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**NC Division of Medical Assistance  
Community Alternatives Program  
For Disabled Adults and Choice  
Option (CAP/DA-Choice)**

**Medicaid and Health Choice  
Clinical Coverage Policy No: 3K-2  
Amended Date: October 1, 2015**

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**Related Clinical Coverage Policies**

Refer to <http://www.ncdhhs.gov/dma/mp/> for the related coverage policies listed below:

- 5A, *Durable Medical Equipment and Supplies*
- 3A, *Home Health Services*
- 3D, *Hospice Services*
- 3H-1, *Home Infusion Therapy*

## **1.0 Description of the Procedure, Product, or Service**

The Community Alternatives Program for Disabled Adults (CAP/DA) is a Medicaid Home and Community–Based Services (HCBS) Waiver Program authorized under § 1915(c) of the Social Security Act. Federal regulations for HCBS waivers may be found in 42 CFR Part 441 Subpart G. The CAP/DA program waives certain NC Medicaid (Medicaid) requirements to furnish an array of home and community based services to adults who are elderly or disabled. The services are designed to provide an alternative to institutionalization for beneficiaries in this target population who prefer to remain in their homes, and would be at risk of institutionalization without these services.

CAP/DA supplements rather than replaces the formal and informal services and supports already available to an individual. CAP/DA services are intended for situations where no household member, relative, caregiver, landlord, community/volunteer agency, or third party payer is able or willing to meet the needs of the beneficiary.

**CAP/DA waiver services are specified below:**

- a. Adult day health
- b. Personal care aide
- c. Home modification and mobility aids
- d. Meal preparation and delivery
- e. Institutional respite services
- f. Non-institutional respite services
- g. Personal Emergency Response Services
- h. Waiver supplies
- i. Participant goods and services
- j. Transition services
- k. Training and education services
- l. Assistive technology
- m. Case management
- n. Care advisor (Choice Option Only)
- o. Personal assistant (Choice Option Only)
- p. Financial management services (Choice Option Only)

### **1.1 Definitions**

#### **1.1.1 Activities of Daily Living (ADLs)**

Basic personal care usually performed by an individual during the course of the day including ambulation, bathing, bed mobility, dressing, eating, personal hygiene, toilet use, and transfers. These activities are directly linked to the

beneficiary's medical condition or diagnosis. These activities are usually performed by unlicensed paraprofessionals and do not constitute skilled medical or skilled nursing care.

### **1.1.2 AQUIP Data Set**

The formal assessment that a social worker and registered nurse complete to determine an individual's care needs for the participation in the Community Alternatives Program for Disabled Adults (CAP/DA).

### **1.1.3 Community Alternatives Program for Disabled Adults (CAP/DA)**

A Medicaid Home and Community-Based Services (HCBS) Waiver Program authorized under § 1915(c) of the Social Security Act serving adults with disabilities 18 years of age and older who are at risk of institutionalization.

### **1.1.4 CAP/DA lead agencies**

CAP/DA lead agencies are the local entry point and approval authority for the CAP/DA and CAP/Choice Option. These agencies may include county Departments of Social Services, county Health Departments, county Agencies on Aging, or hospitals. This local approval authority can also be an agency capable of providing case management and contracted by a lead agency.

### **1.1.5 Choice Option**

An alternative program option offered under the existing traditional Home and Community-Based Services (HCBS) waiver program, Community Alternatives Program for Disabled Adults (CAP/DA). Choice is a beneficiary-directed care option for elderly and disabled adults who wish to remain at home and have increased control over their services and supports. The Choice Option allows beneficiaries to more fully direct their care by selecting and managing their individual workers and by having more flexibility in tailoring plans of care to meet their care requirements.

### **1.1.6 Division of Medical Assistance (DMA)**

The State Medicaid Agency designated to provide training and technical assistance to lead agencies. DMA develops policies and procedures based on Federal guidelines for operating the program. DMA manages the CAP/DA HCBS waiver at the State level and oversees the management and operation by the local Lead Agencies.

### **1.1.7 Instrumental Activities of Daily Living (IADL's)**

Activities performed by a person who is living independently in a community setting during the course of a normal day. These activities are necessary for maintaining a person's immediate environment and include: home maintenance, housework, laundry, meal prep, medication management, money management, phone use, shopping, errands and transportation.

### **1.1.8 Nursing Services**

Professional services provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of a registered nurse.

### 1.1.9 Participant

A participant for the purposes of this policy is a Medicaid beneficiary receiving CAP/DA services.

### 1.1.10 Permanent Private Place of Residence (Home)

A home is a permanent private place of residence that is not licensed or regulated as any kind of group home or other board and care facility. No more than four unrelated people can live in the home.

### 1.1.11 Personal Care Aide or In-Home Aide

A paraprofessional provided through a licensed home care agency who provides hands-on assistance to individuals receiving personal care under this Clinical Coverage Policy.

### 1.1.12 Beneficiary

An individual qualified for Medicaid who is receiving services under this Medicaid program.

### 1.1.13 Risk of Institutionalization

Elderly and disabled adults who meet the nursing facility level of care (LOC) criteria and do not have other available resources, formal or informal, including willing and able family support that can meet their needs.

### 1.1.14 Self-Directed Care

Directing your own services and supports provided in your own home and community. It offers beneficiaries the choice and control over the types of services they receive, when and where the services are provided, and by whom the services are delivered.

## 2.0 Eligibility Requirements

### 2.1 Provisions

#### 2.1.1 General

*(The term "General" found throughout this policy applies to all Medicaid and NCHC policies)*

- a. An eligible beneficiary shall be enrolled in either:
  1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
  2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

### 2.1.2 Specific

*(The term “Specific” found throughout this policy only applies to this policy)*

a. **Medicaid**

Only N.C. Medicaid (Medicaid) beneficiaries 18 years of age and older are eligible to participate in CAP/DA. Medicaid beneficiaries must be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

b. **NCHC**

NCHC beneficiaries are not eligible for CAP/DA-Choice.

## 2.2 Special Provisions

### 2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary’s physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary’s right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider’s documentation shows that the requested service is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition” [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary’s health in the best condition possible, compensate for a health

problem, prevent it from worsening, or prevent the development of additional health problems.

**b. EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

*NCTracks Provider Claims and Billing Assistance Guide:*

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

**2.2.2 EPSDT does not apply to NCHC beneficiaries**

**2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age**

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary

**2.3 Benefit Category**

Only the following Medicaid eligibility groups are eligible for CAP/DA:

- a. Medicaid to the Aged (MAA)
- b. Medicaid to the Blind (MAB)
- c. Medicaid to the Disabled (MAD)

**3.0 When the Procedure, Product, or Service Is Covered**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

**3.1 General Criteria Covered**

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

### 3.2 Specific Criteria Covered

#### 3.2.1 Specific criteria covered by both Medicaid and NCHC

None Apply.

#### 3.2.2 Medicaid Additional Criteria Covered

a. Medicaid covers **CAP/DA** services when a beneficiary meets **all** of the following criteria:

1. 18 years of age and older;
2. Eligible for Medicaid in one of the benefit categories listed in **Subsection 2.3**;
3. Resides in a private residence;

**Note:** Beneficiaries may be living in institutions such as nursing facilities at the time of application and screening, but must be discharged to a private residence before they can actually begin participating in the CAP/DA program.

4. Requires nursing facility level of care;
5. Is at risk of institutionalization within 30 calendar days;
6. Chooses CAP/DA services instead of institutional care;
7. Requires long-term support at a level typically provided in an institution such as a nursing facility;
8. Able to have his or her health, safety and well-being maintained at home within the Medicaid cost limit; and
9. Requires services directly related to a documented medical diagnosis and identified medical care need in order to avoid institutional care in a nursing facility.

b. **CAP/Choice** is an option under CAP/DA when a beneficiary meets all of the following criteria:

1. Understands the rights and responsibilities of directing one's own care;
2. Willing and capable to assume the responsibilities for beneficiary (self)-directed care, or selects a representative who is willing and capable to assume the responsibilities to direct the beneficiary's care; and

**Note:** The prospective beneficiary or their designated representative will be administered a self-assessment questionnaire to determine the beneficiary's ability to direct care or identify training opportunities to build competencies to aid in self-direction.

3. Has an emergency back-up plan with adequate social support to meet the basic needs outlined in the CAP/DA assessment to maintain their health, safety and well-being. The emergency back-up plan is created by the CAP/Choice participant with the assistance of the Care Advisor. This plan outlines who will provide care when key direct care staff cannot provide services or tasks as indicated in the current Plan of Care. Because both personal and home maintenance tasks are essential to the well-being of the participant, the care advisor is responsible for ensuring that an adequate emergency back-up plan is in place. In the event of an

emergency/unplanned occurrence, the plan can include family, friends, neighbors, community volunteers and licensed home care agencies when possible. An emergency back-up plan is necessary for times when the Personal Assistant is absent during regularly scheduled work hours, when an emergency arises, or when a special need arises that the Personal Assistant cannot help with.

**Note:** It is not appropriate to consider a person for CAP/DA simply to qualify him or her for Medicaid.

### **3.2.3 NCHC Additional Criteria Covered**

None Apply.

## **4.0 When the Procedure, Product, or Service Is Not Covered**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

### **4.1 General Criteria Not Covered**

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

### **4.2 Specific Criteria Not Covered**

#### **4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC**

None Apply.

#### **4.2.2 Medicaid Additional Criteria Not Covered**

- a. **CAP/DA** participation and services are not covered for any one of the following:
  1. The CAP indicator code has been removed from the eligibility information system;
  2. The level of care is not prior approved or has been denied;
  3. The beneficiary goes into a nursing facility for a short-term rehabilitation stay or long-term nursing home stay; when a client enters a skilled nursing facility or rehab center for a sort-term stay, their CAP services are temporarily suspended until they are discharged from the facility. They are eligible to be reinstated onto the program.
  4. The beneficiary does not require one or more waiver services in addition to case management services;
  5. The beneficiary resides in an unsafe home environment placing the eligible beneficiary's health, safety and well-being at risk;

6. The beneficiary or family is not compliant with the established Plan of Care, placing the eligible beneficiary's health, safety and well-being at risk;
  7. The beneficiary is in a Medicaid sanction period;
  8. The beneficiary's Medicaid status is in deductible status;
  9. The CAP/DA case manager has been unable to establish contact with the beneficiary or his or her responsible party for more than 60 calendar days; or
  10. The beneficiary does not reside in a permanent private residence.
- b. **CAP Choice** participation and services are not covered for any one of the following:
1. The beneficiary is not willing or capable to assume the responsibilities of beneficiary (self) - directed care and does not have an approved representative who is willing and capable to assume the responsibilities to direct the beneficiary's care;
  2. The beneficiary does not have an emergency back-up plan with adequate social support to meet the basic needs outlined in the CAP/DA assessment to maintain his or her health, safety and well-being; or
  3. The beneficiary demonstrates a continued inability or unwillingness to adhere to the rights and responsibilities of the CAP/Choice program as outlined in the "Beneficiary Rights and Responsibilities" form signed during the admission process.

#### 4.2.3 NCHC Additional Criteria Not Covered

- a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
1. No services for long-term care.
  2. No nonemergency medical transportation.
  3. No EPSDT.
  4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

## 5.0 Requirements for and Limitations on Coverage

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

### 5.1 Prior Approval

Prior approval is required for both CAP/DA and Choice Option.

### 5.2 Prior Approval Requirements

#### 5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

### 5.3 Lead Agency Responsibility

As a local entry point for both CAP/DA and the Choice Option the Lead Agency shall:

- a. Develop referral procedures according to DMA standards and local policy and share these procedures with the appropriate providers and organizations;
- b. Educate the elderly and disabled community about CAP/DA;
- c. Process referrals and manage waiting lists based on DMA standards and local policy;
- d. Provide assistance in obtaining documentation from medical staff to determine level of care;
- e. Provide assistance in verifying with Medicaid Fiscal Agent whether medical documentation supports nursing facility level of care;
- f. Assess beneficiary's appropriateness for CAP/DA and Choice Option; and
- g. Provide Case Management/Care Advisement to the CAP/DA and Choice Option.

### 5.4 Level of Care to Qualify for CAP/DA

A beneficiary being considered for CAP/DA services shall meet the North Carolina Medicaid's nursing facility level of care criteria. Medicaid's Fiscal Agent shall give prior approval for nursing facility level of care. A prior approved authorization and referral indicating nursing facility level of care is the first basic component of determining whether a beneficiary is appropriate for CAP/DA services.

The following criteria are not intended to be the only determinant of the beneficiary's need for skilled or intermediate care. Professional judgment and a thorough evaluation of the beneficiary's medical condition and psychosocial needs are necessary, as well as an understanding of and the ability to differentiate between the need for skilled or intermediate care. The assessment of other health care alternatives should be made as applicable. All professional services that are provided to the beneficiary to maintain, monitor, and/or enhance level of health must be addressed in the medical records and reflected on the prior approval assessment form.

### 5.4.1 Intermediate Level of Care

Intermediate care is that level of care that provides daily care but does not require the skilled nursing services required at the skilled nursing level of care.

Intermediate care provides services only for maintenance or stabilization of the beneficiary's medical condition. Intermediate care is provided under the direction of a physician in order to promote and maintain the highest level of functioning of the beneficiary and to assure quality beneficiary care.

Intermediate care includes daily observation, assessment, planning and management of a recorded treatment plan according to that which is ordered by a physician, and rendering direct services to the beneficiary.

In summary, the philosophy of intermediate care is to maintain beneficiaries at their maximum level of self-care and independence, prevent regression, and/or return them to a previous level or new stage of independence.

#### 5.4.1.1 Requirements for Intermediate Level of Care include the following:

- a. Performance of services that by physician judgment require personnel working under the supervision of a licensed nurse.
- b. Restorative nursing measures to maintain or restore maximum function or to prevent the advancement of progressive disabilities as much as possible. Such measures may include, but are not limited to the following:
  1. Encouraging beneficiaries to achieve independence in activities of daily living (i.e. bathing, eating, toileting, dressing, transfer/ambulation)
  2. Use of preventive measures/devices to prevent or retard the development of contractures, such as positioning and alignment, range of motion, use of handrolls, and positioning pillows.
  3. Ambulation and gait training with or without assistive devices.
  4. Assistance with or supervision of transfers.
- c. Administration or control of medications, according to state law, are to be the exclusive responsibility of licensed nurses and any other specific services subject to such limitations;
- d. Assistance with activities of daily living (i.e., bathing, eating, toileting, dressing, transfer/ambulation) including maintenance of Foley catheters and ostomies, supervision of special diets, and proper skin care of incontinent patients;
- e. Special therapeutic diets: nutritional needs under the supervision and monitoring of a registered dietician with beneficiary requiring a specialized diet
- f. Gastrostomy feedings requiring supervision and observation by licensed nurses
  1. G-tube with flushes
  2. Medications per g-tube when beneficiary on regular or soft diet
  3. Supplemental bolus feedings

- g. Respiratory therapy. Oxygen as a temporary or intermittent therapy or for beneficiaries who receive oxygen therapy continuously as a component of a stable treatment plan
  - 1. Nebulizer usage
  - 2. Pulse oximetry
  - 3. Oral suctioning
- h. Wound care for: Stage I or II decubitus or open areas which are not chronic, extensive, or infected but require assistance with major and minor skin conditions which include dressings, decubitus care, and other chronic skin conditions.
- i. Dialysis: hemodialysis or peritoneal dialysis as part of a maintenance treatment plan
- j. Rehabilitative services: provided by licensed therapist or assistant as part of a maintenance treatment plan
- k. Diabetic care: when daily observation of dietary intake and/or medication administration is required for proper physiological control.

#### **5.4.1.2 Other Factors that alone may not justify Intermediate Level of Care**

Although any one of these factors alone may not justify intermediate level, the following can, when present in combination, justify intermediate level placement.

- a. Need for teaching and counseling related to a disease process and/or disabilities, diet, or medication.
- b. Adaptive programs: (i.e. bowel and bladder training or restorative feeding). Documentation must include the reason the program is needed at the time, the nature of the program, and the beneficiary's progress. When the beneficiary's condition has stabilized or he/she has reached the maximum potential, the beneficiary may no longer require intermediate nursing care.
- c. Ancillary therapies: supervision of beneficiary performance of procedures taught by physical, occupational, or speech therapist. This may include care of braces or prostheses and general care of plaster casts.
- d. Injections: given during the hours a nurse is on duty requiring administration and/or professional judgment by a licensed nurse.
- e. Treatments: temporary cast, braces, splint, hot or cold applications, or other applications requiring nursing care and direction.
- f. Psychosocial considerations: psychosocial condition of each beneficiary will be evaluated in relation to his/her medical condition when determining a change in level of care. Factors taken into consideration along with the beneficiary's medical needs include:
  - 1. Whenever a beneficiary exhibits acute psychological symptoms, these symptoms and the need for appropriate services and supervision must have been documented by physician's orders or progress notes and/or by nursing or

- therapy notes. Proper and timely discharge planning will help alleviate the fear and worry of transfer.
2. Age.
  3. Length of stay in current placement.
  4. Location and condition of spouse.
  5. Proximity of social support.
  6. Effect of transfer on beneficiary, understanding that there can always be, to a greater or lesser degree, some trauma with transfer.
- g. Other conditions that may require intermediate level of care:
1. Blindness.
  2. Behavioral problems such as:
    - A. Wandering.
    - B. Verbal disruptiveness.
    - C. Combativeness.
    - D. Verbal or physical abusiveness.
    - E. Inappropriate behavior (when it can be properly managed at the intermediate level of care).
  3. Frequent falls.
  4. Chronic recurrent medical problems that require daily observation by licensed personnel for prevention and/or treatment.

#### **5.4.2 Skilled Level of Care**

Skilled nursing services, as ordered by a physician, must be medically necessary.

Skilled nursing level of care does not require the degree of medical consultation and support services available in an acute care hospital. Skilled nursing care is provided under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results and to assure quality patient care.

Skilled nursing care includes planning and management of a recorded treatment plan according to that which is established and approved by a physician, and rendering direct services to the beneficiary.

##### **5.4.2.1 Requirements for Skilled Level of Care include the need for any of the following:**

- a. Performance of direct services that by physician judgment requires:
  1. supervision of a registered nurse or licensed practical nurse
  2. other personnel working under the direct supervision of a registered nurse or licensed practical nurse
- b. Observation and assessment of beneficiary needs by a registered nurse or licensed practical nurse: The licensed nursing services should be intensive and directed to an acute episode or a change in the treatment plan that would require such concentrated monitoring. Once a beneficiary's treatment plan becomes stable, he/she would not necessarily require skilled nursing care.

- c. A stabilization period if the beneficiary's medical condition declines. A stabilization period is a period of time where the beneficiary requires intensive intervention due to a recent decline of medical condition. Thus, skilled services may be needed.
- d. Teaching: as part of the active treatment requiring a licensed nurse at the time of the skilled procedure
- e. Treatment due to unplanned weight loss: the weight loss must be significant clinically and in relation to the beneficiary's total body mass. The current diagnosis and beneficiary's usual weight throughout their adult life should be considered. Documentation must address the specific plan of treatment including the use of dietary supplements, therapeutic diets, and frequent recording of the beneficiary's weight.
- f. Intensive rehabilitative services as ordered by a physician and provided at least five (5) times per week, not to exceed six (6) weeks, by a licensed:
  - 1. Physical therapist
  - 2. Physical therapist assistant who performs services under the direction of a licensed physical therapist
  - 3. Occupational therapist
  - 4. Occupational therapy assistant under the direction of a licensed occupational therapist
  - 5. Clinical speech pathologist
- g. Administration and/or control of medication as required by state law to be the exclusive responsibility of licensed nurses:
  - 1. Drugs requiring intravenous, hypodermoclysis or nasogastric tube administration
  - 2. The use of drugs requiring close observation during an initial stabilization period or requiring nursing skills or professional judgment on a continuous basis
  - 3. Frequent injections requiring nursing skills or professional judgment
- h. Nasogastric/gastrostomy feedings requiring supervision and observation by licensed nurses:
  - 1. Newly placed tube x 30 days.
  - 2. Primary source of nutrition by bolus/continuous feedings.
  - 3. Medications per tube when beneficiary on dysphagia diet, pureed diet or soft diet with thickening liquids.
- i. Respiratory therapy:
  - 1. When monitoring need or careful regulation of flow rate of oxygen. This would not apply to beneficiaries who receive oxygen therapy continuously as a component of a stable treatment plan.
  - 2. Nasopharyngeal/tracheal suctioning.
- j. Isolation: when medically necessary as a limited measure because of contagious or infectious disease.
- k. Wound care of:
  - 1. open areas which are infected, extensive, or chronic.
  - 2. decubitus ulcer stage III or IV regardless of treatment.

3. stage II decubitus ulcer with diagnosis of diabetes, peripheral vascular disease, multiple ulcers and/or difficult to treat open areas.
1. Treatment due to uncontrolled diabetes:
  1. when requiring daily administration of sliding scale insulin with daily monitoring of blood glucose levels.
  2. frequent hypoglycemic episodes with documentation requiring IV/IM/oral intervention.

**Note:** Services provided by a rehabilitation aide are not considered skilled nursing care. Services provided only for maintenance or stabilization are not considered skilled nursing care.

#### **5.4.2.2 Factors that alone may not justify skilled level of care**

Although any one of these factors alone may not justify skilled level, the following can, when present in combination, justify skilled care. This determination requires careful judgment.

- a. Diagnostic procedures: frequent laboratory procedures when intimately related to medication administration (i.e. monitoring anticoagulants, arterial blood gas analysis, pro re nata (PRN) blood sugars)
- b. Medications: injections, routine, or PRN medication requiring frequent administration, and/or judgment by a licensed nurse
- c. Treatments/procedures: requiring observation, evaluation and assistance by skilled personnel for proper use or beneficiary's safety (i.e. oxygen, hot packs, hot soaks, whirlpool, catheterizations, diathermy, "Intermittent Positive Pressure Breathing (IPPB), etc.
  1. New intake/output (I/O) catheterization x 30 days for beneficiary/family teaching.
  2. I/O catheterizations averaging ter in die (TID) by licensed nursing.
- d. Mental and behavioral problems: requiring treatment or observation by skilled professional personnel to the extent deemed appropriate for the nursing facility
- e. Dialysis:
  1. Hemodialysis or peritoneal dialysis as part of a maintenance treatment plan
  2. New dialysis, during stabilization period, not to exceed four weeks

### **5.5 CAP/DA Needs Assessment**

The lead agency social worker and registered nurse shall complete the AQUIP Data Set to further determine a beneficiary's needs continue to meet nursing facility level of care criteria. The completed AQUIP Data Set is the second basic component of determining if a beneficiary is appropriate for CAP/DA services. A Continued Needs Review (CNR) needs assessment is completely annually.

## **5.6 CAP/DA Plan of Care**

The information collected through the needs assessment is documented in a Plan of Care (POC). The POC specifies the goals and actions to address the medical diagnosis and identified medical and functional care needs of an approved CAP/DA participant. The POC includes activities such as:

- a. ensuring the active participation of the eligible beneficiary, and working with the individual (or the beneficiary's authorized health care decision maker) and others to develop those goals; and
- b. identifies a course of action to respond to the assessed needs of the eligible individual.

The POC is developed annually and periodically.

## **5.7 Adult Day Health Services**

This service is for adults who are aged, have disabilities or handicaps that need a structured day program of activities and services with nursing supervision. It is an organized program of service provided for four or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting (10A NCAC 06S). The service encompasses both health and social services needed to ensure the optimal functioning of the beneficiary. Additional information is located at: <http://www.ncdhhs.gov/aging/manual/adcadh/Standards2007.pdf>.

## **5.8 Personal Care Aide**

Personal Care Aide provides assistance with personal care and basic home management tasks to beneficiaries who are unable to perform these tasks independently due to physical or mental disabilities. Personal Care Aide Services may be provided in the community, home, workplace, or educational settings at the discretion of the Home Care Provider. Under the Medicaid Infrastructure Grant (MIG) with Vocational Rehabilitation, DMA agreed to provide community based services in the workplace for those beneficiaries under its consumer directed care waiver.

## **5.9 Home Modification and Mobility Aids**

Home modifications and mobility aids include equipment and physical adaptations or minor renovations to the beneficiary's home that are required to meet their needs and are documented in the approved plan of care. Home modifications and mobility aids are provided to enhance the beneficiary's mobility, safety, and independence in the home. This service often plays a key role in preventing institutionalization. This service is not to exceed the limit of \$2000 over the fiscal year (July 1 - June 30) and the \$10,000 limit over the lifetime of the waiver, which is renewed every five years.

## **5.10 Meal Preparation and Delivery**

This service is often referred to as "Meals on Wheels" and provides for the preparation and delivery to the beneficiary's home of one nutritious meal per day.

## **5.11 Institutional Respite Care**

Institutional Respite Care is the provision of temporary support to the primary caregiver(s) of the CAP/DA beneficiary by taking over care of the CAP/DA beneficiary for a limited period of time. The provision of this service takes place in a Medicaid,

certified nursing facility or a hospital with swing beds. This service may be used to meet a wide variety of needs, including family or caregiver emergencies, relief of the caregiver, and planned vacations/special occasions when the caregiver needs to be away from town for some extended period of time. Institutional Respite is computed on a daily rate and in-home respite is computed on 15 minute unit interval. The combined use of both Institutional Respite Care and Non-Institutional Respite Care must not exceed 30 calendar days or 720 hours in one fiscal year. Edits/audits in the system will not deny claims for dates of admission or discharge in a facility or hospital if the participant receives in-home services prior to admission or after discharge.

### **5.12 Non-Institutional Respite Services**

Non-Institutional Respite Care is the provision of temporary support to the primary unpaid caregiver(s) of the CAP/DA beneficiary by taking over the tasks of primary caregiver for a limited period of time. These services are provided in the CAP/DA beneficiary's home and are provided by a Personal Care Aide working through a Homecare Agency Licensed by the State of North Carolina and authorized by the case manager to provide this temporary care. This service may be used to meet a wide range of needs, including family emergencies; planned special circumstances (such as vacations, hospitalizations, or business trips); relief from the daily responsibility and stress of caring for a beneficiary with a disability; or the provision of time for the caregiver(s) to complete essential personal tasks. Institutional Respite is computed on a daily rate and in-home respite is computed on 15 minute unit interval. The combined use of both Institutional Respite Care and Non-Institutional Respite Care must not exceed 30 calendar days or 720 hours in one fiscal year.

### **5.13 Personal Emergency Response Services (PERS)**

This service pays for the monthly service charges or monthly rental charges for a system used to alert a central monitoring facility of medical emergencies that threaten the beneficiary's health, safety and well-being. PERS does not cover the purchase and installation of equipment in the beneficiary's home.

### **5.14 Waiver Supplies**

Waiver supplies include specialized supplies approve through the CAP waiver and are not covered under the State Medicaid Plan. These supplies are provided to the waiver beneficiary to promote the health and well-being of the beneficiary. The service is necessary to avoid institutionalization. The following are waiver items: Nutritional supplements taken by mouth when ordered by a physician, reusable incontinence undergarments, disposable liners for reusable incontinence undergarments, and incontinence pads for personal undergarments and medication dispensing boxes.

### **5.15 Participant Goods and Services**

Participant Goods and Services include services, equipment, or supplies not otherwise provided through this waiver or through the Medicaid State Plan that meet the following requirements:

- a. The item or service would increase the individual's ability to perform ADLs or IADLs;
- b. The item or service would decrease dependence on Personal Assistant Services or other Medicaid-funded services; and

- c. The beneficiary does not have the funds to purchase the item or service. Choice Option beneficiaries may direct the Financial Manager (through the approved plan of care) to save a portion of their monthly beneficiary-directed budget for these items and services.

**Limitations:**

The cost of participant goods and services for each beneficiary must not exceed a limit of \$800.00 annually. Any item over \$200.00 must be approved by a DMA consultant.

## 5.16 Transition Services

Transition services are available to cover one-time expenses, not to exceed \$2500 per beneficiary. These expenditures are for initial set-up expenses for beneficiaries who make the transition from an institution to their own home or apartment in the community. The funds are used to pay the necessary expenses for a beneficiary to establish his or her basic living arrangement. This service does not include ongoing payment for rent.

Such items include:

- a. Equipment, essential furnishings, and household products
- b. Moving expenses
- c. Security deposits or other such payments (e.g., first month's rent) required to obtain a lease on an apartment or home
- d. Set-up fees or deposits for utility or service access (e.g., telephone, electricity, heating)
- e. Environmental health and safety assurances, such as pest eradication, allergen control, one time cleaning prior to occupancy
- f. Personal hygiene supplies
- g. First week supply of groceries
- h. Up to a one month supply of medication in instances when the beneficiary is not provided with medication upon discharge from the nursing facility.

**Limitations:**

- a. Transition services must not exceed \$2500 per beneficiary over the lifetime of the waiver, which is renewed every five years.
- b. Transition services must be used within 90 calendar days from the date the beneficiary transitioned from an institution.

## 5.17 Training and Education Services

Training and education includes training for the beneficiary, a family member who is the primary caregiver, or the Personal Assistant for CAP/DA beneficiaries. The purpose of this training is to enhance the decision-making ability of the beneficiary, enhance the ability of the beneficiary to independently care for themselves, or enhance the ability of the family member or personal assistant in caring for the beneficiary. Training and education include information and techniques for the use of specialized equipment and supplies. All training and education services must be documented in the beneficiary's care plan as a goal with the expected outcomes. This service includes conference registration and enrollment fees for classes.

**Limitations:**

This service is limited to \$500 per fiscal year. Individuals who are paid service providers, with the exclusion of the personal assistant (Choice Option), cannot be trained or educated using this service.

**5.18 Assistive Technology**

Assistive Technology includes items, product systems, supplies, and equipment necessary to the proper functioning of items and systems, whether acquired commercially, modified, or customized, that are used for the purposes of improving or maximizing the functional capabilities of the beneficiary, improve the accessibility and use of the beneficiary's environment, or address 24/7 beneficiary coverage issues. In some cases, the use of assistive technology may reduce the number of hours of personal care that the beneficiary needs. This service may be used for adaptive or therapeutic equipment designed to enable beneficiaries to increase, maintain, or improve functional capacity in performing daily life tasks that would not be possible otherwise; specialized monitoring systems; and specialized accessibility and safety adaptations or additions. This service includes technical assistance in device selection and training in device used by a qualified assistive technology professional, assessment and evaluation, purchases, shipping costs, and as necessary, the repair of such devices. The beneficiary's service plan must clearly indicate a plan for training the beneficiary, family, primary caregiver, personal aides or assistants who will assist in the application or use of the device(s). Professional consultation must be accessed to ensure that the equipment or supply meet the needs of the beneficiary.

**Limitations:**

The following limitations apply to this service:

- a. The cost of assistive technology is limited to \$3,000 per beneficiary per the life of the waiver, which is renewed every five years.
- b. Repair of assistive technology is covered as long as the cost of the repair does not exceed the cost of purchasing a new piece of equipment. The waiver beneficiary shall own the assistive technology. Waiver funding must not be used to replace equipment or devices that have not been reasonably cared for and maintained.
- c. The waiver is the payer of last resort for items that are covered under the state Durable Medical Equipment (DME) list. Equipment requests for items that have a basic counterpart on the state DME list must contain an explanation of why the item on the DME list will not meet the needs of the beneficiary.
- d. Adaptations that add to the total square footage of the home are excluded from this service.

Items not covered by this service include: computer desks and other furniture, heating, ventilation, air conditioning, plumbing, swimming pools, spas, hot tubs, saunas, service and maintenance contracts, and extended warranties.

## **5.19 Case Management**

Case management is assessing, care planning, referral or linkage and monitoring and follow-up. Case management services are necessary to identify needed medical, social, environmental, financial, and emotional needs. These services are provided to maintain the beneficiary's health, safety, and well-being in the community. It is a required component of the CAP/DA program that a case management review is performed at least monthly.

The principal components of case management are:

### **5.19.1 Assessing**

A comprehensive and culturally appropriate assessment should determine the beneficiary's needs, strengths, resources, preferences and goals to develop a Person-Centered Plan of Care. The assessment will identify areas that pose a significant risk to health, safety, and well-being for each CAP/DA and Choice beneficiary. It addresses all basic aspects of the beneficiary's life, including medical, physical or functional, psychosocial, behavioral, financial, social, cultural, environmental, legal, vocational or educational, and other areas. The assessment involves consultation with other natural and paid supports such as family members, medical and behavioral health providers, to form a complete assessment. The social worker and RN shall identify diagnoses and symptoms. The case management assessment includes periodic reassessment to determine whether a beneficiary's needs or preferences have changed.

### **5.19.2 Care Planning**

Care planning is the development and periodic revision of a specific care plan based on the information collected through the assessment and reassessment process.

### **5.19.3 Referral/Linkage**

Referral and related activities link a beneficiary with medical, behavioral, social, and other programs, services, and supports to address identified needs and achieve goals specified in the care plan. The case manager will coordinate with Community Care of North Carolina (CCNC). CCNC as the medical home for CAP/DA provides population health management, disease management and medical coordination of treatment and prevention to beneficiaries enrolled with a network provider and for other high-risk, high cost beneficiaries who are not enrolled. The case manager contacts the local CCNC network to obtain data available in their Provider Portal and follows all the requirements for consents in order to receive information that helps guide beneficiary care.

### **5.19.4 Monitoring/Follow-up**

Monitoring and follow up includes activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses

the needs of the beneficiary. Monitoring activities involve the beneficiary, his or her supports, providers, and others involved in care delivery.

Monitoring and Follow-up also include an annual reassessment to determine if the participant continues to meet the CAP/DA eligibility and level of care criteria of need. This CNR is completed every 12 months based on the initial date of CAP/DA participation.

The CNR includes the following information:

- a. The new physician's recommendation for nursing facility LOC.
- b. Reassessment of the participant's strengths, needs, and appropriateness for CAP/DA.
- c. New POC based on participant's current situation and medical needs.

**Limitations:**

- a. CAP/DA program beneficiaries must not receive another Medicaid-reimbursed case management service in addition to CAP/DA case management.
- b. Non-covered case management activities include employee training for the Case Manager, completing time sheets, travel time, recruiting staff, scheduling and supervising staff, billing Medicaid and documenting case management activities.

**5.20 Care Advisor (Choice Option only)**

The care advisor is a specialized case manager from a CAP/DA local lead agency with an understanding of consumer-directed care. The care advisor focuses on empowering consumers to define and direct their own personal assistance needs and services. The care advisor guides and supports the beneficiary, rather than directing and managing the beneficiary, throughout the service planning and delivery process. The care advisor provides the four basic functions of case management (assessing, care planning, referral/linkage, monitoring/follow-up) however these functions are done under the guidance and direction of the Choice beneficiary.

**Limitations:**

- a. CAP/DA program beneficiaries must not receive another Medicaid-reimbursed case management service in addition to CAP/DA case management.
- b. Non-covered case management activities include employee training for the care advisor, completing time sheets, travel time, recruiting staff, scheduling and supervising staff, billing Medicaid and documenting case management activities.

**5.21 Personal Assistant Services (Choice Option only)**

Personal assistant Services are available only for those beneficiaries who have elected the Choice Option under the CAP/DA Waiver. The personal assistant is hired by the beneficiary to provide help with personal and home maintenance tasks for beneficiaries who are unable to meet these needs independently due to physical or mental impairments. Personal maintenance tasks are basic activities of daily living that must be performed to assure or support one's physical well-being.

**Limitations:** Lifetime hiring ban is placed on any individual who has any one of the following findings on their background check:

- a. Felonies related to manufacture, distribution, prescription or dispensing of a controlled substance;
- b. Felony health care fraud;
- c. More than one felony conviction;
- d. Felony for abuse, neglect, assault, battery, criminal sexual conduct (1<sup>st</sup>, 2<sup>nd</sup> or 3<sup>rd</sup> degree), fraud or theft against a minor or vulnerable adult;
- e. Felony or misdemeanor patient abuse;
- f. Felony or misdemeanor involving cruelty or torture;
- g. Misdemeanor healthcare fraud;
- h. Misdemeanor for abuse, neglect, or exploitation of a minor or disabled adult;
- i. Substantiated allegation of abuse, neglect or exploitation listed with the N.C. Health Care Registry; or
- j. Any substantiated allegation listed with the NC Health Care Registry that would prohibit an individual from working in the Health Care field in the state of NC.

## **5.22 Financial Management Services (Choice Option only)**

Financial management services are provided to ensure that beneficiary-directed funds outlined in individual plans of care are managed and distributed as intended. The Financial Intermediary (FI) files claims through the State of North Carolina designated Medicaid Management Information System (MMIS) and reimburses the personal assistant(s) and individual providers. The FI deducts all required federal, state taxes, including insurance and FI fees, prior to issuing reimbursement or paychecks. The FI entity is responsible for maintaining separate accounts on each beneficiary's services, and producing expenditure reports as required by the state Medicaid agency. The FI also provides payroll statements on at least a monthly basis to the personal assistant(s). The FI conducts necessary background checks and age verification on personal assistants.

### **Limitations:**

Financial Intermediary (FI) is billed through a vendor contract. The rate is \$75 start-up fee and \$75 per beneficiary per month. Unlike other services, this service should not be included in the cost summary of the Plan of Care.

## **5.23 Other Medicaid Services (State Plan Covered)**

CAP/DA beneficiaries may receive regular (non-waiver) Medicaid services according to the specific service policies and procedures, which may limit the receipt of waiver services in some cases. The beneficiary's cost summary must include any non-waiver in-home service that is provided and the case manager must coordinate the provision of all services. Some of the most frequently utilized non-waiver services are Durable Medical Equipment, including orthotics and prosthetics, Home Health Services, Home Infusion Therapy (HIT) and Hospice Services.

### **5.23.1 Durable Medical Equipment (DME)**

DME includes medically necessary equipment, supplies and related authorized waiver supplies when the item(s) is medically necessary and appropriate for use in a patient's private home or an adult care home. The beneficiary's physician must verify the need and DME must be included on the POC. Convenience items or features are not covered, e.g. shampoo trays, gait belts. CAP/DA case managers work with DME suppliers to ensure good patient care and to be knowledgeable of DME being supplied to CAP beneficiaries. Refer to Medicaid's clinical coverage policy 5A, *Durable Medical Equipment and Supplies*, on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/> for additional information..

### 5.23.2 Home Health

Home Health Services are provided by certified home health agencies under a plan of treatment authorized and approved by a physician.

Home Health skilled nursing visits are not required to participate in CAP/DA. CAP/DA beneficiaries must meet all the requirements for Home Health services. Refer to clinical coverage policy 3A, *Home Health Services*, on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/> for additional information.

### 5.23.3 Hospice

Hospice is a package of medical and support services for terminally ill individuals. A beneficiary is considered terminally ill when the medical prognosis is a six month or less life expectancy. Hospice services must be related to the terminal illness and be provided in a private residence, an adult care home, a hospice residential care facility, or a hospice inpatient unit. They can be provided in a hospital or nursing facility under arrangement with the hospice agency.

If a beneficiary is found appropriate for Hospice, he or she may elect Hospice while waiving other Medicaid coverage for the terminal illness. If the beneficiary is also eligible for Medicare, Hospice coverage under both programs must be elected. If a beneficiary is being considered for Hospice care, it must be determined if Medicare or Medicaid is the primary payer.

1. ***If Medicaid is the primary payer***, CAP/DA and Hospice cannot be offered at the same time. The cost of Hospice will not fall within the CAP/DA cost limit. The beneficiary has a choice of which to pursue.
2. ***If Medicare is the primary payer***, the needs of the beneficiary that are not included in the Hospice benefit must be determined. In addition to Case Management, a Medicare Hospice patient may be considered for the following services from CAP/DA:
  - a. Adult Day Health
  - b. Personal Emergency Response Services
  - c. Home Modification and Mobility Aids
  - d. In-Home Respite (Hospice covers Institutional Respite)
  - e. Meal Preparation and Delivery

- f. Medication Dispensing Boxes and Oral Nutritional Supplements under CAP/DA Waiver Supplies (please reference the Hospice policy for any additional items that may be covered by the Hospice benefit).

In-Home Aide services may also be included to the extent that they do not duplicate what the hospice agency is required to provide under hospice aide and homemaker services. When planning CAP/DA In-Home Aide Services, careful coordination must occur to avoid duplication.

Refer to Medicaid's clinical coverage policy 3D, *Hospice Services*, on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/> for additional information.

#### **5.23.4 Home Infusion Therapy (HIT)**

The Home Infusion Therapy (HIT) program covers self-administered infusion therapy and enteral supplies provided to a Medicaid beneficiary residing in a private residence or an adult care home. Covered services include all of the following:

- a. Total parenteral nutrition (TPN);
- b. Enteral nutrition (EN);
- c. Intravenous chemotherapy;
- d. Intravenous antibiotic therapy; and
- e. Pain management therapy, including subcutaneous, epidural, intrathecal, and intravenous pain management therapy.

##### **5.23.4.1 Program Criteria**

HIT services are covered when all criteria in **Clinical Coverage Home Infusion Therapy (HIT) Policy**, are met in accordance with criteria for the specific therapy ordered. Refer to clinical coverage policy 3H-1, *Home Infusion Therapy*, on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/> for additional information.

##### **5.23.4.2 Procedure Codes for Drug Therapies**

HIT drug therapies are covered under a per diem charge. The per diem covers the therapy administration, supplies, and the nursing component (teaching, monitoring) of the therapy. HIT drug therapy must be billed using two HCPCS codes for each day of service to comply with national coding standards in accordance with HIPAA requirements. The applicable therapy code plus the nursing component code must be used for each day of therapy.

## **6.0 Providers Eligible to Bill for the Procedure, Product, or Service**

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and

- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

## **6.1 Provider Qualifications**

### **6.1.1 Adult Day Health Services**

Adult Day Health Services are provided by Adult Day Health Centers certified by the North Carolina Division of Aging and Adult Services according to North Carolina Statute 131-D-6. The certification process is conducted by NC Division of Aging under 10A NCAC 06R, which states further that local departments of social services are responsible for on-going monitoring and annual certification of Adult Day Health Centers.

### **6.1.2 Personal Care Aide**

Personal Care Aides are provided by Homecare Agencies licensed by the State of North Carolina who comply with NC General Statute 131E-135 through 142 and 21 NCAC 36.0403 (a) and 21 NCAC 36.0403 (b). Workers providing Level III – Personal Care tasks must be certified as a Nurse Aide I. The employment of a spouse, parent, child or sibling of the CAP/DA participant shall provide this service only if the person:

- a. Is at least 18 years of age;
- b. Meets the aide qualifications; or deemed competent by the appropriate licensed supervisory professional of the In-Home Care agency to provide the personal care task at that level as defined in 10A NCAC 13J.110; and
- c. Any employment cannot interfere with or negatively impact the provision of services; nor supersede the identified care needs of the CAP/DA participant. This restriction also applies to other relatives and hired personnel.

### **6.1.3 Home Modifications and Mobility Aids**

Home modification and mobility aids shall be provided by a durable medical equipment company or local lead agency through contract who are qualified as enrolled Medicaid providers and who have demonstrated the capacity to make the needed modifications and install equipment according to applicable local and state building codes. Providers must install items according to the manufacturer's specifications and requirements.

### **6.1.4 Meal Preparation and Delivery**

Agencies and organizations providing nutrition services shall meet Division of Aging Services requirements for home delivered meals in compliance with 10A NCAC 06K.0101.

### **6.1.5 Institutional Respite Services**

Institutional respite services shall be provided in a Medicaid certified nursing facility or a hospital with swing beds under 10A NCAC 13D rules for the licensing of nursing homes.

### **6.1.6 Non-Institutional Respite Services**

Non-institutional respite services shall be provided by a homecare agency licensed by the State of North Carolina in accordance with 10A NCAC 13J.1107, In-Home Aide Services. If the beneficiary's plan of care requires the personal

care aide provide extensive assistance which includes substantial hands-on care to a beneficiary who is only able to perform part of the activity, the personal care aide shall be listed on the Nurse Aide Registry pursuant to G.S. 131E-256. This applies to provider-managed Non-Institutional Respite.

The aide providing this service can be the legal representative or legal guardian as long as the individual works for a provider agency, is licensed as a Nurse Aide I and meets the hiring criteria of the agency providing the service.

#### **6.1.7 Personal Emergency Response Services (PERS)**

The emergency response provider must have the capability to provide a 24-hour monitoring system in accordance with the service definition.

#### **6.1.8 Waiver Supplies**

Waiver supplies are specialized medical goods that the provider must be capable of providing of sufficient quality verified by the case manager.

#### **6.1.9 Participant Goods and Services**

These services, equipment, and/or supplies are purchased through the lead agency. Medicaid providers who have the capacity as verified by the case manager shall provide items and services of sufficient quality and appropriate to the needs of the beneficiary. Some items may be purchased directly through a retailer as long as the items meet the specifications of the service definition.

#### **6.1.10 Transition Services**

Medicaid providers who have the capacity as verified by the case manager to provide items and services of sufficient quality to meet the need for which they are intended shall provide transition services. Items and services (including rental housing) must be of sufficient quality and appropriate to the needs of the beneficiary. The beneficiary must provide a receipt for each purchase or invoice for each payment. Some items may be purchased directly through a retailer as long as the item meets the specifications of this service definition.

#### **6.1.11 Training and Education Services**

An organization with a training or class curriculum approved by the Division of Medical Assistance including Universities, Colleges and Community Colleges shall provide training and education services.

#### **6.1.12 Assistive Technology**

Assistive Technology Professionals, Nursing Facility (Rehab), Hospital, or Certified Home Health Agency that are State licensed Occupational Therapists, Physical Therapists or Speech Language Pathologists. (Licensure to include certification of clinical competency which is required for augmentative communication evaluations) shall provide assistive technology. Additional provider qualifications may include Assistive Technology Practitioners (ATP) or Assistive Technology Suppliers (ATS) certified by RENSA. Assistive Technologists shall hold a bachelor's degree in a human services field, special education or related degree, and two years experience working with assistive technology.

### **6.1.13 Case Manager Services**

Social workers and registered nurses shall provide case management services. Case managers must meet the requirements of the NC Division of Public Health Nurse I or Social Worker I or higher.

### **6.1.14 Care Advisor (Choice Option Only)**

Care Advisor service providers include social workers and registered nurses. Care Advisors must meet the requirements of the NC Division of Public Health Nurse I or higher or Social Worker I or higher.

### **6.1.15 Personal Assistant Services (Choice Option Only)**

Personal Care Assistants hired by beneficiaries to provide personal care services qualify to provide the service based on the following criteria;

- a. Must be 18 years of age or older;
- b. Be a relative or individual who is not acting as the legal guardian or legal representative of the beneficiary;
- c. Be absent of a history of abuse, neglect, exploitation, and violent crimes against a child or vulnerable adult;
- d. Be absent of substantiated Allegation of Abuse, neglect or exploitation listed with the N.C. Health Care Registry (refer to **Subsection 5.21** "Limitations" for complete list);
- e. Be absent of any substantiated allegation listed with the NC Health Care Registry that would prohibit an individual from working in the Health Care field in the state of NC; and
- f. Meet other reasonable requirements as specified by the beneficiary.

### **6.1.16 Financial Management Services (Choice Option Only)**

An agency or organization enrolled with Medicaid with at least two years of experience in the following may provide financial management services:

- a. Completing employee payroll activities, including issuing paychecks to employees and paying the necessary state and federal taxes and insurance;
- b. Meets all other requirements set forth in NC DHHS contract for Financial Intermediary; or
- c. Agency or organization must be approved by the Internal Revenue Service to be an employer agent in accordance with Section 3504 of the IRS Code and IRS Revenue Procedure 70-6.

## **7.0 Additional Requirements**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

### **7.1 Compliance**

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s)..

## **7.2 Coordination of Care**

Beneficiaries are eligible to receive all Medicaid services according to Medicaid policies and procedures, except when those policies or procedures restrict participation. For example, a CAP/DA beneficiary may not receive another Medicaid-reimbursed case management service in addition to CAP/DA case management.

## **7.3 Choice Beneficiaries with Deductibles**

A CAP/DA beneficiary who has a deductible is able to participate in the Choice option; however, the beneficiary as well as the personal assistant must understand and agree to the conditions of incurring and paying a deductible monthly. The beneficiary must understand that they are responsible to pay their deductible in order for the personal assistant to get paid. The personal assistant must understand and accept that if the beneficiary does not pay their deductible he or she must not get paid for services rendered until the deductible is met or paid.

## **7.4 Budget and Use of Funds**

The CAP/DA beneficiary plan of care is developed on a year-to-year basis or revised as needed by the Case manger. Plans of care require local approval by the local lead agency. The beneficiary's budget limit is established by methodology used for establishing the CAP/DA budget limits. DMA approves monthly budget limits based on an Intermediate or Skilled Nursing Facility Level of Care. Payment for all services requires documentation that includes timesheets, invoices, and other purchase orders. Requests that are made for services that are not defined by approved service definition, and cost over two hundred dollars (\$200.00), must be submitted in writing and approved by the DMA CAP/DA Consultant.

## **7.5 Health, Safety and Well-being**

The primary consideration underlying the provision of services and assistance for disabled and elderly adults is their desire to reside in a community setting. Enrollment in CAP/DA may be denied based upon the inability of the program to ensure the health, safety, and well-being of the beneficiary under the following circumstances:

- a. Based on assessment of the beneficiary's mental, psychosocial and physical condition and functional capabilities:
  1. The beneficiary is considered to be unsafe when left alone, with or without a Personal Emergency Response System;
  2. The beneficiary lacks the support of a willing and capable caregiver who must provide adequate care to ensure the health, safety, and well-being of the individual when indication that a 24-hour coverage plan is needed; or
  3. The beneficiary's needs cannot be supported by the system of services that is currently available; or
- b. The beneficiary's residence is not reasonably considered to be adequate in that the home does not provide for the beneficiary's safety, and these issues cannot be resolved before well-being can be assured;

- c. The beneficiary's residence or residential environment is unsafe to the extent that it would reasonably be expected to endanger the health and safety of the individual, the individual's caregivers, or the case manager;
- d. The beneficiary's behavior impedes the safety of self and others (e.g. suicidal, injurious to self or others, verbally abusive, or destructive of physical environment); or
- e. The beneficiary chooses to remain in a living situation where there is a high risk or an existing condition of abuse, neglect, or exploitation as evidenced by an assessment.

## 7.6 Hearings and Appeal Process

In accordance with the beneficiary's notices procedure, DMA provides written notice to the beneficiary, legal representative(s), or both, of all adverse decisions. A beneficiary whose level of care request is denied, or whose services are denied, suspended, terminated, or reduced, has the right to appeal.

Examples of such decisions are:

- a. denial of initial or continued participation in the CAP/DA program;
- b. denial of increase, or reduction, of waiver services included in the POC; or
- c. termination from the CAP/DA program.

Only actions initiated by DMA may be appealed. Therefore the following decisions may not be appealed:

- a. A provider's refusal to serve a CAP/DA beneficiary;
- b. A physician's level of care recommendation; or
- c. A physician's order.

## 7.7 Quality Assurance

### 7.7.1 Objectives

Quality assurance activities are conducted to monitor the following:

- a. The health, safety, and well-being of CAP/DA beneficiaries;
- b. The quality, appropriateness, and outcomes of services provided to CAP/DA beneficiaries;
- c. CAP/DA beneficiaries' appropriate (nursing facility) LOC; and
- d. The cost efficiency of the CAP/DA beneficiary's care.

### 7.7.2 Components

Quality improvement activities are a joint responsibility of DMA and the local lead agencies. Local lead agencies and providers cooperate with all quality improvement activities by submitting all requested documents and by providing evidence of follow-up and corrective action when review activities reveal their necessity.

The major components of the quality improvement activities include all of the following:

- a. Review of initial applications and continued need reviews for appropriateness, accuracy, and outcomes;
- b. Review of Medicaid claims billed;
- c. Critical incident reporting; and

d. Site audits of local lead agencies.

### 7.8 Program Integrity

CAP/DA lead agencies that arrange for services that are not documented on the POC and are not medically necessary are referred to Medicaid's Program Integrity unit for evaluation and potential recoupment of reimbursement.

CAP/DA provider agencies that provide services that are not medically necessary or not performed according to the Service Authorization are referred to Medicaid's Program Integrity unit for evaluation and possible recoupment of reimbursement.

### 7.9 Use of Telephony and Other Automated Systems

Providers may utilize telephony and other automated systems to document the provision of CAP/DA services. Guidelines for use of telephony are provided in January 2009 general Medicaid bulletin at <http://www.ncdhhs.gov/dma/bulletin/0109bulletin.htm#tele>.

## 8.0 Policy Implementation/Revision Information

**Original Effective Date:** October 1, 1982

**Revision Information:**

Date	Section Revised	Change
3/1/12	Throughout	Initial promulgation of current program coverage.
3/1/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

### Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

**A. Claim Type**

Professional (CMS-1500/837P transaction)

**B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)**

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

**C. Code(s)**

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

HCPCS Code(s)			
S5102	T2038	S5135	B4158BO
S5125	S5111	T2040	B4159BO
S5165	T2029	B4150BO	B4160BO
S5170	T1016	B4152BO	B4161BO
H0045	T2028	B4153BO	B4162BO
S5150	T4535	B4154BO	
S5161	T4539	B4155BO	
T2025	T2041	B4157BO	

**Unlisted Procedure or Service**

**CPT:** The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

**HCPCS:** The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

**D. Modifiers**

Provider(s) shall follow applicable modifier guidelines.

**E. Billing Units**

Refer to the CAP/DA fee schedule for current rate and billing units:

<http://www.ncdhhs.gov/dma/fee/index/>

**F. Place of Service**

Case management services are provided in the case manager's office, a beneficiary's Permanent Private Place of Residence, Acute Inpatient Hospital, or Nursing Facility. Acceptable places for all other waiver services to be provided are dependent on service type.

**G. Co-payments**

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at

<http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at

[http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter\\_108A/GS\\_108A-70.21.html](http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html)

**H. Reimbursement**

Providers shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>