitoring and actions taken as the result of the monitoring in the client's record.

When you get a claim from a provider, promptly review it to be sure that the billed services were provided as approved on the Plan of Care and as authorized. Be alert for situations that CAP/C and/or Medicaid don’t pay for, such as CAP/C staff providing transportation to a client, or providing services in a preschool, daycare, or doctor’s office. Resolve any discrepancies or questions with the provider agency before sending the claim to the fiscal agent.

NOTE**:** *When reviewing a claim, remember that provider agencies bill their usual and customary charges for all services except Institutional Respite, Home Mobility Aids, and Waiver Supplies. There are controls in the payment system to restrict the amount that Medicaid pays. Compare the charge on the claim with the amount previously agreed upon with the provider agency.*

The other monitoring requirements are:

- *For CAP/C Waiver Supplies, Home Mobility Aids, and Medicaid Medical Supplies* from the case management agency, confirm after the item is delivered to the client that it is appropriate for the client's needs and use. At least quarterly, confirm that the item continues to be needed and used by the client.

- *For other CAP/C services:*

  - *At least MONTHLY*, review the provision of services with the client/responsible party and each provider agency. If the client is receiving CAP/C Nursing, make contact directly with the nursing staff. The contacts may be made by phone.

  - *At least EVERY 90 DAYS*, visit the CAP/C client. During the visit, observe the provision of each on-going CAP/C service that provides direct care to the client. Also, review the supporting documentation for claims. You do not have to review every piece of documentation - review enough so that you are comfortable that the service is being properly provided. You need only review documentation on CAP/C services (CAP/C Nursing, CAP/C Nurse Aide Services). You are not required to review documentation from non-CAP/C services such as therapies.

11.7.2 Home Health Skilled Nursing

You need to be aware of significant changes in your client's physical health status to ensure that the individual's needs can continue to be met effectively through CAP/C. If your client is receiving skilled nursing visits from a home health agency, make a monthly contact with the nurse to review the results of the visit(s). These contacts may be made by telephone or through a review of the nursing notes. Document the contact in the case management notes.

11.7.3 Other Services

Though you do not control the provision of other services, keep aware of what services are being provided and how they are being provided. Work with others involved with the client to help assure proper care and treatment; prevent duplication of services; and coordinate the services with the CAP/C services. Report any duplication of services (e.g., a daily respiratory therapy visit to perform suctioning on a child who already has a nurse for sixteen hours per day) to the child’s physician. Report problems or concerns about a service to the responsible agency. You may also assist the client/responsible party in dealing with the service providers. Monitor the cost of the Medicaid community services as part of your responsibility to maintain cost-effectiveness.

11.7.4 Documenting Your Monitoring Activities

The activities described above are the minimum requirements for monitoring each CAP/C participant's plan of care and must be documented in the client's record. Documentation of these activities serves as a record of the client's overall condition and progress. The monitoring is the basis for planning ongoing care to meet the client's changing needs. In addition, Medicaid considers that a service has been provided only if the provision of the service is clearly documented. Thus, your documentation also serves as a record of services rendered by your agency in exchange for payment from Medicaid.

Depending on the services your client is receiving, your documentation should reflect that you have completed the following monitoring activities:

- Monthly contact with the client/responsible party regarding the provision of CAP/C Nursing Services, CAP/C Nurse Aide (Personal Care) services and Respite.
- Monthly contact with the service provider(s) regarding the provision of CAP/C Nursing and CAP/C Nurse Aide (Personal Care) services.
- If Home Health nursing is provided, make a monthly contact with the home health nurse to review findings and coordinate care.
- A visit with the CAP/C client at least every 90 days to observe the provision of CAP/C Nursing and CAP/C Nurse Aide (Personal Care) services.
- Review of a sample of supporting documentation every 90 days for CAP/C Nursing Services, CAP/C Nurse Aide (Personal Care) services and Respite.
- Contact with the client/responsible party after construction or installation of a home mobility aid to confirm its appropriateness.
- Contact with the client/responsible party every 90 days to confirm the continued appropriateness of CAP/C Waiver Supplies and Medicaid Medical Supplies provided by the case management agency.

  NOTE: *The case manager is required to monitor Medicaid Medical Supplies to ensure that the cost is within the allowable budget. When supplied by a home health agency, they are provided and monitored according to the policies and procedures that govern regular Medicaid home and community care services.*

11.8 Changes in Care

When monitoring reveals a change in the client's needs, situation or condition, consider changing the Plan of Care. Discuss possible changes with the client/responsible party and others involved with the care and treatment of the client. You may also need to consult with other professionals. Follow the instructions in Section 12 if you need to revise the Plan of Care.

Also be alert to changes needed in services other than Medicaid services. You may assist the client/responsible party in considering and obtaining those changes.

11.9 Providing Case Management to a Client in a Hospital or Nursing Facility

There are three situations in which you may bill for Case Management provided to a client while in a hospital or nursing facility ("nursing facility" refers to all care settings billed to Medicaid as NF care, including hospital swing beds and rehabilitation centers).

CAUTION*: When providing case management under any of the following provisions, clearly document that the activities are not those that that should be performed by discharge planning of the facility.*

- *When assessing a* **potential participant** *prior to discharge* from a hospital or nursing facility, you may bill for assessment and care planning activities that do not duplicate the

discharge planning required of the facility. This is an individual new to CAP/C – not someone returning to CAP/C after a NF stay of less than 31 days. The billable activities include the following:

- Confirming that the FL-2 has been approved for CAP/C participation.
- Assessing the client for CAP/C;
- Developing the Plan of Care and submitting it for approval;
- Planning and arranging CAP/C services;
- Developing informal support for the client;
- Coordinating Medicaid eligibility related to CAP/C; and
- Coordinating the planned CAP/C services with the regular Medicaid services arranged by the discharge planner.

NOTE: *Billable case management may begin up to 30 days prior to discharge, but no earlier than the FL-2 approval date. The client must be on Medicaid for the claim to be paid.*

CAUTION*: Procedures for billing for initial CAP/C assessment activities carried out before the client's discharge from a hospital or long term care facility are different from those used to bill for other CAP/C services. Section 21 gives instructions for filling out claims. Follow the instructions carefully for completing item 24B to assure payment for assessing new clients while still in a facility.*

- *When a* **current CAP/C client** *is hospitalized for 30 days or less*, you may perform and bill for case management activities that do not duplicate the discharge planning required of the facility. This includes the following:
  - Arranging for the suspension and resumption of CAP/C services.
  - Determining if a new FL-2 is required
  - Revising the Plan of Care as needed
  - Coordinating with informal support services
  - Coordinating Medicaid eligibility issues related to CAP/C

Though the discharge planner arranges regular Medicaid services, such as Home Health, HIT, Hospice or DME, work cooperatively with the discharge planner and providers to coordinate those services within the overall CAP/C Plan of Care. See Section 15.1 for more information regarding absences.

- *When returning a* **former CAP/C client** *to the program from a NF stay of less than 31 days using the procedures in 15.2*, you may bill for case management activities described in 11.10 prior to the client's discharge.

REMEMBER: *See 15.2 for the billing procedures for Case Management time in this situation.*

11.10 Billable Case Management

Billable case management activities include the following for a specific CAP/C client:

- Assessing the client for CAP/C participation. This includes the time of both members of the assessment team to arrange, coordinate and complete assessment activities. See 11.9 for assessing a client prior to discharge from a facility. See Section 9.5.4 for information about billing for an initial assessment of an individual who does not become a CAP/C participant.

  NOTE: *Billable time for a new client may not begin prior to FL-2 approval. Activities such as obtaining the FL-2 and pre-screening are not billable.*

- Planning CAP/C services, including completing the Plan of Care and revising the Plan as needed.

- Locating service providers for approved CAP/C services and ordering the services from those providers.

- Locating and arranging informal support to meet the client's needs. An example is getting volunteers to do home repairs that are needed for the client's safety.

- Coordinating the provision of the other Medicaid home care services, such as Home Health services and DME.

- Monitoring CAP/C services, including observing the delivery of the service and reviewing claims and related documentation.

- Monitoring the client's situation, including the continuing need for CAP/C participation, the level of care and the appropriate services as well as taking appropriate action on your findings.

- Working with the client, family and others involved in the client's care to assure the client's health, safety and well-being. This includes emergency planning and backup planning activities.

- Coordinating Medicaid eligibility issues with DSS, including those related to helping the client get information to DSS.

- Arranging and coordinating activities related to the termination of CAP/C that occurs prior to the termination date. Activities after discharge, termination or the client's death are not billable.

REMEMBER: *See 11.9 for billable activities related to a client in a hospital or nursing facility.*

Billable time for the above activities includes the time spent with the client, time spent talking with those involved in the client's care, time completing service authorizations and time spent completing other correspondence directly related to the client's care. Travel time is not billable.

Only the activities listed above when they directly relate to an individual CAP/C client are billable. While case managers are usually involved in other tasks as part of their daily activities and as part of their employee responsibilities, those tasks are not billable time. Activities such as attending training; completing time sheets; recruiting, training, scheduling and supervising staff; billing Medicaid; documenting case management activities; and gathering information to respond to quality assurance requests are a few examples of non-billable activities.

As a general rule, monthly case management time should not exceed seven hours on any given client. If you claim more time than that on your Plan of Care, be prepared to show documentation of the time spent.

12. 0 REVISING THE PLAN OF CARE

This section tells when a Plan revision is required and how to complete a revision. The material in this section is directed to the case manager.

Your close contact with the client/responsible party, provider agencies, and others involved with the client should provide prompt indications of any need to change the client's care or treatment. When you find that changes are needed, determine if the Plan of Care needs to be revised or if you should consider termination.

12.1 Required Action on Changes

Your action depends upon the nature of the change.

12.1.1 Change in Goals or Interventions

Since changes to the goals and interventions are usually the result of a change in services or supplies, follow the instructions in section 12.1.6 and 12.1.7 of this chapter regarding approval and signature requirements.

12.1.2 Change in the Unit Rate of a Service or Supply

When the cost of a service changes, recompute the Cost Summary.

Cost Within Limit: If the total cost to Medicaid remains within the cost limit, put a record of the provider's notification of the cost increase, the effective date of the cost increase, and the recomputed Cost Summary in the client's file.

- Send revision to DMA for approval?: No
- Signature Requirements: None

Cost Exceeds Limit: If the total cost to Medicaid exceeds the cost limit, revise the Plan. Determine whether the client can be served within the cost limit or must be terminated. Follow the instructions in this section to revise the Plan and get the revision approved. If it appears the cost cannot be kept within the limit, promptly notify the DMA CAP/C consultant.

- Send revision to DMA for approval?: Yes
- Signature Requirements: If *CAP/C waiver* services are changed to get the plan within budget, the signatures of the client/responsible party and the case manager are required. The signature of the physician is optional. If regular Medicaid supplies or services are changed, only the signature of the case manager is required.

12.1.3 Change in Provider Agencies

Document the change, including the agreement of the client/responsible party to the change. Obtain a signed and dated statement from the client/responsible party that contains the name of the new provider agency, the effective date of the change, and a

statement of agreement to the change. Place the statement in the client's file and document the change in your case management notes.

- Send revision to DMA for approval?: No
- Signature Requirements: Signature of client/responsible party on agreement, as stated above

EXAMPLE: *Susie Jones, a 12 year-old CAP/C client, has been receiving 6 hours per day, Monday through Friday, of CAP/C Nurse Aide (Personal Care) Services from Happy Outcomes Home Care. Because of problems with staffing, Amanda Jones, Susie's mother, wants to change agencies. You help the Mrs. Jones locate another agency, Better Outcomes Home Care, to provide the services beginning August 22, 2005. As part of coordinating the changeover in care, you obtain a brief signed and dated statement from Mrs. Jones that says, "I have selected Better Outcomes Home Care to provide CAP/C Personal Care Services to my child, Susie Jones (MID 999-99-9999Z) beginning on August 22, 2005." You place the statement in the client's file and document the change in your case management notes.*

12.1.4 Change in Informal Support

Document any changes in the child's informal support system. If the change results in a change to the 24 hour coverage schedule, follow the instructions in section 12.1.5. If the change results in a change in the amount of frequency of nurse or aide services, follow the instructions in section 12.1.6. If no other changes result, there is no need to submit the revision; just make sure the next revision or CNR that is submitted contains the updated information.

12.1.5 Change in 24 Hour Coverage Schedule

When the schedule for 24 hour coverage changes, document the change.

- If the change is temporary, follow the guidance in 12.1.6 for temporary changes.

- If the change is part of a Plan revision related to the amount of formal services, update this section as part of that revision. Follow the guidance in 12.1.6 for changes in service.

- If the change is due to a rescheduling of existing services or related caregiver support – such as CAP/C Nursing hours changing from 9 a.m. - 3 p.m. to 1 p.m. - 7 p.m. – document the change by completing a new 24 hour schedule. Note the effective date of the change and have the client/responsible party sign and date the item to indicate agreement to the change. Be sure that there are actual interventions to be performed for the client during the revised hours. See Illustration 12-1 for an example. Maintain the documentation in the client's file.
    - Send revision to DMA for approval?: No
    - Signature Requirements: Signature of client/responsible party on agreement, as stated above.

E. 24 HOUR COVERAGE EFFECTIVE 8/22/00 ACCEPTED Judy Smith, 8/20/2000

If the Assessment shows 24 hour coverage is needed, use this calendar to show coverage plans, including paid and unpaid caregivers. Write the hours covered each day beginning after midnight and who is covering (e.g., "12-8 am -Sam Jones").

	Time Covered/Name of Person Covering
Sunday	12m-7A RN 7A-11p Judy Smith 11p-12m RN
Monday	12m-7A RN 7A-1p Joyce Jones 1P-5P RN 5P-11p Judy 11p-12m RN
Tuesday	Same as Monday
Wednesday	Same as Monday
Thursday	Same as Monday
Friday	Same as Monday
Saturday	Same as Monday

Page 4

Illustration 12-1 – Sample 24 Hour Coverage Change Documentation

12.1.6 Change in Amount, Duration, or Frequency of a Service or Supply

A Plan revision is required when a service or supply is added, reduced, increased, or deleted, or there are changes in duration or frequency of a service.

If the change involves a waiver supply or service (Nursing, Nurse Aide (Personal Care) Services, Respite, Home Modifications, and Case Management)

- Send revision to DMA for approval?: Yes
- Signature Requirements: Signature of client/responsible party and case manager. Physician signature optional.

If the change involves a regular Medicaid supply or service

- Send revision to DMA for approval?: Yes
- Signature Requirements: Case Manager only

Exceptions to this requirement involve:

- **A Temporary, One-Time Change in Approved Services:** A one time change in an approved service usually does not require a Plan revision. Examples of situations which fit this category include:

- An additional nursing visit requested by the physician to meet a short-term need of the client;
- An additional hour of CAP/C Nurse Aide (Personal Care) Services for one day requested by the client/responsible party due to a family emergency; and
- The suspension of CAP/C Nurse Aide (Personal Care) Services for a short period at the request of the client/responsible party during a vacation period or holiday.

Additional situations may occur when a paid caregiver is temporarily not available and the absence of the caregiver does not endanger the client – such as the absence of a CAP/C Nurse Aide when you assure adequate coverage by other sources. Use common sense and discretion in applying this exception, and explain the circumstances in the case management notes. When the temporary change results in less service being provided than in the Plan, document in the case management notes how the client's needs were met during the period. If temporary or one-time services or increased supply needs become recurrent, then the plan of care must be revised to include those services *(**Example**: On Wednesdays, a child attends physical therapy and she is usually quite fatigued after the session. Because of her fatigue, she needs more assistance with her ADLs, and the procedure takes a longer amount of time. The child's parents have been calling every week for the past month to request an extra 30 minutes of service on that day. The extra 30 minutes should be incorporated into the patient's regularly scheduled hours, rather than being approved as a one-time change on such a frequent basis.).*

- **Supply Variations within Estimate:** The supply entries are estimates. The amount used each month may vary from the estimate due to the different number of days in each month and minor changes in the client's condition. You do not have to revise the Plan if the pattern of use remains within the estimate on the Plan.
- **Case Management Variations within Estimate:** The case management entry is an estimate. The amount may vary from month to month due to the length of each month and the changing needs of the client. You do not have to revise the Plan if the pattern of use remains within the estimate on the Plan.
- **Additional Medical Supplies for One Time Need:** Upon occasion, medical supplies beyond those approved on the Plan may be required during a home health visit. This is usually on a one-time basis. You do not have to revise the Plan if you do not expect the client to need the additional supplies on a continuing basis. Whenever this exception is applied, documented the details in the client's record.

***NOTE**: These exceptions are designed to allow flexibility and to reduce the number of Plan revisions. Do not use them to allow the client to continually receive additional care without a revision or to allow a suspension of services that will endanger the client's health, safety, and well-being. The Plan of Care MUST be revised if the exceptions become a recurrent pattern – such as the family requesting extra services each week or month.*

12.2 Time Limit and Effective Date

Plan revisions should be approved before a change is made; however, changes may be approved retroactively for up to 30 days prior to the date that the revised Plan is received by DMA's HCI Unit for approval. Revisions are reviewed in the order in which they are received. Last minute or 'emergency' revisions should be kept to a minimum.

CAUTION: *Plan revisions must be approved to qualify the changes for Medicaid payment.*

12.3 Preparing the Revision

The Cost Summary shows the services the client is to receive beginning with the effective date of the Plan. It also shows services that involve pro-rated costs.

To prepare a Plan revision, complete a new Plan of Care. Use the Plan of Care instructions in Section 10 along with the following guidance.

12.3.1 Deleting a Service

When you stop a service, complete a Cost Summary showing all the entries from the last approved Plan **EXCEPT** for the service that you are terminating. Total the costs on the new cost summary.

EXAMPLE: *The initial Plan was approved for two hours of In-Home Respite a week at a cost of $28.80 per week. This projects to a monthly cost of $123.84 (2 hours/week x $14.40/hour x 4.3 weeks/month). The service is terminated after 20 weeks. Subtract $123.84 from the last cost summary total to get the new total. The initial entry and new entry are shown in Illustration 12-2.*

Original Cost Summary

SERVICE	CODE	PROVIDER AGENCY	FREQUENCY D=Days M=Mos V=Visits H=Hours	FROM/TO	UNIT RATE	AVERAGE MONTHLY COST		
						MEDICAID	OTHER	S
CM Assessment	T1016	Happy Hospital	4 H/Y	N/A	55.28/H	18.43		
Case Management	T1016	Happy Hospital	4 H/M	N/A	55.28/H	221.12		
Nursing Visits	550	Nice Care HH	1 V/M	N/A	101.41/ V	101.41		
*Medical Supplies	N/A	N/A	N/A	N/A	N/A	150.00		
Nurse Aide	S5125	Nice Care HH	6 H/D 5 D/W	N/A	14.40/H	1857.60		
Respite In-Home	S5150	Nice Care HH	2 H/W	N/A	14.40/H	123.84		
***MEDICAL SUPPLIES MUST BE ITEMIZED IN PART C.**					TOTALS	**$2562.40**		

Revised Cost Summary

SERVICE	CODE	PROVIDER AGENCY	FREQUENCY D=Days M=Mos V=Visits H=Hours	FROM/TO	UNIT RATE	AVERAGE MONTHLY COST		
						MEDICAID	OTHER	S
CM Assessment	T1016	Happy Hospital	4 H/Y	N/A	55.28/H	18.43		
Case Management	T1016	Happy Hospital	4 H/M	N/A	55.28/H	221.12		
Nursing Visits	550	Nice Care HH	1 V/M	N/A	101.41V	101.41		
*Medical Supplies	N/A	N/A	N/A	N/A	N/A	150.00		
Nurse Aide	S5125	Nice Care HH	6 H/D 5 D/W	N/A	14.40/H	1857.60		
***MEDICAL SUPPLIES MUST BE ITEMIZED IN PART C.**					TOTALS	$2348.56		

Illustration 12-2 – Service Deletion Example

12.3.2 Adding a Service

When you add a service, complete a Cost Summary showing all the entries as shown on the last approved Plan of Care **PLUS** the service that you are adding.

- Enter the name of the new service, the HCPCS code, the provider agency, and the frequency following the instructions in Section 10.
- Enter the **Unit Rate**.
- Calculate the monthly cost of the added service.
- Total the Medicaid cost and compare it to the Medicaid cost limit. If it is within the limit, proceed with processing the revision.

EXAMPLE 1: *You want to add a Home Mobility Aid to the Plan as your client needs a wheelchair ramp. The total cost of the ramp is $450.00. You pro-rate the total cost over 12 months and get a monthly cost of $37.50 ($450.00/12 months = $37.50). Add $37.50 to the last cost summary total to get the new total. The original and revised entries are shown in Illustration 12-3.*

Original Cost Summary

SERVICE	CODE	PROVIDER AGENCY	FREQUENCY D=Days M=Mos V=Visits H=Hours	FROM/TO	UNIT RATE	AVERAGE MONTHLY COST		
						MEDICAID	OTHER	S
CM Assessment	T1016	Happy Hospital	4 H/Y	N/A	55.28/H	18.43		
Case Management	T1016	Happy Hospital	4 H/M	N/A	55.28/H	221.12		
Nursing Visits	550	Nice Care HH	1 V/M	N/A	101.41/ V	101.41		
*Medical Supplies	N/A	N/A	N/A	N/A	N/A	150.00		
Nurse Aide	S5125	Nice Care HH	6 H/D 5 D/W	N/A	14.4/H	1857.60		
***MEDICAL SUPPLIES MUST BE ITEMIZED IN PART C.**					TOTALS	**$2348.56**		

Revised Cost Summary

SERVICE	CODE	PROVIDER AGENCY	FREQUENCY D=Days M=Mos V=Visits H=Hours	FROM/TO	UNIT RATE	AVERAGE MONTHLY COST		
						MEDICAID	OTHER	S
CM Assessment	T1016	Happy Hospital	4 H/Y	N/A	55.28/H	18.43		
Case Management	T10166	Happy Hospital	4 H/M	N/A	55.28/H	221.12		
Nursing Visits	550	Nice Care HH	1 V/M	N/A	101.41/ V	101.41		
*Medical Supplies	N/A	N/A	N/A	N/A	N/A	150.00		
Nurse Aide	S5125	Nice Care HH	6 H/D 5 D/W	N/A	14.4/H	1857.60		
Home Mobility Aid (Ramp)	S5165	Happy Hospital	N/A	1/05 - 12/05	450.00	37.50		
***MEDICAL SUPPLIES MUST BE ITEMIZED IN PART C.**					TOTALS	$2386.06		

Illustration 12-3 – Service Addition Example 1

EXAMPLE 2: *Your client recently experienced an exacerbation of his condition. This exacerbation resulted in an increase in his care needs. CAP/C Nurse Aide (Personal Care) hours were increased by 2 hours a day for a total of 8 hours/day, 5 days per week, for three weeks to assist his caregivers with his increased needs. The total cost of the increased hours is $432.00 (2 hours x 15 days x $14.40). You prorate the short-term intensive hours over 12 months and get a monthly cost of $36.00. Add $36.00 to the last cost summary total to get the new total. The original and revised entries are shown in Illustration 12-4.*

Original Cost Summary

SERVICE	CODE	PROVIDER AGENCY	FREQUENCY D=Days M=Mos V=Visits H=Hours	FROM/TO	UNIT RATE	AVERAGE MONTHLY COST		
						MEDICAID	OTHER	S
CM Assessment	T1016	Happy Hospital	4 H/Y	N/A	55.28/H	18.43		
Case Management	T1016	Happy Hospital	4 H/M	N/A	55.28/H	221.12		
Nursing Visits	550	Nice Care HH	1 V/M	N/A	101.41/ V	101.41		
*Medical Supplies	N/A	N/A	N/A	N/A	N/A	150.00		
Nurse Aide	S5125	Nice Care HH	6 H/D 5 D/W	N/A	14.4/H	1857.60		
Home Mobility Aid (Ramp)	S5165	Happy Hospital	N/A	1/05 - 12/05	450.00	37.50		
***MEDICAL SUPPLIES MUST BE ITEMIZED IN PART C.**					TOTALS	$2386.06		

Revised Cost Summary

SERVICE	CODE	PROVIDER AGENCY	FREQUENCY D=Days M=Mos V=Visits H=Hours	FROM/TO	UNIT RATE	AVERAGE MONTHLY COST		
						MEDICAID	OTHER	S
CM Assessment	T1016	Happy Hospital	4 H/Y	N/A	55.28/H	18.43		
Case Management	T1016	Happy Hospital	4 H/M	N/A	55.28/H	221.12		
Nursing Visits	550	Nice Care HH	1 V/M	N/A	101.41/ V	101.41		
*Medical Supplies	N/A	N/A	N/A	N/A	N/A	150.00		
CAP/C PCS	S5125	Nice Care HH	6 H/D 5 D/W	N/A	14.40/H	1857.60		
Home Mobility Aid (Ramp)	S5165	Happy Hospital	N/A	1/05 - 12/05	450.00	37.50		
Nurse Aide	S5125	Nice Care HH	2 H/D x 15 D	1/10/05- 1/28/05	14.40H	36.00		
***MEDICAL SUPPLIES MUST BE ITEMIZED IN PART C.**					TOTALS	$2422.06		

Illustration 12-4 – Service Addition Example 2

12.3.3 Changing a Service

When you change a service during the client year, complete a Cost Summary showing all the entries on the last approved Plan **EXCEPT** for the service that you are changing.

- Show the service as you want it to be revised.
- Enter the **Provider Agency, Frequency,** and **Unit Rate.**
- Calculate the monthly cost of the changed service.
- Total the Medicaid cost and compare it to the cost limit. If it is within the limit, proceed with processing the revision.

EXAMPLE: *The initial Plan was approved for six hours per day, five days per week of CAP/C Nurse Aide (Personal Care) a day. This projects to a monthly cost of $1857.60 (6 hours/day x 5 days/week x $14.40/hour x 4.3 weeks/month). The service is changed to seven hours a day after 20 weeks. The new monthly cost of the service is $2167.20 (7 hours/day x 5 days/week x $14.40/hour x 4.3 weeks/ month). The original and revised entries are shown in Illustration 12-5.*

Original Cost Summary

SERVICE	CODE	PROVIDER AGENCY	FREQUENCY D=Days M=Mos V=Visits H=Hours	FROM/TO	UNIT RATE	AVERAGE MONTHLY COST		
						MEDICAID	OTHER	S
CM Assessment	T1016	Happy Hospital	4 H/Y	N/A	55.28/H	18.43		
Case Management	T1016	Happy Hospital	4 H/M	N/A	55.28/H	221.12		
Nursing Visits	550	Nice Care HH	1 V/M	N/A	101.41/ V	101.41		
*Medical Supplies	N/A	N/A	N/A	N/A	N/A	150.00		
Nurse Aide	S5125	Nice Care HH	6 H/D 5 D/W	N/A	14.40/H	1857.60		
Home Mobility Aid (Ramp)	S5165	Happy Hospital	N/A	1/05 - 12/05	450.00	37.50		
***MEDICAL SUPPLIES MUST BE ITEMIZED IN PART C.**					TOTALS	$2386.06		

Revised Cost Summary

SERVICE	CODE	PROVIDER AGENCY	FREQUENCY D=Days M=Mos V=Visits H=Hours	FROM/TO	UNIT RATE	AVERAGE MONTHLY COST		
						MEDICAID	OTHER	S
CM Assessment	T1016	Happy Hospital	4 H/Y	N/A	55.28/H	18.43		
Case Management	T1016	Happy Hospital	4 H/M	N/A	55.28/H	221.12		
Nursing Visits	550	Nice Care HH	1 V/M	N/A	101.41/ V	101.41		
*Medical Supplies	N/A	N/A	N/A	N/A	N/A	150.00		
Nurse Aide	S5125	Nice Care HH	7 H/D 5 D/W	N/A	14.40/H	2167.20		
Home Mobility Aid (Ramp)	S5165	Happy Hospital	N/A	1/05 - 12/05	450.00	37.50		
***MEDICAL SUPPLIES MUST BE ITEMIZED IN PART C.**					TOTALS	$2695.66		

Illustration 12-5 – Service Change Example

12.4 Signature Requirements

Who has to sign the revision depends on what service is being changed. The minimum signature requirements for revisions are listed below by type of service.

- **Regular Medicaid Community Services:** Only the case manager's signature is required on a revision for a change in regular Medicaid community services (such as Home Health and DME). It may be assumed that the provider agency met regulatory requirements, and would not render services that the client did not want. The client record must show that the revision was due to a change in these services, and that you verified the change(s) with the provider agency.

- **Case Management Agency Provided Medical Supplies**: When medical supplies are provided by the case management agency instead of a home health agency, the revision must be signed by the case manager. You can minimize the need for supply revisions by allowing a margin for variations when you develop the initial Plan.

- **Case Management:** Only the case manager's signature is required when the revision changes only the amount of Case Management.

- **Other CAP/C Services:** When the change involves any of the CAP/C services other than Case Management, the signatures of the case manager and client/responsible party are required to show that these individuals agree on the revision. The signature of the client's physician may also be obtained but is not required.

CAUTION: *Although the physician's signature is not required on the Plan of Care, certain services require written orders from the physician. Changes in CAP/C Nursing, nutritional supplements (a component of Waiver Supplies), and Case Management Agency Provided Medical Supplies must be ordered in writing by the client's physician. A copy of the orders for these services must be maintained in the client's record.*

12.5 Getting Approval

Get written approval by following the instructions in Section 14. The section also contains instructions for emergency approvals.

12.6 Case Manager's Actions Upon Notification

If the revision is **approved**, notify the client/responsible party of the approval; implement the change(s); and, if the client has a Medicaid deductible, send a copy of the revised Cost Summary to the Medicaid staff at the county DSS.

If the revision is **denied**, notify all affected parties of the decision. The client/responsible party has the right to appeal the denial of services. They will receive a letter from DMA stating the reason for denial and giving instructions for requesting an appeal.

13. 0 CONTINUED NEED REVIEW

Every 12 months, the client's needs must be completely reassessed to determine if the client remains appropriate for CAP/C. The annual reassessment must be completed to allow the client to remain on the program. The formal reassessment is called a Continued Need Review (CNR). The section describes how to complete the CNR.

The following material is directed to the case manager unless otherwise indicated.

13.1 Due Date

Plan the CNR so that it is completed during the anniversary month of the original FL-2 approval date. The anniversary month is referred to as the "CNR month".

NOTE: *With the exception of situations involving temporary absences and transfers, the CNR month remains the same as long the client remains on CAP/C. Even if the client's level of care changes, the CNR month continues to be the anniversary month of the initial FL-2 approval. See sections 15 and 16, respectively, for information on handling temporary absences and transfers.*

Mail the CNR Assessment and Plan of Care to DMA's HCI Unit for approval so that it is received no later than the fifth day of the month after the CNR month.

CAUTION: *If the CNR is not completed on time, the client may be terminated from CAP/C. Claims for services provided after the CNR month may be denied. DMA may take back payments for services provided after the CNR month.*

13.2 Responsibilities

You are responsible for coordinating the information required for the CNR. This includes planning to be sure that the FL-2 and assessment are completed on time. The client/responsible party is responsible for cooperating in getting the information required to complete the CNR.

13.3 Content Of CNR

The CNR includes a new recommendation for nursing facility care on the FL-2, a complete reassessment of the client and a new Plan of Care.

13.3.1 Level of Care Recommendation

Get a new FL-2 from the physician to determine the client's current level of care. The FL-2 must be signed by the physician **not earlier than the month prior to the CNR month**. (See Section 8 for FL-2 procedures.) If the physician does not recommend ICF or SNF care, immediately contact the DMA HCI Unit as it may have to initiate termination procedures (see Section 17 for termination procedures). The client may not appeal the physician's recommendation to the fiscal agent, DMA, or the case management agency as only the physician can change his or her recommendation. The client is limited to discussing the recommendation with the physician.

- If the physician recommends a different level of NF care, send the FL-2 to the fiscal agent for approval. Follow the instructions in Section 8.

- If the physician recommends the existing level of NF care, do not send the FL-2 to the fiscal agent. Send DSS a copy for its records and keep the original in the client's file.

- The need for hospital level of care will be established by the DMA CAP/C consultant after the continued need for nursing facility care has been confirmed.

REMEMBER: *Medicaid does not pay physicians for completing the FL-2.*

13.3.2 Assessment

Reassess the client's strengths, needs, and appropriateness for CAP/C following the procedures in Section 9. Take a fresh look at all of the factors outlined on the Assessment form. Note changes in the client's situation.

13.3.3 Plan of Care

After completing the assessment, complete a new Plan of Care based on the instructions in Section 10. Add, change, or delete services according to the client's current situation.

13.3.4 Additional Documentation

The physician's request form must be completed at the time of the CNR for each patient who receives CAP/C Nursing services (SC with nurse, or Hospital level). The form does not need to be completed for patients receiving nurse aide care. See section 7.5.3 and Illustration 7-3.

For CNRs on hospital level clients, also send:

- A copy of the most recent CMS-485 form

- A medication administration record corresponding to the dates of the CMS-485 form

- Three to five days of nurses notes corresponding to the dates on the CMS-485 form. It is best to select the days that the client required the most care. If the dates the client required the most care were not within the dates of the CMS-485 form, you may send additional notes for those days.
  Example: *A 10 year old child with chronic lung disease has a CNR due in July. Your assessment indicates, however, that this child is always much sicker during the winter months, and during those months requires more frequent nebulizer treatments, oxygen, and suctioning. You would send in a CMS-485, MAR, and nurses notes for June-July, along with an additional 3-5 days of nurses notes from the previous winter.*

- You may send any additional documentation (e.g., medical reports) that you think may be helpful.

13.4 Getting the CNR Approved

Follow the instructions in Section 14 to get the CNR approved.

13.5 Actions If Approved

If continued CAP/C participation and the Plan of Care are approved, do the following:

- **Give the client/responsible person written notification** of continued CAP/C approval and the services that will be provided.

- **Give written notification to the DSS Medicaid staff** of CAP/C approval with a copy of the new cost summary. Also send a copy of the DMA Plan approval letter with the notification. Illustration 13-1 shows a sample DSS notification memo.

- **Initiate any changes in services** approved on the CNR Plan of Care and continue monitoring services. (See Section 11 for information on service coordination and monitoring.) Make the approved changes without delay so that the client gets the needed treatment and care. The Plan of Care is approved with the expectation that the services are going to be provided. If there are delays in providing services, consider alternative sources of care. The client's record must show the reason for any delays and document the actions taken to assure proper care.

  NOTE: *When the services cannot be promptly implemented, determine if the Plan can be revised to meet the client's needs. If the Plan can be revised, submit a Plan revision for approval. If it is not possible to meet the client's needs, immediately contact the DMA HCI Unit.*

Date

MEMORANDUM

TO: (Name of DSS Medicaid Contact)
(County) Department of Social Services

FM: (Name & Agency of Case Manager)

RE: Approval of CAP/C for (Name and Medicaid ID no. of client)

The above individual has been approved to continue participating in the CAP/C program. The Continued Need Review was approved on _____.

A copy of the approved Plan of Care Cost Summary that shows what CAP services are authorized is attached. A copy of the DMA Plan approval letter is also attached.

Please call me if you have any questions (case manager's phone number)

Attachments (2)

Illustration 13-1 – Sample DSS Notification Memo

13.6 Actions If Denied

If continued participation is denied, initiate the termination procedures in Section 17. The client has the right to appeal the termination. See Section 18 for information on appeals.

13.7 Paying For the CNR

Bill the CNR activities as Case Management following the guidance in 9.5 and Section 21.

14. 0 PLAN APPROVAL

For Medicaid to pay for a CAP/C service, the service must be approved in a Plan of Care according to Medicaid policies and procedures. This section tells who may approve Plans and describes the approval procedures. It is directed towards the case manager unless otherwise indicated.

CAUTION: *Approval of a CAP/C Plan of Care means that CAP/C participation has been approved and the CAP/C services in the Plan are approved. CAP/C Plan of Care approval does not constitute approval of regular Medicaid services. Providers of regular Medicaid services must follow Medicaid policies and procedures for those services. See Section 5 for information about Medicaid's community care services.*

14.1 Approval Authority

DMA is responsible for approving CAP/C participation and the CAP/C services the client may receive.

14.2 Applying CAP/C Criteria

The decision on whether an individual may participate in CAP/C and the services the individual may receive is based on the requirements in 1 and 1.2. The requirements and their application are as follows:

- The person is under 19 years of age. This is documented in part 1 of the Assessment. It is not necessary for the case manager to independently verify age as this will be accomplished during the Medicaid eligibility process.

- The child will live in a private residence while on the program. This is documented in parts 1 and 10 of the Assessment form.

- The person requires nursing facility care (ICF or SNF). The documentation is a current approved FL-2.

  NOTE: *DMA's HCI Unit determines the need for hospital level of care after eligibility for nursing facility care at the SNF level has been established on an FL-2 approved by the fiscal agent. See Section 8 for information on hospital level of care.*

- The person requires Medicaid coverage of CAP/C services in addition to CAP/C Case Management to remain safely at home. This must be supported by the overall assessment findings. The review of this item determines the current unmet needs that may be met only through Medicaid coverage of the CAP/C services.

  REMEMBER: *It is not the purpose of CAP/C to enable individuals to get Medicaid or regular Medicaid services.*

- The person desires to receive CAP/C services instead of institutional care. This is documented by the parent's signature on the client statement of understanding and agreements sections of the CAP/C Plan of Care where the client/responsible party indicates acceptance of the Plan and the choice to participate in CAP/C.

- The person is eligible for Medicaid under CAP/C as defined in Section 6. The DSS Medicaid caseworker handles this determination. The case manager coordinates eligibility referrals and questions as outlined in Section 6.

- The person will have his or her health, safety, and well being maintained at home within the Medicaid CAP/C cost limit. This is determined by reviewing the Assessment and Plan of Care. They must show that this requirement will be met. The formal and informal services on the Plan have to meet the needs identified on the Assessment. In addition, the average monthly Medicaid cost of the Plan must not exceed the CAP/C cost limits for the appropriate level of care.

  NOTE: *The case manager is responsible for being sure that the providers identified on the Plan are enrolled with Medicaid for the specific service.*

14.3 Getting DMA Approval

Send an approval request to DMA's HCI Unit within five workdays after the Plan is finalized. Include a cover letter requesting CAP/C approval and providing the following information:

- The client's name and Medicaid ID number;

- Whether the request is for an initial approval, a Plan revision or a CNR;

- Any significant issues that are not adequately covered in the Plan of Care; and

- Your name and phone number.

In addition to the cover letter, include the following with your request:

- **For initial approvals**, send the following items with the cover letter to your CAP/C consultant so that they will be received by DMA no later than 60 days after the FL-2 approval date:

  - A copy of the completed CAP/C Assessment;

  - A copy of the completed CAP/C Plan of Care;

  - A copy of the approved FL-2;

  - The Physician's Request Form, if the client receives CAP/C Nursing services (not nurse aide services); and

  - Any additional information that may be helpful, such as medical reports.

  NOTE: *If you have all of the information except the approved copy of the FL-2 from the fiscal agent, send a copy of the FL-2 with the phone approval information noted in blocks 12 and 13. You do not have to wait for the fiscal agent's approved copy.*

- **For revised Plans**, send the following items with your cover letter to your CAP/C consultant for approval so that it will be received by DMA no later than 30 days after the effective date of the revision:

- A copy of the revised Plan of Care;
- A copy of the new approved FL-2, if level of care has changed; and
- Any additional information that may be helpful.

***NOTE**: If a level of care change is involved and you have all of the information except the approved copy of the FL-2 from the fiscal agent, send a copy of the FL-2 with the phone approval information noted in blocks 12 and 13. You do not have to wait for the fiscal agent's approved copy.*

The provision for retroactive approvals and the availability of fax transmissions usually eliminate the need for getting an emergency approval by phone. If neither of those options will handle a specific emergency situation, contact your DMA CAP/C consultant. At its discretion, DMA may approve a Plan revision by phone. If a phone request is approved, you must confirm the request by submitting the written request to DMA within five workdays of the phone approval or the approval will be voided.

- **For CNRs**, send the following items with your cover letter so that they will be received by your CAP/C consultant for review and approval no later than the fifth day of the month following the CNR month:

  - A copy of the completed CAP/C Assessment;
  - A copy of the completed CAP/C Plan of Care;
  - A copy of the current FL-2;
  - The Physician's Request Form, if the client receives skilled nursing services; i.e. SCF level with a nurse, or HC level. (not nurse aide services); and
  - Any additional information that may be helpful, such as medical reports.

  For CNRs on hospital level clients, also send:

  - A copy of the most recent CMS-485 form
  - A medication administration record corresponding to the dates of the CMS-485 form
  - Three to five days of nurses notes corresponding to the dates on the CMS-485 form. It is best to select the days that the client required the most care. If the dates the client required the most care were not within the dates of the CMS-485 form, you may send additional notes for those days.
    ***Example:** A 10 year old child with chronic lung disease has a CNR due in July. Your assessment indicates, however, that this child is always much sicker during the winter months, and during those months requires more frequent nebulizer treatments, oxygen, and suctioning. You would send in a CMS-485, MAR, and nurses notes for June-July, along with an additional 3-5 days of nurses notes from the previous winter.*

***NOTE:** If a level of care change is involved and you have all of the information except the approved copy of the FL-2 from the fiscal agent, send a copy of the FL-2 with the phone*

approval information noted in blocks 12 and 13. You do not have to wait for the fiscal agent's approved copy.

DMA will either approve or deny the Plan or request additional information by phone or letter. Please respond within 15 days to the request for additional information to avoid further delays in the approval process.

DMA will make every effort to make the approval/denial decision no later than 15 workdays for a CNR, an initial, or a revision after all information has been received. The workday period begins the date all requested information is received. DMA will notify you of the decision by letter. DMA will also send a copy of the letter to the Medicaid supervisor in the appropriate county department of social services.

15. 0 ABSENCES

This Section provides guidance to the case manager on handling absences from CAP/C participation as well as breaks in services. The material is directed to the case manager.

15.1 Hospitalizations

When a client is admitted to a hospital, determine why the client was admitted, the prognosis and anticipated length of the absence from the home.

REMEMBER: *Carefully document all your findings, decisions and actions in case management notes. Be careful that your actions do not duplicate the responsibilities of the discharge planner – you may not bill for Case Management for those activities that are the responsibility of the discharge planner.*

15.1.1 Anticipated Hospitalization of 30 Days Or Less

When the client enters the hospital:

- Suspend all CAP/C services except for Case Management. Continue to provide Case Management that does not duplicate discharge planning – see 11.9 for details. None of the other CAP/C services may be billed to Medicaid for a client who is in institutional care. Notify service providers that CAP/C services are suspended and let them know you will contact them when services need to be resumed. (Telephone contact is acceptable, although written contact is preferred.)

- Notify the discharge planner that the client is on CAP/C. Ask the discharge planner to coordinate his or her actions with you, including FL-2 actions.

While the client is in the hospital:

- Monitor the client's situation through contacts with the discharge planner and other appropriate parties.

- Be alert to any changes that may extend the hospitalization beyond 30 days or result in a transfer to a nursing facility/rehabilitation center.

  - When the hospitalization is over 30 days, follow the procedures in 15.1.2.

  - If the client is transferred to a nursing facility/rehabilitation center, contact the HCI unit so that termination procedures may be initiated. You will be asked to coordinate this date in conjunction with the DSS Medicaid staff according to the procedures in 17.3.

    EXAMPLE: *Jane Client is admitted to the hospital with the anticipation that she will be discharged to her home after five days. While in the hospital, she develops an infection that extends the stay. On the 20th day, her physician decides that it will be best for Jane to be admitted to a rehab center for several weeks following discharge so that she can receive therapy and other needed care. The rehab center care is billed to Medicaid as NF care. At this point, contact the HCI Unit.*

When the client is expected to be discharged:

- Determine the client's medical situation and related home care needs through contacts with the physician, discharge planner and other appropriate parties. Remember to document your findings in case management notes.

  - Confirm the current approved FL-2 level of care. If the level of care is different at discharge, obtain a new FL-2 from the physician and get the fiscal agent's approval.

  - Determine whether the Plan of Care needs to be revised and take necessary action. If you find that the person's health, safety, and well-being can no longer be met with CAP/C assistance in the home setting, contact the HCI Unit.

    REMEMBER: *The client may need short-term, intensive services, such as under Medicaid Home Health, that need to be included in the Plan.*

- Alert CAP/C providers about when to resume care.

- Inform the DSS Medicaid staff that the client continues on CAP/C. Confirm that the client still has an active CAP indicator in the Eligibility Information System (EIS) – it should not have been removed during the client's hospitalization. If the client's level of care has changed from the level of care prior to hospitalization, inform DSS in writing of the effective date of the CAP indicator change (this is the effective date of the new level of care).

  NOTE: *Because the absence does not exceed 30 days, it is not necessary to treat the client as a new applicant. You do not have to complete a new assessment and POC to reinstate the indicator code.*

After the client returns home, verify that services have resumed and are appropriate for the client's situation.

- If Home Health services have been ordered, a RN from the home health agency will usually make a visit to the client's home shortly after the return home – contact the home health nurse to get an evaluation of the client's situation and to verify what Home Health services are planned.

- Revise the Plan of Care if needed and send to the HCI Unit for approval.

- Continue to use the same CNR schedule.

15.1.2 Hospitalization for Over 30 Days

Hospital stays over 30 days affect Medicaid eligibility and CAP participation. If the client is hospitalized for over 30 days, contact the DSS Medicaid staff to learn when the client's Medicaid status will change. Convey that information to HCI Unit so that termination procedures can be initiated.

- If the client is to be discharged to his home before the proposed effective date of termination, alert the DSS Medicaid staff and the HCI Unit about the client's return

home. If the client's responsible party wishes to resume CAP/C, use the following procedures:

When the client is expected to be discharged:

- Determine the client's medical situation and related home care needs through contacts with the physician, discharge planner and other appropriate parties. Remember to document your findings in case management notes.

- Confirm the current approved FL-2 level of care. If the level of care is different at discharge, obtain a new FL-2 from the physician and get the fiscal agent's approval.

- Determine whether the Plan of Care needs to be revised and take necessary action. If you find that the child no longer meets CAP/C criteria, notify the HCI Unit so that termination procedures may be initiated.

  REMEMBER: *The client may need short-term, intensive services, such as under Medicaid Home Health, that need to be included in the Plan.*

- Alert CAP/C providers about when to resume care.

- Inform the DSS Medicaid staff that the client continues on CAP/C. Confirm that the client still has an active CAP indicator in the Eligibility Information System (EIS) – it should not have been removed prior to the proposed effective date of the DSS Medicaid eligibility change. If the client's level of care has changed from the level of care prior to hospitalization, inform DSS in writing of the effective date of the CAP indicator change (this is the effective date of the new level of care).

After the client returns home, verify that services have resumed and are appropriate for the client's situation.

- If Home Health services have been ordered, a RN from the home health agency will usually make a visit to the client's home shortly after the return home – contact the home health nurse to get an evaluation of the client's situation and to verify what Home Health services are planned.

- Revise the Plan of Care if needed and send to the HCI Unit for approval.

- Continue to use the same CNR schedule.

- If the client is discharged after the effective date and the client wishes to participate in CAP/C, consider the individual as you would any individual applying for the program.

  NOTE: *A person who leaves and re-enters the program during the same waiver year continues to count as one person against the CAP/C allocation. The allocation is a count of individuals who participate during the waiver year. It does not matter if they leave and return to the program during the year.*

15.2 Stays In Rehabilitation Centers and Nursing Facilities

Admission to a nursing facility or a rehabilitation center that is billed to Medicaid as NF care affects Medicaid eligibility and CAP participation. If the client is admitted to a nursing facility/rehab center, contact DMA's HCI Unit so that termination may be initiated.

Because many clients are in nursing facilities/rehabilitation centers for short-term rehabilitation stays that do not exceed thirty days, there is a simplified procedure for returning these individuals to CAP/C. If the client is returning home from the nursing facility/rehab center in less than 31 days and wishes to resume CAP/C, proceed as follows:

NOTE: *The client has already been terminated from CAP/C due to the NF admission. These procedures do not reverse that termination. The nature of this short absence allows the use of a simplified process to get the individual back on the program without requiring all the procedures used for considering a new participant.*

Step 1 ***Prior to discharge*** gather information to help the HCI Unit review the child's situation. Determine the client's medical situation and related home care needs through contacts with the physician, discharge planner and other appropriate parties.

Step 2 The HCI Unit will determine if resumption of CAP/C appears appropriate given the child's current situation.

- ***Resumption Appears Appropriate:*** If resumption of CAP/C seems appropriate, the CAP/C consultant will request that you develop a new Plan of Care and submit it for approval. You also may be requested to obtain a new FL-2 from the physician and get prior approval from the fiscal agent. Go to Step 3.

  REMEMBER: *The client may need short-term, intensive services, such as under Medicaid Home Health, that need to be included in the Plan.*

- ***Resumption Appears Inappropriate:*** If the HCI staff determines that resuming CAP/C appears inappropriate, a CAP/C consultant will contact the parent/responsible party by letter to relay that information. When appropriate, the CAP/C consultant will also provide guidance on any known alternatives. You will receive a copy of that letter. The HCI Unit's evaluation is intended as guidance for the parent/responsible party to help in the care decisions for the child. Even if the HCI Unit determines that resumption appears inappropriate, the parent/responsible party may request that it to be considered.

  - If the parent/responsible party accepts the determination of the HCI Unit, the process ends at this step.

  - If the parent/responsible party wishes the process to continue, contact the HCI unit. The HCI Unit will request you to develop a new Plan of Care, obtain the fiscal agent's approval of a new FL-2, and send the material to the unit. Go to Step 3.

Step 3 The HCI unit will review the submitted material and inform you of the decision.

- ***Resumption Approved:*** If the HCI Unit approves resumption of CAP/C and approves the Plan of Care, notify the parent/responsible party in writing of the CAP/C approval and the services that will be provided. Put a copy of the notice in the child's file. Go to Step 4

- ***Resumption Denied:*** If the HCI Unit denies resumption, it will be handled as a denial of a new application. See 7.9.

Step 4 Get the participation resumed for the child. The procedures are similar to those for a new applicant. Do the following:

- Notify the DSS Medicaid worker in writing of CAP/C approval. The CAP effective date will be the date of discharge. Send a copy of the Cost Summary (pages 2 and 3 of the Plan of Care) with the notification and a copy of DMA's approval letter. The notification will be like that in Illustration 7-4. Follow-up with DSS to assure that the notification was received and the CAP indicator has been entered into the Eligibility Information System. Check the client's Medicaid ID card the next month to see if the CAP indicator (IC for ICF, SC for SNF or HC for Hospital) is in the CAP block on the card.

- Initiate the CAP/C services approved on the Plan of Care and begin monitoring those services. (See Section 11 for information on the case management activities.) Start services without delay to assure that the child receives the necessary treatment and care. The Plan is approved with the expectation that the services are going to be provided. If there are delays in starting services, consider alternative sources of care. The client's record must show the reason for any delays and document the actions taken to assure proper care.

  NOTE*: Contact the HCI unit at any point that you recognize that the approved CAP/C services cannot be initiated. If the services cannot be implemented as approved within 30 days of your notification of the Plan approval, a determination will have to be made whether the Plan can be revised and still meet the child's needs, or the child will have to be terminated from the program.*

  If Home Health services have been ordered, a RN from the home health agency will usually make a visit to the client's home shortly after the return home – contact the home health nurse to get an evaluation of the client's situation and to verify what Home Health services are planned. Revise the Plan of Care if needed and send to the HCI Unit for approval.

- Bill the case management time activities prior to NF discharge as you would if the client was a new applicant being assessed prior to nursing facility discharge. The key entry is the "Place of Service" code in form locator 24B of the CMS-1500. Enter 31 or 32 according to the level of care in the nursing facility/rehab center. See Illustration 20-4 in Section 20 for complete billing instructions. Do not submit the claim until DSS has re-entered the CAP indicator.

- Continue to use the same CNR schedule after readmitting the client to CAP/C.

NOTES: *A person who leaves and re-enters the program during the same waiver year continues to count as one person against the CAP/C allocation. The allocation is a count of individuals who participate during the waiver year. It does not matter if they leave and return to the program during the year.*

15.3 Temporary Absences From Area

When a client temporarily leaves the county, suspend the delivery of CAP/C services by contacting the provider agencies. The length of the absence needs to be tracked, as an extended absence can affect Medicaid eligibility. If the absence is expected to be over 30 days, the local DSS Medicaid staff should be notified. If the client expresses the need for home care assistance while temporarily absent from the county, but remains within the state, Home Health is an option that could be considered (the recipient could not be out of the county for greater than 30 days, and the home health guidelines would have to be met).

REMEMBER: *If the client remains on CAP/C during the absence (that is, the CAP indicator is still active), Medicaid covered home care services need to be included in the Plan of Care.*

16. 0 CASE MANAGEMENT AGENCY TRANSFERS

CAP/C clients must have a CAP/C case manager from a Medicaid enrolled CAP/C case management provider to participate in the program. This section provides guidance on transfers between CAP/C case management agencies. Transfers usually are caused by a move out of a case management agency's service area. Because many of the CAP/C case management agencies are county agencies, a move out of the county often means locating a new case management agency. Transfers may also occur within a county when multiple CAP/C case management agencies are available. The ability to accomplish a transfer depends on the availability of another CAP/C case management agency that can immediately accept the client. The parent/responsible party works with your agency, the new agency and the HCI Unit to accomplish a transfer.

NOTE: *A "transfer" occurs when a client moves from one CAP/C case management agency to another CAP/C case management agency without a break in CAP/C participation. When a break in participation occurs, the client will be considered a CAP/C applicant by the new agency. The new agency will go through the complete process in Section 7. This is not a "transfer" within the context of this section.*

16.1 Case Management Agency Transfer Policy

A case management agency should have a written policy on handling requests for the transfer of a CAP/C client from another agency. The policy should address whether current CAP/C clients are accepted for transfer or placed on a waiting list with other potential new clients. It is important that all transfers are handled consistently by the agency.

REMEMBER: *A "transfer" is when there is no break in CAP/C services. If your agency's policy places potential transfers on a waiting list, the client will be terminated from CAP/C upon discharge from his or her current CAP/C case management provider. You will have to go through the procedures in Section 7 to initiate CAP/C for the child.*

16.2 Notifying DMA of Possible Transfers

If your client is leaving your agency and the parent(s)/responsible party wants to continue the child's participation in CAP/C, notify the DMA HCI Unit immediately.

16.3 Transfer Basics

When a transfer occurs:

- There is a 14 day transition period for the new agency to review and re-authorize services. Service authorizations from the current agency remain in effect during the transition period unless changed or terminated by the new agency. The count of days begins on the transfer date - that is, add 13 days to the transfer date to calculate the last day of the period.

  Example: *The client requests a transfer to be effective January 5. The transition period is January 5 through January 18.*

- Beginning on the transfer date, the new agency handles level of care considerations and Plan of Care issues as it would an ongoing case - that it, it obtains a new FL-2 if it believes the level of care has changed, revises the Plan of Care as needed, and handles any care issues with the HCI Unit.

- The client's CNR date remains the same after the transfer.
- The last day that the current agency may bill for Case Management is the day prior to the transfer date.
- The first day that the new agency may bill for Case Management is the transfer date.

NOTE: *If the transfer is related to the client moving to another county, keep in mind that the Medicaid eligibility staff must end date CAP coverage when the client moves. It is very important that you coordinate your actions on transfers with the Medicaid staff in both counties. See 16.7.*

16.4 Client Responsibilities

To initiate a transfer, the parent/responsible party:

- With the assistance of the current CAP/C case manager and the HCI Unit, locates a new CAP/C case management agency that agrees to provide the service and confirms with the new agency when it will be able to begin providing Case Management; and
- Gives a signed statement to both the current agency and the new agency in advance of the transfer that:
  - Indicates the intent to change agencies;
  - Shows the name of the current agency;
  - Shows the name of the new agency;
  - States the date of the change; and
  - Gives permission for the current agency to release copies of the current FL-2, assessment, Plan of Care and related information to the new agency.

16.5 Current Agency Responsibilities

The current agency – the agency providing Case Management prior to the transfer – works with the parent/responsible party and the HCI unit to help locate a new CAP/C case management agency. This is part of discharge planning and is a billable case management activity.

If you are the case manager in the current agency, take action to smooth the transfer. When you receive the client's signed transfer request, including permission to release information to the new agency, make sure that all the key parties are informed.

- Call the new case management agency to get the name of its contact person for handling the transfer.
- If the client is moving, arrange for CAP/C Nursing and/or CAP/C Nurse Aide (Personal Care) Services, as applicable, to continue in the client's new home during the transition period. Determine if the client is moving out of the service area of the current provider(s) – if so, work with those providers, the new case management agency, and the client/responsible party to authorize services from a new agency.

- Send a notice to each current provider of CAP/C services that tells the provider:
  - The transfer date;
  - The date that your authorization for services ends - the last day of the transition period;
  - If the client ***remains*** in the provider's service area, to expect an authorization from the new case management agency before your authorization ends;
  - If the client is ***moving*** out of the provider's service area, the date to end CAP/C services – either the date of the move or an earlier date if desired by the parent(s)/responsible party;
  - The new case management agency may change or stop the services prior to the end of the transition period; and
  - The name, address and phone number of the new case management agency, plus the name of a contact at the agency.
- Notify DSS in writing of the transfer. See 16.7.
- Send a notice to each provider of the other community services, such as Home Health, that tells the provider that case management responsibilities are being transferred. Include the transfer date and the name, address, phone number and contact person for the new case management agency.
- Send a copy of each of the above notices, plus a copy of the current FL-2, assessment, Plan of Care and service authorizations to the new agency.

16.6 New Agency Responsibilities

When the new agency receives the client's signed transfer request, it informs the current agency of the contact person to handle the transfer. The new agency begins planning to complete its transfer activities.

Beginning on the transfer effective date, the new agency is responsible for the client. It has 14 days to have new service authorizations in the hands of the providers.

If you are the case manager in the new agency, immediately review the client's situation to determine if changes in services are needed. Visit his home, go over his most recent assessment and current Plan of Care, and contact providers and caregivers as needed. Document your findings in your case management notes.

- Revise the Plan of Care as needed and obtain the HCI Unit's approval. Initiate changes as soon as you see that they are needed - do not wait until the end of the transition period to change or stop services. At a minimum, you must send in to DMA a copy of assessment sections 1, 3, 4, and 8 with updated information.
- If the level of care seems inappropriate, contact the client's physician about a new FL-2.
- Establish working relationships with the CAP/C providers, the other community care services providers, the client's Medicaid worker at DSS, and the others involved in the client's care.

- Perform the other Case Management activities outlined in Section 11.

16.7 Coordination with Medicaid Eligibility Staff

Notify the DSS Medicaid eligibility staff of the change in CAP/C case management agencies. If the change involves a move to another county, remember that the Medicaid eligibility staff must stop CAP coverage when the client leaves the county. Eligibility staff in the new county will need to re-enter the CAP indicator code so that the child will once again have CAP coverage. It is therefore very important that you coordinate your actions on transfers related to a move between counties with the Medicaid staff in both counties.

Include the effective date and the name, address, contact person and phone number for the new case management agency. Remind DSS in the notice that this transfer does not affect eligibility for CAP/C and DSS does not need to take any action in EIS.

17. 0 TERMINATIONS

This section provides guidance on terminating CAP/C participation. The termination may be due to a variety of reasons, including ineligibility for Medicaid, institutionalization, or failure to qualify for program participation. Depending on the reason, termination may be initiated by the county department of social services or DMA's HCI Unit. The HCI Unit is responsible for sending the termination of CAP/C notice to the client and responsible party.

The following material covers the usual situations. It is directed to the case manager. Contact your DMA CAP/C Consultant if you need additional guidance or have a situation not covered in this section.

17.1 Medicaid Eligibility Terminations

If DSS proposes to terminate the client's Medicaid eligibility, it will send a notice to the client/responsible party. Medicaid rules determine the timing of the notice. In most instances, it is sent at least 10 workdays prior to the proposed date of action. The notice will state the proposed termination date, the reason for termination, and appeal rights. Medicaid terminations usually are effective the last day of the month. In some instances, the client's eligibility for Medicaid will continue through the appeal process.

The DMA CAP/C Nurse Consultant should take the following actions when DSS terminates Medicaid eligibility:

- Inform the client in writing that CAP/C participation and all services in the Plan will terminate when eligibility for Medicaid ceases. Send a copy of the letter to the Case Manager.

The Case Manager should take the following actions when DSS terminates Medicaid eligibility:

- Continue CAP/C services as long as the client remains eligible for Medicaid and CAP/C. If the client continues to receive Medicaid as the result of an appeal request, continue CAP/C services as long as the client continues to otherwise meet CAP/C criteria.

- Notify service providers in writing of termination of CAP/C participation due to termination of Medicaid eligibility. Promptly document that notice.

17.2 Level of Care Terminations

When the client's physician recommends other than ICF or SNF care on the FL-2 or the fiscal agent will no longer approve ICF or SNF care, the client must be terminated from CAP/C.

- If the physician does not recommend either NF or Hospital level of care, follow the termination procedures in 17.4. There is no appeal of the physician's recommendation as DMA may not overturn the recommendation.

- If EDS will not approve the level of NF care requested by the physician, the client may appeal the decision. See 18 for details.

  NOTE: *If the client is appealing the decision to DMA, the client may continue CAP/C services until the outcome of that appeal process as long as the client meets all other eligibility*

requirements. If the appeal process does not overturn the fiscal agent's decision, initiate termination actions according to the procedures in 17.3.

- If DMA terminates hospital level of care, the client may appeal the decision. See 18 for details.

17.3 CAP/C Terminations

Terminations are completed with full regard for the client's rights, including those related to a fair hearing. Both the DMA HCI Unit and the case management agency have responsibilities in the termination process.

17.3.1 Case Manager's Responsibilities

When any of the following occur, immediately notify the DMA HCI Unit by phone. The CAP/C consultant will tell you what additional information is required.

- The client dies.
- The client is to be admitted to a nursing facility or ICF/MR.
- The client's hospital stay extends over 30 days, causing the client to be considered as in long term care for Medicaid eligibility purposes.
- The client is being discharged by the CAP/C case management agency and there is not a new agency to provide services. See Section 16 to also consider a possible transfer. A CAP/C client must have a CAP/C case manager to participate in the program.
- The client/responsible party withdraws from the program by providing a signed statement that clearly states that he/she no long desires to participate in CAP/C. This includes withdrawals because the client is starting services with another CAP program. You may use the signed statement provided by DMA, or you may create your own form that has the same information.

  REMEMBER: *Withdrawals due to moving to another CAP program must be carefully coordinated with the new CAP program case manager, DMA's HCI staff, and the Medicaid eligibility worker.*

- The patient is approaching his nineteenth birthday. Eligibility for CAP/C expires on the day before the nineteenth birthday. The last day of services is the day before the client turns 19. No CAP/C services are to be provided on the day of the nineteenth birthday.
- Adequate care cannot be provided for the client to meet the health, safety and well-being criteria. The usual reasons include but are not limited to:
  - The client's living situation presents needs that cannot be met.
  - The client/responsible party does not receive needed services. Notify the HCI unit if the family has gone without nursing or aide services for more than 30 days

or if there is a recurring problem staffing the services, whether it is because the client refused to accept services/caregivers or because there is not an enrolled provider available.

- The client/responsible party fails to comply with care requirements as stated in the letter of understanding.

- The client requires more care than may be safely provided in the home
- The client's healthcare care needs can not be met within the CAP/C cost limit for his or her level of care.

As case manager, you serve as contact person for both the client and the DMA HCI Unit. In addition to notifying the DMA HCI Unit of possible causes for termination, your responsibilities include:

- Clarifying the reasons for termination with the client and client's family.
- When you receive a letter from the HCI Unit that services are terminated, notifying service providers to discontinue services when the termination is final and documenting that notification. If notified by the HCI Unit that services are to resume due to an appeal, again notifying the service providers and documenting that notification. Continuing all case management activities if services are resumed until notified of the final appeal decision. If there is an appeal, but the recipient is not eligible to continue their current services, case managers should still keep at least monthly contact with the family to monitor for changes in the child's health or needs, particularly those changes that could affect the initial decision or the outcome of the appeal. Notify DMA of these changes. In all cases, if a CNR comes due while an appeal is outstanding, please do the CNR and submit it to DMA..
- Clarifying procedures for requesting a hearing as needed with the client/family and assisting in the appeals process. See Section 18 for details.
- Immediately notifying the DMA HCI Unit by phone if the client's situation changes so that a proposed termination may no longer be appropriate.
- Keeping the DMA HCI Unit informed of any requests for a hearing.

17.3.2 DMA HCI Unit Responsibilities

The DMA HCI Unit is the agency that actually terminates CAP/C participation. Before acting, the DMA HCI Unit will obtain input from you. If termination has to be pursued, the DMA HCI Unit will notify you of the decision by phone and coordinate actions with the Medicaid eligibility staff as needed.

17.3.3 Termination Effective Date

The proposed effective date depends on the cause of the termination and the type of notice required. See Illustration 17-1 Termination Guide for the effective date and cause of

terminations. This guide should assist you in planning the discharge arrangements with the family.

Generally, the effective date and the timing of the notice depend on whether the change was initiated by the client or DMA.

Client Initiated: If the client either states in writing that he wants a service to be reduced or terminate ***or*** gives information that requires a termination or reduction of a service and indicates that he understands that termination or reduction will be the result of supplying that information:

- The effective date of the action must be as soon as possible; and
- The notice is sent before or on the effective date of the action by DMA.

DMA Initiated: If DMA initiates a Plan to reduce or delete a CAP/C service:

- The effective date of the action may be no earlier than 10 calendar days after the notice is mailed to the client.

17.3.4 Notice to the Client

For terminations other than those due to the client's death, the DMA HCI Unit sends the client a written notice. A copy of the notice is sent to you and the Medicaid eligibility supervisor.

For DMA-initiated terminations, the notice includes the following:

- A statement that clearly identifies the action that is being taken by CAP/C. If the action is a reduction, the statement includes the amount of the reduction.
- The reason(s) for the action.
- Reference(s) from the CAP/C policy, rule, law, or regulation or other applicable DMA publications supporting the action.
- The effective date of the action.
- The client’s right to request a fair hearing.
- The time frame for requesting a fair hearing. This is 60 days from the date of the notice.
- An explanation regarding the conditions for continuing the service at its previously approved level pending the hearing decision.

For client-initiated terminations, the notice includes the following:

- A statement that clearly identifies the action being taken. If the action is a reduction, the statement includes the amount of the reduction.

- The reason(s) for the action.
- The effective date of the action.

17.4 Withdrawals Due To Acceptance by Another CAP Program

When a CAP/C client is moving to another CAP program, the client/responsible party withdraws from CAP/C before beginning participation in the other program. The timing of the withdrawal must be carefully coordinated with the client, both CAP programs, the HCI Unit, provider agencies and the DSS Medicaid worker. Immediately contact the HCI Unit when you become aware that a client is applying for another CAP program.

17.5 Readmissions

If a former CAP/C client wishes to be readmitted to CAP/C, consider the client a new participant and follow the procedures in Section 7. A person who leaves and re-enters the program during the same waiver year continues to count as one person against the program's annual limit. The annual limit is a count of individuals who participate during the waiver year - it does not matter if they leave and return to the program during the year.

Note: *For a patient who has been terminated due to exceeding the cost limitations secondary to equipment costs, those costs will still be considered on the plan of care if the client reapplies within the one year proration period.*

Termination Guide

Death	
Proposed Effective Date	Date of death
Notice Is Sent On…	No notice is sent
Stop Services On…	Date of death
Reinstate Services if hearing requested?	Not applicable
Admission To NF Client is to be admitted to a nursing facility, including rehabilitation facilities paid by Medicaid as a nursing facility	
Proposed Effective Date	Date of admission
Notice Is Sent On…	Before or on the date of admission
Stop Services On…	Date of admission
Reinstate Services if hearing requested?	No (Refer to 15.2 if client is discharged in 30 days or less)
Hospital Stay Over 30 Days Client 's hospital stay extends over 30 days, causing the client to be considered as in long term care for Medicaid eligibility purposes	
Proposed Effective Date	Because the CAP termination is linked to DSS changing the client's Medicaid eligibility status, the effective date is the same as the effective date of the status change.
Notice Is Sent On…	Before or on the proposed effective date
Stop Services On…	Proposed effective date ***REMEMBER****: Though the client's eligibility for CAP will continue in EIS until the effective date, the client may not receive CAP services other than as described in 15.1 while in the hospital.*
Reinstate Services if hearing requested?	No (Refer to 15.1.2 if client is discharged before proposed effective date)
CAP/C Case Management Not Available (See Section 16 to consider a possible transfer.)	
Proposed Effective Date	Date of discharge from the current CAP/C case management agency
Notice Is Sent On…	Before or on the proposed effective date
Stop Services On…	Proposed effective date
Reinstate Services if hearing requested?	No
Move Out Of Private Residential Setting Client moves out of his/her private residence to a setting such as an adult care home (such as a rest home, group home or family care home)	
Proposed Effective Date	Date of the move
Notice Is Sent On…	Before or on the proposed effective date
Stop Services On…	Proposed effective date
Reinstate Services if hearing requested?	No

Illustration 17-1 – Termination Guide

Termination Guide - *Continued*

Withdrawal Client or responsible party withdraws from the program by providing a signed statement that clearly states that he/she no longer desires to participate in CAP/C. *See 17.4 for additional guidance when the withdrawal is due to acceptance in another CAP program.*	
Proposed Effective Date	Date that the client or responsible party indicates he/she wishes to withdraw. If there is no withdrawal date given by the client or responsible party, the termination will be effective the last day of the month in which the withdrawal was requested.
Notice Is Sent On…	Before or on the proposed effective date
Stop Services On…	Proposed effective date
Reinstate Services if hearing requested?	No
Fiscal Agent Decides No Longer NF Level of Care **The fiscal agent** determines that the client no longer qualifies for NF level of care and all appeals/reconsiderations of that decision are final.	
Proposed Effective Date	Last day of the month following completion of the 10 day advance notice period
Notice Is Sent On…	At least 10 workdays before the proposed effective date. Coordinate actions and the proposed date with DSS Medicaid staff so that both have the same proposed effective dates.
Stop Services On…	Proposed effective date
Reinstate Services if hearing requested?	If the client requests a hearing no more than 10 days after the effective termination date, services may be reinstated pending a hearing decision. If services are reinstated, the case manager must inform the client that if the termination decision is upheld, DMA may hold the client responsible for the payment for the services.
Physician Decides No Longer NF Level of Care The client's physician determines that the client does not qualify for NF level of care – that is, the physician indicates other than IC or SN on the FL-2	
Proposed Effective Date	The last day of the month in which the case manager obtains the physician's recommendation
Notice Is Sent On…	Before or on proposed effective date
Stop Services On…	Proposed effective date
Reinstate Services if hearing requested?	No

Illustration 17-1 – Termination Guide *(Continued)*

Termination Guide - *Continued*

Health, Safety and Well-Being Cannot Be Met Adequate care cannot be provided for the client to meet the health, safety and well-being criteria. The usual reasons include: • The client's living situation presents needs that cannot be met. • The client or responsible party refuses to accept needed services. • The client or responsible party fails to comply with care requirements. • Enrolled providers are not available to render needed services. This may be due to insufficient resources in the county or agencies refusing to provide care.	
Proposed Effective Date	Last day of the month following completion of the 10 day advance notice period. ***EXAMPLE:*** *You determine on September 22 that the client cannot be maintained safely in the home and DMA sends the client a written notice. Because the 10 workday period goes into October, the proposed effective date is October 31.*
Notice Is Sent On…	At least 10 workdays before the proposed effective date. Coordinate actions and the proposed date with DSS Medicaid staff so that both have the same proposed effective dates.
Stop Services On…	Proposed effective date unless the client requests a hearing prior to or on the proposed effective date.
Reinstate Services if hearing requested?	If the client requests a hearing no more than 10 days after the effective termination date, services may be reinstated pending a hearing decision. If services are reinstated, the case manager must inform the client that if the termination decision is upheld, DMA may hold the client responsible for the payment for the services.
Cost Limit Exceeded The client requires more care than may be covered in the CAP/C cost limit for which the client is approved. ***REMEMBER:*** If the client's needs have exceeded the SNF budget a request for Hospital level of care may be appropriate. Call a CAP/C consultant to discuss the case.	
Proposed Effective Date	Last day of the month following completion of the 10 day advance notice period.
Notice Is Sent On…	At least 10 workdays before the proposed effective date. Coordinate actions and the proposed date with DSS Medicaid staff so that both have the same proposed effective dates.
Stop Services On…	Proposed effective date unless the client requests a hearing prior to or on the proposed effective date. If services are continued pending a hearing, the case manager must inform the client that if the termination decision is upheld, DMA may hold the client responsible for the payment for the services.
Reinstate Services if hearing requested?	If the client requests a hearing no more than 10 days after the effective termination date, services may be reinstated pending a hearing decision. If services are reinstated, the case manager must inform the client that if the termination decision is upheld, DMA may hold the client responsible for the payment for the services.

Illustration 17-1 – Termination Guide *(Continued)*

Termination Guide - *Continued*

CAP/C Services Not Needed The client does not require CAP/C waiver services (other than possibly case management) to remain safely at home.	
Proposed Effective Date	Last day of the month following completion of the 10 day advance notice period.
Notice Is Sent On…	At least 10 workdays before the proposed effective date. Coordinate actions and the proposed date with DSS Medicaid staff so that both have the same proposed effective dates.
Stop Services On…	Proposed effective date unless the client requests a hearing prior to or on the proposed effective date. If services are continued pending a hearing, the case manager must inform the client that if the termination decision is upheld, DMA may hold the client responsible for the payment for the services.
Reinstate Services if hearing requested?	If the client requests a hearing no more than 10 days after the effective termination date, services may be reinstated pending a hearing decision. If services are reinstated, the case manager must inform the client that if the termination decision is upheld, DMA may hold the client responsible for the payment for the services.

Illustration 17-1 – Termination Guide *(Continued)*

18. 0 APPEALS OF CAP/C DECISIONS

This section outlines the appeals process for the denial and termination of CAP/C participation. At the end of the section there is general information on appeals of Medicaid eligibility and level of care decisions to help you refer your client to the appropriate persons or agencies. See the Termination Guide in Section 17 for guidance on continuing services while an appeal is in process.

There are certain actions that may affect an individual's receipt of CAP/C services that may not be appealed. These include:

- **A provider's termination or denial of services**. A provider of CAP/C services and other Medicaid services may refuse to serve a CAP/C client. The provider's decision may not be appealed to Medicaid.

  EXAMPLE: *Suzie's mother has been verbally abusive to the personal care aides who have provided care for Suzie. The provider agency has worked with the case manager in trying to alleviate the problem, but the child's mother continues to be abusive. The provider agency refuses to continue serving the client.*

- **A physician's level of care recommendation** may not be appealed to Medicaid.

  EXAMPLE: *Mrs. Brown wants CAP/C services for her son, Johnnie. However, Johnnie's physician states that he does not need the level of care provided in a nursing facility. Mrs. Brown's only option is to pursue the matter with Johnnie's physician.*

- **A physician's order for services** may not be appealed to Medicaid. Medicaid only pays for services recommended by a physician. If the client's physician recommends termination or denial of a service, the physician's recommendation may not be appealed to Medicaid.

  EXAMPLE: *Mrs. Frazier believes that her daughter would benefit from physical therapy and requests that this service becomes a part of her Plan of Care. The client's physician states physical therapy is not needed and refuses to order the service. Mrs. Frazier's only option is to pursue the issue with her daughter's physician.*

18.1 Client Right to Appeal

18.1.1 Terminations

A client has the right to appeal when CAP/C participation is terminated for one of the following reasons:

- Admission to a nursing facility or ICF/MR.
- Hospital stay over 30 days.
- Move out of a private residential setting (such as into an adult care home or group home).
- Health, safety and well-being cannot be assured.
- CAP/C Case Management Services not available.
- Care exceeds cost limit.

- Not qualified for NF care
- Does not need CAP/C services to remain in the home.

See chapter 17 for procedures and appeal rights related to terminations.

18.1.2 Denial

The client also has the right to appeal the denial of CAP/C participation. A denial of CAP/C participation means that the initial Plan of Care is not approved by DMA and services will not be initiated for an individual who:

- Is approved for ICF or SNF level of care.
- Is eligible for the appropriate category of Medicaid.
- Has been assessed for CAP/C.

If the client appeals the denial, CAP/C participation may not begin until the issue under appeal is resolved and all CAP/C requirements are met.

18.1.3 Other

In addition to the right to appeal a denial or termination of program participation, a CAP/C client has the right to appeal:

- A reduction of a CAP/C service in the Plan of Care,
- A termination of a CAP/C service in the Plan of Care,
- A denial of a request to increase an existing CAP/C service in the Plan of Care, and
- A denial of a request to add a CAP/C service to a Plan of Care.

There is an exception to the above when a reduction or termination of a service is the result of a Federal or State action requiring an automatic change that adversely affects some or all recipients. DMA will inform the local lead agencies when this exception applies as part of the notice of any such action.

Denied Service Request – Current CAP/C Client

If a CAP/C client asks about getting an additional CAP/C service or increasing an existing CAP/C service, the case manager discusses the implications of the possible change with the client. This includes the case manager's assessment of whether the change is likely to be approved. If the requested revision does not appear appropriate; however, the client requests that the revision be considered:

1. The case manager prepares a revised plan to include the requested change and obtains the client's signature. Section 12, Revising the Plan of Care, provides the guidance for preparing and processing Plan revisions.
2. The case manager submits the proposed revised plan to DMA to make the approval decision.

3. If the revision is denied, DMA notifies all affected parties of the decision The written notice to the client will contain

    - A statement that clearly identifies the CAP/C service that is being denied or is not being increased. If the requested action is an increase, the statement includes the amount of the increase being denied.

    - The same information listed in section 17.3.4 of this CAP/C Manual.

Denied Service Request – Potential CAP/C Client

If someone applying for CAP/C asks about getting an additional CAP/C service or an increased amount of a proposed CAP/C service, the case manager discusses the implications of the possible change with the client. This includes the case manager's assessment of whether the change is likely to be approved. If the client wants to pursue his request, he has two options:

1. The client may proceed through the CAP/C approval process based on the proposed Plan of Care prepared by the case manager, and, if CAP/C participation is approved, request a revision to the Plan; ***or***

2. The client may ask that the proposed plan be amended to include his request with the understanding that the approval of CAP/C participation will be based on the amended plan. A denial of the plan will result in a denial of CAP/C participation.

If the client chooses the second option:

1. The case manager rewrites the proposed plan to include the requested changes and obtains the client's signature

2. The case manager submits the proposed plan and related documentation to make the approval decision to DMA. If the participation based on the requested plan is denied, DMA sends a denial notice.

3. If the client appeals the denial, CAP/C participation may not begin until the issue under appeal is resolved and all CAP/C requirements are met.

18.2 Appeal Procedures

When the DMA HCI Unit denies or terminates CAP/C for one of the reasons noted in 18.1, a hearing officer from the Division of Social Services holds the appeal hearing. The arrangement that allows DSS to hold the hearings helps assure the objectivity of the hearing decision. The hearing is held in the county where the client resides.

The CAP/C consultant from the DMA HCI Unit who is assigned to the case has the primary role in this process, preparing the information for the hearing and representing the State's position. As case manager, your help is needed to coordinate actions, assemble information, and keep the client informed.

18.2.1 Time Limit For Requesting A Hearing

The client has 60 days from the date the denial or termination was mailed to request a hearing.

18.2.2 Submitting the State Hearing Request

If the client requests a hearing, the case manager immediately notifies the DMA CAP/C consultant who made the denial or termination decision of the client's request for a State appeal. DMA completes a Request for State Appeal (DSS-1473) with guidance and assistance from the CAP/C Case Manager as needed, and forwards it to the Division of Social Services in Raleigh.

18.2.3 Continuation of the Service Pending Appeal Decision

Whether the service continues beyond the proposed effective date of the action depends on the client's action regarding an appeal. The client may continue to receive the service at the previous level or a lower level pending an appeal decision in certain situations.

- ***Stop/reduce the service*** on the proposed effective date unless the client requests a hearing prior to or on the proposed effective date ***and*** the client requests that services be continued.

- ***Reinstate the service*** if the client requests a hearing no more than 10 calendar days after the effective date ***and*** the client requests that the service be reinstated pending a hearing decision.

During the appeal process, the case manager continues the usual activities regarding the other services on the Plan of Care, including recommending changes to services or deleting services to DMA as appropriate. This documentation becomes a part of the patient's file. Revisions and CNRs will only be approved by DMA, however, on an emergency basis, and approval is contingent on the appeal decision.

Example 1*: The proposed Plan reduces CAP/C Nurse Aide (Personal Care) Services from 8 hours per day Monday through Friday, to 6 hours per day Monday through Friday, effective August 1. The proposed Plan contains a nutritional supplement at the same level as the previous POC. The reduction is put into effect November 1. On November 3, the client requests an appeal and the reinstatement of the CAP/C Nurse Aide (Personal Care) Services at the previous level. Reinstate the Nurse Aide (Personal Care) Services at 8 hours per day, Monday through Friday.*

Example 2*: The scenario is the same as above with the exception that the client does not request an appeal until November 15. In this instance, the Nurse Aide (Personal Care) hours remain at the new level – 6 hours per day, Monday through Friday.*

18.2.4 Scheduling the State Hearing

The State hearing officer will schedule the hearing within 90 days of the date of the request. The hearing officer notifies the client, the case management agency, and the CAP/C consultant of the date, time, and location of the hearing.

18.2.5 Preparing For the State Hearing

The DMA CAP/C Consultant handling the case has the primary responsibility for preparing for the hearing; however the consultant will need your help gathering information. The consultant submits a case summary to the hearing officer containing the following information:

- Client's name, address, and Medicaid identification number.
- Description of the issue.
- Reason(s) for denial/termination.
- References from the CAP/C manual supporting denial or termination, with copies of the referenced policy attached.
- Copy of the denial/termination notice sent to the client.
- Name, agency address, and phone number of consultant.
- Name, agency address, and phone number of case manager.

18.2.6 Conducting the Hearing

A hearing officer from the Division of Social Services will conduct the hearing. State hearings are usually held at the county DSS. DMA's CAP Consultant presents the reasons for DMA's decision. Because the decision is based on information that you provided to the consultant, your participation in the hearing is needed to verify the accuracy of the information and assist the consultant as appropriate.

18.2.7 The Hearing Decision

The State hearing officer will notify the client and the case management agency of the decision by certified mail within 90 days of the date the hearing was requested.

- If the decision is upheld, the case manager terminates services effective no more than two workdays after both the client/responsible party and case manager are aware of the hearing decision.

  EXAMPLE: *The hearing officer issues a decision on November 1 that the termination of CAP/C for Sammie Alleghany was correct. The case manager receives the decision on Friday, November 3. She immediately calls Mrs. Alleghany to verify that she is aware of the decision and notifies her that Tuesday, November 7 will be the last day of coverage for CAP/C services. The case manager follows-up with calls to the providers to terminate CAP/C services.*

- If reversed, the case manager, acting on guidance from the HCI Unit, continues or initiates services, as appropriate.

- **If a denial is reversed,** Medicaid coverage is available for all CAP/C services provided according CAP/C policies and procedures retroactive to the CAP effective date.

- **If a termination is reversed,** Medicaid coverage is available for all CAP/C services provided according to the client's latest approved CAP/C Plan of Care retroactive up to the effective date of the proposed termination. The services must have been provided according to the policies and procedures in this manual.

REMEMBER: *Notify the DSS Medicaid staff of the decision.*

18.3 Other Appeals

Though appeals on Medicaid eligibility decisions and level of care decisions are not "CAP appeals," the following general information will help you work with your clients.

18.3.1 Appealing Medicaid Eligibility

The county departments of social services (DSSs) take applications and determine eligibility for Medicaid. If your client wants to appeal a decision about eligibility for Medicaid, refer the individual to the local DSS. The client has at least 60 days from the date of the notice of denial or termination to request an appeal. An impartial official of the county department of social services will hear the appeal, make a decision, and notify the individual of the decision. If the individual disagrees with the decision and wants another hearing, he must contact the department of social services and request a State hearing. A hearing officer from the North Carolina Division of Social Services will conduct this hearing.

EXAMPLE: *Felicia was in an automobile accident over a year ago which left her a quadriplegic and in need of intensive home care services. She has been participating in CAP/C since the accident. You have just been informed by the Medicaid case worker that Felicia is no longer eligible for Medicaid because of a change in her financial situation resulting from an insurance settlement. You contact Felicia's parents and advise them that CAP/C participation will terminate at the time Medicaid eligibility terminates. They want CAP/C services to continue and disagree with the decision to terminate. CAP/C participation cannot be appealed in this situation because the child is no longer eligible for Medicaid. If the parents disagree with the Medicaid eligibility decision, they may request a hearing with the DSS. If Medicaid eligibility continues pending a hearing decision, the client remains eligible for all Medicaid services for which she qualifies, including CAP/C, until the Medicaid eligibility termination is final.*

18.3.2 Appealing Level of Care Decisions

The client may appeal the fiscal agent's decision on the nursing facility level of care as well as a DMA decision on hospital level of care. The fiscal agent reviews FL-2s for DMA and either approves or denies the level of nursing home care (ICF or SNF) recommended by the client's physician. The DMA HCI Unit makes hospital level of care decisions – the fiscal agent must first approve the individual for SNF care before hospital level is considered.

- If your client was referred for ICF or SNF care and disagrees with the decision made by the fiscal agent, you or the physician may submit additional information to the

fiscal agent on behalf of your client supporting the level of care that was recommended by the physician. If the fiscal agent does not change its decision after reviewing the additional information, the fiscal agent will notify the county DSS of its decision. The client may appeal the decision to the Division of Medical Assistance.

EXAMPLE: *The case manager is coordinating Sonya's CNR. Her condition has improved, and although the physician continues to recommend ICF, the case manager is not certain she still meets ICF criteria. She contacts the fiscal agent. The fiscal agent reviews the FL-2 and states that Sonya does not meet ICF criteria. The case manager informs Sonya's parents that CAP/C will terminate. They want to appeal the decision. Sonya's parents may appeal the level of care decision.*

- If DMA denies a request for hospital level of care and the client disagrees with the decision, a DMA hearing may be requested. Contact the CAP/C consultant to initiate the request. The consultant will see that the parent/responsible party receives a written denial and instructions for requesting an appeal.

19. 0 PROVIDER ENROLLMENT

Provider enrollment is part of the effort to assure that services are provided to CAP/C clients by qualified agencies. A provider must be enrolled with DMA for a specific CAP/C service to be entitled to payment for that service.

NOTE: *A provider of regular Medicaid services does not need a CAP provider agreement to provide the regular services to a CAP client. For example, an enrolled home health agency does not need a CAP provider agreement to provide skilled nursing visits to a CAP/C recipient.*

19.1 The Purpose of Enrollment

An agency's enrollment with DMA does two things:

- It documents that the agency agrees to provide services to Medicaid recipients under the conditions of enrollment; and
- Allows the agency to be paid according to Medicaid policies and procedures for the services that it provides to Medicaid recipients.

19.2 Who May Be Enrolled

An agency's enrollment depends on three factors:

- It must meet the qualifications to provide the service(s) for which it wishes to be enrolled. See Section 4 for the qualifications for each CAP/C service.
- It must agree to all of the conditions of participation.
- It must complete and submit the appropriate enrollment forms to DMA's Provider Services Unit. Forms and additional information can be found at http://www.dhhs.state.nc.us/dma/provenroll.htm.

19.3 Responsibilities of an Enrolled Provider

The provider agency is responsible for meeting the terms of the provider participation agreement. The conditions of participation are included in the agreement. Please refer to the agreement, found on the DMA website at http://www.dhhs.state.nc.us/dma/Forms/provenroll/cap.htm. In addition to the responsibilities listed there for all Medicaid providers, there are additional responsibilities specific to CAP/C.

Responsibilities specific to CAP/C include:

- Rendering the services as authorized by the CAP/C case manager.
- Making documentation of the provision of CAP/C services available to the CAP/C case manager as well as the other parties required by Medicaid policies and the participation agreement. See Section 20 for record keeping requirements.
- Promptly notifying the CAP/C case manager of changes in the client's situation and needs.

- Promptly notifying the CAP/C case manager and other appropriate parties of any difficulties with the delivery of the service.

19.4 Requesting Enrollment as a New CAP Provider

A single application and agreement is used to apply for enrollment to render CAP services for any of the CAP programs and for all business locations in which the provider is authorized by law or regulation to render the service.

The following outlines the basic steps for an agency to be enrolled with DMA. They are in the order that they are usually accomplished. The information is directed to a potential provider.

Step 1 Review Provider Qualifications

Review the provider qualifications in Section 4 for the service that you wish to provide. Be sure that you meet those qualifications before requesting enrollment.

Step 2 Request Enrollment Forms

Contact DMA's Provider Services Unit to request an application and provider agreement. See Appendix B for the address and phone number. These can also be found on the DMA website at http://www.dhhs.state.nc.us/dma/provenroll.htm.

Step 3 Send Completed Forms to Provider Services

Complete the forms as instructed by Provider Services. Be sure the forms contain the required signatures. Send the forms to Provider Services at the address in Appendix B. The effective date of enrollment may be no earlier than the first day of the month in which the completed forms are received by Provider Services.

NOTE: *Send all copies of the agreement to DMA. Please do not remove the provider copy of the participation agreement. It will be signed and returned to you if your enrollment is approved by DMA. See Step 4.*

Step 4 Receive Notification of DMA's Action

If your agency is approved for enrollment, Provider Services will:

- Assign your agency a provider number for the service;
- Notify your agency in writing of the provider number and its effective date; and
- Send your agency a signed copy of the provider participation agreement.

Provider Services will notify you if your request is denied or if there are questions.

19.5 Changing Services in the Agreement

If an enrolled CAP provider wishes to add or delete services from its agreement, it follows the same basic steps as for the initial enrollment. The provider:

- Makes sure that it is qualified to provide any services that it wishes to add to the agreement;
- Contacts Provider Services for forms and instructions to amend the agreement; and
- Sends the completed, signed forms to Provider Services.

Provider Services will send you written notification of its action on the request. You may not bill for services prior to receiving written approval from Provider Services.

19.6 Changing Agency Ownership

The Medicaid participation agreement is not transferable. If a provider agency is sold or merged with another agency, the new entity must be enrolled if it wants to continue to be paid by Medicaid. The new agency must notify DMA's Provider Services Unit within 5 days of the action if it wishes to continue as a Medicaid provider. If the notification is received after 5 days, there may be a break in enrollment. A break in enrollment means that no Medicaid payments will be available between the date of the change in ownership and the effective date of the new enrollment.

19.7 Other Agency Changes

An enrolled provider notifies DMA's Provider Services in writing:

- *Within 15 working days* if it no longer meets Medicaid provider enrollment requirements. This includes the failure of the agency to be qualified to provide the service for which it is enrolled.

  CAUTION: *If an agency does not meet Medicaid requirements at the time a service is rendered, the service is not covered by Medicaid. If the agency is paid for such a service, the payment is subject to recoupment by DMA.*

- *Within 5 days* if the agency changes its name, address or IRS number for reasons other than a change in ownership. See 19.6 for information about changes in ownership.

19.8 Terminating Enrollment

If a provider no longer wishes to be enrolled, it notifies DMA's Provider Services Unit in writing. The participation agreement may be terminated without cause by either party with written advance notification to the other party at least 30 days before the termination date. In addition, participation may be terminated as outlined in the agreement and in Medicaid policies.

Also send notice in writing to the HCI Unit Supervisor at least 30 days before the termination date. A notice of 120 days is preferred so that there is adequate time to find another provider.

If your agency's Medicaid enrollment is ending, remember to contact the CAP case manager to coordinate the transfer or termination of any services that your agency is providing to CAP/C clients.

20. 0 DOCUMENTATION AND RECORDS

The case management agency and other CAP/C providers must document services and keep records according to Medicaid requirements. A provider must document the provision of a service before seeking Medicaid payment. The provider's records must provide an audit trail for services billed to Medicaid.

This section provides the Medicaid requirements for client records maintained by the CAP/C case management agency, including those for the case management agency services – Case Management, Home Mobility Aids, CAP/C Waiver Supplies, and case management agency supplied Medicaid medical supplies. Case management agencies must also keep related personnel, financial and other management records as required by the Medicaid Provider Participation Agreement, the policies and procedures in this manual, Medicaid rules, and State and Federal law. The requirements for other CAP/C providers and services are in 11.11 of the *Medicaid Community Care Manual*.

REMEMBER: *This section includes Medicaid's minimum requirements for client records and related information. Nothing in this section relieves a case management agency or other provider from the licensing rules and other applicable requirements.*

20.1 How Long Records Must Be Kept

The provider must maintain the records for five years from the date of service.

20.2 Availability of Records

The provider must furnish information regarding its Medicaid payments that is requested by DMA and its agents, the Office of the Attorney General, the Department of Health and Human Services, the Center for Medicare and Medicare Services, and any other entities specified in the Medicaid Provider Participation Agreement. In addition, the provider must allow the CAP/C case manager to review the documentation that supports a claim for CAP/C services. HIPAA Privacy regulations 45 CFR Part 164.502 and .508 allow for disclosure of this information without client authorization for payment activities including but not limited to review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges.

20.3 What the Case Management Agency Keeps

The case management agency maintains client records that contain:

- All FL-2's.
- CAP/C Assessments and Plans of Care, Plan revisions, and related correspondence.
- DMA Plan approval letter.
- Physicians' orders for Medicaid Medical Supplies provided by the Case Management Agency and nutritional supplements provided as a component of Waiver Supplies.
- Service authorizations.
- Notice of CAP/C participation to providers of Medicaid home and community care services.

- Case management records as required in 20.6.
- Other correspondence related to the client's participation in CAP/C.
- Copies of claims that it submits to Medicaid and third party payers as well as related correspondence.

NOTE: *Electronic records, when applicable, are acceptable.*

REMEMBER: *If the case management agency provides other CAP/C services, such as CAP/C Nurse Aide (Personal Care), it follows the instructions in the Medicaid Community Care Manual for documenting those services.*

NOTE: *When another CAP/C provider bills services, DMA does not expect the case management agency to maintain copies of the other agency's service documentation. The case manager reviews the material according to Section 11. DMA does not require the case manager to maintain copies of the material in the case management agency records.*

20.4 Information Common to All Client Records

All records (both case management agency and provider records) must contain the client's name and MID as on the Medicaid ID card. Service documentation must contain:

- What service was provided;
- The date that the service was provided;
- Where the service was provided; and
- The required documentation for the specific service – see 20.5 and 20.6.

20.5 CAP/C Records for Case Management Agency Services

In addition to the information required for all services – the information listed in 20.4 – the case management agency maintains the following specific information for each service:

- **Case Management:** The case management agency keeps case management notes signed by the case manager that document client assessment and ongoing case management activities to plan, coordinate, and monitor care. CAP/C Case Management notes are written in a running narrative and include all contacts and activities related to your client's care. They document the date of the case management activity; the time (in minutes) involved in the activity; and a description of the activity. Each entry must contain sufficient detail to support your claim for reimbursement. For example, if the activity involved a telephone call, the entry must briefly describe the purpose of the call. A brief summary is sufficient. The notes may be handwritten or typed. Illustration 20-1 shows a sample of case management notes.

  NOTE: *If the notes are computer-generated or typed and the same case manager completed all of the activities that are documented on a single page, the case manager may sign once at the bottom of the page. The case manager also enters the date that the page was signed beside the signature. If the notes are handwritten, the case manager signs each entry.*

- **CAP/C Waiver Supplies:** The case management agency maintains an invoice from the supplier that shows the date the item was provided to the client, a description of the item, and the cost of the item, including charges for delivery and taxes. If nutritional supplements are provided, there must be signed physician's orders for the supplement in the record.

- **Home Mobility Aids/Home Modifications:** The case management agency maintains an invoice from the supplier/installer that shows the date the item was provided to the client, a description of the item, and the cost of the item and related charges (applicable charges for delivery, installation, and taxes). For Home Mobility Aids that require permits for construction or installation, a receipt for the permit is required if the cost is claimed.

- **Medicaid Medical Supplies:** When Medicaid Medical Supplies from the Home Health list are supplied by the case management agency, the agency maintains an invoice from the supplier that shows the date the item was provided to the client, a description of the item, and the cost of the item, including charges for delivery and taxes. The records must also include a signed physician order for all items billed.

  REMEMBER: *If these supplies are provided by a home health agency as a Home Health service, the agency follows its regular Medicaid requirements for providing, billing, and documenting the service.*

20.6 What Providers of the Other CAP/C Services Keep

Documentation requirements for the other CAP/C services are in 11.11 of the *Medicaid Community Care Manual.* In addition to the information required for all services – the information listed in 20.4 – the provider maintains:

- Service authorizations from the CAP/C case manager, including any amendments to those authorizations, and related correspondence.

- Copies of claims submitted to Medicaid and third party payers, as well as related correspondence.

- Specific service documentation:

  - **CAP/C Nursing Services:** Nursing notes that fully document the provision of the service and the care and treatment provided to the client. The notes must establish when the care was provided, document all nursing interventions (time, activity and results), and substantiate that care was provided according to the physician's orders and CAP/C service authorization. In addition to providing documentation for billing, nursing notes are periodically reviewed by the case manager and the HCI staff to determine the continuing need for CAP/C Nursing Services as well as assisting in level of care determinations.

  - **CAP/C Nurse Aide (Personal Care) Services:** Time logs kept in either weekly or daily formats maintained by each aide that provides services. After providing the service, the aide enters the date of service, the time the service begins, the time it ends, and the tasks performed. The aide signs and dates the log to certify that he/she worked the time and dates listed, and performed the indicated tasks. The client/responsible party must sign the log to certify that the tasks were performed satisfactorily and the time is correct.

- **Respite Care:** Records that document the dates and times that the care was provided, where it was provided, and who provided the care.

Name: Janie Smith		**MID/Record#:** 999-99-9999 A
DATE	**TIME**	**ACTIVITIES**
5-11-00	80'	Faxed notice of approval with DMA's approval and cost summary to Susie Jones, DSS Medicaid case worker. Also completed and mailed notice of approval to Janie's parents. Telephoned Happy County Home Health; spoke with Jonetta Jackson, supervisor, and finalized arrangements for CAP/C Nursing Services; completed and faxed service authorization and a copy of the plan of care. Telephoned Mrs. Smith to let her know that the nurse would begin work on Monday, 4-15. Completed and mailed notices of CAP/C participation to Good Health Medical Supply Company regarding DME items and related supplies.
TOTAL	80'	
5-12-00	9'	Telephoned Ralph Rampbuilder to request that ramp be built as soon as possible based on specifications and estimate previously agreed upon; will have it completed by 5/21 at latest.
5-12-00	4'	Received telephone call from Frank at Good Health Medical Supply to clarify directions to Janie's home. Tub bench and new wheelchair will be delivered tomorrow.
TOTAL	13'	
5-18-00	9'	Received telephone call from Ralph Rampbuilder who advised that ramp is completed. Advised that I would visit client and inspect ramp tomorrow. Telephone call to Mrs. Smith; she is making arrangements to meet with me tomorrow at her home during her lunch hour.
TOTAL	9'	
5-19-00	77'	Home visit today. Verified that ramp was satisfactorily completed. Discussed nursing services with Mrs. Smith and she feels things are going well. I observed that the nurse interacted well with Janie. Reviewed the flow chart and progress notes which indicated that appropriate services were being provided by the nursing agency. Also spoke with the nurse to review service provision and confirmed that the service plan is appropriate to Janie's needs.
TOTAL	77'	
6-1-00	10'	Reviewed and approved claims from Happy County Home Health for CAP/C Nursing Services covering service provision in April. No discrepancies between amount authorized and billed were noted.
TOTAL	10'	
SIGNATURE _____		**DATE** _____

Illustration 20-1 – Sample Case Management Notes

21. 0 FILING CLAIMS

Payment is available for the CAP/C services that are provided according to Medicaid's policies and procedures. Sections 11 of the *Medicaid Community Care Manual* contain instructions for filing claims for CAP/C services other than those provided by CAP/C case management agencies. The manual can be found on the DMA website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm, section 3. The following is provided for the benefit of the case management agency staff, including the CAP/C case managers. It is directed at the provider agency unless otherwise indicated.

21.1 Who's Involved In Claims Processing

In addition to the CAP/C case manager and the CAP/C provider agencies, the following have a role in the processing of claims:

- **DMA** establishes what services are covered, how they are paid and the payment rates. It contracts with a fiscal agent to process claims. The roles within DMA are:
  - **Provider Services Unit** handles enrollment of providers.
  - **Claims Analysis Unit** assists in resolving claims problems related to Medicaid eligibility.
  - **Third Party Recovery (TPR) Section** handles third party payment issues. You send claims involving third party payers through this section. Also, the TPR Section recovers Medicaid payments when third party payers are identified after a claim has been paid.
  - **Rate Setting Unit** establishes rates for Medicaid services.
  - **Medicaid Management Information System (MMIS) Unit** coordinates operation of the claims processing system with the fiscal agent, and establishes codes and system controls.
- The fiscal agent is responsible for the payment of Medicaid claims. In addition to processing claims, it offers assistance in claims matters through several methods:
  - **Telephone Inquiry Services**, handled by service relations analysts, answer questions about claims payments, pending claims, claims filing, obtaining forms and covered services. The service is available Monday through Friday from 8:00 a.m. to 4:30 p.m. at the number in Appendix B.
  - **Automated Voice Response,** an automated phone response system, is available to handle provider inquiries about Medicaid eligibility and eligibility-related information, claims status, checkwrites, and DME prior approval, plus a number of other topics. Calls must be made from a phone with touch-tone capability. See the Basic Medicaid Billing Guide at http://www.dhhs.state.nc.us/dma/prov.htm#pub.
  - **Provider Representatives** are available to assist providers through visits and training. They will research individual provider problems and suggest ways to improve your processing of claims. Representatives can be contacted through the fiscal agent's numbers listed in Appendix B.

21.2 Who May File A Claim

You may file a claim with Medicaid if you are enrolled with DMA to provide the service you are billing, and the service is provided according to Medicaid policies.

21.3 What May Be Billed

You may bill for the services that you provide to Medicaid recipients when the services are provided according to Medicaid policies and procedures. You must be qualified and enrolled with DMA to provide the service that you bill. It must be provided as approved on the client's CAP/C Plan of Care and ordered by the client's CAP/C case manager.

CAUTION: *Medicaid is responsible for paying for a service as it is approved on the client's CAP/C Plan of Care. If a CAP/C case manager orders something not approved on the Plan of Care, payment is resolved between the local CAP/C case management agency and the provider agency. Remember that CAP/C case managers may authorize only CAP/C services.*

Appendix C shows the unit of service and the maximum payment for each CAP/C service. The fee schedule can also be found on the DMA website at http://www.dhhs.state.nc.us/dma/fee/fee.htm.

- **For Case Management**, billable activities include those listed in Section 11 when you complete them for a specific CAP/C client. Bill your customary charge for the units provided to the client for each date of service. Convert the total minutes provide on each date of service to 15-minute units following the same procedures as those used for CAP/C Nurse Aide (Personal Care), CAP/C Nursing, and Respite Care - In-Home Nursing Or In-Home Nurse Aide.

  See 9.5.4 for information about billing for an initial assessment of an individual who does not become a CAP/C participant.

- **For CAP/C Waiver Supplies**, bill the lower of your cost for the item, including delivery charges and taxes, plus 10 percent for overhead, ***and*** the Medicaid maximum rate listed on the applicable Medicaid fee schedule. Your cost is what you pay the supplier.

- **For Home Mobility Aids**, bill your cost for the item, including applicable installation and delivery charges, taxes, and permit fees. Your cost is what you pay the supplier/installer.

- **For Respite Care - Institutional**, bill your Medicaid institutional rate for the client's level of care for the calendar days of respite provided to the client.

- **For the following services**, bill your customary charge for the units provided to the client for each date of service.

  CAP/C Nursing
  CAP/C Nurse Aide (Personal Care)
  Respite - In-Home Nursing
  Respite – In Home Nurse Aide

The above services are billed in 15 minute units. Though a full 15 minutes of service is expected to be provided for each unit billed, at times it will not be possible to complete a service exactly in a 15 minute period. At those times, you convert time to units as follows:

Step 1 Total the amount of time spent providing the service during the day.

Step 2 Divide the total by 15 to get the number of full units.

Step 3 Add an additional unit if the remainder is 8 minutes or more.

EXAMPLE: *A CAP client receives 28 minutes of Case Management in the morning, and 12 minutes in the afternoon - a total of 40 minutes. 40 divided by 15 equals 2 units with a remainder of 10. Because the remainder is greater than 8, an additional unit may be billed. A total of 3 units may be billed.*

- **For Regular Medicaid Medical Supplies Provided By The Case Management Agency,** bill your cost for the item, including delivery charges and taxes. You may add up to 10 percent for overhead. Your cost is what you pay the supplier.

21.4 What You Will Be Paid

The basis for your payment depends on the specific service. Appendix C shows the maximum payment for each service as of March 1, 2006. See 21.5 for information about payments involving third parties.

- **For CAP/C Waiver Supplies**, the payment is based on the lower of the billed amount and the maximum allowable rate for the item on the applicable fee schedule.

- **For Home Mobility Aids/Home Modifications**, the payment is based on the billed amount subject to the annual limit.

- **For Medicaid Medical Supplies by the case management agency**, the payment is based on the lower of the billed amount and the maximum allowable rate for the item on the Home Health fee schedule.

- **For Respite Care - Institutional**, the payment is based on the Medicaid rate for the client's type and level of care.

- **For the following services**, the payment is based on the lower of the provider agency's billed customary charge and the maximum rate:

Case Management	CAP/C Nurse Aide (Personal Care)
CAP/C Nursing	Respite Care - In-Home Nursing
	Respite Care - In Home Nurse Aide

21.5 Third Party Coverage

Medicaid is the payer of last resort, unless there is an exemption from this requirement specifically included in federal law. The key points to remember are:

- Unless otherwise noted, you must pursue payment from other parties, such as Medicare, CHAMPUS/CHAMPUS-VA and private insurers when a client has such coverage for the

rendered service. In addition to the coverage identified on the Medicaid ID card, you must ask the client if other coverage exists and pursue that coverage.

- If a third party covers the service and pays less than Medicaid's allowable charge, you may bill Medicaid for the difference between the third party payment and the Medicaid maximum allowable.

- If the third party payment is more than the Medicaid allowable charge, you must accept that payment as payment in full. Medicaid will not pay the difference between the charge and the third party payment. You may not bill the client for the difference.

- State and Federal third party liability (TPL) laws mandate that Medicaid not pay for services denied by private health plans due to non-compliance with those private plan requirements. If the service would have been a covered service and payable by the private plan, but some requirement of the plan was not met, then Medicaid will not pay for this service.

Instructions for the usual situations involving third party coverage follow.

21.5.1 Payment Equals or Exceeds Medicaid Rate

If the third party pays you an amount equal to or more than Medicaid's maximum allowable charge, do not bill Medicaid. You must accept the third party payment as payment in full.

21.5.2 Payment Less Than Medicaid Rate

If the third party payment is less than the Medicaid allowable charge, you may submit a claim to Medicaid for the difference between the third party payment and the Medicaid allowable charge. Include the third party information on the claim.

21.5.3 Payment Denied By Third Party

If the third party denies payment of a properly submitted and documented claim, you may bill Medicaid. Attach a copy of the insurance denial to the Medicaid claim form that is sent to the fiscal agent.

An acceptable denial is a letter or EOB from the insurance company or a letter from the group/employer on the employer's letterhead. If the denial is questionable, such as a returned claim with "applied to deductible" noted, send the claim with the denial and a completed DMA-2057, Health Insurance Information Referral form, to the TPR Section. The form is available on the DMA website at http://www.dhhs.state.nc.us/dma/forms.html#tpr.

If you cannot get a written denial, send a completed DMA-2057 to the TPR Section with your claim.

NOTE: *Blue Cross/Blue Shield will not verify coverage for DMA; therefore, you must obtain written denials for such coverage. A printout from a Blue Cross/Blue Shield terminal is acceptable.*

21.5.4 Potential Coverage Not Available

If you identify potential coverage on the Medicaid ID card or through information from the patient, you must verify whether it exists for your service. If the insurer does not cover the service or states that there is no coverage (the coverage was canceled or never existed), send the claim with a completed DMA-2057 to DMA's TPR Section at the address in Appendix B.

Within 10 workdays of receiving the material, the TPR Section will verify the information and either return the claim to you with instructions or send it to EDS for processing.

21.5.5 Insurer Pays Client

If the private insurer pays the client, you may bill the client for the amount of the insurance payment.

- If the amount is unknown, you may bill the client for the total charges until the amount is determined.
- When you determine the amount of the payment, you may bill Medicaid if the amount of the payment is less than the Medicaid allowable charge. Enter the amount of the private insurer's payment in the appropriate block of the claim form.
- You may continue to bill the client for the amount of the insurance payment until you are paid that amount by the client

21.5.6 Payment Related To Injuries and Illnesses

In instances where a third party may be liable for coverage of an injury or illness, such as those due to an on-the-job illness not covered by Workmen's Compensation or those due to accidents, you may immediately file a Medicaid claim by sending a completed claim with a DMA-2043 to the TPR Section at the address in Appendix B. This can be found on the DMA website at http://www.dhhs.state.nc.us/dma/forms.html#pr. When you file the Medicaid claim, you give up the right to make a claim against the responsible party's insurer or the patient's attorney. Once Medicaid makes payment, the state of North Carolina has a subrogation claim against the responsible individual.

21.5.7 Third Party Payment After Medicaid Payment

If you learn of third party health insurance coverage after being paid by Medicaid, you should file your claim with the health insurance carrier and refund to Medicaid the lesser of the two payments.

EXAMPLE: *You provide a service to a Medicaid patient for which your charge is $50. You are unaware of possible third party payment; therefore, you file a Medicaid claim. Medicaid pays you $40 for the service. Later, you learn that the patient may have private insurance coverage. You file a claim with the insurer and are paid $45. You must reimburse Medicaid $40 - the amount it paid you.*

Send a check for the refund made payable to the fiscal agent with a completed Medicaid Refund form to the address in Appendix B.

In "tort" cases such has auto accidents, worker compensation claims, and medical negligence, once you file a claim with Medicaid and have received payment, your claim has been paid in full. Upon receipt of payment from the third party liability carrier, you must refund to Medicaid the amount of Medicaid's payment and you must also refund to the patient or the liability carrier any remaining amount. By billing Medicaid and receiving payment, the provider relinquishes any right upon Medicaid's payment for that service through assignment and subrogation. This includes the prohibition of the provider billing for or receiving a recovery for the difference between the amount Medicaid paid and the provider's full charges. This practice violates both State and Federal laws.

The provider has the option to defer billing Medicaid and instead to pursue a claim for full charges with the liability carrier. As long as the provider has filed a claim with the liability carrier within one year from date of service, and is diligently pursuing reimbursement from that liability carrier, the provider may file a claim with Medicaid within 180 days of a denial or payment from the insurance carrier or attorney, even though it may be greater than the 12-month time limit for filing with Medicaid.

NOTE: *Please help DMA keep its records accurate. If you discover that the insurance information on the Medicaid ID card is wrong, please send a completed DMA-2057 to TPR or notify your county DSS.*

21.5.8 Medicaid Treatment of Insurance Plan Payments and Denials

The recipient and the provider both have responsibility for complying with private plan requirements. If the recipient did not inform the provider of the existence of the recipient's private plan, and the plan's requirements were not met because the provider was unaware of them, the provider may bill the patient for those services if both the private plan and Medicaid deny payment due to noncompliance.

Similarly, if a recipient fails to cooperate in any way in meeting any private plan requirement, the provider may bill the recipient for the service(s). However, if the recipient presents the private payer information, and the provider is aware that the provider is not a participating provider in that plan or cannot meet any other private plan requirement, the provider must inform the recipient of that fact and that the recipient will be responsible for payment. Recipients and providers were notified of this policy in November 1997.

21.6 Time Limits

The fiscal agent must receive your claim within:

- **365** days of the date of service; or
- **Within six months** of Medicare or other third party payment, or final denial when the date of that action is beyond the 365 day limit. See the additional information below about applying this six month limit.

You may have a claim processed based on the six month third party payer's rule if:

- You filed the third party claim within the applicable 365 day time limit;
- There was a possibility of receiving payment from the third party; and
- You made bona fide and timely efforts to get a payment or a final denial from the third party.

DMA may waive the above time limits if the client's Medicaid eligibility determination leaves you with less than 60 days to submit the claim for an eligible date of service.

21.7 How to Prepare a Claim

The CMS-1500 form is used to file claims for CAP/C services. Instructions for completing the CMS-1500 are in Illustration 21-1. A sample claim is shown in Illustration 21-2. Both illustrations are at the end of this section.

21.8 Electronic Claims

You may file a claim electronically to reduce the potential for errors in claims processing and speed payment to your agency.

The process of submitting claims to Medicaid through electronic media is referred to as Electronic Claims Submission (ECS). This type of claim submission offers the provider a low-cost, highly reliable alternative to paper claim submission. The fiscal agent currently processes claims through the following electronic formats: modem, magnetic tape, and diskette. Ninety percent of all Medicaid claims are currently submitted electronically.

For more information on electronic claims, contact the fiscal agent at the address in Appendix B. Information can also be found on the DMA website in the most current version of the Medicaid Billing Guide, http://www.dhhs.state.nc.us/dma/medbillcaguide.htm.

21.9 Signature on File Certification

You may file a paper claim without a signature if your agency has submitted a Provider Certification for Signature on File to the fiscal agent. A copy of the certification form may be obtained by calling the fiscal agent’s Provider Services Unit. The certification is signed by an individual who has authority to sign contracts on behalf of the agency. The signature on the certification must be an original signature - do not use a signature stamp.

Send the completed certification at least two weeks before submitting a claim without a signature to the fiscal agent’s Provider Relations at the address in Appendix B.

21.10 Submitting Claims

Send the paper claim or a printout of the electronic claim to the CAP/C case manager for approval before sending it to the fiscal agent. The case manager will review the claim to see if it accurately reflects authorized services.

CAUTION: *Do not send a paper or an electronic claim to the fiscal agent before the case manager approves the claim. Claims submitted and paid by Medicaid without the case manager's approval are subject to recoupment by DMA.*

- **Accurate Claims:** The case manager approves a "paper claim" by signing the bottom of the claim form. The case manager either returns the claim to the provider or sends it to the fiscal agent according to the agreement between the provider and case manager. The case manager approves an electronic claim by signing the bottom of the printout and returning the printout to the provider agency.

- **Inaccurate Claims:** The case manager contacts the provider agency to resolve the discrepancy.

NOTE: *It is very important for case managers to promptly review claims, resolve any discrepancies and approve claims for payment. Case managers and CAP/C providers are encouraged to work cooperatively to establish and maintain a good workflow for claims approval.*

21.11 When to Expect Payment

The payment system checks for eligibility on the date of service, looks for duplicate claims, verifies nursing facility level of care prior approval, verifies CAP/C eligibility, checks charges against maximum allowable rates and completes other operations to control payment. If a "detail" or line item on a claim is "clean" - that is, the system detects no errors in relation to its controls, the fiscal agent processes it for payment.

Checks are issued on a regular schedule referred to as the "Checkwrite Schedule." The schedule is printed in the monthly *Medicaid Bulletin*. The check is sent directly to the enrolled provider agency. It covers all items on the claim that cleared the system controls. Note that a claim may be paid or partially paid. A partially paid claim is one for which some, but not all, details are paid.

EXAMPLE: *A claim for CAP/C Case Management for services on July 8 and July 15 is submitted. If the line or "detail" for July 8 has no errors, and the line or "detail" for July 15 contains an error, payment will be made for the July 8 services as a partial payment of the claim. The claim for July 15 will have to be corrected and resubmitted.*

NOTE: *Providers can speed receipt of payment and avoid potential lost checks by authorizing the fiscal agent to directly deposit the payment in the agency's checking or savings account. The fiscal agent can electronically transfer funds to the agency's account through its "automatic deposit" process. Contact the fiscal agent's Finance Unit for details.*

HOW TO COMPLETE THE CMS-1500

1.	Place an **X** in the MEDICAID block.
1a INSURED'S ID NUMBER	Enter the client's Medicaid ID number (nine digits and the alpha suffix) from the client's Medicaid ID card.
2. PATIENT'S NAME	Enter the client's last name, first name and middle initial from the Medicaid ID card.
3. PATIENT'S BIRTH DATE/SEX	Enter the recipient's date of birth using eight digits. ***EXAMPLE:*** *June 14, 1999 is* **06141999***.* **Note:** A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims. Place an **X** in the appropriate block to show the client's sex.
4. INSURED'S NAME	Leave blank
5. PATIENT'S ADDRESS	Enter the client's street address, including the city, state and zip code. The information is on the Medicaid ID card. Entering the telephone number is optional.
6.- 8	Leave blank.
9. OTHER INSURER'S NAME	Enter applicable private insurer's name. If the client is on Medicare, enter "*This is a Medicare non-covered service"*
9a. - 9d.	Enter applicable insurance information.
10. IS PATIENT'S CONDITION…?	Place an **X** in the appropriate block for each question.
11. – 14.	Optional.
15. -16.	Leave blank.
17., 17.a. and 18.	Optional.
19. – 20.	Leave blank
21. DIAGNOSIS OR NATURE OF ILLNESS	Enter the ICD-9-CM code(s) to describe the primary diagnosis related to the service. You may also enter related secondary diagnoses. Entering written descriptions is optional.
22. MEDICAID RESUBMISSION CODE	Leave blank.
23. PRIOR AUTHORIZATION NUMBER	Enter the nursing facility level of care (FL-2) prior approval number (Service Review Number) that is applicable for the dates of service on the claim.

Illustration 21-1 – CMS-1500 Instructions

NOTE: *Blocks 24A through 24K are where you provide the details about what you are billing. There are several lines for listing services. Each line is called a "detail". When completing these blocks:*

- *Use one line for each HCPCS code that you bill on a given date.*
- *If you provide more than one unit of the same item on one day, include all the items on the same line. For example, if you provide 150 diapers (T4529) on August 2, include all of the diapers on one line. Enter 150 units in 24G for that date of service.*
- *Include only dates of service for which the client is eligible for Medicaid.*

24A DATE(S) OF SERVICE, FROM/TO	Your entry depends upon the service. Note: A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims. **CAP/C Case Management:** Use a separate line for each day that the service is provided. Place the date of service in the FROM block. Enter the same date in the TO block. **CAP/C Nursing:** Use a separate line for each day that the service is provided. Place the date of service in the FROM block. Enter the same date in the TO block. **CAP/C Nurse Aide (Personal Care):** Use a separate line for each day that the service is provided. Place the date of service in the FROM block. Enter the same date in the TO block. **CAP/C Waiver Supplies:** Use a separate line for each HCPCS code billed on a date of service. Enter a HCPCS code only once for each date of service. If multiple quantities of the same item (code) are provided on the same date, the amount is listed in **24G**. Place the date of service – the date the supplies are delivered – in FROM block. Enter the same date in the TO block. **Home Mobility Aids/Home Modifications:** Use a separate line for each day that aids are provided. Combine the cost of all items provided on that day. Place the date of service for that day in the FROM block. Enter the same date in the TO block. ***EXAMPLE:*** *The client gets a grab bar and railing on 7/2 and a ramp on 7/7, use two lines – the grab bar and railing are combined for the 7/2 line and the ramp is placed on a separate line for 7/7.* **Medicaid Medical Supplies (Not a CAP service – supplies are billed by ONLY the local CAP/C case management agency when it supplies items on the Home Health supply list):** Use a separate line for each HCPCS code billed on a date of service. Enter a HCPCS code only once for each date of service. If multiple quantities of the same item (code) are provided on the same date, the amount is listed in **24G**. Place the date of service – the date the supplies are delivered – in FROM block. Enter the same date in the TO block. **Respite Care - In-Home Nursing and In-Home-Nurse Aide:** Use a separate line for each day that the service is provided. Place the date of service in the FROM block. Enter the same date in the TO block. **Respite Care - Institutional:** Combine all consecutive days of service on one line. The FROM entry is the first date of service and the TO entry is the last consecutive date of service. If the service is provided for only a single day, list it on a separate line. Remember, when consecutive days are billed on a line, the units in **24G** must equal the number of days in **24A**.

Illustration 21-1– CMS-1500 Instructions – *Continued*

24B PLACE OF SERVICE	Your entry depends upon the service: **Case Management:** For ongoing Case Management done at the case manager's office, enter **11**. For ongoing Case Management done outside the case manager's office and Case Management to assess a client at home, enter **12**. For Case Management provided to assess a CAP applicant who is in a hospital, enter **21**. For Case Management provided to assess a CAP applicant who is receiving care in a facility, which will be billed as nursing facility (NF) care, enter **32**. ***REMEMBER:*** *If you are billing for Case Management that was provided to assess to a new client while the individual was still in a hospital or long term care facility, wait until the client is discharged home and the DSS has entered the CAP indicator in the claims reimbursement system.* **All Other CAP/C Services,** enter **12**.
24C TYPE OF SERVICE	Enter **01**.
24D PROCEDURES, SERVICES…	Enter the appropriate HCPCS code and modifier, if applicable. See Appendix C for the CAP/C codes. Refer to the Home Health Supply List for the codes for supply items.
24E DIAGNOSIS…	Leave blank.
24F CHARGES	Enter the total charge for the service on the line. **Service measured by 15-Minute Unit, Day or Month:** The charges are your unit rate times the number of units billed on a line. **CAP/C Waiver Supplies:** The charges are your unit rate times the number of units billed on a line **Home Mobility Aids:** The charges are the total amount for the items provided on the date of service. **Home Health Medical Supplies:** The charges are your unit rate times the number of units billed on the detail line.
24G DAYS OR UNITS	Enter the number of units billed on the line. **Services Measured by 15-Minute Unit or Day:** Enter the number of 15-minute units or days as appropriate. **CAP/C Waiver Supplies:** Enter **the number of units (each, for incontinence supplies; 100 calories for formulas)**. **Home Mobility Aids:** Enter **1**. **Home Health Medical Supplies:** Enter the quantity provided for the HCPCS code billed on the detail line.

Illustration 21-1 – CMS-1500 Instructions - *Continued*

24H – 24I	Leave blank.
24J – 24K	Optional.
25. FEDERAL TAX I.D. NUMBER	Optional
26. PATIENT'S ACCOUNT NO.	Optional. A provider has the option of entering either the recipient control number or medical record number in this block. This number will be keyed by EDS and reported back to the provider in the medical record field of the RA. This block will accommodate up to 20 characters (alpha or numeric) but only the first nine characters of this number will appear on the RA.
27. ACCEPT ASSIGNMENT	Leave blank.
28. TOTAL CHARGE	Enter the sum of the charges listed in Item **24F**.
29. AMOUNT PAID	Enter the total amount received from third party payment sources OTHER THAN MEDICARE. Do not enter Medicare payments or previous Medicaid payments.
30. BALANCE DUE	Subtract the amount in Item **29** from the amount in Item **28** and enter the result here.
31. SIGNATURE OF PHYSICIAN OR SUPPLIER...	Leave blank if there is a signature on file with the fiscal agent (see 21.9) – otherwise, an authorized representative of your agency must sign and date the claim in this block. A written signature stamp is acceptable.
32. NAME AND ADDRESS OF FACILITY...	Optional.
33. PHYSICIAN'S/ SUPPLIER'S BILLING NAME...	Enter your agency's name, address, including ZIP code, and phone number. The name and address must be EXACTLY as shown on your Medicaid CAP participation agreement.
PIN#	Leave blank.
GRP#	Enter your seven-digit Medicaid CAP provider number.

Illustration 21-1 – CMS 1500 Instructions - *Continued*

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) ☒ MEDICAID (Medicaid #) ☐ CHAMPUS (Sponsor's SSN) ☐ CHAMPVA (VA File #) ☐ GROUP HEALTH PLAN (SSN or ID) ☐ FECA BLK LUNG (SSN) ☐ OTHER (ID) ☐

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 900-12-3456Q

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Jane A.

3. PATIENT'S BIRTH DATE MM 06 DD 14 YY 1999 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 100 Sunny Lane

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Anywhere STATE: NC

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE: 26666 TELEPHONE (Include Area Code): (919) 123-4567

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): This is a Medicare non-covered service.

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 359.1
2. 786.0
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 2004036091234

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 09 06 05	09 06 05	11	01	T1016			41 46	3				
2 09 14 05	09 14 05	12	01	T1016			82 92	6				
3 09 23 05	09 23 05	11	01	T1016			13 82	1				
4 09 28 05	09 28 05	12	01	B4160	80		31 80	60				
5 09 28 05	09 28 05	12	01	T4529			81 00	90				
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ 251 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 251 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Happy County DSS
101 DSS Street
Anywhere, NC 26666
PIN# (919) 444-5566 GRP# 3409999

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE* APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Sample

Illustration 21-2 – Sample CMS-1500

21.12 AYMENT REVIEW, FRAUD AND ABUSE

As a CAP/C case manager, you share responsibility with your agency, DMA, the fiscal agent, and others involved with CAP/C for assuring that Medicaid funds are properly used.

21.12.1 The Purpose of Prevention and Detection Efforts

DMA has policies and procedures to prevent and detect abuse, over utilization and fraudulent practices by providers, recipients or others involved with Medicaid. This is part of DMA's efforts to ensure the most effective use of Medicaid funds. The policies and procedures provide for due process in investigations, including applicable appeal and fair hearing rights. Within DMA, the Program Integrity Section is primarily responsible for detecting misuse of Medicaid funds. Additional information about Program Integrity is on DMA's website – www.dhhs.state.nc.us/dma/pi.html.

21.12.2 Provider Education

To assist your agency in complying with Medicaid's requirements, DMA supplies a provider manual containing information on participation, coverage, limitations and reimbursement. DMA and the fiscal agent update this information through monthly *Medicaid Bulletins*. They also offer provider seminars throughout the state. Each has staff to provide guidance and assistance, and help is available by phone or mail. The address and phone numbers of key contacts are listed in Appendix B.

21.12.3 Reporting Fraud, Abuse and Misuse of Funds

If you suspect misuse or abuse of Medicaid, contact DMA's Program Integrity Section at the number listed in Appendix B.

NOTE: *Quality of care and other concerns related to a provider's licensure or certification should also be reported to the appropriate licensing/certifying authority.*

NOTE: Please see the Basic Medicaid Billing Guide at http://www.dhhs.state.nc.us/dma/prov.htm#pub for further information regarding claims; including tracking claims, adjusting claims, and third payment reimbursement.

GLOSSARY

The following definitions apply to the terms, abbreviations and acronyms used in this manual.

Adult Care Homes as used in this manual includes facilities licensed as an adult care home under Chapter 131D of the General Statutes. It also includes care homes licensed under Chapter 122C or under Chapter 131E of the General Statutes whose residents may receive State/County Special Assistance.

AI is the indicator in the CAP block on the Medicaid ID card that identifies the patient as a participant in the Community Alternatives Program for Persons with AIDS (CAP/AIDS). The participant qualifies for the ICF level of nursing facility care.

Approved Plan of Care refers to a plan of care prepared according to the instructions in this Manual and approved by the Division of Medical Assistance.

AS is the indicator in the CAP block on the Medicaid card that identifies the patient as a participant in the Community Alternatives Program for Persons with AIDS (CAP/AIDS). The participant qualifies for the SNF level of nursing facility care.

Blue Card refers to the color of the Medicaid ID card issued to those persons eligible under regular Medicaid eligibility requirements. See 3.2 for details.

Buff Card refers to the color of the Medicaid ID card issued to those persons eligible for coverage of Medicare covered services. The holders of this card are Medicare-Aid recipients – one classification of MQB coverage.

CAP is the acronym for the Community Alternatives Programs – programs that provide an alternative to institutional care.

CAP/AIDS is the acronym for the Community Alternatives Program for Persons with AIDS – a program that provides home care as an alternative to nursing facility care for persons with AIDS, children up to age two who are HIV seropositive, and children two through 12 years of age who are HIV seropositive and have at least two conditions that place the child in clinical category A,B or C as defined by the Centers for Disease Control (CDC).

CAP/C is the acronym for the Community Alternatives Program for Children – a program that offers home care for medically fragile children who otherwise would require nursing facility care or long term hospital care.

CAP/DA is the acronym for the Community Alternatives Program for Disabled Adults – a program that provides home care for adults who otherwise would require nursing facility care.

CAP effective date is the date that the client's coverage for CAP services begins. Except as it is modified when a client transfers from another CAP program to CAP/C, it is the latest of three dates:

The date of Medicaid application.

The date of the FL-2 approval.

The date of deinstitutionalization.

CAP-MR/DD is the acronym for the Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities – a program that provides home and community care for persons who otherwise would require care in an intermediate care facility for the mentally retarded (ICF/MR).

Carolina ACCESS is a Medicaid program created to improve recipients' access to primary care. Medicaid contracts with primary care physicians to deliver and coordinate health care. The primary care physician becomes the recipient's "care coordinator" for the delivery or arrangement of needed services.

CI is the indicator in the CAP block on the Medicaid ID card that identifies the patient as a participant in the Community Alternatives Program for Disabled Adults (CAP/DA). The participant qualifies for the ICF level of nursing facility care.

Client refers to a participant in one of the CAP programs.

Client year describes the 12-month period used for planning services on the Plan of Care. It begins the month of the CAP effective date and ends 12 months later. For example, if the CAP effective date is in July, the client year is July through the following June.

CM is the indicator in the CAP block on the Medicaid ID card that identifies the patient as a participant in the Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD).

CMS is the Centers for Medicare and Medicaid Services – the Federal agency that administers Medicare and Medicaid for the Federal government.

CMS-1500 is the format used to submit Medicaid claims for CAP services. See Section 21 for details.

Complex care is defined as nursing assessments requiring interventions that can only be performed by a licensed nurse. The purpose of having a licensed nurse with the recipient is not for observation or monitoring in case an intervention is required. "Just in case something happens' is not covered.

Continuous care means skilled nursing assessment and intervention which is performed at least every two to four hours during the hours that Medicaid-reimbursed nursing service is provided.

Co-payment is the amount that a Medicaid recipient is responsible for paying for certain services, such as prescriptions and physician visits. CAP clients do not pay co-payments. None of the community care services require co-payments. See 6.1.6.

County DSS refers to the county department of social services – the local agency that determines Medicaid eligibility and eligibility for other assistance programs, and provides many services in the county.

CS is the indicator in the CAP block on the Medicaid ID card that identifies the patient as a participant in the Community Alternatives Program for Disabled Adults (CAP/DA). The participant qualifies for the SNF level of nursing facility care.

Deductible - see Medicaid Deductible.

Deeming is a Medicaid eligibility term that refers to considering the income and/or resources of a Medicaid applicant's parent (s) or spouse as available to the applicant. The income or resources are "deemed" to be available to help meet the applicant's needs. See 6.2.1 for details.

DFS is the North Carolina Division of Facility Services in the Department of Health and Human Services. This is the agency that licenses home care agencies, certifies home health agencies, and performs a variety of licensure, service monitoring and health planning activities.

DMA is the North Carolina Division of Medical Assistance in the Department of Health and Human Services. This is the agency that operates the Medicaid program for North Carolina.

DME is durable medical equipment. See Section 5.1 for an overview of DME coverage.

DMH/DD/SAS is the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services in the Department of Health and Human Services. This is the agency that administers services and programs related to mental health, developmental disabilities and substance abuse.

DOS is date of service – the date that a service is provided to a Medicaid recipient.

DSS is used in two ways. Used alone, it refers to the North Carolina Division of Social Services in the Department of Health and Human Services. This is the agency that administers public assistance programs (other than Medicaid) and service programs for children and adults. When DSS is preceded by "county," it refers to the department of social services located in each county in the State.

ECS is electronic claims submission – a paperless method of submitting claims to EDS.

EDI is electronic data interchange – a service available through approved vendors that allows providers access to Medicaid eligibility and other selected information.

EFT is electronic funds transfer – the procedure for EDS to electronically transfer claims payments to a provider's bank account.

EN is enteral nutrition – the feeding of a patient with a solution/formula rich in nutrients via nasogastric or gastrostomy tube.

Enrollment is the term used for a provider becoming eligible for Medicaid payment. The provider "enrolls" with DMA to get a provider number that allows the provider to bill for services. See Section 19 for details.

Fiscal agent is the term for the firm that handles claims processing and other responsibilities, such as prior approval for nursing facility level of care, for DMA.

HC is the indicator in the CAP block on the Medicaid ID card that identifies the patient as a participant in the Community Alternatives Program for Children (CAP/C). The participant qualifies at a hospital level of care.

HCI Unit is the Home Care Initiatives Unit within the Community Care Section of DMA. This is the unit responsible for CAP/C as well as PDN and HIT.

HCPCS stands for Healthcare Common Procedure Coding System and it is used to describe the billing codes (the "HCPCS codes") for CAP, DMA, medical supplies and HIT.

HIPP is the acronym for the Health Insurance Premium Payment Program, a program that pays health insurance premiums for Medicaid recipients when it is cost effective to do so and other requirements are met.

HIT is the acronym for Medicaid's coverage for home infusion therapy. HIT coverage includes enteral therapy (EN), total parenteral therapy (TPN), antibiotic therapy, pain management therapy and chemotherapy for cancer. See 5.3 for details.

HIV CMS refers to HIV Case Management Services – a program that assists Medicaid recipients in gaining access to needed medical, social, educational and other services.

HMO is a health maintenance organization.

Home care agency is an agency that is licensed by DFS to provide home care services and directly related medical supplies and appliances to an individual at his home. Home care services include nursing care: physical, occupational, or speech therapy; medical social services; "hands-on" in-home aide services; infusion nursing services; and assistance with pulmonary care, pulmonary rehabilitation or ventilation.

Home Care Licensure Rules refers to the regulations for the licensing of home care agencies in NCAC Title 10: Chapter 3, Subchapter 3L, that are administered by DFS. Licensure subjects all home care agencies to meet certain basic requirements relating to the structure of the agency, personnel qualifications and supervision, client rights, client records, quality assurance and functions of various types of personnel.

Home health agency is an agency that is Medicare-certified and licensed by DFS to provide home care services and medical supplies. See 5.2 for information about Home Health.

Hospice refers to Medicaid's all-inclusive coverage of care related to a patient's terminal illness or a provider of this care, depending upon its use in the sentence. When used in this manual to designate a provider of Hospice care, it refers to an agency that is Medicare-certified and licensed by DFS to provide hospice care. See 5.4 for details.

IC is the indicator in the CAP block on the Medicaid ID card that identifies the patient as a participant in the Community Alternatives Program for Children (CAP/C). The participant qualifies for the ICF level of nursing facility care.

ICF stands for intermediate care facility - the lowest of two levels of care provided by a facility licensed by the state as a nursing home. Intermediate level of care for CAP/C is approved by the fiscal agent for those children who require some daily licensed nursing care, but not continuous skilled nursing care. It is intended to maintain clients at their maximum functional level, prevent regression, and/or return them to a previous level of independence. The following factors frequently indicate the need for intermediate level of care (this list is not all-inclusive): need for assistance with activities of daily living including incontinence care, ambulation assistance, and supervision of special diets; use of preventive measures/devices to prevent or retard the development of contractures (e.g., AFOs, range of motion); therapy services less than five times per week.

ICF/MR is an intermediate care facility for the mentally retarded – a licensed facility that provides care and treatment for individuals with mental retardation and certain developmental disabilities.

ICN is the internal control number assigned to a claim by EDS. On a RA, the ICN is shown as the claim number.

LPN is a licensed practical nurse. It refers to a practical nurse licensed to practice in North Carolina.

Medicaid deductible is the amount of medical expenses for which the individual is responsible before Medicaid will pay for a covered service. Also referred to as "Spenddown". See 6.1.5 and 6.2.5 for details.

Medicaid ID card is the card issued monthly to identify individuals eligible for Medicaid coverage. The cards are blue, pink or buff – each color denotes a certain type of coverage. See 6.3 for details.

Medically fragile refers to children who have: 1) a primary diagnosis or diagnoses that are medical – not psychological, behavioral, cognitive, or developmental, 2) a serious, ongoing illness or chronic condition requiring prolonged hospitalization and ongoing medical treatments and monitoring, 3) a need for devices or care to compensate for he loss of bodily function, and 4) a need for physician-ordered, continuous in-home care that requires the presence or oversight of a Registered Nurse.

Medically necessary is the term used to describe if a patient has a medical necessity for the service. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

MID is the acronym for Medicaid Identification Number – the individual identification number assigned to each Medicaid recipient. It consists of nine digits and an alpha suffix.

NCAC is the North Carolina Administrative Code – the state regulations.

OT refers to occupational therapy or occupational therapist, depending upon its use in the sentence. When used in this manual to designate an occupational therapist, it refers to one licensed to practice in North Carolina.

PCS is Personal Care Services – a home care service that provides in-home aide services to meet the patient's medically related personal care needs. See 5.5 for details.

PDN is Private Duty Nursing – a home care service that provides continuous, complex, and substantial nursing care for patients in their homes. See 5.6 for details.

POC stands for Plan of Care

Provider is the term used for the entity enrolled with Medicaid to provide a service.

Provider Participation Agreement is a written contract between the Division of Medical Assistance and a Medicaid provider stating that the provider understands and will follow Medicaid policies and procedures as well as applicable laws and regulations. See Sections 19 for details.

PT refers to physical therapy or physical therapist, depending upon its use in the sentence. When used to designate a physical therapist, it refers to one licensed to practice in North Carolina.

RA refers to Remittance Advice – see Remittance and Status Report.

Recipient is a person authorized for Medicaid coverage.

Remittance and Status Report (RA) is a report issued by the fiscal agent that gives a provider detailed information on the status of claims. If a provider has more than one provider number, they will receive a separate RA for each number. See Section 22 for additional information.

REOMB is the Recipient Explanation of Medical Benefits – a form that DMA sends to Medicaid recipients to verify that they received the services billed to Medicaid.

Risk of institutionalization refers to children who: 1) are prior-approved through the fiscal agent for nursing facility level of care, 2) without in-home nursing care, would need to be institutionalized in a nursing facility or hospital as determined by statement of the responsible party, and 3) do not have other available resources, formal or informal, including daycare/developmental daycare or family support, that can meet their needs.

Revenue code is the term for the codes used to bill for Home Health, Hospice, PCS and PDN.

RN is a registered nurse licensed to practice in North Carolina.

Short term, intensive services refers to services that are more extensive than the client normally requires and are provided over a period of 60 days or less. They are provided to meet a short term need, such as following a hospitalization or to bridge a temporary loss of care from a family member. See Section 10 for details relative to the Plan of Care for CAP/C clients.

SC is the indicator in the CAP block on the Medicaid ID card that identifies the patient as a participant in the Community Alternatives Program for Children (CAP/C). The participant qualifies for the SNF level of nursing facility care.

Skilled Nursing means assessment, judgment, intervention, and evaluation of interventions that require the education, training, and experience of a licensed nurse. Skilled nursing excludes tasks which can be delegated to unlicensed personnel.

SNF refers to a Skilled Nursing Facility - the highest of two levels of care provided by a facility licensed by the state as a nursing home. Skilled level of care for CAP/C is approved by the fiscal agent for those children who require continuously available skilled nursing care but not the degree of support available in an acute care hospital. The following factors frequently indicate the need for skilled level of care (this list is not all-inclusive): gastrostomy feedings; tracheostomy care; therapy services at least five times per week.

Spenddown - see Medicaid Deductible.

SSI refers to Supplemental Security Income, a federal program of cash assistance for persons who are over 65, disabled, or blind with limited income and resources. The program is administered through the Social Security Administration.

Substantial care means multiple interrelated nursing assessments requiring interventions that can only be performed by a licensed nurse.

TPL is third party liability. This refers to an entity, such as a private insurer, being responsible for paying for part or all of the cost of a service. See 21.5 for details.

TPN is total parenteral nutrition – the intravenous feeding of a patient with a solution/formula rich in nutrients. Patients who receive TPN have a gastrointestinal dysfunction that prevents them from absorbing adequate oral nutrition.

Unit of service is the least amount of a service which may be billed.

Waiver refers to the Home and Community-Based Services waivers granted by the Center for Medicare and Medicaid Services that allows North Carolina to operate the Community Alternatives Programs.

Waiver services refers to the services authorized in Home and Community-Based Services waivers granted by the Center for Medicare and Medicaid Services. When used in relation to CAP/C, the term refers to those services called "CAP/C services" in this manual.

Waiver year refers to the 12-month period that CMS uses to authorize, monitor, and control waiver programs and expenditures. The waiver year begins on the effective date of the waiver approval and includes the 12 months following the date. The waiver year for CAP/C is July through the following June.

WHO TO CONTACT

This appendix tells you the contact:

- ***For information about*** services, programs, claims issues, prior approval and other related issues. This is information that goes beyond that provided in this manual. Please review your manual before calling for information.
- ***To get*** forms and other printed material.
- ***To determine*** claims status, Medicaid eligibility and MID numbers
- ***To report*** possible fraud and program abuse, possible licensure violations and recipient insurance information.

It also provides the addresses to send various forms and other information. See ***Send forms for***.

Also see DMA's website – www.dhhs.state.nc.us/dma – for information, publications and forms.

For information about:	***Contact:***
Advance Directives	Clinical Policy Section, DMA – 919-855-4270
Automated Voice Response	See Basic Medicaid Billing Guide, Appendix A
Automatic Deposits	See Electronic Funds Transfer (EFT)
Baby Love	Baby Love Program Coordinator, DMA - 919-855-4320
CAP/AIDS	AIDS Care Unit, Division of Public Health - 919-715-3122 or 919-715-3169
CAP/C	Home Care Initiatives Unit, DMA - 919-855-4380 2501 Mail Service Center, Raleigh, NC 27699-2501
CAP/DA	CAP/DA Lead Agency for your county or the CAP Unit, DMA - 919-855-4360
CAP-MR/DD	Area MH/DD/SAS program serving your county, or the CAP-MR/DD staff at DMA 919-855-4290
Carolina ACCESS	Carolina ACCESS Representative at your county department of social services
Checkwrite Dates	Use Automated Voice Response or Medicaid Bulletins
Claims Adjustments and Inquiries	EDS Provider Services Unit – 1-800-688-6696 or 919-851-8888
Claims Status	Use Automated Voice Response

– More on next page –

For information about:	***Contact:***
Claims Submission	EDS Provider Services Unit – 1-800-688-6696 or 919-851-8888
Claims Tracking	EDS Provider Services Unit – 1-800-688-6696 or 919-851-8888
Electronic Claims Submission (ECS)	EDS ECS Department - 1-800-688-6696 or 919-851-8888
Electronic Data Interchange (EDI)	EDS - 1-800-688-6696 or 919-851-8888
Electronic Funds Transfer (EFT)	EDS Finance Unit – 1 800-688-6696 or 919-851-8888
Fraud and Program Abuse Reporting	Program Integrity Section, DMA - 919-647-8000 WEB Site: www.dhhs.state.nc.us/DMA/pi.htm
Health Check	Health Check– 1-800-367-2229 or DMA, 919-647-8170
Health Insurance Premium Payment Program (HIPP)	HIPP Coordinator Division of Medical Assistance 2508 Mail Service Center Raleigh, NC 27699-2508 919 647-8100
HIV Case Management Services (HIV CMS)	AIDS Care Unit, Division of Public Health - 919-715-3122 or 919-715-3169
HMO Coverage	Managed Care Unit, DMA - 919-647-8170
Home Care/Home Health/Hospice Licensure	Licensure & Certification Section, Acute and Home Care Branch, DFS - 919-733-7461
Home Health/Hospice Medicare Certification	Licensure & Certification Section, Acute and Home Care Branch, DFS - 919-733-7461
Independent Practitioners (IP) Program	Medical Policy, DMA - 919-855-4310
Insurance Codes	TPR Section, DMA - 919-647-8100
Medicaid Deductibles	Your county department of social services
Medicaid Eligibility Requirements	Your county department of social services
Patient Self Determination Act	See Advance Directives

– More on next page –

For information about:	***Contact:***
PDN Prior Approval	HCI Unit, DMA – 919-855-4390
Provider Certification for Signature on File	EDS Provider Services Unit - 1-800-688-6696 or 919-851-8888
Third Party Recovery	Program Integrity, TPR Section, DMA - 919-647-8100

To get:	***Contact:***
NOTE: *Several of the forms listed below are available at DMA's website –* www.dhhs.state.nc.us/dma*. When accessing the website, click on* Forms and Publications (*under* Services and Publications), *click on the form that you want, and print.*	
Adjustment Request Forms	EDS Provider Services Unit - 1-800-688-6696 or 919-851-8888 or obtain at www.dhhs.state.nc.us/dma
Authorization Agreement for Automatic Deposit	See Electronic Funds Transfer (EFT) Forms
CAP/C Manuals	HCI Unit, DMA – 919-855-4380
Claims Inquiry Forms	See Resolution Inquiry Forms
Community Care Manuals	Obtain at www.dhhs.state.nc.us/dma
Electronic Claims Agreements	EDS ECS Department - 1-800-688-6696 or 919-851-8888
Electronic Claims Software	EDS ECS Department - 1-800-688-6696 or 919-851-8888
Electronic Funds Transfer (EFT) Forms	EDS Finance Unit - 1-800-688-6696 or 919-851-8888 or obtain at www.dhhs.state.nc.us/dma
Fee Schedules	Fax request to DMA using the form published periodically in Medicaid Bulletins and available on DMA's website at www.dhhs.state.nc.us/dma
FL-2's	EDS Provider Services Unit - 1-800-688-6696 or 919-851-8888
CMS-1500's	Not available from EDS or DMA - Obtain from commercial vendors. There is also a link to them on the www.dhhs.state.nc.us/dma website.
Health Insurance Information Referral Form	Obtain at www.dhhs.state.nc.us/dma
PDN Referral Forms & Medical Update Formats	Home Care Initiatives Unit, DMA - 919-855-4390, or obtain from website www.dhhs.state.nc.us/dma

– More on next page –

To get:	***Contact:***
Provider Certification for Signature on File	EDS Provider Services Unit – 1-800-688-6696 or 919-851-8888 or obtain at www.dhhs.state.nc.us/dma
Provider Enrollment Applications	Provider Services Unit, DMA 2506 Mail Service Center Raleigh, NC 27699-2506 919-855-4050 or obtain at www.dhhs.state.nc.us/dma
Refund Forms	See Adjustment Request Forms
Resolution Inquiry Forms	EDS Provider Services Unit – 1-800-688-6696 or 919-851-8888 or obtain at www.dhhs.state.nc.us/dma
Third Party Insurance Code Book	Third Party Recovery Section, DMA 2508 Mail Service Center Raleigh, NC 27699-2508 919-647-8100
Third Party Insurance Forms	EDS Provider Services P.O. Box 30968 Raleigh, NC 27622 1-800-688-6696 or 919-851-8888 or obtain at www.dhhs.state.nc.us/dma

To determine:	***Contact:***
CAP Participation	See Medicaid ID Card or use Automated Voice Response
Claims Status	Use Automated Voice Response
HMO Participation	Use Automated Voice Response
Hospice Participation	Use Automated Voice Response
Insurance Coverage Information	Use Automated Voice Response
Medicaid Eligibility	Use Automated Voice Response
Medicaid Identification Number	If you know the recipient's Social Security Number and date of birth, use Automated Voice Response If you do not know the SSN and DOB, call DMA's Claims Analysis Unit – 919-855-4045.

To report:	***Contact:***
Fraud and Program Abuse	Program Integrity Section, DMA 2515 Mail Service Center Raleigh, NC 27699-2515 919-647-8000
Home Care/Home Health/Hospice Licensure & Certification Violations	Licensure & Certification Section, Acute and Home Care Branch, DFS - 919-733-7461
Home Care Service Complaints	Home Care Hotline, DFS 1-800-624-3004
Recipient Insurance Information	Your county department of social services

Send forms for:	***To:***
Electronic Funds Transfers (Automatic Deposit)	EDS Finance Unit P.O. Box 300009 Raleigh, NC 27622
Eligibility Denial Follow-up	Claims Analysis Unit, DMA 2519 Mail Service Center Raleigh, NC 27699-2519 919-857-4018
ECS Agreement	Provider Services Unit, DMA 2506 Mail Service Center Raleigh, NC 27699-2506
CMS-1500's	EDS P.O. Box 30968 Raleigh, NC 27622
Lost Claim Inquiry(Resolution Inquiry Form)	EDS Provider Services P.O. Box 300009 Raleigh, NC 27622
Overpayments (Adjustment Request Form)	EDS Adjustment Unit P.O. Box 300009 Raleigh, NC 27622
PDN Referrals	HCI Unit, DMA 2501 Mail Service Center Raleigh, NC 27699-2501 919-855-4390 FAX# 919-715-9025

– More on next page –

Send forms for:	***To:***
Provider Certification for Signature on File	EDS Provider Relations P.O. Box 300009 Raleigh, NC 27622
Refunds (Adjustment Request Form)	EDS Finance Unit P.O. Box 300009 Raleigh, NC 27626
Time Limit Override (Resolution Inquiry Form)	EDS Provider Services P.O. Box 300009 Raleigh, NC 27622
Third Party Insurance Information	Third Party Recovery Section, DMA 2508 Mail Service Center Raleigh, NC 27699-2508 919-647-8100
Underpayments (Adjustment Request Form)	EDS Adjustment Unit P.O. Box 300009 Raleigh, NC 27622

Community Alternatives Program for Children (CAP/C)

Current Codes as of 07/01/2006

CAP/C Service	HCPCS Code	Maximum Payment	Billing Unit
CAP/C Case Management	T1016	refer to CAP/C fee schedule	15 minutes
CAP/C Nursing Services	T1000	refer to CAP/C fee schedule	15 minutes
CAP/C Nurse Aide (Personal Care) Services	S5125	refer to CAP/C fee schedule	15 minutes
CAP/C Waiver Supplies – disposable liner/shield for incontinence	T4535	refer to CAP/C fee schedule	each
CAP/C Waiver Supplies – incontinence product, diaper/brief, reusable, any size	T4539	refer to CAP/C fee schedule	each
CAP/C Waiver Supplies – formula taken by mouth	HCPCS code for formula with "BO" modifier	varies according to formula – see DME fee schedule	100 calories
Home Modifications	S5165	$1500.00 per state fiscal year	each
Respite Care – Institutional	H0045	refer to CAP/C fee schedule	Day
Respite Care – In-Home Nursing	T1005	refer to CAP/C fee schedule	15 minutes
Respite Care – In Home Nurse Aide	S5150	refer to CAP/C fee schedule	15 minutes

NOTES:

1. *Calculate the cost for CAP/C Waiver Supplies according to the instructions in 21.3.*

2. *Calculate the cost for Home Mobility Aides according to the instructions in 21.3. All the items provided on a date of service are billed together as one item on the claim. As of July 1, 2005, the total cost of all Home Mobility Aids paid in a State fiscal year – July through the following June – is $1,500.00.*

3. *The total respite care paid by Medicaid in a State fiscal year – July through the following June – may not exceed 720 hours.*