

APPENDIX A OTHER RESOURCES

Child Service Coordination Program (CSC)

WHAT IS IT?

The Child Service Coordination program provides formal case management services to eligible children at risk or diagnosed with special needs. Child Service Coordination identifies and provides access to needed preventive and specialized support services for children and their families through collaboration

WHAT IS INCLUDED?

Support and assistance for medical services, which may include

- periodic medical, behavioral, and psychosocial evaluations
- help communicating with doctors
- making appointments
- exploring child care options
- locating transportation
- locating financial assistance
- social support
- making referrals to other agencies or programs
- providing education regarding parenting skills and child development

WHAT IS NOT INCLUDED?

- Services for children who do not meet the risk or diagnostic criteria
- Service provided on the same day as
 - Home visit for newborn care and assessment
 - Home visit for postnatal assessment and follow-up care
 - Maternal care skilled nurse home visit
 - Maternal outreach worker services
 - Maternity care coordination

WHO CAN GET IT?

- Families of children birth to three years of age at high risk for developmental disabilities, social or emotional problems, or chronic illnesses, and who are not receiving services through the Early Intervention Infant-Toddler Program.
- Children aged three and four years with an actual diagnosis of developmental disability, social or emotional problems, or chronic illness.

Eligibility is based on risk factors and diagnoses, not income.

HOW MUCH CAN THEY GET?

There are a maximum allowed number of hours per month of case management services that can be provided. There are also minimum requirements for the frequency and type of contact the case manager must have with the child and family. Within those parameters, the amount of service is determined by the family's needs and the plan of care.

WHERE CAN THEY GET IT?

CSC workers can meet with the child and family in their family's home or any other place the family chooses.

CAN THEY GET IT WHILE THEY ARE ON THE CAP/C PROGRAM?

No. This is considered duplication of services.

WHO CAN PROVIDE IT?**Agencies**

The program is run through the local health department, or through a Developmental Evaluation Center, Federally Qualified Health Center, Rural Health Clinic, or Sickle Cell agency enrolled with the Health Department.

Individuals

The individual case managers (child service coordinators) are Registered Nurses or Social Workers who have experience working with children and families, or others who meet the criteria for education and experience described in the CSC policy.

WHAT DOES IT COST? HOW IS IT BILLED?

The program is free to participants.

A participant does not have to have Medicaid to receive CSC, but if they do have it services will be billed to Medicaid using the CMS-1500, HCPCS code T1016.

Please see the "Basic Medicaid Billing Guide" located at

<http://www.dhhs.state.nc.us/dma/basicmed/index.htm> for complete information.



HOW DO I REFER SOMEONE?

Contact your local health department or the Children and Youth Branch of the North Carolina Division of Public Health. The telephone number for the Children and Youth Branch is (919) 707-5611.



This material is only a brief general overview of this program. Please refer to the *Medicaid Clinical Coverage Policies and Provider Manuals* and the monthly *Medicaid Bulletins* for more information. You will find these publications at <http://www.dhhs.state.nc.us/dma/provider/index.htm>

APPENDIX A OTHER RESOURCES

Community Alternatives Program for Disabled Adults (CAP-DA)

WHAT IS IT?

The Community Alternatives Program for Disabled Adults (CAP/DA) provides a package of services to allow adults who qualify for nursing facility care to remain in their private residences. The program is available in all North Carolina counties. The program contributes to the quality of life of the participants and their families/caregivers, while providing care that is cost-effective in comparison to the Medicaid cost for nursing facility care.

WHAT IS INCLUDED?

- Adult Day Health services
- Personal Care Aide services
- Waiver supplies: reusable incontinence garments and disposable liners, incontinence pads for personal undergarments, oral nutrition for persons age 21 and older (for recipients aged 18 through 20 oral formula is available as a state plan service), and medication dispensing boxes
- Case Management
- Choice Option: Care Advisor, Financial Management Services, and Personal Assistant Services
- Home Modifications and Mobility Aids: wheelchair ramps; grab bars and handrails; widening of doorways/passages; modification of

bathroom; bedroom modifications to accommodate hospital beds and/or wheelchairs; kitchen modifications; floor coverings for ease of ambulation; hydraulic, manual, or electronic lifts; non-skid surfaces; and lift chairs

- Meal preparation and delivery
- Respite care, institutional and non-institutional
- Personal Emergency Response Services
- Assistive Technology
- Crisis Services
- Training and education services
- Transition services
- Participant Goods and Services

WHAT IS NOT INCLUDED?

Each of the above services within the waiver has its own criteria for what is or is not included. Please refer to the CAP-DA Clinical Coverage Policy. Any CAP-DA services provided while the recipient is in an institution such as a hospital, nursing facility, or ICF-MR facility are not included.

WHO CAN GET IT?

Individuals who:

- are age 18 and older
- are eligible for regular Medicaid
- live in a private residence and is at risk of being placed in a nursing facility or lives in a nursing facility and wants to return to a private residence
- require Nursing Facility Level of Care as determined through the Medicaid prior approval process

- Require CAP/DA services to remain safely at home/in the community
- Can have their health, safety, and well-being maintained at home within the established cost limits of the program
- Desire CAP/DA services instead of institutional care

HOW MUCH CAN THEY GET?

There are limits on some individual services; for example, respite and home modifications.

Additionally, the cost of in-home services, including waiver services, DME, orthotics and prosthetics, and home health services and supplies, is limited to a monthly budget for each recipient determined by his/her level of care.

WHERE CAN THEY GET IT?

Services may be provided in the recipient's home, school, community, or adult day health center, depending upon the specific service and the approved Plan of Care.

CAN THEY GET IT WHILE ON THE CAP/C PROGRAM?

No. A recipient can not be on two waiver programs simultaneously.

WHO CAN PROVIDE IT?

Each individual service has its own providers and its own criteria for provider qualifications. Please refer to the CAP-DA Clinical Coverage Policy for detailed information

(<http://www.dhhs.state.nc.us/dma/mp/index.htm>).

In certain cases, family members can be providers.

WHAT DOES IT COST? HOW IS IT BILLED?

Each service within CAP-DA has its own HCPCS code, billing unit, and unit rate. You can find this information at:

http://www.dhhs.state.nc.us/dma/fee/CAP_DA.pdf and
http://www.dhhs.state.nc.us/dma/fee/CAP_Choice.pdf.

Use the CMS-1500.

Please see the “Basic Medicaid Billing Guide” located at

<http://www.dhhs.state.nc.us/dma/basicmed/index.htm> for complete information.

**HOW CAN I REFER SOMEONE?**

Contact the local CAP/DA lead agency. The list of agencies and their contact information can be found at

<http://www.dhhs.state.nc.us/dma/cap/CAPContactList.pdf>.

This material is only a brief general overview of this program. Please refer to the *Medicaid Clinical Coverage Policies and Provider Manuals* and the monthly *Medicaid Bulletins* for more information. You will find these publications at <http://www.dhhs.state.nc.us/dma/provider/index.htm>



APPENDIX A OTHER RESOURCES

Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD)

WHAT IS IT?

The Community Alternatives Program for Mentally Retarded/Developmentally Disabled Individuals (CAP/MR-DD) Program is designed to give persons with mental retardation and developmental disabilities a cost-effective alternative to care in an intermediate care facility for persons with mental retardation (ICF-MR). The goal of CAP/MR-DD is to allow individuals to return to and live in their community with as much independence as possible.

WHAT IS INCLUDED?

There are two CAP-MR/DD waiver programs: the Comprehensive waiver and the Supports waiver.

Services offered under the Comprehensive Waiver include: personal care, home and community supports, respite, home supports, residential supports, crisis services, behavior consultation, adult day health, day supports, transitional work services, long term vocational supports, supported employment, individual caregiver training and education, personal emergency response system, specialized consultative services, specialized equipment and supplies, transportation, vehicle adaptations, home modifications, and augmentative communication. Case Management will be provided through the state general plan.

Services offered under the Supports Waiver include: personal care, home and community supports, respite, crisis services, behavior consultation, adult day health, day supports, transitional work services, long term vocational supports, supported employment, individual caregiver training and education, personal emergency response system, specialized consultative services, specialized equipment and supplies, transportation, vehicle adaptations, home modifications, and augmentative communication. Case Management will be provided through the state general plan. The Supports Waiver also includes the option of self-directed services with the assistance of a support broker and financial management service.

WHAT IS NOT INCLUDED?

Each of the services within the waiver has its own criteria for what is or is not included. Please refer to the CAP-MR/DD Clinical Coverage Policy. Any CAP-MR/DD services provided while the recipient is in an institution such as a hospital, nursing facility, or ICF-MR facility are not included.

WHO CAN GET IT?

An individual who:

- Is age three or older
- has a diagnosis of mental retardation OR a condition closely related to mental retardation (specified in the policy).
- meets the requirements for ICF-MR level of care.
- is eligible for Medicaid coverage, or will be eligible for Medicaid under the CAP-MR/DD eligibility criteria.
- resides in an ICF-MR facility and wants to return home or is at high risk of being placed in an ICF-MR facility.

- can have his or her health, safety and well being can be maintained in the community under the program.
- requires CAP-MR/DD services, based on medical necessity criteria, as identified through a family or person-centered planning process.
- desires CAP-MR/DD participation rather than institutional services.

HOW MUCH CAN THEY GET?

The amount and duration of services provided are determined through the person-centered planning process with the individual's planning team. Services are based on the needs and preferences of the individual, the availability of other formal and informal supports, and rules of the funding source.

The Comprehensive Waiver and the Supports Waiver each have their own annual cost limit per recipient. Waiver services count toward the cost limit.

WHERE CAN THEY GET IT?

CAP-MR/DD may be provided at the recipient's home or in the community. It may not be provided at school.

CAN THEY GET IT WHILE ON THE CAP/C PROGRAM?

No. An individual may not be on two waiver programs simultaneously.

WHO CAN PROVIDE IT?

Each individual service has its own providers and its own criteria for provider qualifications. Please refer to the CAP-MR/DD Clinical Coverage

Policy (<http://www.dhhs.state.nc.us/dma/mp/index.htm>) for detailed information.

In certain cases, family members can be providers.

All CAP-MR/DD services must be provided by an agency enrolled with DMA and endorsed by the LME to provide the specific service.

WHAT DOES IT COST? HOW IS IT BILLED?

Each service within CAP-MR/DD has its own HCPCS code, billing unit, and unit rate. You can find this information at:

http://www.dhhs.state.nc.us/dma/fee/CAPMRDD1009_comp.pdf

(comprehensive waiver) and

http://www.dhhs.state.nc.us/dma/fee/CAPMRDD1009_support.pdf

(supports waiver).

Use the CMS-1500.

Please see the “Basic Medicaid Billing Guide” located at

<http://www.dhhs.state.nc.us/dma/basicmed/index.htm> for complete

information.



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HOW CAN I REFER SOMEONE?

Contact the LME (Local Management Entity) for the recipient’s geographic area. A list of the LMEs, with contact information, can be found at <http://www.dhhs.state.nc.us/mhddsas/lmedirectory.htm>.

This material is only a brief general overview of this program. Please refer to the *Medicaid Clinical Coverage Policies and Provider Manuals* and the monthly *Medicaid Bulletins* for more information. You will find these publications at <http://www.dhhs.state.nc.us/dma/provider/index.htm>



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APPENDIX A OTHER RESOURCES

Community Support Services - Child

WHAT IS IT?

Community Support services are community-based, rehabilitative in nature, and intended to meet the mental health and/or substance abuse needs of children and adolescents who have significant identified symptoms that seriously interfere with or impede their roles or functioning in family, school, or community. These services are designed to

- enhance the skills necessary to address the complex mental health and/or substance abuse symptoms of children and adolescents who have significant functional deficits due to these disorders, to promote symptom reduction and improve functioning in their daily environments;
- assist the child/adolescent and family in acquiring the necessary skills for reaching recovery from mental health and/or substance abuse disorders, for self management of symptoms and for addressing vocational, housing, and educational needs;
- link recipients to, and coordinate, necessary services to promote clinical stability and meet the mental health/substance abuse treatment, social, and other treatment support needs while supporting the emotional and functional growth and development of the child; and
- monitor and evaluate the effectiveness of delivery of all services and supports identified in the Person Centered Plan.

WHAT IS INCLUDED?

Community Support Services includes the following, as clinically indicated:

- Facilitation of the Person Centered Planning process with the Child and Family Team which includes the child, parent or legal guardian, and others identified as important in the recipient's life (e.g., family, friends, providers);
- Identification of strengths that will aid the child and family in the child's recovery, as well as the identification of barriers that impede the development of skills necessary for functioning in the community that will be addressed in the Person Centered Plan;
- Initial development, implementation, and ongoing revision of Person Centered Plan;
- Monitoring the implementation of the Person Centered Plan, including involvement of other medical and non-medical providers, the child and the family, and other natural and community supports;
- Individual (1:1) interventions with the child or adolescent, unless a group intervention is deemed more efficacious;
- Therapeutic interventions that directly increase the acquisition of skills needed to accomplish the goals of the Person Centered Plan;
- Identification and self-management of symptoms;
- Identification and self-management of triggers and cues (early warning signs);
- Monitoring and evaluating the effectiveness of interventions as evidenced by symptom reduction and progress toward goals identified in the Person Centered Plan
- Direct preventive and therapeutic interventions, associated with the mental health or substance abuse diagnosis that will assist with skill

- building related to goals in the Person Centered Plan as related to the mental health or substance abuse diagnosis and symptoms;
- Direct interventions in escalating situations to prevent crisis (including identifying cues and triggers);
 - Assistance for the youth and family in implementing preventive and therapeutic interventions outlined in the Person Centered Plan (including the crisis plan);
 - Response to crisis 24/7/365 as indicated in the recipient's crisis plan and participation in debriefing activities to revise the crisis plan as needed;
 - Relapse prevention and disease management strategies;
 - Psychoeducation regarding the identification and self-management of prescribed medication regimen, with documented communication to prescribing practitioner(s);
 - Psychoeducation and training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs identified in the Person Centered Plan. Psychoeducation services and training furnished to family members and/or caregivers must be provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual. Psychoeducation imparts information to the recipients, families, caregivers, and/or other individuals involved with the recipient's care about the recipient's diagnosis, condition, and treatment for the express purpose of helping to assist with developing coping skills. These skills will support recovery and encourage problem solving strategies for managing issues posed by the recipient's condition. Psychoeducational activities are performed for the direct benefit of the Medicaid recipient and help the recipient develop increasingly sophisticated coping skills for handling problems resulting from their condition. The goal of

psychoeducation is to reduce symptoms, improve functioning, and meet the goals outlined in the Person Centered Plan.

- Coordination and oversight of initial and ongoing assessment activities; and
- Ensuring linkage to the most clinically appropriate and effective services.

WHAT IS NOT INCLUDED?

Services provided by more than one Community Supports provider organization at a time.

Services provided while a child is in an inpatient setting or in an Institution for Mental Disease, or an intensive in-home service, Multi-Systemic Therapy, partial hospitalization, PRTF, substance abuse residential service, or intensive substance abuse service.

WHO CAN GET IT?

Individuals for whom

A. significant impairment is documented in at least two of the life domains related to the recipient's diagnosis, that impede the use of the skills necessary for independent functioning in the community. These life domains are as follows: emotional, social, safety, medical/health, educational/vocational, and legal.

AND

B. there is an Axis I or II MH/SA diagnosis (as defined by the DSM-IV-TR or its successors), other than a sole diagnosis of Developmental Disability

AND

C. there is a substance abuse diagnosis, American Society for Addiction Medicine (ASAM) criteria is met.

AND

D. the recipient is experiencing functional impairments in at least two of the following areas as evidenced by documentation of symptoms:

1. is previously or imminently at risk for institutionalization, hospitalization, or placement outside the recipient's natural living environment;
2. is receiving or needs crisis intervention services;
3. has unmet identified needs related to MH/SA diagnosis as reported from multiple agencies, needs advocacy, and service coordination as defined by the Child and Family Team;
4. is abused or neglected as substantiated by DSS, or is found in need of services by DSS, or meets dependency as defined by DSS criteria (GS 7B101);
5. exhibits intense verbal aggression, as well as limited physical aggression, to self or others, due to symptoms associated with the mental health and/or substance abuse diagnosis, which is sufficient to create functional problems in the home, community, school, job, etc.; or
6. is in active recovery from substance abuse or dependency and is in need of continuing relapse prevention support

AND

E. There is no evidence to support that alternative interventions would be equally or more effective based on North Carolina community practice standards (e.g., Best Practice Guidelines per the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine) as available or based on established utilization review criteria established by the NC Department of Health and Human Services.

HOW MUCH CAN THEY GET?

Medicaid may cover up to a maximum number of hours per week. Within that parameter, the amount of services is based on the medical necessity documented in the required Person Centered Plan, the Medicaid vendor's authorization request form, and supporting documentation.

WHERE CAN THEY GET IT?

Community Support providers must deliver services in various environments, such as homes, schools, courts, detention centers and jails (State funds only*), homeless shelters, street locations, and other community settings.

CAN THEY GET IT WHILE THEY ARE ON THE CAP/C PROGRAM?

This needs to be considered on a case-by-case basis. Case Management services are bundled into Community Support Services. An individual may not receive more than one Medicaid reimbursed case management service at a time. Therefore, it would need to be demonstrated that the individual's particular plan of care under Community Support Services contained no case management other than through the CAP/C program.

WHO CAN PROVIDE IT?

Agencies

The service will be provided by an endorsed community support agency. The endorsement process includes Community Support service specific checklist, and adherence to the following:

- Rules for MH/DD/SA Facilities and Services;
- Confidentiality Rules;
- Client Rights Rules in Community MH/DD/SA Services;

- Records Management and Documentation Manual for Providers of Publicly Funded
- MH/DD/SA Services, CAP-MR/DD Services and LMEs;
- Implementation Updates to rules, revisions and policy guidance; and
- North Carolina DMH/DD/SAS Person-Centered Planning Instruction Manual.

Community Support services must be delivered by practitioners who are employed by mental health or substance abuse provider organizations that

- meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS);
- fulfill the requirements of 10A NCAC 27G; and
- employ at least one full-time licensed professional.

Persons employed or contracted must meet the requirements specified (10A NCAC 27G .0104) for Qualified Professional (QP), Associate Professional (AP), and Paraprofessional status.

Individuals

All staff that provide services must have a minimum of 20 hours of training specific to the requirements of the service definition within the first 90 days of employment.

- 6 hours service definition specific training
- 3 hours crisis response training
- 6 hours Person Centered Thinking training
- QP staff responsible for Person Centered Plan (PCP) development—
3 hours PCP Instructional Elements training

- 2–5 hours in other topics related to service and population(s) being served.

WHAT DOES IT COST? HOW IS IT BILLED?

Code	Description	Bill with Modifier	Billing Unit
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes	HA – denotes individual	1 unit =15 minutes
		HQ – denotes group	

Use the CMS-1500.

Please see the “Basic Medicaid Billing Guide” located at <http://www.dhhs.state.nc.us/dma/basicmed/index.htm> for complete information.



MORE
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HOW DO I REFER SOMEONE?

Contact the LME. A list with contact information is available at <http://www.dhhs.state.nc.us/MHDDSAS/lmedirectory.htm>.

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APPENDIX A OTHER RESOURCES

Early Intervention Services

WHAT IS IT?

Early Intervention refers to the system of services provided by many different agencies and programs for children birth to five and their families. There are two parts to Early Intervention - the Infant-Toddler Program for children birth to three (legislated by IDEA Part C) and the Preschool Program for children ages three to five (legislated by IDEA Part B).

WHAT IS INCLUDED?

Required Infant-Toddler Program services include (this means that they are required to be made available to a child who needs them, no that every child is required to use every one of them):

- • Assistive Technology Services and Devices
- • Audiology Services
- • Early Identification and Screening
- • Evaluations and Assessments
- • Family Training, Counseling, and Home Visits
- • Health Services
- • Medical Services (diagnosis and evaluation)
- • Nursing Services
- • Nutrition Services
- • Occupational Therapy
- • Physical Therapy

- • Psychological Services
- • Respite Services
- • Service Coordination
- • Social Work Services
- • Special Instruction
- • Speech-Language Therapy
- • Transportation and Related Costs
- • Vision Services
- Other Infant-Toddler Services
- These services are sometimes suggested. The family may receive help locating and accessing these services.
- Child care
 - • Well-child care
 - • Genetic counseling
 - • WIC Program (Women, Infants, and Children)
- Preschool Program Services
- Assistive Technology Services and Devices
- Audiology/Hearing
- Early Identification and Screening
- Health
- Medical Services for Evaluation
- Multidisciplinary Evaluations
- Occupational Therapy
- Parent Training and Information
- Physical Therapy
- Psychological Services
- Special Education
- Speech/Language Therapy
- Transportation

- Vision
- Social Work
- Recreation – including Therapeutic Recreation

WHAT IS NOT INCLUDED?

- Services that do not fit under the definition of early intervention services
- Services not agreed upon as needed by the IFSP team (due process rights apply)

WHO CAN GET IT?

Infant-Toddler Program

- A child under three years of age who has
 - A cognitive, physical, communication, social-emotional or adaptive developmental delay
 - or
 - A diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

Preschool Program

- All 3- and 4- year-old children who have disabilities
- Five-year-olds with disabilities who aren't old enough for kindergarten

HOW MUCH CAN THEY GET?

Infant-Toddler Program

The types and amounts of services received are based upon an IFSP (Individual Family Service Plan) developed by the family and their Early Intervention team based upon the Infant-Toddler Program Evaluation and Assessment.

Preschool Program

The types and amounts of services received are based upon an IEP (Individualized Education Plan) developed by the family and their IEP team.

WHERE CAN THEY GET IT?

Infant-Toddler Program

Services are provided in natural environments. This may include different places, such as home, daycare, and community. Natural environments are “settings that are natural or normal for the child’s age peers who have no disabilities.”

Preschool Program

Services take place in the school setting or as designated in the IEP.

CAN THEY GET IT WHILE THEY ARE ON THE CAP/C PROGRAM?

Yes, however, take care to make sure that the services are not duplicative of CAP/C services. For service coordination in the Infant-Toddler Program, the CAP/C Case Manager usually assumes the functions of the Early Intervention Service Coordinator (IESC).

WHO CAN PROVIDE IT?

Infant-Toddler Program

The local Children’s Developmental Services Agency (CDSA) contracts with community agencies to provide the required services listed on the family’s IFSP.

Preschool Program

The Local Educational Agency (LEA) provides or contracts staff to provide the required services listed on the child’s IEP.

WHAT DOES IT COST? HOW IS IT BILLED?

Infant-Toddler Program

The CDSA and its contracted community providers use a sliding fee scale to determine what portion of the charges the family will be responsible for paying and what portion will be paid for by the Infant-Toddler Program.

With the family's permission, the CDSA and its contracted providers will bill the child's insurance company for required services. However, they must allow the family the option to pay the fee rather than having the insurance company billed. Medicaid will be billed for services if the child is covered by Medicaid. Medicaid reimbursement codes and rates can be obtained by completing the Fee Schedule Request Form located at <http://www.dhhs.state.nc.us/dma/forms/pubr.pdf>.

Preschool Program

Schools do not bill families and generally do not bill private insurance for services. Medicaid is sometimes billed. Medicaid reimbursement codes and rates can be found on the Local Educational Agencies fee schedule, located at <http://www.dhhs.state.nc.us/dma/fee/index.htm>

Please see the "Basic Medicaid Billing Guide" located at <http://www.dhhs.state.nc.us/dma/basicmed/index.htm> for complete information.

HOW DO I REFER SOMEONE?

Infant-Toddler Program

Referrals may be made by telephone, fax, in writing, or in person to the local CDSA. A list of CDSAs and contact information can be found at <http://www.ncei.org/ei/itp/cdsa.html>.

Preschool Program

If the child has participated in the Infant-Toddler Program, that program will help transition the child into the preschool program.



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If not, call the Exceptional Children Preschool Coordinator in your local school district to set up an appointment for a developmental screening. Contact information is available at <http://www.osr.nc.gov/pdf/EC-PartIIIContactList2.pdf>.



MORE
INFORMATION

This material is only a brief general overview of this program. Please refer to the program's website at <http://www.ncei.org/ei/index.html> for additional information.

APPENDIX A OTHER RESOURCES

Exceptional Children's Assistance Center (ECAC)

WHAT IS IT?

ECAC is a private non-profit parent organization committed to improving the lives and education of ALL children through a special emphasis on children with disabilities.

ECAC affirms the right of all individuals, from all backgrounds and cultures, with or without disabilities, to an appropriate education and other needed services.

They seek to make that right a reality by providing information, education, outreach, and support to and for families with children across the state of North Carolina.

WHAT IS INCLUDED?

- NC Parent Training & Information Center (PTI)
A project for parents and families with children who have disabilities or special needs and their teachers and other professionals. The PTI provides parents and families with the information and skills needed to be their child's BEST Advocate!
- Parent Partners, a Parent Information and Resource Center (PIRC)
- a project for families, students and educators in Title 1 schools, with an emphasis on providing education and information on No Child Left Behind.

- NC Family to Family Health Information Center (HIC)
provides information and support to families with children who have special health care needs, including information about the NC Medicaid Waiver Program, private and public health insurance, Medical Home and more.
- Bridging the Gap
- Staff and volunteers provide early intervention information to families of children in Neonatal Intensive Care and Pediatric Intensive Care Units in several North Carolina hospitals.
- Parents as Instructors Project
- offers stipends to families of children with disabilities who serve as presenters, panelists, or instructors in Birth - Kindergarten college or university teacher preparation programs.
- Parent Partners
- is a Parent Information and Resource Center (PIRC) providing information and training to families, schools, and community organizations about the importance of family involvement in education. The project's primary focus is families of students in Title 1 Schools.
- Behavior and Reading Information Center (BRIC)
- is a national project housed at the University of North Carolina at Charlotte and operating in the Charlotte Mecklenburg School System. ECAC partners with UNCC to provide parent information, training, and support.
- North Carolina State Improvement Project
- is a system change project funded by the US Department of Education. This collaborative project with the NC Department of Public Instruction provides information to families on effective

educational practices such as reading and positive behavioral support.

- North Carolina Family Voices
- collaborates with the national Family Voices organization to develop a network of families and friends speaking on behalf of children with special health care needs.
- System of Care Technical Assistance Project
- provides training, technical assistance, coordination, and support to the leaders of parent organizations developed through the North Carolina System of Care and designed to serve families of children with serious emotional, behavioral or mental health challenges.
- Family Support Technical Assistance Project
- enhances the capacity of local family and consumer management teams to effectively operate Family Support projects in connection with NC First in Families.
- Regional Parent Technical Assistance Center (RPTAC)
- ECAC serves as the Regional Parent Technical Assistance Center for Parent Training and Information Centers (PTIs) and Community Parent Resource Centers (CPRC) funded by the US Department of Education, Office of Special Education Programs. As a part of the national Technical Assistance Alliance for Parent Centers, ECAC provides services to 29 centers in 16 states, the District of Columbia, Puerto Rico and the US Virgin Islands.
- Parents as Collaborative Leaders
- Improving Outcomes for Children with Disabilities is a national project to develop research-based training materials and internship experiences to support parents of children with disabilities in becoming active leaders in policy development and evaluation.

Mecklenburg County Parent Voice

- offers support and information to families and youth with serious emotional, behavioral, or mental health problems residing in Mecklenburg County.
- ONE Voice for Families
- is a parent advocacy organization serving Cherokee, Clay, Graham, Haywood, Jackson, Macon and Swain Counties in the mountains of our state. ONE Voice provides information, support and advocacy to families of children with behavioral/emotional challenges.
- North Carolina Parents as Teachers Network
- provides coordination and technical assistance to the Parents as Teachers programs in the state through staff housed at ECAC.

WHAT IS NOT INCLUDED?

For this information, please contact ECAC at (800) 962-6817 or <http://www.ecac-parentcenter.org/index.htm>.

WHO CAN GET IT?

For this information, please contact ECAC at (800) 962-6817 or <http://www.ecac-parentcenter.org/index.htm>.

HOW MUCH CAN THEY GET?

For this information, please contact ECAC at (800) 962-6817 or <http://www.ecac-parentcenter.org/index.htm>.

WHERE CAN THEY GET IT?

For this information, please contact ECAC at (800) 962-6817 or <http://www.ecac-parentcenter.org/index.htm>.

CAN THEY GET IT WHILE THEY ARE ON THE CAP/C PROGRAM?

Yes.

WHO CAN PROVIDE IT?

For this information, please contact ECAC at (800) 962-6817 or <http://www.ecac-parentcenter.org/index.htm>.

WHAT DOES IT COST? HOW IS IT BILLED?

For this information, please contact ECAC at (800) 962-6817 or <http://www.ecac-parentcenter.org/index.htm>.

HOW DO I REFER SOMEONE?

There are four ECAC offices. For contact information for the one nearest you, please see <http://www.ecac-parentcenter.org/about/contact.htm>
Their toll-free number is (800) 962-6817.

This material is only a brief general overview of this program. Please refer to the ECAC web site at <http://www.ecac-parentcenter.org/index.htm> for more information.



APPENDIX A OTHER RESOURCES

Family Support Network of North Carolina (FSN-NC)

WHAT IS IT?

Family Support Network of North Carolina (FSN-NC) promotes and provides support for families with children who have special needs. Through a network of affiliated local programs, families can access parent-to-parent support, information, workshops, and other activities.

WHAT IS INCLUDED?

- Central Directory of Resources
- Disability-specific information and information about resources available by telephone at (800) 852-0042, from their web site at www.fsnc.org, or by sending an e-mail to cdr@med.unc.edu.
- Family Support Services
 - parent to parent matching with trained support parent
 - support groups and workshops for families and service providers
 - presentations to increase public awareness of disability-related issues
- Education and Outreach Activities
 - Educational activities of Family Support Network of North Carolina are available to family members and service providers. Service providers can receive training at both pre-service and in-service levels. University students and Pediatric and Family Medicine Residents can learn about family-centered care and community-based support.

- Research and Evaluation
- Family Support Network of North Carolina is committed to evaluating the programmatic activities of the organization and the benefits of these activities to the community. Family Support Network of North Carolina utilizes a variety of methods to evaluate and assist program development, implementation, and adaptation. Family Support Network of North Carolina also participates in local and state committees working to improve process and outcome evaluation efforts across the State.

WHAT IS NOT INCLUDED?

For this information, please refer to <http://www.fsnncc.org/home.htm> and/or contact one of the FSN offices (information on website).

WHO CAN GET IT?

For this information, please refer to <http://www.fsnncc.org/home.htm> and/or contact one of the FSN offices (information on website).

HOW MUCH CAN THEY GET?

For this information, please refer to <http://www.fsnncc.org/home.htm> and/or contact one of the FSN offices (information on website).

WHERE CAN THEY GET IT?

For this information, please refer to <http://www.fsnncc.org/home.htm> and/or contact one of the FSN offices (information on website).

CAN THEY GET IT WHILE THEY ARE ON THE CAP/C PROGRAM?

Yes.

WHO CAN PROVIDE IT?

For this information, please refer to <http://www.fsnn.org/home.htm> and/or contact one of the FSN offices (information on website).

WHAT DOES IT COST? HOW IS IT BILLED?

For this information, please refer to <http://www.fsnn.org/home.htm> and/or contact one of the FSN offices (information on website).

HOW DO I REFER SOMEONE?

Contact the local program. A directory can be found at <http://www.fsnn.org/LocalFSNs/findlocal.htm>

This material is only a brief general overview of this program. Please refer to the FSN-NC web site at <http://www.fsnn.org/home.htm> for more information.



MORE
INFORMATION

**APPENDIX A
OTHER RESOURCES**

Health Insurance Premium Payment (HIPP)

WHAT IS IT?

The Health Insurance Premium Payment (HIPP) program is a cost-effective premium payment program for Medicaid recipients with catastrophic illnesses such as end-stage renal disease, chronic heart problems, congenital birth defects, cancer, and AIDS. These recipients are often at risk of losing private health insurance coverage due to nonpayment of premiums. DMA will consider the benefit of paying health insurance premiums for Medicaid recipients when the cost of the premium, deductible, and co-insurance is less than the anticipated Medicaid expenditure.

WHAT IS INCLUDED?

DMA will pay the premiums on existing policies or those known to be available to the recipient (for example, through COBRA). Premiums are paid for a family coverage policy when the policy is cost effective and it is the only way the recipient can be covered. The recipient is not required to enroll in a plan that is not a group health insurance plan through an employer.

WHAT IS NOT INCLUDED?

Family members who are not eligible for Medicaid cannot receive Medicaid payment for deductible, co-insurance, or cost-sharing obligations.

Insurance not received through an employer does not qualify.

WHO CAN GET IT?

Individuals who:

- are authorized for Medicaid
- have access to private health insurance through an employer

HOW MUCH CAN THEY GET?

The premium will be paid in full as long as it is determined to be cost-effective for Medicaid.

Cost-effectiveness is re-determined annually.

WHERE CAN THEY GET IT?

Not Applicable.

CAN THEY GET IT WHILE ON THE CAP/C PROGRAM?

Yes.

WHO CAN PROVIDE IT?

Not Applicable.

WHAT DOES IT COST? HOW IS IT BILLED?

There is no cost. HIPPP provides the funds to the family, who in turn pay the insurance company.

HOW DO I REFER SOMEONE?

Complete the Health Insurance Premium Payment (HIPP) Application located at <http://info.dhhs.state.nc.us/olm/forms/dma/dma-2069.pdf>.

Please see the “Basic Medicaid Billing Guide” located at <http://www.dhhs.state.nc.us/dma/basicmed/index.htm> for complete information.



APPENDIX A OTHER RESOURCES

HIV Case Management (HIV CMS)

WHAT IS HIV CASE MANAGEMENT?

HIV case management is a client-focused strategy that:

- provides medically necessary services to enhance recipients' health status and level of functioning, and
- promotes cost effectiveness.

It is designed to empower clients through education, referrals and facilitating access to care, assisting clients to gain the tools needed to be their own advocates and navigate the health care and social services systems to improve health outcomes. HIV Case management is not intended to be an ongoing service, but rather to be short term, goal-oriented, tailored to meeting the specific immediate needs of the client, with the intention of facilitating the client's ability to meet his or her own needs.

The goals of HIV case management are:

- to improve eligible client's access to a wide range of appropriate services;
- to promote continuity of care by coordinating service delivery arrangements;
- to enhance client's health status and level of functioning; and
- to promote efficiency by reducing or containing the overall cost of services.

WHAT IS INCLUDED?

HIV case management includes the following core components: intake, assessment, care planning, resource development, service coordination, monitoring, reassessment and discharge.

HIV CMS allows reimbursement for *service coordination*.

Examples include:

- Assisting clients locate and schedule a doctor's appointment.
- Referring clients for food assistance.
- Referring clients for budget counseling.
- Assisting clients to locate mental health or substance use providers.
- Referring clients to housing assistance programs.

WHAT IS NOT INCLUDED?

HIV Case management is not intended to be an ongoing service.

HIV CMS does not allow reimbursement for *direct service provision*.

Examples include:

- Driving a client to a doctor's appointment.
- Picking up and delivering food to a client.
- Assisting clients to set up and maintain a budget.
- Providing education, mental health or substance use counseling for clients.
- Driving clients around to look at apartments or houses.

WHO CAN GET IT?

HIV CMS is provided for North Carolina residents who are

- HIV positive
- Medicaid eligible or eligible to receive services under the Ryan White Modernization Act of 2006

- not in an institution.

HOW MUCH CAN THEY GET?

There is a limit of four hours per month of case management services per recipient.

WHERE CAN THEY GET IT?

HIV Case Management cannot provide reimbursable services to clients who are hospitalized, residing in nursing homes or incarcerated in any correctional setting (this includes city, county, State and Federal prisons/jails).

CAN THEY GET IT WHILE THEY ARE ON THE CAP/C PROGRAM?

No. Case management is a required component of the CAP/C program, and there can only be one Medicaid-reimbursed Case Manager per recipient.

WHO CAN PROVIDE IT?

A provider of HIV Case Management Services, in addition to meeting Medicaid provider requirements, must also be certified as a qualified HIV case management provider.

Each individual Case Manager and Supervisor must meet minimum requirements of education and experience, as well as continuing education.

WHAT DOES IT COST? HOW IS IT BILLED?

HIV Case Management services are billed in 15 minute units using code T1017. The current reimbursement rate can be obtained by completing

the Fee Schedule Request Form at

<http://www.dhhs.state.nc.us/dma/Forms/pubr.pdf> .

Please see the "Basic Medicaid Billing Guide" located at

<http://www.dhhs.state.nc.us/dma/basicmed/index.htm> for complete

information.



MORE
INFORMATION

HOW CAN I REFER SOMEONE?

Contact the Division of Medical Assistance (919 855 4380). They will give you information on local agencies to contact.

This material is only a brief general overview of this program. Please refer to the *Medicaid Clinical Coverage Policies and Provider Manuals* and the monthly *Medicaid Bulletins* for more information. You will find these publications at <http://www.dhhs.state.nc.us/dma/provider/index.htm>



MORE
INFORMATION

APPENDIX A OTHER RESOURCES

Independent Practitioners Program (IPP)

WHAT IS IT?

Independent Practitioner Services provide assessments and treatments from the following disciplines:

- Audiology
- Speech/Language
- Occupational Therapy
- Physical Therapy
- Respiratory Therapy

WHAT IS INCLUDED?

Audiology

Assessment	Treatment
a. auditory sensitivity (including pure tone air and bone conduction, speech detection, and speech reception thresholds) b. auditory discrimination in quiet and noise c. impedance audiometry (tympanometry and acoustic reflex testing) d. hearing aid evaluation (amplification selection and	a. auditory training b. speech reading c. augmentative and alternative communication training (including sign language and cued speech training)

verification) e. central auditory function f. evoked otoacoustic emissions g. brainstem auditory evoked response (a.k.a.. ABR)	
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Speech/language

Assessment	Treatment
a. expressive language b. receptive language c. auditory processing, discrimination, and memory d. augmentative and alternative communication e. vocal quality f. resonance patterns g. articulation/phonological development h. pragmatic language i. rhythm/fluency j. oral mechanism/swallowing k. hearing status based on pass/fail criteria	a. articulation/phonological training b. language therapy c. augmentative and alternative communication training d. auditory processing/discrimination training e. fluency training f. voice therapy g. oral motor training; swallowing therapy h. speech reading

Occupational Therapy

Assessment	Treatment

Appendix A Independent Practitioners

<ul style="list-style-type: none"> a. activities of daily living assessment b. sensorimotor assessment c. neuromuscular assessment d. fine motor assessment e. feeding/oral motor assessment f. visual perceptual assessment g. perceptual motor development assessment h. musculo-skeletal assessment i. gross motor assessment j. functional mobility assessment 	<ul style="list-style-type: none"> a. activities of daily living training b. neuromuscular development c. muscle strengthening, endurance training d. feeding/oral motor training e. adaptive equipment application f. visual perceptual training g. facilitation of fine motor skills i. fabrication and application of splinting and orthotic devices j. manual therapy techniques k. sensorimotor training l. pre-vocational training m. functional mobility training n. perceptual motor training facilitation of gross motor skills
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Physical Therapy

Assessment	Treatment
<ul style="list-style-type: none"> a. neuromotor assessment b. range of motion, joint integrity, functional mobility, and flexibility assessment c. gait, balance, and coordination assessment d. posture and body mechanics assessment e. soft tissue assessment 	<ul style="list-style-type: none"> a. manual therapy techniques b. fabrication and application of orthotic device c. therapeutic exercise d. functional training e. facilitation of motor milestones f. sensory motor training g. cardiac training h. pulmonary enhancement

<p>f. pain assessment</p> <p>g. cranial nerve assessment</p> <p>h. clinical electromyographic assessment</p> <p>i. nerve conduction, latency and velocity assessment</p> <p>j. manual muscle test</p> <p>k. reflex integrity</p> <p>l. activities of daily living assessment</p> <p>m. cardiac assessment</p> <p>n. pulmonary assessment</p> <p>o. sensory motor assessment</p> <p>p. feeding/oral motor assessment</p>	<p>i. adaptive equipment application</p> <p>feeding/oral motor training</p> <p>k. activities of daily living training</p> <p>l. gait training</p> <p>m. posture and body mechanics training</p> <p>n. muscle strengthening</p> <p>o. gross motor development</p> <p>p. modalities</p> <p>q. therapeutic procedures</p> <p>r. hydrotherapy</p> <p>s. manual manipulation</p> <p>t. wheelchair management</p>
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Respiratory Therapy

Assessment	Treatment
<p>a. collection of specimen for arterial blood gas analysis (ABGs)</p> <p>b. pulmonary function studies</p> <p>c. breath sounds</p> <p>d. acute and chronic lung disease patients</p> <p>e. ventilator dependent patients</p>	<p>a. bronchodilator and aerosol therapy</p> <p>b. oxygen therapy</p> <p>c. sterile and non-sterile suctioning techniques</p> <p>d. tracheostomy care</p> <p>e. chest vibrations, postural drainage, and breathing techniques</p> <p>f. ventilator care</p> <p>g. monitoring of respiratory status</p>

	(ABGs, pulse oximetry, pulmonary function studies, sputum cultures, apnea-bradycardiac monitors, etc.)
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WHAT IS NOT INCLUDED?

Assessment services do not include interpretive conferences, educational placement or care planning meetings, or mass or individual screenings aimed at selecting children who may have special needs.

Treatment services do not include consultation activities, specific objectives involving English as a second language, or a treatment plan primarily dealing with maintenance/monitoring activities.

WHO CAN GET IT?

Recipients who:

- Are under the age of 21
- Are Medicaid eligible
- Have a need for specialized therapy services confirmed by a
- licensed Medical Doctor, MD, Doctor of Podiatric Medicine, DPM, Doctor of Osteopathic Medicine, DO, Physician Assistant, PA, Nurse Practitioner, NP or Certified Nurse Midwife, CNM
- Meet the criteria for medical necessity as defined by the policy
- guidelines (national standards, best practice guidelines, etc.) recommended by the authoritative bodies for each discipline.

HOW MUCH CAN THEY GET?

The amount of service is determined by the prior approval process.

Prior approval is required at the start of all treatment services. There are prescribed ranges and a cap on the services that will be approved. After this initial prior approval expires, approval is required for continued treatment.

WHERE CAN THEY GET IT?

A patient may receive PT, ST, and OT services in the office, home, school, through the Head Start program, and/or child care (i.e., regular and developmental day care) settings. A patient may receive RT services in the office or home.

CAN THEY GET IT WHILE ON THE CAP/C PROGRAM?

Yes. The Case Manager should ensure that IP services do not duplicate similar services provided through Early Intervention, home health, the school system, or in-home nurse/nurse aide staff.

Respiratory therapy services during the same hours as private duty nursing or CAP/C nursing services shall be limited to one evaluation visit. Services may not be billed at the same time as those of another Medicaid provider who can provide the same services such as, Private Duty Nurses, CAP C Nurses etc. In the case of medically fragile children who are on life sustaining devices such as oxygen, mechanical ventilation CPAP etc an initial training of 1 – 2 hours with each nurse caring for the patient with a follow-up each quarter may be provided if needed. The purpose of the respiratory therapy visit is to teach and train caregivers and licensed nursing staff, as needed, regarding the recipient's care. Ongoing respiratory therapy visits during nursing services is considered duplication of care. The Nursing agency is responsible for ensuring the competency of staff

WHO CAN PROVIDE IT?

Providers must be enrolled with Medicaid and meet discipline-specific licensing criteria.

WHAT DOES IT COST? HOW IS IT BILLED?

Each service within each discipline has its own code, billing unit, and unit rate. These can be found at:

- http://www.dhhs.state.nc.us/dma/fee/pracfees/Multi_Specialty_Fee_1009.pdf (multiple independent practitioners)
- http://www.dhhs.state.nc.us/dma/fee/pracfees/Occupational_Therapy_Fee_1009.pdf (occupational therapy)
- http://www.dhhs.state.nc.us/dma/fee/pracfees/Physical_Therapy_Fee_1009.pdf (physical therapy)
- http://www.dhhs.state.nc.us/dma/fee/pracfees/Respiratory_Therapy_Fee_1009.pdf (respiratory therapy)
- http://www.dhhs.state.nc.us/dma/fee/pracfees/Speech_Audiology_Therapy_Fee_1009.pdf (speech therapy and audiology)

Use the CMS-1500.

Please see the “Basic Medicaid Billing Guide” located at

<http://www.dhhs.state.nc.us/dma/basicmed/index.htm> for complete information.



HOW DO I REFER SOMEONE?

Detailed information and instructions for registering and submitting requests is available on the Carolinas Center of Medical Excellence (CCME) website <http://www.medicicaidprograms.org/nc/therapyservices>).

This material is only a brief general overview of this program. Please refer to the *Medicaid Clinical Coverage Policies and Provider Manuals* and the



monthly *Medicaid Bulletins* for more information. You will find these publications at <http://www.dhhs.state.nc.us/dma/provider/index.htm>.

Appendix A Independent Practitioners

APPENDIX A OTHER RESOURCES

Medicaid Durable Medical Equipment (DME) Medicaid Orthotics and Prosthetics (O&P)

WHAT IS IT?

Medicaid covers the equipment and related supplies listed on the Durable Medical Equipment Fee Schedule and on the Orthotic and Prosthetic Devices 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.

WHAT IS INCLUDED?

Equipment

- Inexpensive or Routinely Purchased
- Capped Rental/Purchased Equipment: These items are rented or purchased as follows:
 1. The item is rented if the physician, physician assistant, or nurse practitioner documents that the anticipated need is six months or less.
 2. The item may be rented or purchased if the physician, physician assistant, or nurse practitioner documents that the anticipated need exceeds six months.

Once rental is initiated on an item, a subsequent request for prior approval of purchase of that item will be denied. The item becomes the property of the recipient when the accrued rental payments reach Medicaid's allowable purchase price.

Example: If the monthly rental for an item is \$30 and the new purchase price is \$200, Medicaid will pay six full months of rental, plus no more than \$20 in the seventh month of rental. At that time, the item becomes the property of the recipient, and no more rental payments are made.

- Equipment Requiring Frequent and Substantial Servicing: These items are rented.
- Oxygen and Oxygen Equipment: Oxygen and items dealing with oxygen delivery are in this category.
- Prosthetics and Orthotics: Prosthetics and orthotics are purchased, and are available for recipients when they meet the criteria listed in Clinical Coverage Policy #5B (<http://www.ncdhhs.gov/dma/mp/mpindex.htm>).
- Related Medical Supplies: Supplies are covered when they are provided for use with a DME item owned by the recipient.
- Service and Repair: The service and repair of a DME item owned by a recipient is covered over the useful life of the item.
- Individually Priced Items: These are items that are reviewed on an individual basis and manually priced.

WHAT IS NOT INCLUDED?

Convenience items or features are not covered.

WHO CAN GET IT?

All Medicaid recipients are eligible for DME. All services, including Enteral Nutrition therapy, provided to an MPW recipient must be pregnancy related.

HOW MUCH CAN THEY GET?

Most equipment has a quantity limit (how many you can have in a given period of time; for example, four oropharyngeal suction catheters per month) or a lifetime (how often an item can be replaced; for example, one bath chair every three years).

WHERE CAN THEY GET IT?

DME, orthotics, and prosthetics, are approved for use in the home. They will not be approved for sole use in the school or other setting. If a recipient needs the item during the school day, the recipient is expected to transport the item to and from the school.

CAN THEY GET IT WHILE THEY ARE ON THE CAP/C PROGRAM?

Yes. Providers must notify the CAP case manager of all items they anticipate providing to a recipient who participates in a CAP program. The CAP case manager must be aware of all services being provided to a recipient to coordinate care and keep care cost-effective.

WHO CAN PROVIDE IT?

Providers must be enrolled with DMA and meet the following conditions to qualify for participation with Medicaid as a DME supplier.

a. Providers cannot accept prescriptions for Medicaid-covered equipment from any physician, physician assistant, or nurse practitioner, or practitioner who has an ownership interest in their agency.

- b. Providers must be enrolled and participate in Medicare as a DME supplier.
 - c. Service must be provided on an emergency basis, 24 hours per day, 7 days per week, for life-sustaining equipment.
 - d. The providing agency must be located within the boundaries of North Carolina or in an adjoining state from which North Carolina recipients living on the border can use the agency as a general practice. Out-of-state providers will be enrolled when the product they supply or manufacture is not available through an enrolled provider located within the state or border area.
 - e. Providers must have a North Carolina Board of Pharmacy permit or letter of exemption.
 - f. Providers must be either a business entity authorized to conduct business in the state or in the locality where the business site is located. Proof of authorization shall include a certificate of assumed name, certificate of authority, certificate of good standing, license, permit or privilege license; or
2. a Medicaid-enrolled home health agency, a state agency, a local health department, a local lead agency for the Community Alternatives Program for Disabled Adults, a local lead agency for the Community Alternatives Program for the Mentally Retarded/Developmentally Disabled, or an agency that provides case management for the Community Alternatives Program for Children.

Note: Providers must be enrolled and meet the provider qualifications on the date that service is provided.

WHAT DOES IT COST? HOW IS IT BILLED?

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. Capped rental items are paid until the amount paid in rental equals the Medicaid maximum allowed cost on the fee schedule; the item is then considered purchased.

Please see the "Basic Medicaid Billing Guide" located at <http://www.dhhs.state.nc.us/dma/basicmed/index.htm> for complete information.



HOW DO I REFER SOMEONE?

Please refer to Clinical Coverage Policy Number 5A , Attachment C, for complete information regarding how a recipient receives DME.

Please refer to Clinical Coverage Policy Number 5B , Attachment C, for complete information regarding how a recipient receives Orthotics and Prosthetics.

This material is only a brief general overview of this program. Please refer to the *Medicaid Clinical Coverage Policies and Provider Manuals* and the monthly *Medicaid Bulletins* for more information. You will find these publications at <http://www.dhhs.state.nc.us/dma/provider/index.htm>



Appendix A

OTHER RESOURCES

Medicaid Home Health

WHAT IS HOME HEALTH?

Home Health Services include medically necessary skilled nursing services, specialized therapies (physical therapy, speech-language pathology and occupational therapy), home health aide services, and medical supplies provided to recipients who reside in private residences. Skilled nursing, specialized therapies and medical supplies can also be provided if the recipient resides in an adult care home (such as a rest home or family care home).

WHAT IS INCLUDED?

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
- Physical therapy services
- Speech-therapy services
- Occupational therapy services
- Home Health Aide Services, when a skilled service is also being rendered.
- Medical supplies. This list is available on DMA'S website at <http://www.dhhs.state.nc.us/dma/fee/fee.htm>.

WHAT IS NOT INCLUDED?

- Unskilled services (home health aide visit) when there are no skilled services (nursing or therapy visits) being provided
- Maintenance occupational, physical, and speech therapy services.
- Medical supply items routinely furnished as part of recipient care (minor medical and surgical supplies routinely used in recipient care such as alcohol wipes, applicators, lubricants, lemon-glycerin mouth swabs, thermometers, and thermometer covers). These items are considered part of an agency's overhead costs and cannot be billed and reimbursed as separate items.
- Services that duplicate another provider's service, or are experimental, investigational, or part of a clinical trial
- Home Health Aide services provided on the same day as Personal Care Services (PCS), or CAP/C, CAP-DA, or CAP-Choice home aide services.
- Services not ordered by a physician and included on the authorized POC.
- Home Health services related to the terminal illness when the recipient has elected Medicare or Medicaid hospice benefits. Home Health services can be provided when they are unrelated to the terminal illness.

WHO CAN GET IT?

- Recipients with 'regular' Medicaid
- Recipients of Medicaid for Pregnant Women, if the service is required for a pregnancy-related condition. Prior approval is required.

- Clients whose medical records include documentation supporting why the services should be provided in the recipient's home instead of the physician's office, clinic or other outpatient setting. Recipients who are Medicare Qualified Beneficiaries are not eligible for Medicaid-covered home health services.

HOW MUCH CAN THEY GET?

For Skilled Nursing and Home Health Aide visits, a visit begins when a service is initiated and does not end until the delivery of the service is completed. The total time spent per week in skilled nursing visits and home health aide visits cannot exceed eight hours per day and 34 hours per week.

For Specialized Therapies, the type, amount, frequency, and duration of treatment visits are limited to what is ordered by the physician and documented in the Plan of Care. Specialized therapy treatment is subject to the limits and requirements and prior approval process.

Supplies are limited to what is ordered by the physician and documented in the Plan of Care.

WHERE CAN THEY GET IT?

- In a private residence
- In an Adult Care Home or Group Home (except for Home Health Aide services)

CAN THEY GET IT WHILE THEY ARE ON THE CAP/C PROGRAM?

Yes. Beware of duplication of services between CAP/C Nursing services and Home Health Nurse visits, and between CAP/C Nurse Aide services and Home Health Aide services.

Home Health Nurse and CAP/C Nurse services may not be provided on the same day. Home Health Aide services and CAP/C Pediatric Personal Care services may not be provided on the same day.

WHO CAN PROVIDE IT?

To qualify for enrollment as a Medicaid home health provider, the agency must be Medicare-certified and licensed by DHSR to provide home health services. All services shall be provided by staff employed by or under contract to the home health agency.

- Skilled nursing services are furnished by a Registered Nurse (RN) or Licensed Practical Nurse (LPN).
 - Physical Therapy is furnished by a licensed physical therapist (PT) or a licensed physical therapist assistant under the direction of a licensed PT
 - Speech Therapy is furnished by a licensed speech-language pathologist
 - Occupational Therapy is furnished by a licensed occupational therapist (OT) or by a licensed occupational therapy assistant under the direction of a licensed OT
 - Home Health Aide Services are furnished by a Nurse Aide I or II
- Medical supplies available under Home Health also may be provided by a CAP/C case management agency.

WHAT DOES IT COST? HOW IS IT BILLED?

The revenue codes used for billing home health skilled visits, home health aide visits, and specialized therapies are listed in the table below.

Code	Description	Unit of Service
RC420	Physical therapy - general classification	1 visit

RC430	Occupational therapy – general classification	1 visit
RC440	Speech therapy – general classification	1 visit
RC424	Physical therapy evaluation or re-evaluation	1 visit
RC434	Occupational therapy evaluation or re-evaluation	1 visit
RC444	Speech therapy evaluation or re-evaluation	1 visit
RC550	Skilled nursing-home health – general classification	1 visit
RC551	Skilled nursing – visit charge	1 visit
RC559	Skilled nursing - other	1 visit
RC580	Home health – other visit – general classification	1 visit
RC581	Home health – other visit – visit charge	1 visit
RC589	Home health – other visit - other	1 visit
RC570	Home health aide – general classification	1 visit

The maximum allowable rate is based on the Home Health Maximum Reimbursement Rate Schedule, which is available on DMA’s Web site at <http://ncdhhs.gov/dma/fee/fee.htm>.

The Claim Type is: Institutional (UB-04/837I transaction)

Please see the “Basic Medicaid Billing Guide” located at <http://www.dhhs.state.nc.us/dma/basicmed/index.htm> for complete information.

HOW DO I REFER SOMEONE?

Contact the recipient’s physician or the home health agency of their choice.

This material is only a brief general overview of this program. Please refer to the *Medicaid Clinical Coverage Policies and Provider Manuals* and the monthly *Medicaid Bulletins* for more information. You will find these publications at <http://www.dhhs.state.nc.us/dma/provider/index.htm>



APPENDIX A OTHER RESOURCES

Medicaid Home Infusion Therapy (HIT)

WHAT IS HOME INFUSION THERAPY (HIT)?

Home Infusion Therapy (HIT) is a Medicaid program that covers self-administered drug infusion therapies and enteral nutrition supplies for a patient when the therapy or supply is medically necessary.

WHAT IS INCLUDED?

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

- Total Parenteral Nutrition (TPN)
- Enteral Nutrition (EN)
- Chemotherapy (Intravenous)
- Antibiotic Therapy (Intravenous)
- Tocolytic Therapy (for management of pre-term labor)
- Pain Management Therapy (Subcutaneous, Epidural, Intrathecal and Intravenous)

The infusion nursing services component of drug therapies includes

- assessing the recipient for the appropriateness of HIT
- monitoring the recipient
- teaching the recipient and/or primary caregiver about the HIT administration
- changing intravenous (IV) sites and dressings

- drawing blood for laboratory analysis
- supervising the first dose

The pharmacy component of drug therapies includes

- monitoring the drug therapy to ensure that the drugs and related fluids are dispensed according to the physician's plan of care (POC) and standards of practice
- developing a medication history and recipient profile
- consulting with physicians and nurses on the therapy
- providing drug use evaluations
- providing quality assurance; and
- procuring drugs and maintaining the inventory, reconstituting drugs, preparing dosage(s), labeling drugs, and delivering to a recipient's

Drug therapies also include medical equipment and supplies needed for the therapy according to the POC and standards of practice.

Training, including educational and counseling services, must be provided to ensure the safe and effective administration of HIT. The services are provided through a combination of verbal and written instructions.

Nutrition supply services include

- the rental or purchase of pumps used for EN and TPN and the IV pole ordered by the physician
- formulae/solutions ordered by the physician
- medical supplies ordered by the physician
- the cost of delivery of supplies and items to the recipient's residence.

Note: Nursing services are not covered.

WHAT IS NOT INCLUDED?

- Service that duplicates another provider's service

- Service that is experimental, investigational, or part of a clinical trial
- Drug therapy provided for services other than chemotherapy, antibiotic therapy, tocolytic therapy, or pain management
- Services when the recipient is receiving Medicare-covered home health nursing services
- Drug therapy when the recipient is receiving Medicaid Private Duty Nursing (PDN) services

WHO CAN GET IT?

- Recipients with regular Medicaid identification cards
- Recipients of Medicaid for Pregnant Women, if the service is required for a pregnancy-related condition. Prior approval is required.

Recipients who are Medicare Qualified Beneficiaries are not eligible for Medicaid-covered home health services.

- Recipients whose clinical status is stable as determined by the attending physician
- Recipients who have an available site for the administration of the therapy
- Recipients who live in a home environment that is conducive to the provision of the HIT therapy, i.e., clean environment with electricity, water, telephone access, refrigeration, and physical space to support HIT supplies
- Recipients who are or who have a caregiver who is capable, able, and willing to self-administer the therapy following appropriate teaching and with adequate monitoring

HOW MUCH CAN THEY GET?

HIT services are limited to what is medically reasonable and necessary to treat the recipient's disease, injury, illness, or condition and what is ordered by the physician.

WHERE CAN THEY GET IT?

- A private residence
- An adult care home (such as a domiciliary care or family care home).

CAN THEY GET IT WHILE THEY ARE ON THE CAP/C PROGRAM?

Yes, except the nursing component of drug infusion therapy would be duplicative of CAP/C Nurse Services, and both services would not be covered.

WHO CAN PROVIDE IT?

HIT services are provided by an agency licensed by the Division of Health Service Regulation (DHSR) as a home care agency and approved to provide infusion nursing services.

Pharmacy services are provided by a registered pharmacist employed or under contract to the HIT agency.

Infusion nursing services are provided by a licensed nurse who is directly employed and/or contracted by the HIT agency.

The staff member cannot be the recipient's spouse, child, parent, grandparent, grandchild, or sibling, or be a person with an equivalent step- or in-law relationship to the recipient.

WHAT DOES IT COST? HOW IS IT BILLED?

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 Outpatient Pharmacy Program.

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.

The maximum allowable rate is based on the Home Infusion Therapy Rate Schedule, which is available on DMA's Web site at

<http://ncdhhs.gov/dma/fee/fee.htm>.

HIT services are billed on the CMS-1500 claim form.

Please see the "Basic Medicaid Billing Guide" located at

<http://www.dhhs.state.nc.us/dma/basicmed/index.htm> for complete information.



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HOW DO I REFER SOMEONE?

Contact the recipient's physician or the home health agency of their choice.

This material is only a brief general overview of this program. Please refer to the *Medicaid Clinical Coverage Policies and Provider Manuals* and the monthly *Medicaid Bulletins* for more information. You will find these publications at <http://www.dhhs.state.nc.us/dma/provider/index.htm>.



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APPENDIX A OTHER RESOURCES

Medicaid Hospice

WHAT IS HOSPICE?

The Medicaid hospice benefit is a coordinated program of services that provides medical, supportive, and palliative care to terminally ill recipients and their families/caregivers. An individual is considered terminally ill if he or she has a medical prognosis of a six month or less life expectancy.

The services are provided according to a care plan established by an interdisciplinary group of medical professional and social support staff employed by, or under contract with, the hospice agency, as allowed by the Centers for Medicare and Medicaid Services (CMS). Each care plan describes the method of providing services to meet the recipient's medical, psychosocial, and spiritual needs. The hospice benefit covers all care pertaining to the terminal illness.

There are four levels of hospice care:

- Routine Home Care

Routine home care is the basic level of care provided to support a recipient. It is provided in a private residence or a hospice residential care facility. It also may be provided in a nursing facility or an adult care home if the facility has a contractual arrangement with the hospice agency.

- Continuous Home Care

Continuous home care is provided during a medical crisis as needed to keep the recipient at home and when the recipient's physician believes

that he/she needs continuous care, primarily nursing care, to achieve palliation or management of acute medical symptoms. The recipient 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 a RN or LPN must be provided for at least half of the hours of care in a day. Homemaker and home health aide services may be used to supplement the nursing care for the remaining hours.

- **Inpatient Respite Care**

Inpatient respite care is short-term care to relieve family members and other unpaid caregivers who care for a recipient in a private residence. Respite may be provided only on an occasional basis for up to five consecutive days for each occurrence, as defined by agency policy and based on the needs of the primary caregiver. It is provided in a hospice inpatient facility, a hospital, or a nursing facility under contractual arrangement with the hospice agency.

- **General Inpatient Care**

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 contractual arrangement with the hospice agency.

WHAT IS INCLUDED?

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

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

- Counseling services, including dietary, spiritual, and bereavement counseling, for the patient, family members and others caring for the patient
- Hospice 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
- Nursing Facility room and board when the recipient electing hospice services is a resident. The hospice reimburses the nursing facility under a contractual arrangement.

WHAT IS *NOT* INCLUDED?

- Services that duplicate another provider's procedure
- Services that are experimental, investigational, or part of a clinical trial.
- Services that are not related or a direct result of the terminal illness.

WHO CAN GET IT?

- Recipients with regular Medicaid identification cards
- Recipients of Medicaid for Pregnant Women, if the service is required for a pregnancy-related condition. Prior approval is required.

Recipients who are Medicare Qualified Beneficiaries are not eligible for Medicaid-covered home health services.

- Dually eligible recipients are eligible for hospice services. Medicaid and Medicare hospice must be elected simultaneously, and Medicare is the primary payer, and
- Recipients who are terminally ill – that is, have a medical prognosis of life expectancy of six months or less that is supported by a physician's written certification.

HOW MUCH CAN THEY GET?

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.

WHERE CAN THEY GET IT?

- The recipient's private residence
- An adult care home (considered the recipient's residence)
- A hospice residential care facility or hospice inpatient unit

- A hospital or nursing facility or Intermediate Care Facility for the Mentally Retarded (ICF-MR) under a contractual arrangement with the hospice agency

CAN THEY GET IT WHILE THEY ARE ON THE CAP/C PROGRAM?

Yes, but be careful not to duplicate or replace the care that is the responsibility of the hospice agency. CAP/C services should augment hospice care. The CAP/C Case Manager should work closely with the hospice agency to avoid duplication of service.

WHO CAN PROVIDE IT?

To qualify for enrollment as a Medicaid hospice provider, the agency must be Medicare-certified to provide hospice services within North Carolina and be licensed to provide hospice services by the Division of Health Service Regulation.

WHAT DOES IT COST? HOW IS IT BILLED?

Hospice services are provided and billed according to level of care and the location of the recipient for each day of the benefit period. Consult the Hospice fee schedule located at

<http://www.dhhs.state.nc.us/dma/fee/index.htm>.

Please see the "Basic Medicaid Billing Guide" located at

<http://www.dhhs.state.nc.us/dma/basicmed/index.htm> for complete information.

HOW DO I REFER SOMEONE?

Contact the Medicaid-enrolled hospice agency of the recipient's choice.

This material is only a brief general overview of this program. Please refer to the *Medicaid Clinical Coverage Policies and Provider Manuals* and the



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monthly *Medicaid Bulletins* for more information. You will find these publications at <http://www.dhhs.state.nc.us/dma/provider/index.htm>.

**APPENDIX A
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**Medicaid Personal Care Services (PCS)
Medicaid Personal Care Services Plus (PCS+)**

WHAT IS IT?

In-home Personal Care Services (PCS and PCS +) is a Medicaid program that provides a range of hands-on human assistance to eligible Medicaid recipients of all ages, who have disabling medical conditions. These programs provide assistance to enable program participants to accomplish tasks they would normally do for themselves if they did not have a disability.

WHAT IS INCLUDED?

Hands-on assistance with the following five qualified activities of daily living (ADLs):

- Mobility
- Eating
- Bathing
- Dressing
- Toileting

In certain instances, assistance may also be provided with home management tasks that are essential to the health and welfare of the recipient, although secondary to the personal care tasks being performed, and are for the benefit of the recipient rather than the recipient's family.

WHAT IS NOT INCLUDED?

- PCS when the recipient's primary need is housekeeping or homemaking
- PCS when substantially equivalent services are furnished to the recipient by another state-funded or federally funded program
- PCS when the recipient is receiving nursing facility services, adult care home (including group home) services, hospital inpatient services or PCS-type services at school.
- The following specific services are not covered within PCS:
 - Skilled nursing services provided by a LPN or RN
 - Non-hands-on assistance with ADLs
 - Care of non-service-related pets and animals
 - Yard or home maintenance work
 - Medical and non-medical transportation
 - Child care, day care, or after school care
 - Assistance with homework
 - Money management
 - Companion sitting or leisure activities
 - Shopping or other errands
 - Continuous monitoring or ongoing recipient supervision
 - Personal care or home management tasks for other residents of the household
 - Cueing, Prompting, Guiding, or Coaching
(The encouragement and instruction in self care may be a component of PCS, but under this Clinical Coverage Policy, these activities do not constitute a covered service in and of themselves.)

WHO CAN GET IT?

Individuals who meet regular Medicaid eligibility requirements and who:

- live in a home that is a safe environment in which to provide PCS.
- have no other third-party payer responsible for covering personal care services or similar in-home aide services.
- have no household member, relative, caregiver, or volunteer to provide the authorized services on a regular basis.
- require personal care services directly linked to a documented medical condition causing functional limitations in activities of daily living.
- have a medical condition that requires the direct and ongoing care of a physician.
- have a medical condition that may deteriorate without the prescribed hands-on personal care services.
- are medically stable and does not require continuous monitoring by a licensed health care professional.
- are at risk of placement in a nursing facility, adult care home, or similar facility if the prescribed personal care services are not provided.
- are enrolled in Carolina Access and have a primary care physician

PCS also covers individuals with Medicaid for Pregnant Women when:

- prior approval is obtained
- the recipient has been confined to bed by an obstetrician
- the recipient has premature labor pains threatening miscarriage or premature birth
- the recipient is pregnant with twins or multiples

Appendix A PCS, PCS +

- the recipient has pre-eclampsia with hypertension and edema, or hyperemesis gravidarum with dehydration
- the recipient has a pre-existing medical condition exacerbated by pregnancy that requires hands-on assistance with personal care tasks.

Medicare-Qualified Beneficiaries (MQB) are not eligible for PCS.

Medicaid recipients on Medicaid or Medicare B hospice may not receive PCS.

HOW MUCH CAN THEY GET?

Medicaid provides coverage of up to 60 hours of PCS per month under its basic PCS program, and up to 80 hours of PCS per month under its PCS-Plus program. The number of hours authorized is determined by Medicaid following an in-home, hands-on assessment by a registered nurse employed by or under contract to DMA or its designee.

WHERE CAN THEY GET IT?

Services are covered in the recipient's private residence.

CAN THEY GET IT WHILE THEY ARE ON THE CAP/C PROGRAM?

Yes. However, an individual may not receive both Medicaid PCS and CAP/C Pediatric Personal Care. When the care needs of the individual fall within the NA I or lower scope of practice, the services are provided by PCS. When the care needs of the individual fall within the NA 1+ or NA II scope of practice, the services are usually provided through CAP/C Pediatric Personal Care.

WHO CAN PROVIDE IT?

In-home aides that meet the qualifications contained in the North Carolina Home Care Licensure Rules (10A NCAC 13J.1110). The aide can

not be the recipient's spouse, child, parent, sibling, grandparent, grandchild, or have an equivalent step- or in-law relationship with the recipient. The aide can not live with the recipient.

Additionally, there is a Nurse Supervisor who is licensed by the North Carolina Board of Nursing as an RN and is responsible for supervision of the in-home aides and all evaluation and care planning activities performed by the PCS provider organization. The Nurse Supervisor may be an employee of the PCS provider organization or under contract to the PCS provider organization.

WHAT DOES IT COST? HOW IS IT BILLED?

The revenue codes used for billing PCS are listed in the table below.

Code	Description	Unit of Service
S5125	PCS	15 minutes
99509	PCS Plus	15 minutes

The maximum allowable rate is based on the Home Care Maximum Reimbursement Rate Schedule, which is available on DMA's Web site at <http://ncdhhs.gov/dma/fee/fee.htm>.

Use the CMS-1500.

Please see the "Basic Medicaid Billing Guide" located at <http://www.dhhs.state.nc.us/dma/basicmed/index.htm> for complete information.

HOW DO I REFER SOMEONE?

A referral for a PCS Assessment may be requested by the recipient, the recipient's family or legally responsible person, a county agency, or other non-PCS provider through the recipient's primary care physician. PCS Providers are prohibited from soliciting Medicaid recipients to participate in PCS or referring recipients for PCS Assessments.

An Independent Assessment Entity (IAE) will determine the qualifying ADLs, the level of assistance required, the amount and scope of PCS to be provided, and the end date for approved services and the date of the next reassessment.

This material is only a brief general overview of this program. Please refer to the *Medicaid Clinical Coverage Policies and Provider Manuals* and the monthly *Medicaid Bulletins* for more information. You will find these publications at <http://www.dhhs.state.nc.us/dma/provider/index.htm>.



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Medicaid Private Duty Nursing

WHAT IS IT?

Private Duty Nursing (PDN) is substantial, complex, and continuous skilled nursing service that requires more individual and continuous care than is available from a visiting nurse or is routinely provided by the nursing staff of a hospital or skilled nursing facility.

WHAT IS INCLUDED?

- Medically necessary private duty RN or LPN services, in a client's home, under the direction of the client's primary physician.
- Medical supplies as listed on the Home Health fee schedule, when they are ordered by a physician, are documented in the recipient's plan of care, and are medically necessary as part of the recipient's home care.

WHAT IS NOT INCLUDED?

- Care of clients residing in group homes, adult care homes, or family care homes; clients in a medical facility; or clients in a place other than their private primary residence.
- Custodial or companion care
- Respite
- Transportation

- Care that could be delegated to a nurse aide when that is the only type of care that is needed
- Observation or monitoring without the requirement of supportive interventions
- Care when the client has no caregiver support (both primary and backup trained caregivers are required).
- Care during the same hours of the day that the recipient is receiving personal care services (PCS or PCS-Plus), home health services or respiratory therapy treatment.
- Care in the school, when the services are provided by the school as part of an individual education plan (IEP).
- Care when the client receives hospice services under Medicaid or Medicare, or home infusion therapy under Medicaid.
- Care of clients with Medicare-AID cards.

WHO CAN GET IT?

- Recipients who meet regular Medicaid eligibility criteria.
- Recipients with Medicaid for Pregnant Women, if the services are required for a pregnancy-related condition.
- Recipients who meet a minimum threshold of 60 points for technology needs on the HNRC.

HOW MUCH CAN THEY GET?

The number of hours per day of PDN services is based on the recipient's medical needs and caregiver availability. Approval will be granted as the number of hours per day, the number of days per week, and the starting and ending dates of the approval period. (The recipient must be reauthorized at the end of the approval period. There is no limit as to how many times a recipient can be reauthorized.) DMA determines the

amount, duration, scope, and sufficiency of PDN services required by the recipient.

WHERE CAN THEY GET IT?

PDN services can be provided only in the recipient's private primary residence.

CAN THEY GET IT WHILE ON THE CAP/C PROGRAM?

Yes. However, when a CAP/C client needs this type of service, it is usually provided through CAP/C Nursing Services rather than PDN. If a recipient wishes to receive PDN, explain to the recipient/caregiver that similar services are available under CAP/C. In the event the recipient does receive PDN, the PDN provider is responsible for meeting PDN requirements and service limitations. PDN and CAP/C Nursing may not be provided on the same day.

The following chart shows the differences between CAP/C Nurse services and PDN services:

	Private Duty Nursing (PDN)	Community Alternatives Program for Children (CAP/C)
Type of Program	Optional State Plan program	1915c Waiver
Financial Eligibility	Requires regular Medicaid eligibility	Must be eligible for MAB, MAD, I-AS, H-SF; and parents' income is not considered
Client Type	All ages Require high-acuity RN/LPN care	Ages 0 through 20 Require RN/LPN care or NA care
Prior Approval	No FL2 requirement Referral form Letter of medical necessity from Physician Hourly Review Tool (test) DMA Nurse Consultant reviews information and approves/denies as indicated	Must be a risk of institutionalization (FL-2 required) Must be medically fragile Requires Referral Form to be approved by DMA, then EDS-approved FL-2, local Case Mgr makes in-home initial assessment and develops plan of care approved by DMA DMA Nurse Consultant reviews assessment and plan of care and approves/denies as indicated
Services Offered	Receives only regular Medicaid services	May receives regular Medicaid services in addition to the following Waiver Services

		<ul style="list-style-type: none"> ➤ Case Management ➤ Participant-Directed Care ➤ CAP/C Nursing ➤ Pediatric Personal Care ➤ In Home Respite Care (nurse or aide) ➤ Institutional Respite Care ➤ Attendant Care Services ➤ Waiver Supplies ➤ Home Modifications ➤ Vehicle Modifications ➤ Community Transition Funding ➤ Nutrition Services ➤ Caregiver Training and Education ➤ Palliative Care ➤ Transportation ➤ Tele-health
Recertification	Every 60 days provider agency submits CMS Form 485 and 486 to DMA; nurses notes reviewed upon request	Annual Continued Needs Review (CNR) including FL-2, assessment, plan of care, as well as CMS Form 485, Physicians Request Form, MAR, and nursing and other service notes as applicable
Provider Type	Must use only one agency to provide the nursing staff	Nurse or NA staff can be provided by multiple agencies if needed
Care coordination/case management	Provider nursing agency coordinates services	Case manager (which is required component of program) provides comprehensive coordination of care including assessment, planning, and coordinating services, and including linkage to non-Medicaid resources.
Cost	No cost neutrality requirement	Cost neutrality requirement to waiver; care needs must be safely met within amount and/or cost limitations on each service

WHO CAN PROVIDE IT?

Agencies

PDN services are provided by home care agencies enrolled as a N.C.

Medicaid provider approved by DMA to provide PDN services.

Only one provider can be paid per recipient for each approved calendar day, midnight to midnight.

Individuals

PDN services are rendered by an RN or LPN who is licensed by the NCBON and employed by a licensed home care agency.

The nurse must not be a member of the recipient's immediate family (spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step- and in-law relationships) or a legally responsible person who maintains his or her primary residence with the recipient.

WHAT DOES IT COST? HOW IS IT BILLED?

All nursing is billed in 15-minute units under HCPCS procedure code T1000. Medical supplies are billed using HCPCS supply codes as indicated on the Home Health Fee Schedule.

Multi-recipient nursing (congregate nursing) is billed in 15-minute units under HCPCS procedure code G0154.

Please see the "Basic Medicaid Billing Guide" located at <http://www.dhhs.state.nc.us/dma/basicmed/index.htm> for complete information.

HOW DO I REFER SOMEONE?

To request PDN service, submit the following documentation to DMA:

- The PDN Prior Approval Referral Form
- A Physician's Request Form for PDN services or a letter of medical necessity

These forms are available at

<http://www.dhhs.state.nc.us/dma/services/pdn.htm>. The fax number and address to where the forms should be sent is located on the PDN Prior Approval Referral Form.

This material is only a brief general overview of this program. Please refer to the *Medicaid Clinical Coverage Policies and Provider Manuals* and the



monthly *Medicaid Bulletins* for more information. You will find these publications at <http://www.dhhs.state.nc.us/dma/provider/index.htm>.

APPENDIX A OTHER RESOURCES

Medicaid Transportation

WHAT IS IT?

Assistance with transportation of Medicaid recipients to and from medical appointments with Medicaid-enrolled providers to receive Medicaid covered services.

WHAT IS INCLUDED?

Means of transportation may include:

- Gas vouchers
- City bus
- County coordinated transportation system
- Cab/taxi service
- Personal vehicle
- Free transportation (i.e., family, friend, etc)

Medicaid transportation may include "related travel expenses" when the transportation need is other than routine.

- Overnight lodging and meals
- Attendant expenses, including overnight lodging, meals, and salary

WHAT IS NOT INCLUDED?

- Transportation for which medical care is the primary reason for service and the service is covered by Medicaid.
- Expenses of an attendant to sit with a patient after admission to a medical facility.
- Transportation provided by other means when free transportation is available and suitable to the recipient's needs.
- Direct reimbursement for purchase price of a vehicle for transportation. The purchase of a vehicle may be recovered over the life of the vehicle through trip reimbursement.
- Use of an ambulance when it is not medically necessary and other means are suitable.
- Private or public provider costs which are higher than appropriate and less expensive means of transportation are available.
- Routine transportation to school on a school day even though health services may be provided in the school during the day.
- Travel to visit a hospitalized patient (except to provide or learn to provide care for a patient).
- Empty trip when recipient only travels one way of a two way trip.
- Transportation of a deceased person by ambulance when the person was pronounced dead by someone legally authorized to make such a pronouncement prior to calling the ambulance.
- Transportation to a provider at a greater distance when the medical services are available at a shorter distance.
- Driver wait time (unless included in the per trip cost).
- Transportation to an institution for mental disease (a facility primarily engaged in providing diagnosis, treatment, or care of

persons with mental diseases) for patients between the age of 21 – 65.

- Transportation to receive a Medicaid covered service when medical care is not the primary reason for the trip.
- Deadhead Miles (Miles from a transportation provider's office/home/garage to the Medicaid recipient's residence are deadhead miles. Medicaid only pays from point of pickup to the point of drop off. Deadhead miles should be factored in the total cost in setting mileage rates.)
- Transportation to receive a medical service when the medical provider is not a qualified Medicaid provider (not enrolled in NC Medicaid).
- Transportation to receive a medical service that is not a Medicaid covered service. This includes medical services that do not qualify for Medicaid payment due to coverage limitations (visit limit exceeded) or medical provider has not received prior approval when required.
- Transportation to receive a Medicaid covered service when transportation reimbursement has been added into the Medicaid provider's fee. (some MH/DD/SA services)
- Reimbursement for payment of an attendant's salary when:
 - Attendant is a member of the recipient's family, or
 - *Attendant is paid to remain with a recipient who is a patient in a medical facility.*

Reimbursement for transportation costs and travel related expenses for one parent, guardian, or parental designated escort can be claimed when circumstances require. Salary to accompany a minor child is not an allowable travel expense. Note: The parent,

guardian, or designated escort is not required to be a Medicaid recipient.

WHO CAN GET IT?

All Medicaid recipients unless

- the recipient is authorized for Medicare-Aid (M-QB)
- the recipient's application is pending
- the recipient is on a deductible for Medicaid
- the recipient is authorized for North Carolina Health Choice.

HOW MUCH CAN THEY GET?

Medicaid will approve the least expensive means of transportation suitable to the recipient's individual needs.

For travel-related expenses, there are both chronological and monetary limits.

WHERE CAN THEY GET IT?

To and from the recipient's home and place of medical services.

CAN THEY GET IT WHILE ON THE CAP/C PROGRAM?

Yes.

WHO CAN PROVIDE IT?

Drivers must be at least 18 years of age, properly licensed, and have a clean driving record.

Vehicles must have valid State Registration stickers.

Liability insurance must be carried.

WHAT DOES IT COST? HOW IS IT BILLED?

There is no cost to the recipient.

Please see the "Basic Medicaid Billing Guide" located at <http://www.dhhs.state.nc.us/dma/basicmed/index.htm> for complete information.



HOW DO I REFER SOMEONE?

Contact the local Department of Social Services.



This material is only a brief general overview of this program. Please refer to <http://info.dhhs.state.nc.us/olm/manuals/dma> for the complete policy.

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APPENDIX A OTHER RESOURCES

North Carolina Assistive Technology Program

WHAT IS ASSISTIVE TECHNOLOGY?

The North Carolina Assistive Technology Program (NCATP) is a state and federally funded program created to increase statewide access of assistive technology to people of all ages and disabilities.

Assistive Technology (AT) is any piece of equipment or device that a person with a disability uses to make everyday living easier and be more independent.

WHAT IS INCLUDED?

- Hands-on demonstration of AT for computer use, activities of daily living, listening, communication, telecommunication, mobility, education, learning, leisure, play, alarm/emergency systems, and environmental control
- Short-term AT loan to try out devices
- AT resource information and referral to other programs
- Awareness activities on AT and general overview of NCATP services
- Advocacy for individuals and their families on their rights to AT services
- Funding resource information based on the person's needs
- Access to previously owned devices on the NC Technology Exchange post website (www.pat.org)

- Agencies, schools, and other organizations can purchase
 - Technical assistance in selecting devices showing the range of AT options
 - Assistive technology assessments
 - Feature matching and device trial
 - Training on specific devices/software
 - Consultation services
 - Specialized workshops/seminars, group training, and technical presentations

WHAT IS NOT INCLUDED?

This would depend upon the funding source and the determination of medical necessity.

WHO CAN GET IT?

- Children, adults, and older adults with disabilities and their families
- Older adults experiencing difficulty with daily activities
- Professionals in disability related fields such as health care, social services, education, or other human services
- Employers and employees in private and public settings

HOW MUCH CAN THEY GET?

The amount of assistive technology a person receives is based on medical need and funding source.

WHERE CAN THEY GET IT?

Assistive technology may be used in the home, school, workplace, in leisure and recreation, community living, and for independent living.

CAN THEY GET IT WHILE THEY ARE ON THE CAP/C PROGRAM?

Yes.

WHO CAN PROVIDE IT?

NCATP Assistive Technology Consultants and Assistive Technology Specialists are highly qualified professionals with technical expertise in the field of Assistive Technology. Staff education and experience are in the fields of speech language pathology, occupational therapy, rehabilitation engineering, computer technology, therapeutic recreation and education.

WHAT DOES IT COST? HOW IS IT BILLED?

Assistive technology may be funded by any of the following sources, dependent upon the recipient's age, disability, income, and geographic area and the focus of the funding source:

- Early Intervention Branch
- Children and Youth Branch
- School
- Vocational Rehabilitation
- Independent Living
- Medicaid (EPSDT)
- CAP-MR/DD
- NC Health Choice
- Private insurance
- Private foundations
- Personal finances

HOW DO I REFER SOMEONE?

Contact your nearest AT center. Visit www.ncatp.org for locations.



This material is only a brief general overview of this program. Please refer to www.ncatp.org for more information.

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APPENDIX A OTHER RESOURCES

North Carolina Health Choice (NCHC)

WHAT IS IT?

Health Choice is a free or reduced price comprehensive health care program for children. If a family makes too much money to qualify for Medicaid but too little to afford rising health insurance premiums, the child(ren) may qualify for Health Choice.

WHAT IS INCLUDED?

The core program includes:

- Physician and clinic services
- Laboratory and radiology services
- Surgical services
- Prescription drugs
- Dental services
- Vision
- Hearing
- Durable medical equipment and supplies such as wheelchairs
- Physical therapy, occupational therapy and therapy for individuals with speech, hearing and language disorders
- Hospice care
- Home health care (limited)
- Inpatient mental health services (requires precertification)

- Outpatient mental health services (requires precertification after 26 outpatient visits per year)
- Inpatient substance abuse treatment and outpatient substance abuse treatment (requires precertification)

Special needs children with chronic mental or physical conditions or illness may receive services beyond those listed above if the services are medically necessary (requires precertification). Specifically, they may qualify for:

- Medical nutrition therapy
- Formulas for children fed by tube
- Aids for daily living and personal care (like bathing and eating equipment)
- Seating and positioning equipment
- Standing and walking aids
- Mobility products and accessories (like wheelchairs)
- Miscellaneous medical supplies
- Community Support Services
- Day Treatment
- Intensive In Home Service
- Multisystemic therapy
- Mobile crisis
- Diagnostic assessment
- Targeted case management
- Residential treatment services (Level i-IV)
- Emergency respite services

WHAT IS NOT INCLUDED?

Non-covered services

- Taxi, bus, gasoline or other personal transportation costs

- Experimental / investigational procedures and any direct or indirect complications
- Surgical / medical procedures specifically listed by the American Medical Association or the North Carolina Medical Society as having questionable or no medical value.
- Nonskilled services
- Custodial care
- Drugs or devices not given unrestricted market approval by the FDA (Food and Drug Administration)
- Dental implants, dentures, crowns, bridges, onlays, inlays, braces and / or pulling impacted teeth and / or repositioning impacted teeth (Note: Dentures, crowns and bridges can be covered if accident-related)
- Braces and orthodontics for TMJ (even in the presence of an accident)
- Dental services that are the result of an accident that occurred while your child was eating or drinking
- Anesthesia administered by the doctor in an office setting
- Telephone consultations or services
- Durable Medical Equipment (DME) set up and dispensing fees
- Care provided by more than one doctor for the same condition on the same day
- Cosmetic services / surgery and complications from previous cosmetic surgery
- Vitamins, food supplements or replacements, nutritional supplements, formulas or special foods of any kind unless they require a physician's prescription to purchase and are for the treatment of certain medical conditions.
- Orthoptics or visual training exercises

- routine check-ups, tests or reports that are needed for such things as school, camp, legal, employment, insurance, sports or travel.

Non-covered Equipment and Supplies

- Air conditioners, air filtration systems, air cleaners and filters
- Elevator
- Bed, residential-type Heat lamps
- Bed board Intercoms (communicators)
- Bath, including jacuzzi, sauna, sitz, whirlpool, and tub and shower accessories (including bath chair systems)
- Mattress (except with hospital bed)
- Chairs, including recliner, "Roll-away," and Auto-tilt Medical alert equipment/services
- Clothing Scales (food or weight)
- Computers Telephone Alert System
- Humidifiers, dehumidifiers, and vaporizers Vacuum cleaners
- Exercise, sports and massage equipment, (regardless of the reason) including exercise bicycle, gravity inversion equipment, muscle stimulator/massager, treadmill exerciser, weights, weight bench, swimming pool, parallel bars, massage devices and vibration unit
- Safety equipment, including restraints (padding) and grab bars, (including bathroom rails)
- Sick room supplies, including bed bath, pillows (cervical or lumbar), emesis basin, heating pad, ice
- blanket, lambs wool pad, lap tray, surgical face mask and table
- Wheelchair accessories, including basket/tote bag, beverage holder, bumper wheels, curb ramp, curb ramp holder, custom handle, lap tray, lift (van), lifting handle, power seat lift, ramps and structural modifications, luggage rack and auto wheelchair carrier

- Youth equipment, including adaptive clothing, air mat, balls, beams, blocks, bolster, classroom aids,
- cognitive or developmental supplies, crawling aids, cylinders, feeding utensils, grooming supplies, ramps, swings, tables, toys (adaptive/educational) and Tyke-Hike
- Youth seating equipment, including car seat, classroom chair, high chair (feeder chair), infant relaxers, pony seats, stools and straddle chairs
- Bath, paraffin Fracture cast sock
- Biomechanical orthotic device Hand controls, automobile
- Blood pressure cuff/kit, Hydrocollator
- Cast impressions Molded shoe
- Cranial prosthesis (wig) Neuro aides/pads
- Cryo cuff/cold therapy Nightguards or athletic mouthguards
- Dentures (unless due to accident) Orthotic stabilizers
- Diathermy machine Postural drainage board
- Electrostatic machine Pre-set Portable Oxygen Center
- Electrical continence aid Rectal dilator
- Electrocardiocorder Speech teaching machines
- Extend-A-Hand Spinal-pelvic stabilizers
- Fiberglass stabilizers Temporomandibular joint appliance (unless due to accident)

Non-covered mental health, alcohol or drug services:

- Testing done only to determine educational or learning problems.
- Court ordered treatment except when pre-certified by the Mental Health Case Manager as medically necessary.
- Two or more psychotherapy visits in the same day.
- Any type of service provided over the telephone.

- Any non-covered medical service delivered in a mental health, alcohol or drug treatment setting.

WHO CAN GET IT?

Children who

- live in NC
- are age 6 to 18,
- have no health insurance
- meet family income requirements. There may be allowances for child care, work-related expenses, and children with special healthcare needs.

HOW MUCH CAN THEY GET?

This would depend on the individual service or supply being provided under Health Choice.

WHERE CAN THEY GET IT?

Some covered services may be covered in settings outside a provider's office, such as the child's home or school. Examples include home health care, therapies, caregiver education, case management, and other developmental disability services. Services provided in alternate settings always require prior approval.

CAN THEY GET IT WHILE ON THE CAP/C PROGRAM?

No. Once an individual has been approved for CAP/C , they are given Medicaid.

WHO CAN PROVIDE IT?

This is a list of health care professionals whose care or treatment is covered by NC Health Choice.

- Doctor of medicine (MD)
- Doctor of osteopathy (DO)
- Doctor of podiatry (DPM)
- Doctor of chiropractic (DC)
- Doctor of dental surgery (DDS) or (DMD)
- Licensed physician assistant (PA)
- Licensed physical, speech, respiratory and occupational therapists
- Nurse (some advanced practice registered nurses, registered nurses and licensed practical nurses)
- Home care aide (under the direct supervision of a registered nurse and employed by a licensed home care agency)

The following professionals can provide mental health as well as alcohol and drug treatment services covered by NC Health Choice. Licensed psychiatrist (MD) or (DO)

- Licensed psychologist (PhD), (EdD) or (PsyD)
- Certified clinical social worker (CCSW)
- Licensed clinical social worker (LCSW)
- Licensed professional counselor (LPC)
- Licensed marriage and family therapist (LMFT)
- Certified fee-based pastoral counselor (PhD)
- Licensed psychological associate (LPA)
- Licensed physician assistant; must be supervised and employed by a psychiatrist
- Certified clinical specialist in psychiatric and mental health nursing (RN, certified by the American Nurses Credentialing Committee which now certifies clinical specialists as Advanced Practice Registered Nurses, Board Certified)

- Registered nurse (RN) or (RN-C); must be supervised and employed by a licensed psychiatrist or licensed psychologist

The following list may only provide care for alcohol and drug treatment.

- Certified substance abuse counselor (CSAC)
- Physician (MD) or (DO) licensed as an MD or DO in the state in which service are provided and be certified by the American Society of Addiction Medicine

This is a list of health care professionals whose care or treatment is not covered by NC Health Choice.

- Person not licensed to practice in North Carolina (or not licensed in the state in which service is rendered)
- Doctor of holistic / naturopathic medicine
- Homeopath
- Acupuncturist
- Doctor of Chinese / Oriental Medicine
- Massage therapist

WHAT DOES IT COST? HOW IS IT BILLED?

HealthChoice sometimes requires enrollment fees and copays from recipients.

Please see the "Basic Medicaid Billing Guide" located at <http://www.dhhs.state.nc.us/dma/basicmed/index.htm> for complete information.

HOW DO I REFER SOMEONE?

N.C. Health Choice is available only to those children who do not qualify for Medicaid. There is not a separate application for Health Choice. All children who are not eligible for Medicaid are evaluated for Health Choice.



If you are applying for the Special Needs Plan, the child's doctor needs to complete the Physician Certification form.

Applications are taken in person and by mail at the Department of Social Services (DSS). Please see <http://www.dhhs.state.nc.us/dss/local/index.htm> for a directory of local DSS offices.

This material is only a brief general overview of this program. Please refer to <http://www.ncdhhs.gov/dma/healthchoice/index.htm>.



MORE
INFORMATION

APPENDIX A OTHER RESOURCES

North Carolina Health Insurance Risk Pool (NCHIRP)/

WHAT IS IT?

Group health care coverage for people who cannot obtain health insurance or reasonably priced health insurance because of their medical history.

WHAT IS INCLUDED?

Just like most traditional employer-sponsored health plans, Inclusive Health covers a broad range of services, including preventive care, urgent care, outpatient services, a prescription drug benefit and other common health care services. Inclusive Health offers four different plan options.

Please see http://www.inclusivehealth.org/docs/NCHIRP_Policy1119.pdf for details regarding covered services.

WHAT IS NOT INCLUDED?

Exclusions are similar to those of other employer-sponsored group plans.

Please see http://www.inclusivehealth.org/docs/NCHIRP_Policy1119.pdf.

WHO CAN GET IT?

Individuals who meet all of the following:

- are a legal resident of the United States.
- You are a resident of the State of North Carolina.

- do not have access to any other group coverage including access to coverage through a spouse or as a dependent on a parent or guardian's policy.
- do not qualify for a government program such as Medicare, Medicaid, SCHIP or Social Security Disability.

and meet one of the following:

- have been rejected or refused by an insurer for similar coverage for medical reasons.
- have been offered coverage by an insurer but with conditional rider limiting coverage.
- You have been refused coverage except at a higher premium rate than Inclusive Health.
- have similar coverage, but at a single rate higher than Inclusive Health.
- have a diagnosed medical condition, outlined by Inclusive Health, which allows automatic enrollment into Inclusive Health.
- are a federally-qualified, HIPAA-eligible individual, including those who currently have this coverage through an insurer.
- are a resident eligible for the Federal Health Coverage Tax Credit (trade- displaced workers, PBGC recipients).
- are an eligible individual with other non-group coverage in place; you can move to Inclusive Health at any time

HOW MUCH CAN THEY GET?

There is a benefit maximum for some services. There is also an overall lifetime maximum.

WHERE CAN THEY GET IT?

Not Applicable.

CAN THEY GET IT WHILE ON THE CAP/C PROGRAM?

No. If you are eligible for Medicare or Medicaid, you cannot purchase Inclusive Health coverage. If you have Inclusive Health, it will terminate when you become eligible for Medicaid or Medicare.

WHO CAN PROVIDE IT?

Not Applicable

WHAT DOES IT COST? HOW IS IT BILLED?

Premium payments are made from the recipient to Inclusive Health via monthly automatic bank draft.

HOW DO I REFER SOMEONE?

Visit the website at: <http://www.inclusivehealth.org/index.htm>. From there, you can apply on-line, by mail, or by phone (1-866-665-2117). You may also find a local agent/broker; there is a list by county on the website.



MORE
INFORMATION

This material is only a brief general overview of this program. Please refer to <http://www.inclusivehealth.org/index.htm>.

APPENDIX A OTHER RESOURCES

WIC

WHAT IS WIC?

WIC is the Special Supplemental Nutrition Program for Women, Infants, and Children. It is a federal program designed to provide food to low-income pregnant, postpartum and breastfeeding women, infants and children until the age of five.

WHAT IS INCLUDED?

Foods for Infants

The Program strongly encourages and provides support for breastfeeding. However, bottle-fed infants receive the WIC contract standard milk and soy based iron-fortified infant formula for the first year of life. Beginning at six months of age, infants may also receive iron-fortified infant cereal and fruit and vegetable juices high in vitamin C.

In some cases, when medical conditions contraindicate the use of the WIC contract standard milk or soy based formulas, infants may receive a special formula.

Foods for Women and Children

Women and children (one to five years of age) participating in WIC receive food instruments for milk, cheese, eggs, cereals high in iron, peanut butter or dried beans or peas, and fruit or vegetable juices high in vitamin C. Women who exclusively breastfeed their babies may also receive carrots and canned tuna fish. Special formulas or nutritional

supplements are also available to women and children participants with certain medical conditions.

Nutrition Education

Nutrition education is a major benefit of the Program and is provided to all adults and, whenever possible, to children directly. The goals of nutrition education are:

- To teach about the relationship between nutrition, physical activity and good health.
- To improve the eating and exercise habits as they relate to the participant's nutritional risk.
- To promote optimal use of the WIC Program's supplemental foods, and other nutritious foods.
- To provide nutrition education that is appropriate to an individual's age, educational background, household situation, language, cultural and ethnic preferences, and nutritional needs.

Referrals for Health Care

WIC serves as an adjunct to the health care system. WIC enjoys a reciprocal relationship with the health care community, receiving referrals from private and public health care providers and providing referrals as needed for health and social services. Referrals from WIC include immunizations and substance abuse counseling and treatment. WIC encourages persons already receiving medical services to remain under their physicians' care. It also encourages individuals not receiving medical care to seek and maintain appropriate care.

WHAT IS NOT INCLUDED?

- Foods not on the WIC food list
- Assistance for individuals who do not meet residency, financial, or nutritional risk criteria

WHO CAN GET IT?

Pregnant, postpartum and breastfeeding women; infants; and children until the age of five who

- live in North Carolina
- have a family income less than 185% of the U.S. Poverty Income Guidelines. A person receiving Medicaid, Work First Families Assistance (TANF), or assistance from the NC Food and Nutrition Services automatically meets the income eligibility requirement
- are at nutritional risk. A nutritionist or other health professional makes the nutritional risk assessment at no cost to the participant, usually at the local WIC office.

HOW MUCH CAN THEY GET?

There are maximum monthly allowances on the quantity of formula and food that can be provided. These maximums are determined by age group and other factors.

In addition, there are limits on the duration of services, after which a recipient would have to re-certify.

WHERE CAN THEY GET IT?

Participants exchange WIC food instruments (which list specific foods and quantities) and cash-value vouchers (for fruits and vegetables) at authorized retail grocery stores and pharmacies. In some cases, special formulas are distributed directly to the participant from the WIC local agency.

CAN THEY GET IT WHILE ON THE CAP/C PROGRAM?

Yes. Doing so is encouraged, because it helps keep down Medicaid costs. (Ultimately, it is the recipient's choice.)

WHO CAN PROVIDE IT?

A directory of WIC offices is available at <http://www.nutritionnc.com/wic>.

WHAT DOES IT COST? HOW IS IT BILLED?

For CAP/C recipients, Medicaid will supply the amount of medically necessary formula that exceeds the quantity and duration limits of WIC. Reimbursement is according to the Durable Medical Equipment or Home Infusion Therapy fee schedules located at

<http://www.dhhs.state.nc.us/dma/fee/index.htm>.

Please see the "Basic Medicaid Billing Guide" located at

<http://www.dhhs.state.nc.us/dma/basicmed/index.htm> for complete information.

HOW DO I REFER SOMEONE?

To apply for the WIC Program please contact the office of the local WIC agency that serves the residents of the county in which you live.

To find the location of the WIC office for your county, you may:

- check the County Directory on the WIC website at <http://www.nutritionnc.com/wic/>
- contact your local health department
- call the NC Family Health Resource Line at 1-800-FOR-BABY (1-800-367-2229).



MORE
INFORMATION



MORE
INFORMATION

This material is only a brief general overview of this program. Please refer to <http://www.nutritionnc.com> for more information.

**APPENDIX A
OTHER RESOURCES**

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Please insert your own information regarding local or other resources not included in this Appendix.

If the resource you add is available state-wide, and you think it would be helpful to include in future editions of this manual, please send the information to

Division of Medical Assistance
HCI Unit, CAP/C Program
2501 Mail Service Center
Raleigh NC 27699-2501

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APPENDICES

**APPENDIX B
GLOSSARY**

The following definitions apply to the terms, abbreviations and acronyms used in this manual.

Abuse is the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation of an individual. Types of abuse include (but are not necessarily limited to): (a) physical abuse (a physical act by an individual that may cause physical injury to another individual); (b) psychological abuse (an act, other than verbal, that may inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade or demean an individual); (c) sexual abuse (an act or attempted act such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and/or inappropriate or unwanted touching of an individual by another); and, (d) verbal abuse (using words to threaten, coerce, intimidate, degrade, demean, harass or humiliate an individual).

Adult Care Homes includes facilities licensed as an adult care home under Chapter 131D of the General Statutes. It includes adult care homes licensed under 10A NCAC 13F and family care homes licensed under 10A NCAC 13G. Additionally Mental Health Licensed Supervised Living Homes licensed under Chapter 122C of the General Statutes whose residents may receive State/County Special Assistance are granted a Medicaid Provider Number.

Appendix B Glossary

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.

Assessment is one or more processes that are used to obtain information about an individual, including his/her condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that an individual requires waiver services as well as the development of the service plan.

Assurance refers to the commitment by a state to operate a HCBS (Home and Community Based Services) waiver program in accordance with statutory requirements. Approval of a new waiver is contingent on CMS determining that the program's design will result in meeting the assurances contained in 42 CFR §441.302. Renewal of a waiver is contingent on CMS finding that a waiver has been operated in accordance with the assurances and other Federal requirements.

Blue Card is a now outdated term. It refers to the color of the Medicaid ID card that used to be issued to those persons eligible under regular Medicaid eligibility requirements.

Buff Card is a now outdated term. It refers to the color of the Medicaid ID card that used to be issued to those persons eligible for coverage of Medicare covered services. The holders of this card are Medicare-Aid recipients – one classification of MQB (Medicare Qualified Beneficiaries) coverage.

CAP is the acronym for the Community Alternatives Programs – programs that provide an alternative to institutional care.

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. It is the latest of three dates:

The date of the 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.

Caregiver is a person who helps care for someone who is ill, has a disability, and/or has functional limitations and requires assistance. Informal caregivers are relatives, friends, or others who volunteer their

help. Paid caregivers provide services in exchange for payment for the services rendered.

Case Management is a set of activities that are undertaken to ensure that the waiver participant receives appropriate and necessary services. Under a HCBS waiver, these activities may include (but are not limited to) assessment, service plan development, service plan implementation and service monitoring as well as assistance in accessing waiver, State plan, and other non-Medicaid services and resources.

CFR is the Code of Federal regulations. The CFR contains the regulations that have been officially adopted by Federal agencies. Federal regulations that govern the Medicaid program are contained in 42 CFR §430 *et seq.*

Chronic Illness is a long- term or permanent illness that may result in some type of disability for which assistance may be required on a continuing basis.

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.

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 in the Department of Health and Human Services that is responsible for federal administration of Medicaid, Medicare and State Children’s Health Insurance Program (SCHIP) programs.

CMS 372(S) is the annual report that a state must submit to CMS following the completion of each waiver year that details: (a) the number of unduplicated individuals who participated in a waiver during the waiver year, (b) the unduplicated number of persons who utilized each waiver service and the amount of funds expended for each service; (c) expenditures for Medicaid state plan services on behalf of waiver participants. The information submitted via the CMS-372(S) provides evidence of the waiver's cost neutrality on an ongoing basis.

CMS-1500 is the format used to submit Medicaid claims for CAP services.

Complaint refers to the formal expression of dissatisfaction by a participant with the provision of a waiver service or the performance of an entity in conducting other activities associated with the operation of a waiver.

Complex care is defined as care requiring actual hands-on nursing or nurse aide intervention as opposed to supervision or observation

Continuous care is defined as care requiring interventions which are performed at least every two to four hours during the hours that Medicaid-reimbursed nursing service is provided, or fills the duration of those hours, and cannot be provided as a home health visit.

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

Cost Neutrality is the requirement that an HCBS waiver must be designed and operated so that the average cost per unduplicated participant

of furnishing waiver services and other Medicaid benefits is no greater than the average cost per unduplicated individual of furnishing institutional services and other Medicaid benefits to institutionalized persons at the same level of care. Cost neutrality must be demonstrated prospectively in order for a new waiver or a waiver renewal to be approved. It also must be verified each year that the waiver is in effect (by the submission of the annual CMS 372(S) report).

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.

Critical Incident (Event) is an alleged, suspected, or actual occurrence of: (a) abuse (including physical, sexual, verbal, and psychological abuse); (b) mistreatment or neglect; (c) exploitation; (d) serious injury; (e) death other than by natural causes; (f) other events that cause harm to an individual; and, (g) events that serve as indicators of risk to participant health and welfare such as hospitalizations, medication errors, use of restraints or behavioral interventions.

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. In the CAP/C waiver, this deeming requirement is waived so that only the income of the child is considered.

DHSR is the North Carolina Division of Health Services Regulation [formerly the Division of Facility Services (DFS)] 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.

Disability for Social Security purposes and in the case of children (age 17 and younger) means that the child has a physical or mental condition that results in marked and severe functional limitations. The condition also must be expected to result in death or to last for a continuous period of not less than 12 months. For persons 18 and older, disability means the inability of that person to engage in substantial gainful activity or work) by reason of any medically determinable physical or mental condition that can be expected to result in death or to last for a period of not less than 12 months.

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.

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.

Duration of services is the length of time that a service will be provided. A limit on the duration of services means that the service will no longer be provided after a specified period of time or, after a specified period of time, the necessity of the service is subject to review and reauthorization.

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.

Entrance is the result of completing all processes that must be completed in order for an individual to begin to receive waiver services. A person may start to receive waiver services when: (a) the person has been determined to meet

applicable Medicaid eligibility criteria; (b) there has been a determination that the person is a member of a target group that is included in the waiver; (c) there has been a determination that the person requires a level of care specified for the waiver; (d) the person has exercised freedom of choice and has elected to receive waiver instead of institutional services; and, (e) a service plan has been developed that includes one or more waiver services.

EPSDT is Early and Periodic Screening, Diagnosis and treatment. It is Medicaid's comprehensive child health program for individuals under the age of 21. EPSDT is authorized under § 1905 (r) of the Act and includes the performance of periodic screening of children, including vision, dental, and hearing services. § 1905 (r) (5) of the Act requires that any medically necessary health care service that is listed in § 1905 (a) of the Act be provided to an EPSDT beneficiary even if the service has not been specifically included in the State plan. Federal EPSDT regulations are located in 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act.

Fair Hearing is the administrative procedure established in § 42 CFR Subpart E (42 CFR § 431.200 through § 431.250), 42 C.F.R. Subpart J, and 42 U.S.C. 1396a(a)(3), that affords individuals the statutory right and opportunity to appeal adverse decisions regarding Medicaid eligibility or benefits to an independent arbiter. An individual has the right to request a Fair Hearing when denied eligibility, when eligibility is terminated, or when denied a covered benefit or service.

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.

Fraud and Abuse In the context of providers billing for Medicaid services, fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law. Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program. State plan requirements concerning fraud detection and investigation are located in 42 CFR § 455.12 *et seq.*

Freedom of Choice of Provider as specified in § 1902 (a) (23) of the Act and 42 CFR § 431.51, the right of a Medicaid beneficiary to obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is 9a) qualified to furnish the services; and (b) willing to furnish them to the beneficiary.

Freedom of Choice is the right afforded to an individual who is determined to be likely to require a level of care specified in a waiver to choose either institutional or home and community based services, as provided in § 1915 (c) (2) (C) of the Act and in 42 CFR § 441.302(d).

Frequency of services refers to how often a service will be furnished to a beneficiary.

Habilitation refers to services that are provided in order to assist an individual to acquire a variety of skills, including self-help, socialization, and adaptive skills. Habilitation is aimed at raising the level of physical, mental, and social

functioning of an individual. Habilitation is contrasted to rehabilitation which involves the restoration of function that a person has lost.

HC is one of the indicators 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, Home Health, Hospice, Home Infusion Therapy, and HIV Case Management.

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.

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 DHSR to provide in-home aide, certified Nurse Aide or Nurse services

Home Care Licensure Rules refers to the regulations for the licensing of home care agencies, contained in NCAC Title 10: Chapter 13, Subchapter 13J, which are administered by DHSR. 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 DHSR to provide home care services and medical supplies. Home health services may include part-time or intermittent nursing care and home health aide services, physical therapy, occupational therapy, speech pathology and certain medical supplies that are provided to Medicaid beneficiaries in the place of residence. Home health services must be ordered by a physician under a plan of care that the physician reviews every 60 days.

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 DHSR to provide hospice care.

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.

IDEA is the Individuals with Disabilities Education Improvement Act. It is a federal law (P.L. 108-446; 20 USC § 1400 *et seq.*) that ensures “that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living”.

Institution refers to a hospital, nursing facility or ICF/MR.

Katie Beckett Option is the popular name for the Medicaid optional eligibility group under § 1902(e)(3) of the Act that permits a state to extend Medicaid eligibility to children with disabilities or chronic conditions under the age of 19 who require the level of care provided in a hospital, nursing facility, or ICF/MR but who can be cared for at home and would not otherwise qualify for Medicaid unless institutionalized. This option is sometimes called the TEFRA 134 option. Federal regulations concerning this optional eligibility group are located in 42 CFR § 435.225.

Legal Representative is a person who has legal standing to make decisions on behalf of another person (e.g., a guardian appointed by the court or an individual who has power of attorney granted by the person)

Legally Responsible Individual is a person who has legal obligation under the provisions of state law to care for another person. Legal responsibility is defined by the state and usually includes the parents (natural or adoptive) of minor children, legally-assigned caretaker relatives of minor children, and sometimes spouses.

Level of Care is the specification of the minimum amount of assistance that an individual must require in order to receive services in an institutional setting under the State plan.

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 "Spendedown".

Medicaid ID card is the card issued monthly to identify individuals eligible for Medicaid coverage.

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 the 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 refers to services or supplies that are proper and needed for the diagnosis and treatment of a medical condition, are provided for the diagnosis, direct care, and treatment of the condition, and meet the standards of good medical practice.

Medication error refers to a mistake in medication administration that includes but is not necessarily limited to the following: (a) wrong medication (an individual receives and takes medication which is intended for another person, discontinued, or inappropriately labeled), (b) wrong dose (an individual receives the incorrect amount of medication); (c) wrong time (an

individual receives medication dose at an incorrect time interval); and (d) omission (missed dose) is when an individual does not receive a prescribed dose of medication, not including when an individual refuses to take medication.

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.

Monitoring is the ongoing oversight of the provision of waiver and other services to determine that they are furnished according to the participant's service plan effectively meet his/her needs, including assuring health and welfare. Monitoring activities may include (but are not limited to) telephone contact, observation, interviewing the participant and/pr the participant's family (as appropriate) (in person or by phone) and/or interviewing service providers.

NCAC is the North Carolina Administrative Code – the state regulations.

Nursing Facility (NF) sometimes referred to as nursing homes. Institutions that primarily provide

- Skilled nursing care and related services for residents who require medical or nursing care;
- Rehabilitation services for the rehabilitation of injured, disabled, or sick persons; and/or
- Health-related care and services, on a regular basis, to individuals who because of their physical or mental condition require care and services above the level of room and board, which can be made available to them only through institutional facilities.

Neglect is the failure to provide an individual the reasonable care that s/he requires, including but not limited to food, clothing, shelter, medical care, personal hygiene, and protection from harm.

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.

Participant, or Client refers to an individual who has met waiver entrance requirements, chooses to receive waiver services, enters the waiver, and subsequently receives waiver services authorized in a service plan.

PCS is Personal Care Services – a home care service that is provided to persons with disabilities and chronic conditions of all ages to enable them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may take the form of hands-on assistance or as cueing so that the person performs the task him/herself. Such assistance most often relate to performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs) which includes assistance with daily activities such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, medication management, etc. in-home aide services to meet the patient's medically related personal care needs.

PDN is Private Duty Nursing – a home care service that provides continuous, complex, and substantial nursing care for patients in their homes.

Person Centered Planning refers to an assessment and service planning process is directed and led by the individual, with assistance as needed or desired from a representative or other persons of the individual's choosing. The process is designed to identify the strengths, capabilities, preferences, needs, and desired outcomes of the individual. The process may include other

persons, freely chosen by the individual, who are able to serve as important contributors to the process. The PCP process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that assist him/her to achieve personally defined outcomes in the community.

Prior Authorization is a mechanism that is employed to control the use of covered items (such as durable medical equipment or prescription drugs) or services (such as inpatient hospital care). When an item or service is subject to prior authorization, payment is not made unless approval for the item or service is obtained in advance either from state agency personnel or from a state fiscal agent or other contractor.

POC stands for Plan of Care. The POC, or service plan, is the written document that specifies the waiver and other services (regardless of funding source) along with any informal supports that are furnished to meet the needs of and to assist a waiver participant to remain in the community. The service plan must contain, at a minimum, the types of service to be furnished, the amount, the frequency and duration of each service and the type of provider to furnish each service.

Private Residence as used in the waiver, is

- The home that a waiver participant owns or rents in his or her own right or the home where a waiver participant resides with other family or friends. A private residence is not a living arrangement that is owned or leased by a service provider, or
- The home of a caregiver who furnishes foster or respite care to a waiver participant

Provider is the term used for a qualified individual or entity that has 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.

Provider Qualification refers to standards established by the state that specify the education, training, skills, competencies and attributes that an individual or provider agency must possess in order to furnish services to waiver participants.

Quality Assurance is the process of looking at how well a service is provided. The process may include formally reviewing the services furnished to a person or group of persons, identifying and correcting problems, and then checking to see if the problem was corrected.

Quality Improvement is the performance of discovery, remediation and quality improvement activities in order to ascertain whether the waiver meets the assurances, correct shortcomings, and pursue opportunities for improvement.

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.

Rehabilitation is services that have the purpose of improving/restoring a person's physical or mental functioning. Such services may include therapeutic services such as occupational and physical therapy services, as well as mental

health services such as individual and group psychological therapies, psychosocial services, and addiction treatment services.

Rehabilitative services may be provided at home, in the community, or in long-term care facilities.

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.

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. 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.

SC is one of the indicators that identifies the patient as a participant in the Community Alternatives Program for Children (CAP/C). This participant qualifies at a nursing facility level of 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.

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 refers to care needs that only be met within the scope of practice of the staff appropriate for the service provided; care tasks are not delegable to a lower level of staff

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.

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 1 through the following June 30.

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APPENDICES

APPENDIX C **Contact Information**

CONTACTING CAP/C

Mailing Address

Division of Medical Assistance

HCI Unit, CAP/C

2501 Mail Services Center

Raleigh, NC 27699-2501

Inaccurately or incompletely addressed mail may be very delayed in reaching the CAP/C Unit.

Please use mail for sending CNRs and other lengthy documents.

Physical Address

1985 Umstead Drive

Raleigh, NC 27603

(the Kirby Building on the Dorothea Dix campus)

Fax

919 715 9025

Please do not fax CNRs or other lengthy documents; send them by US mail

Referrals and urgent revisions may be faxed.

Information requested from you by your Nurse Consultant may be faxed

Main Phone

919 855 4380

If you wish to contact us by telephone, our voice mail IS confidential. Leaving a detailed voice message will ensure a more prompt and accurate response to your question. When calling the main phone number, please specify which consultant you wish to speak to, or which county you are from so that your call may be properly directed. Phone calls will be returned by the end of the next business day or as otherwise stated in the staff member's outgoing voice mail message. If you have not heard back from us within the time specified, please call again.

Staff

Each county has a particular CAP/C Nurse Consultant assigned to it. When you need to contact a consultant, your first contact should always be the consultant assigned to your county. If your consultant is unavailable and your question cannot wait until her return, one of the other consultants will help you. The list of which consultant is assigned to which county can be found at <http://www.dhhs.state.nc.us/dma/>. We try to keep assignments as consistent as possible, but may occasionally need to make some changes based on counties census' or internal staffing.

Direct Phone

Teresa Piezzo	Supervisor	919 855 4385
Robert Dean	Administrative Assistant	919 855 4381
Jennifer Brest	Lead CAP/C Nurse Consultant	919 855 4382
Patricia Miller	CAP/C Nurse Consultant	919 855 4386
Patricia Meyer	CAP/C Nurse Consultant	919 855 4388
Sandra Mangum	CAP/C Nurse Consultant	919 855 4392
Sandra Wheeler	CAP/C Nurse Consultant	919 855 4383
Carol Davis	CAP/C Nurse Consultant (part-time, temporary)	919 855 4384

E-mail

Teresa Piezzo	Supervisor	teresa.piezzo@dhhs.nc.gov
Robert Dean	Administrative Assistant	robert.l.dean@dhhs.nc.gov
Jennifer Brest	Lead CAP/C Nurse Consultant	jennifer.brest@dhhs.nc.gov
Patricia Miller	CAP/C Nurse Consultant	patricia.miller@dhhs.nc.gov
Patricia Meyer	CAP/C Nurse Consultant	patricia.meyer@dhhs.nc.gov
Sandra Mangum	CAP/C Nurse Consultant	sandra.f.mangum@dhhs.nc.gov
Sandra Wheeler	CAP/C Nurse Consultant	sandra.wheeler@dhhs.nc.gov
Carol Davis	CAP/C Nurse Consultant (part-time, temporary)	carol.c.davis@dhhs.nc.gov

The state email system is not secure. Please do not send patient names, MID numbers, or other protected health information within an email. You may use patient initials.

If you must send confidential email to DMA:

- Send it as a password protected attachment to the email. Arrange with your Consultant (via telephone) a password for you to use.

Type and save your question/information as a Word document.

Go to Tools, click on the down arrow, and click on Options, then Security.

In the 'Password to open' box, enter the password, click OK, re-enter the password, click OK.

Click on File, Send To, Mail recipient (as attachment).

Open the email message and type the subject and body of your message.

- If you have the zix mail system, you may send it by zix mail

If you must receive confidential email from DMA

- It will be sent as a password protected attachment; your consultant will call you to tell you the password, or
- It will be sent to you via zix mail

Remember that emails are public records. Do not say anything in an email that you would not want repeated in court, in the newspaper, or to anyone other than the person you sent the email to.

Other Case Management Agencies

If you need to contact a case management agency in another county, please refer to the CAP/C Agency Contact List at

<http://www.dhhs.state.nc.us/dma/capc/capcagency.htm>.

OTHER IMPORTANT CONTACT INFORMATION

This following information 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/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
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

for information about:	Contact:
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, DHSR - 919-733-7461
Home Health/Hospice Medicare Certification	Licensure & Certification Section, Acute and Home Care Branch, DHSR - 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
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

Appendix C Contact Information

To get:	Contact:
<p>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.</p>	
Adjustment Request Forms	EDS Provider Services Unit - 1-800-688-6696 or 919-851-8888 or obtain at http://www.dhhs.state.nc.us/dma/forms/ma.pdf
Authorization Agreement for Automatic Deposit	See Electronic Funds Transfer (EFT) Forms
CAP/C Manuals	http://www.dhhs.state.nc.us/dma/capc/capcmanual.pdf
Claims Inquiry Forms	See Resolution Inquiry Forms
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 http://www.dhhs.state.nc.us/dma/forms/eft.pdf
Fee Schedules	Fax request to DMA using the form published periodically in Medicaid Bulletins and available on DMA's website at http://www.dhhs.state.nc.us/dma/fee/index.htm
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.
Health Insurance Information Referral Form	Obtain at http://info.dhhs.state.nc.us/olm/forms/dma/dma-2057.pdf
PDN Referral Forms & Medical Update Forms	Home Care Initiatives Unit, DMA - 919-855-4390, or obtain from website http://www.ncdhhs.gov/dma/provider/forms.htm
Provider Certification for Signature on File	EDS Provider Services Unit – 1-800-688-6696 or 919-851-8888 or obtain at http://www.nctracks.nc.gov/provider/forms/pc.pdf

To get:	Contact:
Provider Enrollment Applications	<p><u>Mailing Address</u> N.C. Medicaid Provider Enrollment CSC PO Box 300020 Raleigh NC 27622-8020</p> <p><u>Physical Address</u> N.C. Medicaid Provider Enrollment CSC 2610 Wycliff Road, Suite 102 Raleigh NC 27607-3073</p> <p>Phone: 866-844-1113 Fax: 866-844-1382 ncmedicaid@csc.com</p>
Refund Forms	See Adjustment Request Forms
Resolution Inquiry Forms	EDS Provider Services Unit – 1-800-688-6696 or 919-851-8888 or obtain at http://www.ncdhhs.gov/dma/forms/mri.pdf
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 http://www.ncdhhs.gov/dma/provider/forms.htm

Appendix C Contact Information

To determine:	Contact:
CAP Participation	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, DHSR - 919-733-7461
Home Care Service Complaints	Home Care Hotline, DHSR 1-800-624-3004
Recipient Insurance Information	Your county department of social services

Appendix C Contact Information

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
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 FAX# 919-715 2859
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
Underpayments (Adjustment Request Form)	EDS Adjustment Unit P.O. Box 300009 Raleigh, NC 27622

APPENDICES

APPENDIX D

Important Dates and Deadlines

CASE MANAGER TRAINING

Case Managers new to CAP/C should complete DMA training within 90 days of employment or within 90 days of beginning to work within the CAP/C program.

REFERRALS AND WAIT LISTS

If a referral is approved, you must contact the recipient/family within two weeks of the date of the approval letter.

If you can not begin serving that recipient within two weeks of the date of the approval letter, the recipient is then considered to be on a wait list.

Wait list information is due to DMA by the 5th of every month.

If the referral is denied, the recipient has 60 days from the date of the denial letter to request an 'assessment anyway'. After 60 days, they will need to complete a new referral.

<u>FL-2</u>		<u>MEDICAID APPLICATION</u>	
<p>Must be called into EDS within 30 days of MD signature</p> <p>Must be received by EDS within 10 workdays of the telephone approval</p> <p>You should receive the stamped copy of the FL-2 within 60 days.</p> <p>Must be renewed annually, on or before the day the form was approved by EDS (or if not applicable the date of the physicians signature).</p>		<p>Application expires 45 or 90 days after application date (length of time depends on if the applicant is also applying for disability). CAP/C services must be approved before the Medicaid application expires.</p>	
<u>INITIAL</u>	<u>EXPEDITED INITIAL</u>	<u>REVISION</u>	
<p>Must be approved within 60 days of FL-2 approval <u>and</u> by the Medicaid application date</p> <p>If a client is in a nursing facility or hospital, , do not start your assessment until within 30 days of discharge. Case Management provided before that time can not be reimbursed.</p>	<p>Preliminary approval lasts for six weeks.</p> <p>Complete assessment, plan of care, etc, must be received by DMA within 30 days of start of services.</p>	<p>May be approved retroactively for up to 30 days prior to the date that the revised plan is approved. In other words, the effective date may be no earlier than 30 days prior to the date received by DMA.</p> <p>If a verbal approval for a change in services due to an urgent need is given, the written plan of care revision must be signed within five business days.</p>	
	<u>CNR</u>		
<u>REQUESTS FOR ADDITIONAL INFORMATION</u>			
<p>Requested information must be provided within 15 business days of the request. If the information cannot be provided within 15 business days, you must notify the Consultant before the 15 days passes. Up to an additional 15 business days can be granted. After 30 business days, if the requested information is not received, the recipient is subject to losing his or her CAP/C services.</p>			

<u>MONITORING – RECIPIENT/FAMILY</u>	<u>MONITORING – PROVIDERS</u>	<u>MONITORING – CLAIMS AND NOTES</u>
<p>Monthly contact</p> <p>Quarterly home visit</p> <p>Contact within 72 hours of hospital discharge</p> <p>Contact after construction or installation of home modifications.</p>	<p>Monthly contact with providers of waiver services.</p> <p>Quarterly contact with providers of other services.</p> <p>Service Authorizations and Participation Notices renewed annually and with changes.</p>	<p>Quarterly review of random sample of nurses’ notes or nurse aide task sheets.</p> <p>Review and sign claims within 15 business days of receiving them from the provider.</p> <p>Providers have one year from the date of service to file a claim.</p>
<u>INCIDENT REPORTING</u>		
<p>Incident reports should be submitted within 5 business days of the incident, or if the incident is a hospitalization, within five business days of hospital discharge.</p>		
<u>TERMINATIONS AND APPEALS</u>		
<p>If the recipient/family voluntarily withdraws from the CAP/C program, the termination date is the one they choose.</p> <p>If DMA terminates the recipient/family’s participation, the effective date is usually the last day of the month following 10 days advance notice.</p> <p>Medicaid eligibility always terminates at the end of the month, even if CAP/C services end prior to that.</p> <p>A recipient/family has 30 days from the date of their denial letter to file a request for an appeal.</p> <p>Charts must be kept for at least six years from the date of service, but it is recommended that they be kept until the child’s 24th birthday.</p>		

Appendix D	Important Dates and Deadlines
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APPENDICES

APPENDIX E CAP/C Process Algorithms

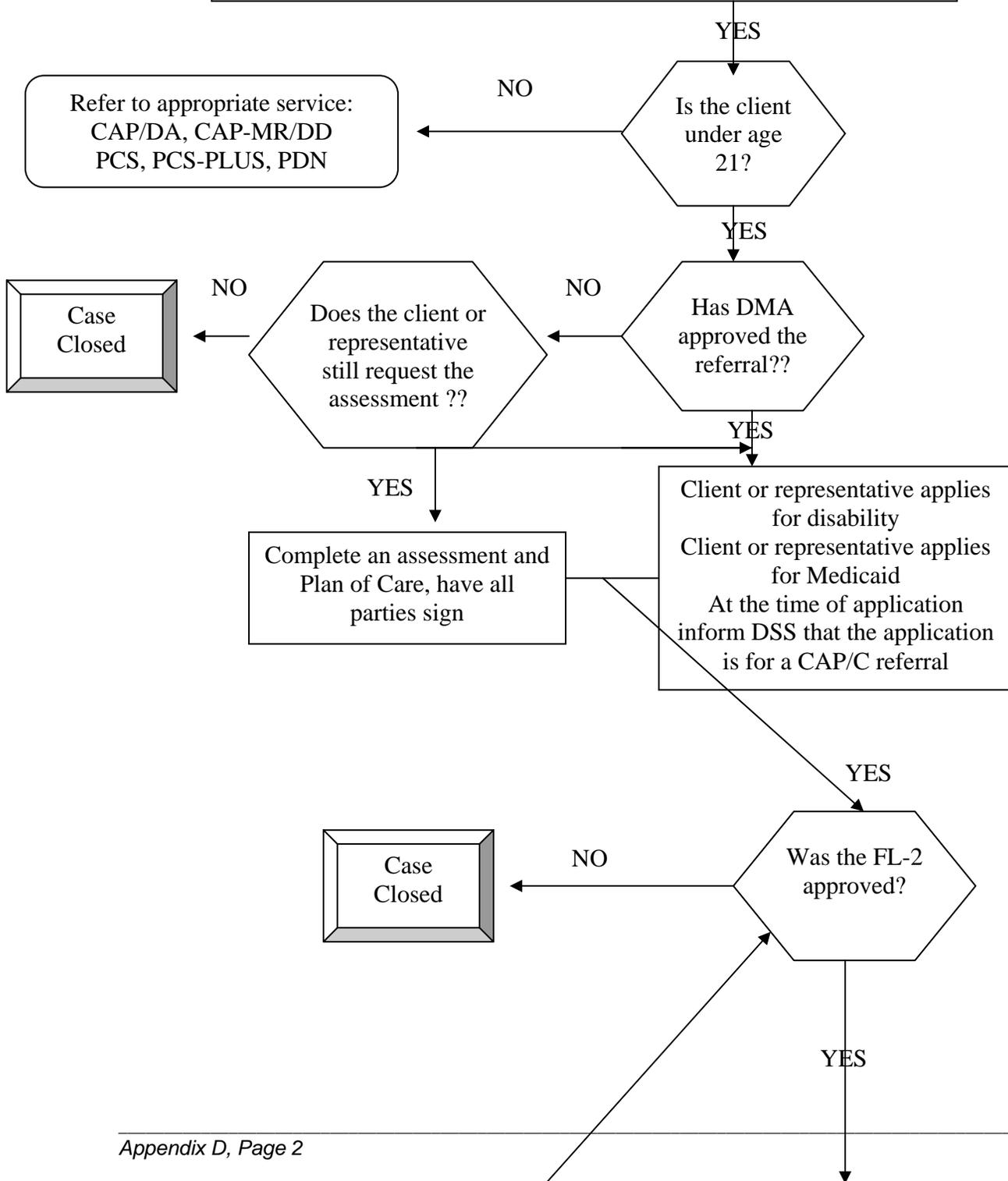
The following algorithm illustrates the general steps of the CAP/C process. Please refer to the appropriate chapter of the CAP/C Manual for more detail.

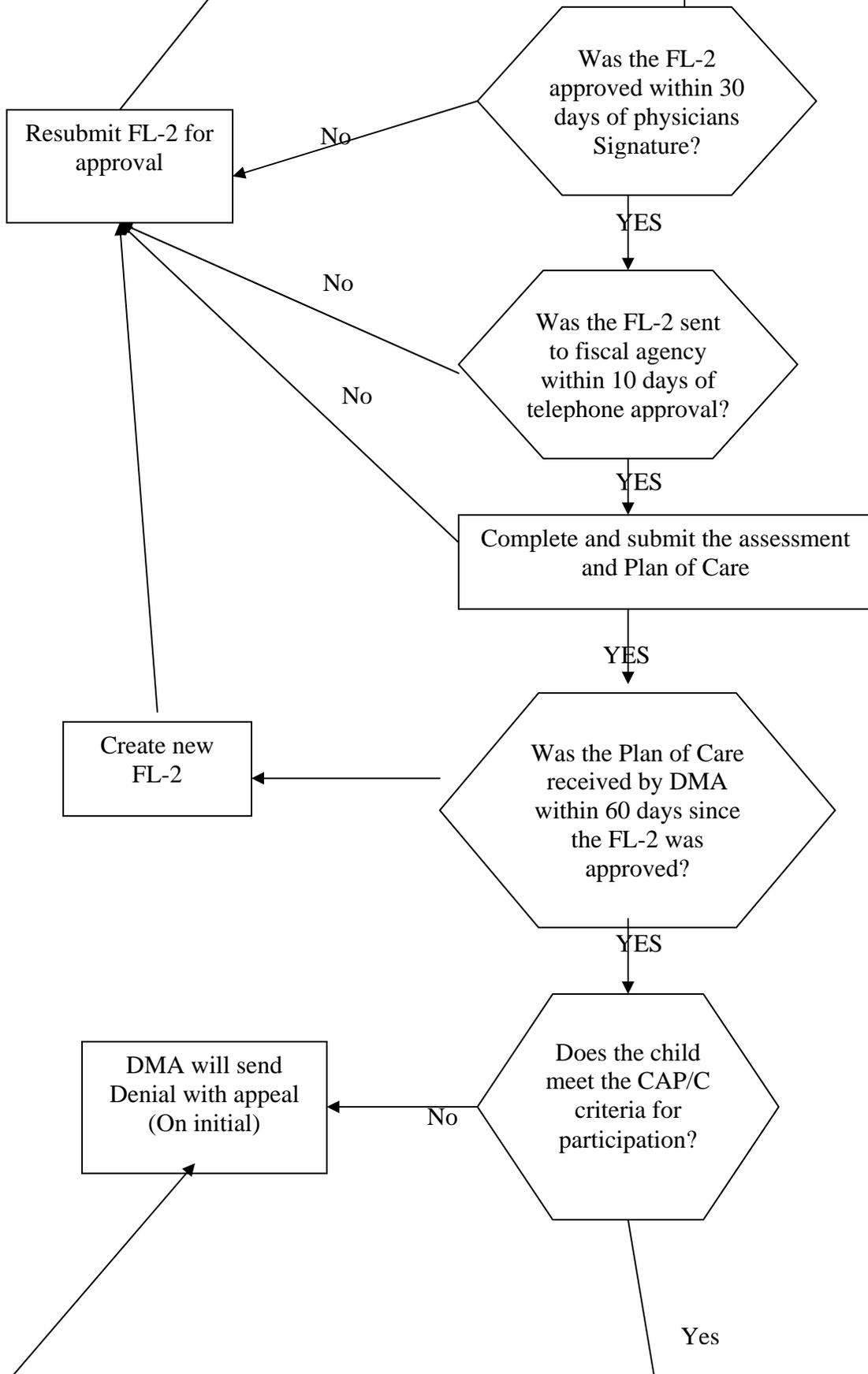


Appendix E CAP/C Process Algorithms

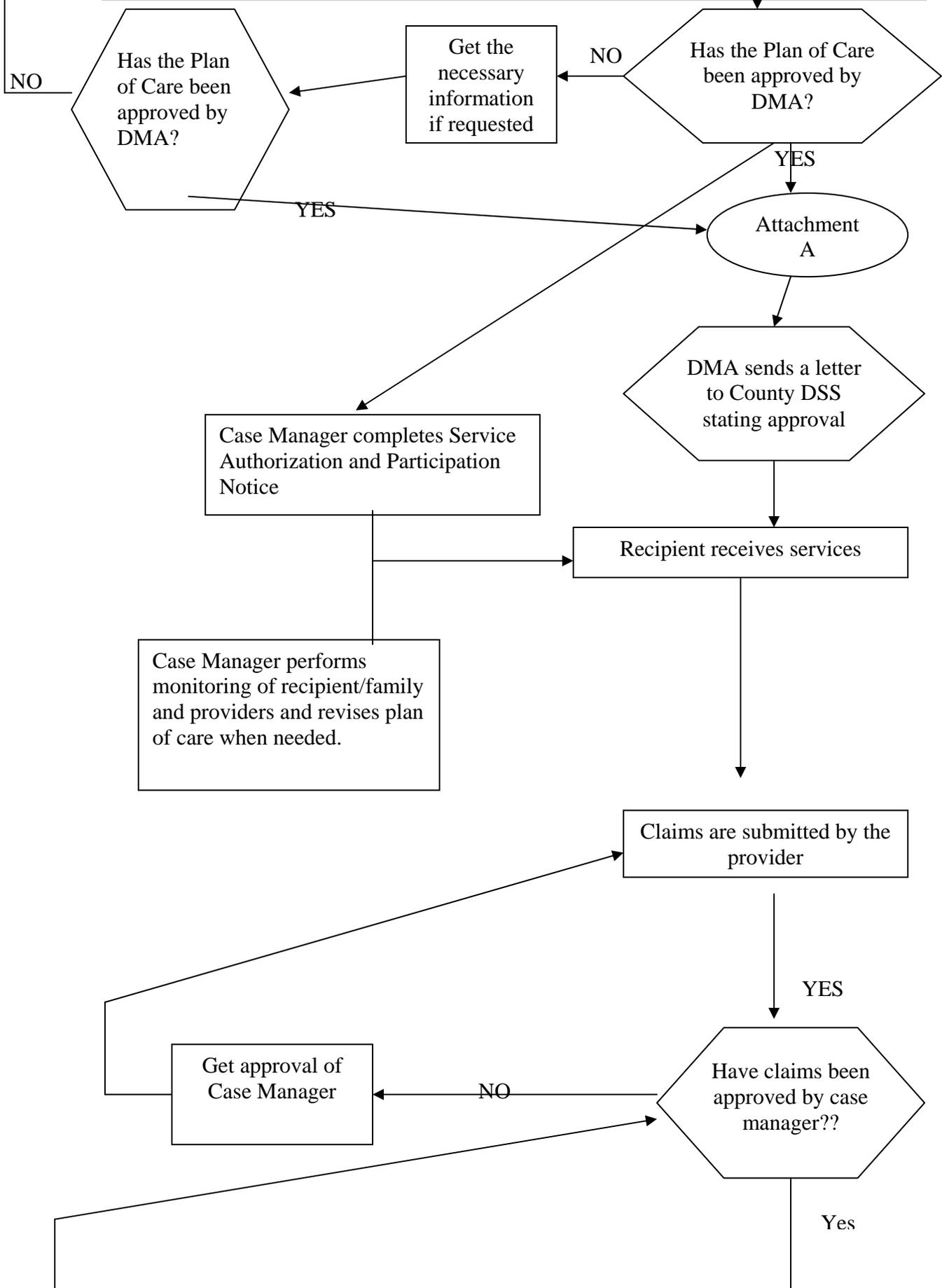
Initial referral comes into the CAP/C office from a community referral service, can be: MD, Case Manager, Client Representative

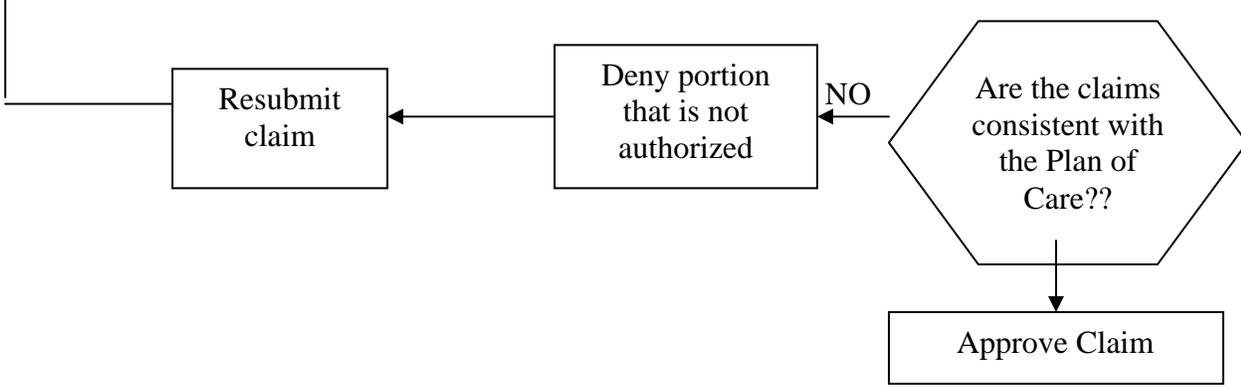
All initial referrals are reviewed by the CAP/C consultants and a team decision is made for the appropriateness of an assessment of the referred client.





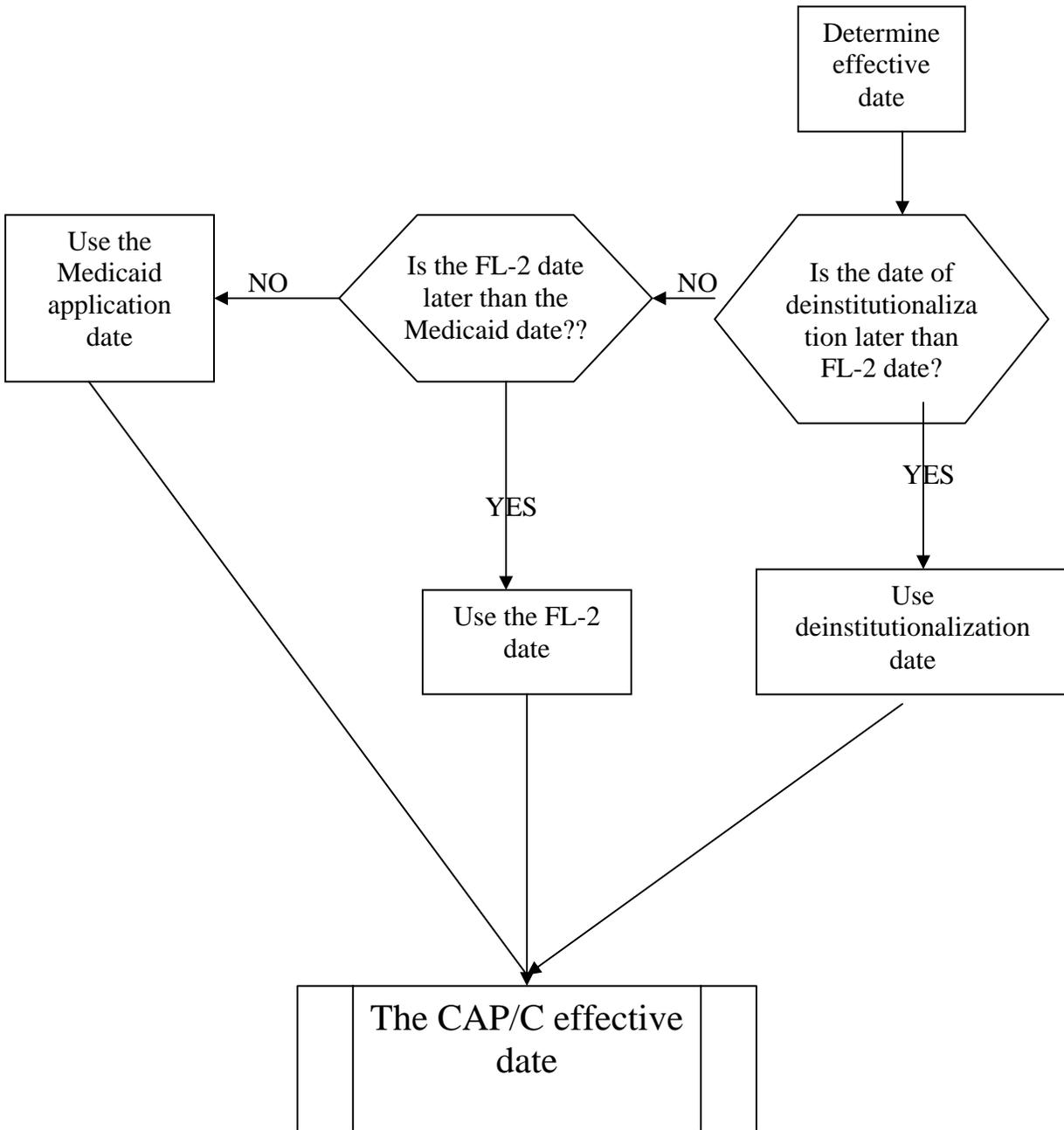
Appendix E CAP/C Process Algorithms





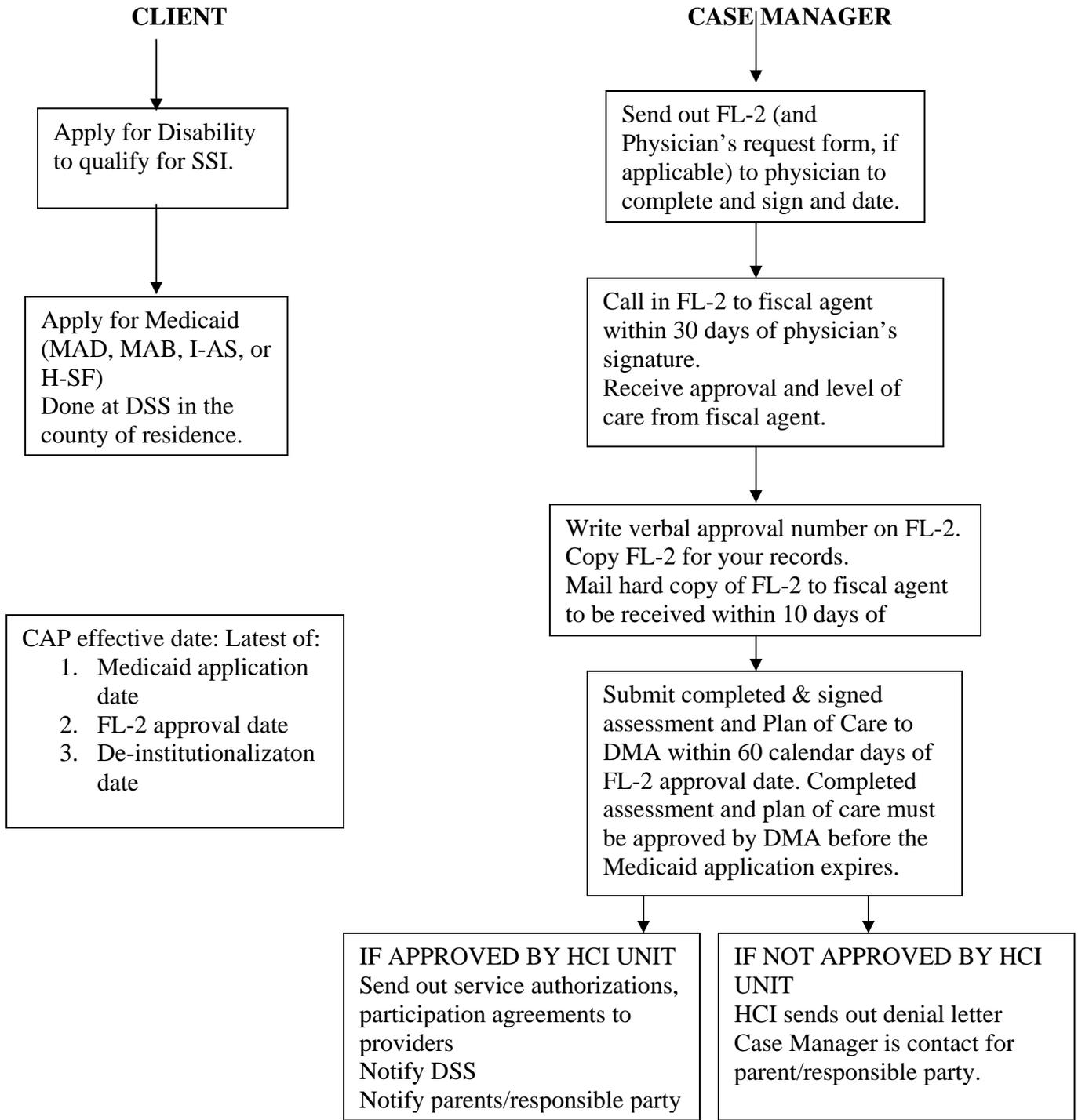
Appendix E CAP/C Process Algorithms

Determining the CAP Effective Date

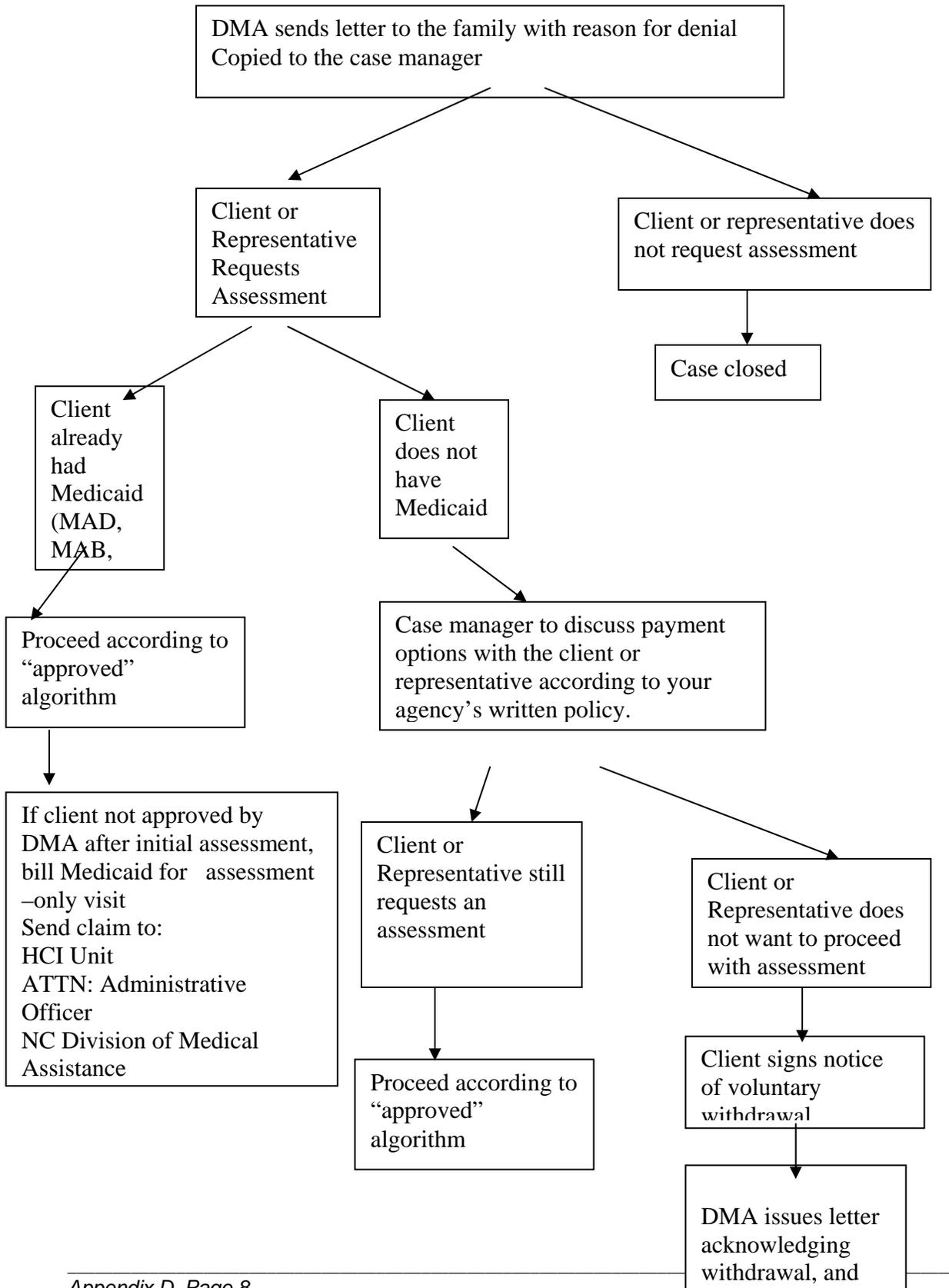


Client **approved** for assessment by DMA after receiving CAP/C Referral.

These steps must be coordinated to happen at the same time



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

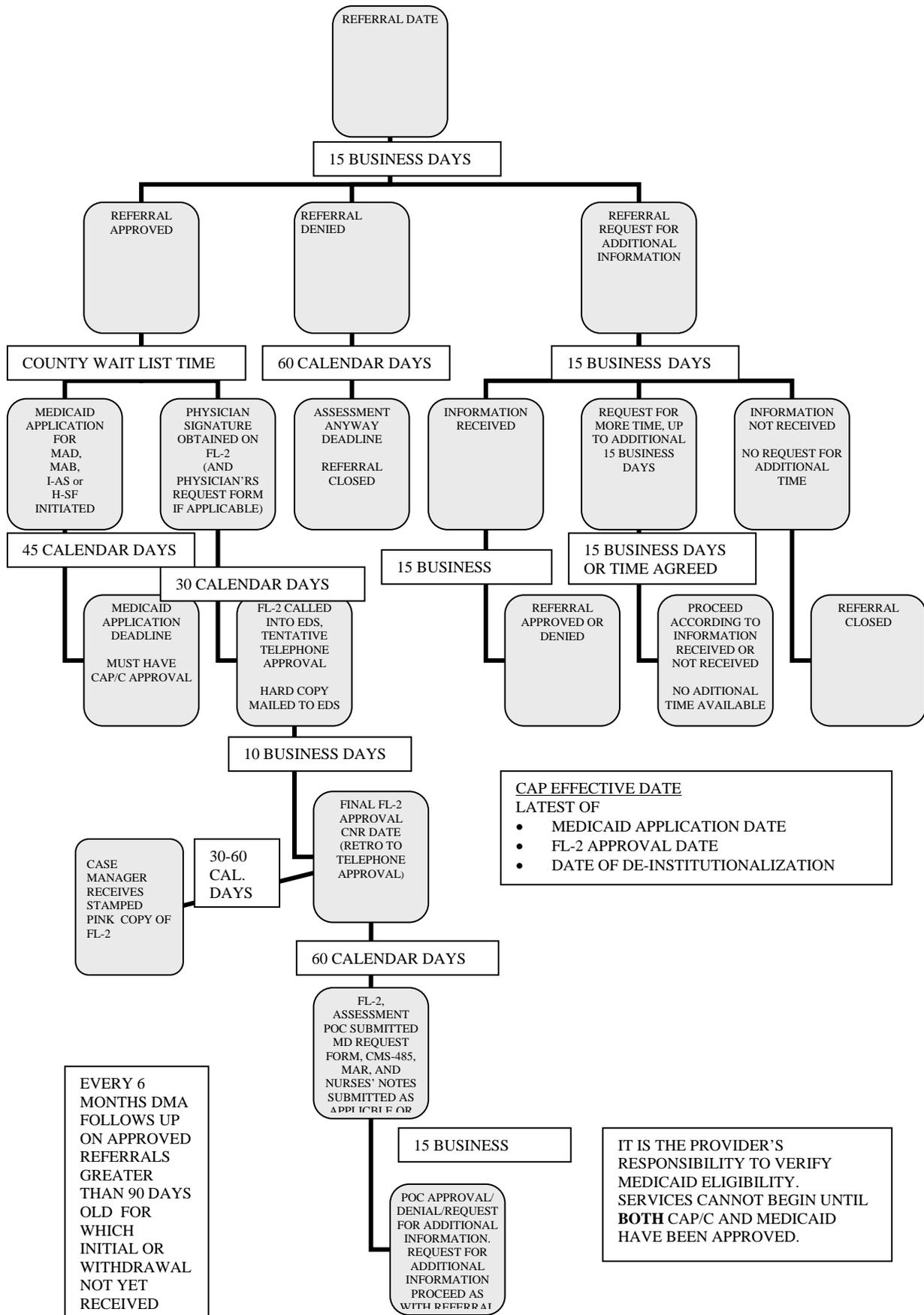


PROCESSING OF INITIAL APPLICATION

NAME _____ **MID** _____ - _____ - _____

- ___/___/___ Date of referral.
- ___/___/___ Date referral submitted to DMA.
- ___/___/___ Date DMA decision received.
- ___/___/___ Talked with client/family to explain CAP/C procedures and services and discuss needs.
- ___/___/___ Notified DSS that the client is applying for CAP/C and referred the client/family to DSS (even if they are already on Medicaid)
- ___/___/___ 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.
- ___/___/___ Initial application completed with appropriate signatures.
- ___/___/___ Initial application sent to DMA.
- ___/___/___ Approval or denial received from DMA.
- If approved:
- ___/___/___ DSS notified of approval, Medicaid eligibility confirmed & CAP effective date coordinated.
- ___/___/___ Client's responsible party notified of approval.
- ___/___/___ Services started.
- If denied:
- ___/___/___ DSS notified
- ___/___/___ Request for appeal submitted

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



APPENDICES

APPENDIX F
Normal Pediatric Developmental Milestones

The chart on the following pages is a guideline as to what typically developing children can do as far as language, movement, eating, toileting, and bathing/dressing/grooming, at various ages and stages of development.

This information is useful in differentiating age-appropriate needs from medical needs.

NORMAL PEDIATRIC DEVELOPMENTAL MILESTONES					
AGE	LANGUAGE	MOVEMENT	EATING	TOILETING	BATHING/DRESSING/ GROOMING
birth	cries	kicks legs, thrashes arms			
1 mo	cries in a special way when hungry, responds to voices.	raises head and chest when lying on stomach			
2 mo	makes sounds – ah, eh, ugh, smiles	holds heads steady when held sitting	reacts to sight of bottle or breast		
3 mo		makes crawling movements	one hand on bottle while feeding		
4 mo	squeals, ah-goo, laughs	holds own hands together			
5 mo	makes ‘raspberry’ sound	rolls over stomach to back			
6 mo	babbles, responds to name	rolls over back to stomach			
7 mo	da, ba, ga, ka, ma	sits without support			
8 mo	ma-ma, da-da, ba-ba	crawls	feeds self cracker or cookie		
9 mo	imitates speech sounds you make	pulls self to standing	both hands to hold bottle		
10 mo	understands single words like bye-bye, nite-nite	sidesteps around furniture while holding on			
11 mo	uses mama and dada specifically for parent	stands alone well	picks up spoon by handle		
12 mo	says one word clearly	climbs up on chairs or other furniture, walks with one hand held	transition to ‘sippy cup’ and milk instead of formula		cooperates with dressing, removes socks, holds foot out for shoe, holds arm out for sleeve, pushes arms and legs through shirts and pants

NORMAL PEDIATRIC DEVELOPMENTAL MILESTONES					
AGE	LANGUAGE	MOVEMENT	EATING	TOILETING	BATHING/DRESSING/ GROOMING
15 mo	says 2 words besides mama and dada., makes sounds in sequences that sound like sentences, points	walks without help, crawls up stairs	feeds self with a spoon		
18 mo	uses 5-10 words as names of things, follows a few simple instructions	runs stiffly	eats with a fork, drinks from cup using two hands		helps brush teeth
2 y	2-3 word sentences; beginning to understand rules of grammar – “runned”, “mouses”; receptive skills exceed expressive skills	runs well		may be ready for toilet training	removes unfastened coat, removes shoes if laces untied, finds armholes in shirt and helps push garment down
2 ½ y	Refers to self as “I” Knows full name	goes up stairs alternating feet			removes pull-down garment with elastic waist, tries to put on socks, puts on front-button type shirt, unbuttons one large button
3 y	300-500 word vocabulary; speech mostly understandable to strangers; may lisp; may stutter; may substitute w for r, d for th, and t for k	stands on one foot momentarily, rides tricycle	one handed cup holding, drinks from open cup without spilling	uses toilet often, needs help with wiping after bm, dry during the day but occasionally wets bed at night	washes hands assisted, unbuttons clothing, buttons large front buttons, puts on shoes – may be wrong feet, does not tie; puts on/takes off t-shirt with assistance, zips/unzips without separating/inserting shank

NORMAL PEDIATRIC DEVELOPMENTAL MILESTONES					
AGE	LANGUAGE	MOVEMENT	EATING	TOILETING	BATHING/DRESSING/ GROOMING
3 ½ y	combines sentences using 'and', 'or', or 'but'	hops on one foot without support, cuts across paper with small scissors			Washes face without help
4 y	vocabulary 1500 words or more; speaks in 6-8 word sentences; may continue with lisping, stuttering, and sound substitutions as above	climbs well, hops on one foot	holds utensils like an adult, makes own bowl of cereal	toilets independently, night time bedwetting still common	brushes teeth with supervision only; washes hands unassisted; removes T shirt independently, uses buckles, zippers, and laces, knows front and back of clothing, puts on shoes with little assistance
4 ½ y	reads a few letters	skips, broad jumps			
5 y	speaks fluently; may lisp; may stutter; may substitute f for th and w for r, l, or y; may mispronounce 3-4 syllable words	swings, pumps self prints first name		20% of five years old still have night-time bedwetting	dresses and undresses alone except some help with buttons, zippers, shoelaces; wants to bathe on their own but still needs assist washing body and hair

NORMAL PEDIATRIC DEVELOPMENTAL MILESTONES					
AGE	LANGUAGE	MOVEMENT	EATING	TOILETING	BATHING/DRESSING/ GROOMING
6y	can spell some simple words; may still mispronounce some 3-4 syllable words; may still substitute w for r and f for th; may still lisp; stutters only when emotional	somersaults	may start using knife to cut soft foods or spread butter	night time bedwetting still common, untreated until age 8	Buttons back buttons; ties shoes
8y					selects clothes appropriate for weather

Appendix F	Normal Pediatric Developmental Milestones
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APPENDICES

APPENDIX G Equipment and Supplies

This appendix will help familiarize you with the types and combinations of equipment and supplies that CAP/C children typically use.

Appendix G Equipment and Supply Needs

If the child has this...	then he/she definitely needs this...		and might need this.	
GT button (Mic-Key or Bard) continuous feeding	low profile gastrostomy kit	4 per year	feeding pump	one time purchase or 10 month rental
	low profile gastrostomy extension kit – continuous	2 per month	IV pole	one time purchase or 10 month rental
	enteral feeding supply kit, pump fed	15-30 per month	Farrel valve	15-30 per month
	formula	as prescribed	site care supplies – gauze hydrogen peroxide cotton applicators	30-60 per month 1 pint per month 60 per month

If the child has this...	then he/she definitely needs this...		and might need this.	
GT button (Mic-Key or Bard)	low profile gastrostomy kit	4 per year	feeding pump	one time purchase or 10 month rental
bolus feeding	low profile gastrostomy extension kit – bolus	2 per month	IV pole	one time purchase or 10 month rental
	enteral feeding supply kit, gravity fed	15-30 per month	site care supplies – gauze hydrogen peroxide cotton applicators	30-60 per month 1 pint per month 60 per month
	or enteral feeding supply kit, pump fed	15-30 per month		
	or enteral feeding supply kit, syringe	15-30 per month		
	or 60 cc syringes	2-15 per month		
	formula	as prescribed		

Appendix G Equipment and Supply Needs

If the child has this...	then he/she definitely needs this...		and might need this.	
gastrostomy or jejunostomy tube feeding, bolus feedings	gastrostomy/jejunostomy tube	2 per month	feeding pump	one time purchase or 10 month rental
	enteral feeding supply kit, gravity fed	15-30 per month	IV pole	one time purchase or 10 month rental
	or enteral feeding supply kit, pump fed	15-30 per month		
	or enteral feeding supply kit, syringe	15-30 per month		
or 60 cc syringes	2-15 per month	site care supplies – gauze hydrogen peroxide cotton applicators	30-60 per month 1 pint per month 60 per month	
formula	as prescribed			

If the child has this...	then he/she definitely needs this...		and might need this.	
gastrostomy or jejunostomy tube feeding, continuous feeding	gastrostomy/jejunostomy tube	2 per month	feeding pump	one time purchase or 10 month rental
	enteral feeding supply kit, pump fed	15-30 per month	IV pole	one time purchase or 10 month rental
	formula	as prescribed	Farrel valve	15-30 per month
			site care supplies – gauze hydrogen peroxide cotton applicators	30-60 per month 1 pint per month 60 per month

Appendix G Equipment and Supply Needs

If the child has this...	then he/she definitely needs this...		and might need this.	
NG feeding, bolus feedings	nasogastric tubing with sytlet or nasogastric tubing without stylet	10-30 per month	feeding pump	one time purchase or 10 month rental
	Levine tube	1 0-30 per month 10-30 per month		
	enteral feeding supply kit, gravity fed or enteral feeding supply kit, pump fed or enteral feeding supply kit, syringe or 60 cc syringes	15-30 per month 15-30 per month 15-30 per month 2-15 per month	IV pole	one time purchase or 10 month rental
	formula	as prescribed		
	syringes	2-15 per month	site care supplies – hydrogen peroxide cotton applicators tape transparent dressing	1 pint per month 60 per month 1-2 rolls per month 10-30 per month

If the child has this...	then he/she definitely needs this...		and might need this.	
NG feeding, continuous	nasogastric tubing with sytlet or nasogastric tubing without stylet or Levine tube	10-30 per month 10-30 per month 10-30 per month	feeding pump	one time purchase or 10 month rental
	enteral feeding supply kit, pump fed	15-30 per month	IV pole	one time purchase or 10 month rental
	formula	as prescribed	Farrel valve	15-30 per month
	syringes	2-15 per month	site care supplies – hydrogen peroxide cotton applicators tape transparent dressing	1 pint per month 60 per month 1-2 rolls per month 10-30 per month

Appendix G Equipment and Supply Needs

If the child has this...	then he/she definitely needs this...		and might need this.	
trach	trach tube, non-cuffed*	4-6 per month	trach inner cannula	30 per month
	or			
	trach tube, cuffed	4-6 per month		
	or		<div data-bbox="1146 386 1766 459" style="border: 1px solid black; padding: 2px;"> Always keep one trach that is one size smaller in case there is a problem during trach change </div>	
	trach tube, metal	permanent		
	trach care kit – new trach**	30 per month	Passey-Muir valve (tracheostomy speaking valve)	up to 7 per month
	or			
trach care kit – established trach	30 per month	<div data-bbox="1146 625 1766 698" style="border: 1px solid black; padding: 2px;"> Trach care kits are useful only for trachs size 6 and up </div>		
or				
individual trach care supplies				
hydrogen peroxide	2 pints per month			
normal saline	1 bottle per month			
cotton applicators	100 per month			
gauze	100 per month			
trach ties	1-2 per day	trach mask	30 per month	
or				
trach tube collar/holder	12 per month			
		humidifier	one time purchase or 10 month rental	
		thermovent/moisture exchanger	up to 60 per month	

If the child has this...	then he/she definitely needs this...		and might need this.	
suctioning	suction pump	one time purchase or 10 month rental	saline bullets	up to 400 per month
	suction canister, disposable or suction canister, non-disposable	one per month two per year		
	suction tubing	2 per month		
	tracheal suction catheter and/or oropharyngeal suction catheter	up to 720 per month 4 per month		

Appendix G Equipment and Supply Needs

If the child has this...	then he/she definitely needs this...		and might need this.	
oxygen, continuous	oxygen concentrator or stationary oxygen system, gas or stationary oxygen system, liquid	cont. rental cont. rental cont. rental	pulse oximeter	cont. rental
	backup portable oxygen, gas and contents or backup portable oxygen, liquid and contents	cont. rental as prescribed cont. rental as prescribed	humidifier	one time purchase or 10 month rental

If the child has this...	then he/she definitely needs this...		and might need this.	
oxygen, PRN	portable oxygen, gas and contents or portable oxygen, liquid and contents	cont. rental as prescribed cont. rental as prescribed	pulse oximeter	cont. rental

Appendix G Equipment and Supply Needs

If the child has this...	then he/she definitely needs this...		and might need this.	
Ventilator*	ventilator without pressure support or ventilator with pressure support	continuous rental	<div data-bbox="1108 386 1730 456" style="border: 1px solid black; padding: 5px; text-align: center;"> Contact power company for service registration. </div>	
	breathing circuit	2 per month		
	ambu- bag	up to 2 per year		

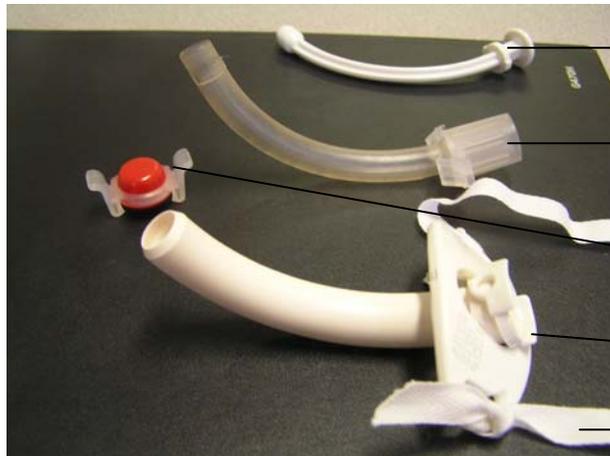
If the child has this...	then he/she definitely needs this...		and might need this.	
CPAP or BiPAP	CPAP machine or BiPAP machine	one time purchase or 10 month rental		
	tubing	two per year		
	filter, disposable or filter, non-disposable	one per month		
	and	six per year		
	full face mask and full face interface, replacement for full face mask	two per year		
	and head gear	two per year		
	and chin strap	one per year		
	or			
	replacement cushion for use on nasal mask interface and replacement pillow for nasal cannula interface	two per year		
	and nasal interface, mask or cannula	two per year		
	and head gear	two per year		

Appendix G Equipment and Supply Needs



60 cc catheter tip syringe

60 cc leur lock syringe



stylet

disposable inner
cannula

trach plug

trach

trach ties

SUCTION SET-UP



oropharyngeal suction catheter

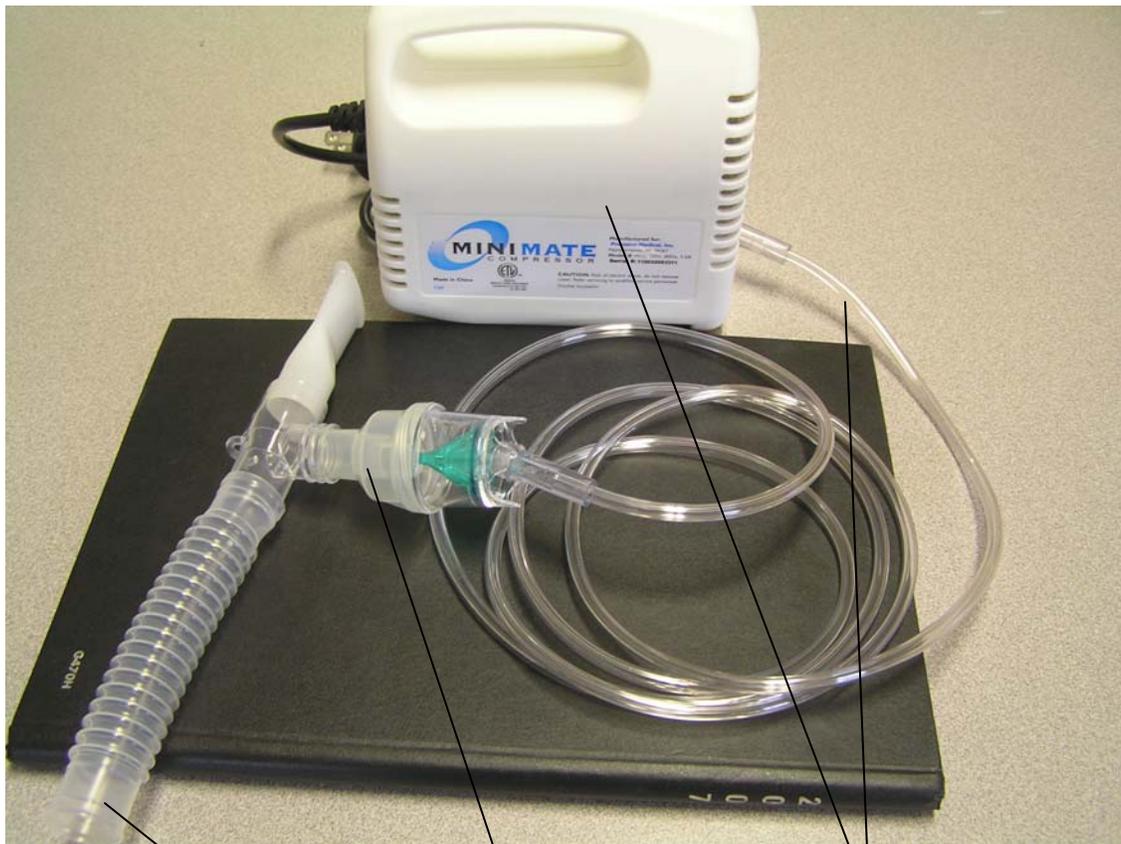
tubing used with suction pump

respiratory suction pump, home model, portable or stationary, electric suction machine

canister, disposable, used with suction pump

Appendix G Equipment and Supply Needs

NEBULIZER SET UP



corrugated tubing,
disposable, used with
large volume nebulizer,
100 feet

large volume nebulizer,
disposable, unfilled, used with
aerosol compressor

nebulizer with
compressor

APPENDICES

APPENDIX H SCOPES OF PRACTICE

The information in this appendix will help you determine the level of staff that can most appropriately meet your patient’s needs.

Much of this information is taken from the NC Board of Nursing’s website. Please see <http://www.ncbon.org/> for the most up-to-date information.



10A NCAC 13J .1107 IN-HOME AIDE SERVICES

(a) If an agency provides in-home aide services, the services shall be provided in accordance with the client's plan of care. Agencies participating in the Home and Community Care Block Grant or Social Services Block Grant through the Division of Aging and Adult Services shall comply, for those clients, with the in-home aide service level rules contained in 10A NCAC 06A and 10A NCAC 06X which are hereby incorporated by reference with all subsequent amendments. All other agencies providing in-home aide services shall comply with the provisions in Paragraphs (b) and (c) of this Rule.

(b) If the client's plan of care requires the in-home aide to provide extensive assistance to a client who is totally dependent in the activity or requires substantial hands on care and physical support including more than guided maneuvering of limbs or weight bearing assistance, the in-home aide shall be listed on the Nurse Aide Registry pursuant to G.S. 131E-255. However, if the client's plan of care requires the in-home aide to provide only limited assistance to the client which includes hands-on care involving guided maneuvering of limbs with eating, toileting, bathing, dressing, personal hygiene, self monitoring of medications or other non weight bearing assistance, the in-home aide shall not be required to be listed on the Nurse Aide Registry. Agencies shall be in compliance with this Paragraph no later than April 1, 2008.

(c) In-home aides shall follow instructions for client care written by the health care practitioner required for the services provided. In-home aide duties may include the following:

- (1) help with prescribed exercises which the client and in-home aides have been taught by a health care practitioner licensed pursuant to G.S. 90;
- (2) provide or assist with personal care (i.e., bathing, care of mouth, skin and hair);
- (3) assist with ambulation;
- (4) assist client with self-administration of medications which are ordered by a physician or other person authorized by state law to prescribe;
- (5) perform incidental household services which are essential to the client's care at home; and
- (6) record and report changes in the client's condition, family situation or needs to an appropriate health care practitioner.

History Note: Authority G.S. 131E-140;

Eff. July 1, 1992;

Amended Eff. October 1, 2007; October 1, 2006; February 1, 1996.

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 Health Services Regulation.

1. Personal Care

- Bathing (assist, bed bath, tub bath, shower, sitz)
- Mouth care
- Skin care
- Hair 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 body cavities/wounds
- Maintain gastric suction*

5. Safety

- Side rails/call rails
- Mitts and restraints
- CPR/Heimlich Maneuver
- Infection control (handwashing, isolation technique, universal precautions)

6. Special Procedures

- Vital signs
 - temperature – oral and axillary
 - pulse – radial and apical
 - 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

The licensed nurse maintains accountability and responsibility for the delivery of safe and competent care. Decisions regarding delegation of any of the above 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 not involve on-going assessment, interpretation or decision-making that cannot be logically separated from the task itself.

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

* Tasks which are within the scope of practice for an NA I, but are not required to be taught in the Division of Health Service Regulation approved 75 hour course.

NAI+4**Nurse Aide II Tasks Performed by Nurse Aide I Personnel**

As of December 1992, an agency may select up to four Nurse Aide II tasks which may be performed in that agency by Nurse Aide I personnel who have not completed an entire Nurse Aide II Training and Competency Evaluation Program nor have NAI listing.

Process for an agency to choose up to four Nurse Aide II tasks to be performed by Nurse Aide I personnel:

STEP 1**EITHER:**

- a. Obtain the appropriate curriculum module (see list below) and related skills checklist competency evaluation for the task(s) by contacting the nursing department of continuing education division of your nearest community college or the North Carolina Board of Nursing. Request each module by number and title. OR
- b. Submit your curriculum for the Nurse Aide II task(s) to the Board of Nursing for review and approval prior to teaching the Nurse Aide I.

STEP 2

Notify the Board of Nursing of the Nurse Aide II task(s) that will be performed by Nurse Aide I personnel in your agency and for which all Board stipulations have been met. Use the [Notification of Nurse Aide II Task\(s\) Form](#). Each agency will receive a verification letter once the Board has been appropriately notified.

STEP 3

Maintain documentation of training and competency evaluation for each Nurse Aide I who is approved to perform Nurse Aide II task(s) within the agency.

1. 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 (over 48 hours old)****6. Wound irrigation****7. intravenous fluid – assistive activities**

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

8. elimination procedures (

- ostomy care
- irrigations

9. nutritional activities

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

- 10. urinary catheters
 - catheterizations
 - irrigation of tubing

ROLE OF NURSING II ON HEALTH CARE TEAM

The licensed nurse maintains accountability and responsibility for the delivery of safe and competent care. Decisions regarding delegation of any of the above 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 not involve on-going assessment, interpretation or decision-making that cannot be logically separated from the task itself

- As part of accountability, the licensed nurse must monitor the client's status and response to care provided on an on-going basis.

Other Nurse Aide Tasks

The licensed nurse maintains accountability and responsibility for the delivery of safe and competent care. Decisions regarding delegation of any 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 not involve on-going assessment, interpretation or decision-making that cannot be logically separated from the task itself.

As part of accountability, the licensed nurse 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.

A Nurse Aide may give scheduled medication, including medication via a gastrostomy tube, when the following criteria are met

- The medication must be pre-filled and labeled by the caregiver or RN
- The supervising RN must approve and delegate this function to the NA
- The task must be listed on the Plan of Care
- The caregiver has signed a statement agreeing to the plan and maintaining ultimate responsibility for the medication administration.

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.org NCAC 36.0221 section B.

The Nurse Aide may not administer PRN medications.

DELEGATION: NON-NURSING FUNCTIONS
Position Statement for RN and LPN Practice

Technical tasks which support the care of clients, such as laboratory functions, (blood glucose testing, phlebotomy), EKG procedure, pulse oximetry, handing instruments/x-rays or performing audiometric screening, not requiring the professional judgment of a licensed nurse are generally considered non-nursing activities and may be delegated by the licensed nurse to unlicensed assistive personnel as allowed by agency policy/procedures. As with all patient care activities that a licensed nurse delegates, the licensed nurse is held accountable for assuring that the unlicensed personnel is competent in safely performing the delegated activities. Under nursing law the licensed nurse may only delegate those common repetitive tasks which frequently recur in the daily care of a client or group of clients, and which do not require the professional judgment of a licensed nurse. Patient-care activities that are done infrequently should not be delegated by the licensed nurse to unlicensed personnel.

Administrative Rule 21 NCAC 36.0221 License Required outlines the criteria that **MUST** be met prior to nursing delegation of tasks to unlicensed personnel.

Tasks may be delegated to an unlicensed person which:

- 1) frequently recur in the daily care of a client or group of clients;
- 2) are performed according to an established (standardized) sequence of steps;
- 3) involve little or no modification from one client-care situation to another;
- 4) may be performed with a predictable outcome; and
- 5) do not inherently involve ongoing assessment, interpretation, or decision-making which cannot be logically separated from the procedure(s) itself;
- 6) are allowed by agency policy/procedures.

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FAX (919) 781-9461
Nurse Aide II Registry (919) 782-7499
www.ncbon.com

Origin 4/1993 Page 1 of 1 Revised: 1/2002, 04/2007



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**DELEGATION:
ASSIGNMENT AND DELEGATION OF NURSING ACTIVITIES BY THE RN AND LPN**

Position Statement for RN and LPN Practice

Implementation of nursing activities is a component of practice for both the RN and LPN, based on Administrative Rules [21 NCAC 36.0224 \(d\)](#) Components of Practice for the Registered Nurse and [21 NCAC 36.0225 \(d\)](#) Components of Practice for the Licensed Practical Nurse. The North Carolina Board of Nursing has developed the following interpretative statement regarding the assignment, delegation and supervision of direct patient care activities.

The terms used in this statement are based on the following definitions*:

Authority - The source of the power to act.

Accountability - Being responsible and answerable for actions or inactions of self or others in the context of delegation. The licensed nurse retains the accountability for the assignment and/or delegation

Assignment - Designating responsibility for implementation of a specific activity or set of activities to a person licensed and competent to perform such activities.

Delegation - Transferring to a competent individual the authority to perform a selected activity in a selected situation. The delegator retains accountability for the delegation.

Supervision - The provision of guidance or direction, evaluation, and follow-up for accomplishment of a patient care activity which has been delegated by a licensed nurse or physician to unlicensed assistive personnel (UAP). Supervision is that component of assignment and/or delegation by which the licensed nurse maintains accountability for the nursing care given by personnel to whom the care has been assigned and/or delegated.

NOTE: The level of supervision by the licensed practical nurse is limited to those follow-up activities required to validate that the nursing care tasks have been performed as assigned and/or delegated and according to established standards of practice.

UAP (Unlicensed Assistive Personnel) - Any unlicensed personnel, regardless of title, who may participate in patient care activities through the delegation process.

* *Definitions adapted from National Council of State Boards of Nursing.*

The registered nurse maintains overall accountability for the coordination and delivery of nursing care to the individual client or group of clients for whom the registered nurse has accepted responsibility for delivery of nursing care. Based upon the assessment of the client's status, clinical competence of other licensed and unlicensed personnel and the variables in each practice setting, the registered nurse may assign and/or delegate nursing care activities to other registered nurses, licensed practical nurses or unlicensed personnel as appropriate to the level of knowledge and skill of the individual to whom care is assigned and/or delegated and within the legal scope of practice for each level of licensed or unlicensed individual.

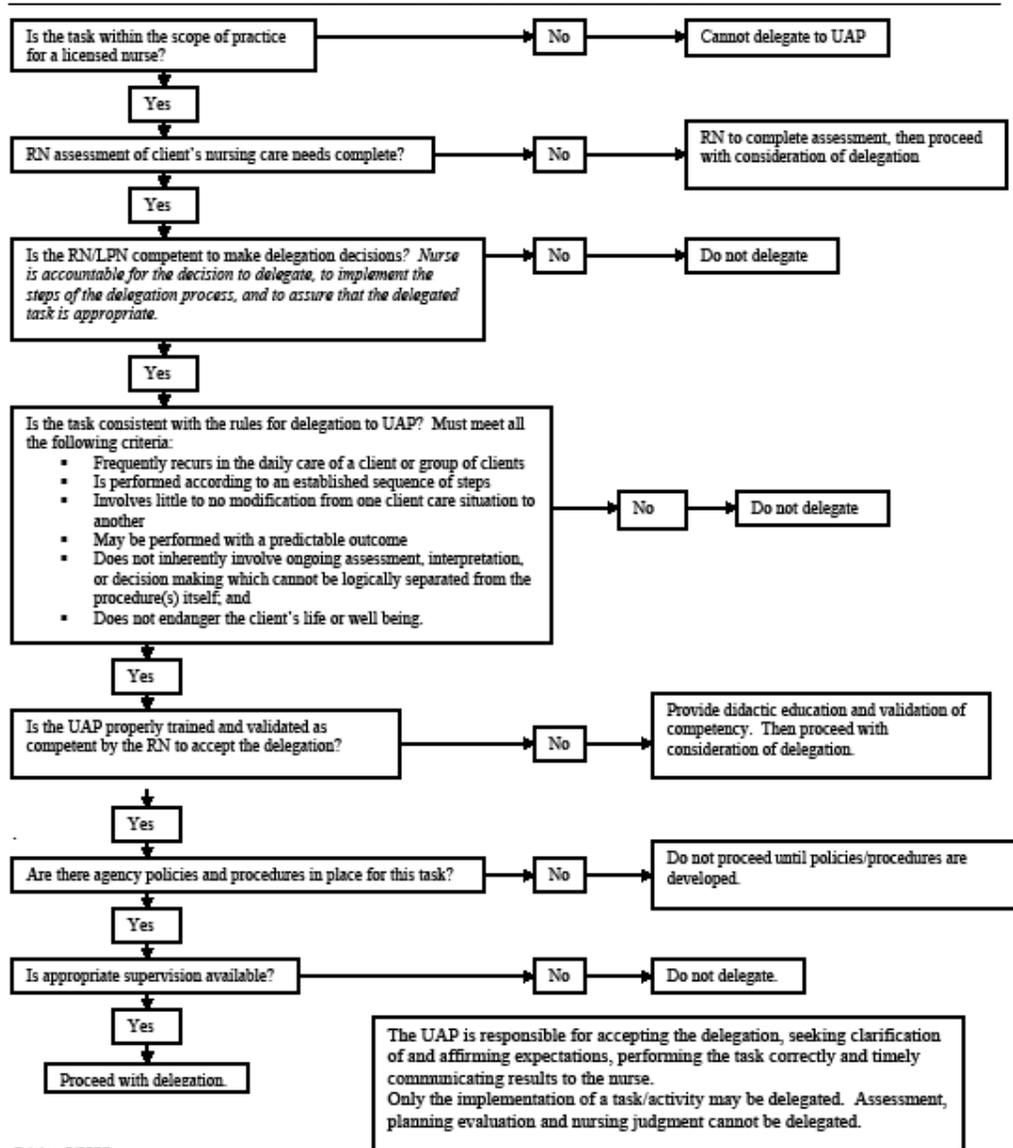
Approved 9/89
Revised 1/91, 3/26/02, 4/2007

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DECISION TREE FOR DELEGATION TO UAP



Origin: 5/2000
 Revised 4/2007

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HOME CARE

Position Statement for RN and LPN Practice

The registered nurse has overall responsibility for both the initial and on-going nursing assessment consisting of the determination of nursing care needs (21 NCAC 36.0224) based upon the collection and interpretation of data relevant to the health status of the client. Within a home care agency, the registered nurse may assign nursing care responsibilities and tasks to the licensed practical nurse consistent with a number of critical factors that include, but are not limited to:

- Qualifications of the licensed practical nurse in relation to client's need and plan of nursing care;
- Stability of the client's clinical condition;
- Complexity of the task as well as the task's potential threat to the client's well-being;
- Limitation of licensed practical nurse's role in teaching and counseling to reinforcing activities planned and initiated by the registered nurse;
- Continuous availability of the registered nurse, on site when necessary, for direct participation in nursing care and supervision of the licensed practical nurse;
- Registered nurse is accountable for evaluation of client's response to care provided and subsequent modification to plan of care or discharge of client from service; and
- Established agency policies, procedures, practices, and channels of communication which lend support to the types of nursing services offered by the agency, and through which the registered nurse maintains accountability for nursing care given by all personnel to whom that care is delegated.

The licensed practical nurse may participate in the assessment of the client's health status, including reaction to illness and treatment regimens (Nursing Practice Act and Administrative Rules 21 NCAC 36.0224 and 21 NCAC 36.0225). Participation of the licensed practical nurse includes:

- Collection of data according to structured written guidelines, forms, and policies;
- Recognition of existing relationships between data gathered and the client's health status;
- Determination of the need for immediate nursing interventions; and

The Licensed Practical Nurse implements the health care plan by performing nursing tasks assigned by and performed under the supervision or directions of a registered nurse, physician, or other person with statutory authority to provide such supervision (21 NCAC 36.0225 (d)).

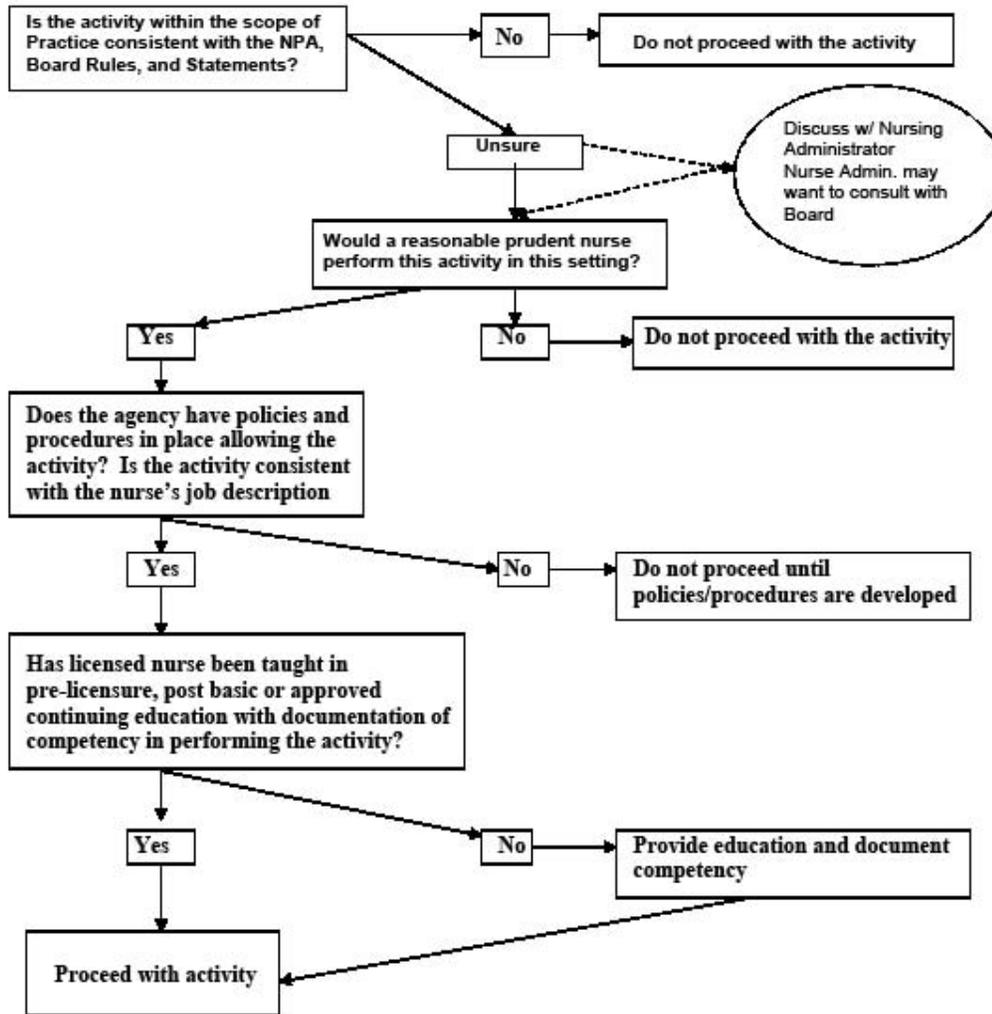
Written: 1/90
 Revised: 1/91, 3/2007

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P.O. BOX 2129
 Raleigh, NC 27602
 (919) 782-3211
 FAX (919) 781-9461
 Nurse Aide II Registry (919) 782-7499
 www.ncbon.com

**SCOPE OF PRACTICE DECISION MODEL
 FOR THE RN AND LPN**



Origin: 5/2000
 Revised 1/2002, 4/2004, 4/2007

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Nurse Aides and medication administration

Tasks may be delegated to an unlicensed person which:

- 1) frequently recur in the daily care of a client or group of clients;
- 2) are performed according to an established (standardized) sequence of steps;
- 3) involve little or no modification from one client-care situation to another;
- 4) may be performed with a predictable outcome; and
- 5) do not inherently involve ongoing assessment, interpretation, or decision-making which cannot be logically separated from the procedure(s) itself;
- 6) are allowed by agency policy/procedures.

Medication Administration, specifically, may be delegated to unlicensed personnel when:

- 1) Assistance takes place in the client's place of residence (private home, multi-unit independent living setting or community residential care setting, or in a day program) in which the client's health care is incidental to the personal care required;
- 2) A physician or other person authorized by state law has prescribed the medication to be taken on a routine basis;
- 3) The client requires physical and/or verbal assistance due to a disability or health impairment that prevents total independence in this act;
- 4) The client, his/her significant other, or the registered nurse planning the care maintains ultimate responsibility for administration of the medication(s); and
- 5) The client or significant other agrees in writing to the established plan of care for assistance with self-administration of medications; and when applicable, agrees in writing to accept ultimate responsibility for the medication administration.

****NOTE:** Pre-filling and labeling must be done by the licensed nurse or client's significant other and marked with client's name and time of dose. **The unlicensed assistant may not perform pre-filling and labeling of medication holders.**

Clarifications

1. The Board of Nursing makes an exception for CAP clients. Generally, they advise against Nurse Aides in Home Health/Home Care administering any type of medications. However, they realize the need of families to be out of the home at times, and the need to have care in the home that can meet all of the child's needs.
2. Administration of medication via an NG can not be delegated to the NA.
3. Administration or medication via any type of injection (SC, IM, IV) can not be delegated to the NA.
4. Administration of medication PO or via GT can be delegated to a NA if both sets of delegation criteria above are met.
5. Administration of scheduled controlled substances (i.e., phenobarbital for seizures, or valium for spasticity) PO or via GT IS allowed if A) both sets of delegation criteria above are met and B) the NA has access only to the dose of medication she is to administer.

Beware that, according to the above criteria, the nurse must be knowledgeable of and comfortable with the patient's reaction to the medication. Many nurses may be uncomfortable with delegating this task because the nurse has so little contact with the child/family/NA (just the supervisory visit).

6. Scheduled nebulizer treatments may be administered by a NA if both sets of delegation criteria above are met. The same caution as above applies. The nurse needs to be comfortable with the patient's response to the medication and needs to be comfortable delegating that task to the NA.

7. Patients health and response to medications may change over time. What may have been appropriate to delegate at one time may not be appropriate any longer, or vice-versa.

APPENDICES

APPENDIX I Advance Directives



Appendix I Advance Directives

The information in this section is taken directly from the *Medical Care Decisions and Advance Directives Brochure, Expanded Version*, located at

<http://www.ncdhhs.gov/dma/pub/consumerlibrary.htm#notice>. It may be

easier to view on-line. It is actually intended for consumers.

There is also a condensed version of this information at the same website.

 MORE INFORMATION

MEDICAL CARE DECISIONS AND ADVANCE DIRECTIVES:

What You Should Know

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Who decides about my medical care or treatment?

If you are 18 or older and are able to make and communicate health care decisions, you have the right to make decisions about your medical and mental health treatment. You should talk to your physician or other health care or mental health provider about any treatment or procedure so that you understand what will be done and why. You have the right to say yes or no to treatments recommended by your physician or mental health provider. If you want to control decisions about your medical and mental health care even if you become unable to make decisions or to express them yourself, you should be sure to tell your physician or mental health provider and your family and friends what you want, but you also should have an advance directive.



MEDICAL CARE DECISIONS AND ADVANCE DIRECTIVES: What You Should Know

1

Advance Directive

WHAT IS AN ADVANCE DIRECTIVE?

An advance directive is a set of directions you give about the medical and mental health care you want if you ever lose the ability to make decisions for yourself. North Carolina has three ways for you to make a formal advance directive. These include: *living wills*; *health care powers of attorney*; and *advance instructions for mental health treatment*.

DO I HAVE TO HAVE AN ADVANCE DIRECTIVE AND WHAT HAPPENS IF I DON'T?

Making an advance directive is your choice. If you become unable to make your own decisions, and you have no advance directive, your physician or mental health care provider will consult with someone close to you about your care. Discussing your wishes for medical and mental health treatment with your family and friends now is strongly encouraged, as this will help ensure that you get the level of treatment you want when you can no longer tell your physician or other health care or mental health providers what you want.



MEDICAL CARE DECISIONS AND ADVANCE DIRECTIVES: What You Should Know

Living Will

In North Carolina, a *living will* is a legal document that tells others that you want to die a natural death if you:

- become incurably sick with an irreversible condition that will result in your death within a short period of time;
- are unconscious and your physician determines that it is highly unlikely you will regain consciousness; or
- have advanced dementia or a similar condition which results in a substantial cognitive loss and it is highly unlikely the condition can be reversed.

In a *living will*, you can direct your physician not to use certain life-prolonging treatments such as a breathing machine ("respirator" or "ventilator"), or to stop giving you food and water through a tube ("artificial nutrition or hydration" through feeding tubes and IVs).

A *living will* goes into effect only when your physician and one other physician determine that you meet one of the conditions specified in the *living will*. Discussing your wishes with family, friends, and your physician now is strongly encouraged so that they can help make sure that you get the level of care you want at the end of your life.

MEDICAL CARE DECISIONS AND ADVANCE DIRECTIVES: What You Should Know



WHAT IS A LIVING WILL?



3

Health Care Power of Attorney

WHAT IS A HEALTH CARE POWER OF ATTORNEY?

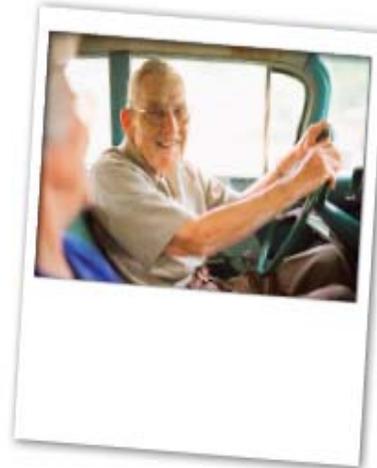
A *health care power of attorney* is a legal document in which you can name a person(s) as your health care agent(s) to make medical and mental health decisions for you if you become unable to decide for yourself. You can say what medical or mental health treatments you would want and not want. You should choose an adult you trust to be your health care agent. Discuss your wishes with that person(s) before you put them in writing. Again, it is always helpful to discuss your wishes with your family, friends, and your physician or eligible psychologist. A *health care power of attorney* will go into effect when a physician states in writing that you are not able to make or to communicate your health care choices. If, due to moral or religious beliefs, you do not want a physician to make this determination, the law provides a process for a non-physician to do it.



MEDICAL CARE DECISIONS AND ADVANCE DIRECTIVES: What You Should Know



Advance Instruction for Mental Health Treatment



An *advance instruction for mental health treatment* is a legal document that tells physicians and mental health providers what mental health treatments you would want and what treatments you would not want, if you later become unable to decide for yourself. You also can name a person to make your mental health decisions at that time. Your *advance instruction for mental health treatment* can be a separate document or combined with a *health care power of attorney* or a *general power of attorney*. An *advance instruction for mental health* may be followed by a physician or mental health provider when your physician or an eligible psychologist determines **in writing** that you are no longer able to make or communicate mental health care decisions.

WHAT IS AN ADVANCE INSTRUCTION FOR MENTAL HEALTH TREATMENT?

MEDICAL CARE DECISIONS AND ADVANCE DIRECTIVES: What You Should Know

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Other Questions

HOW DO I MAKE AN ADVANCE DIRECTIVE?

You must follow several rules when you make a formal *living will*, *health care power of attorney* or an *advance instruction for mental health treatment*. These rules are to protect you and ensure that your wishes are clear to the physician or mental health provider who may be asked to carry them out. A *living will*, a *health care power of attorney* and an *advance instruction for mental health treatment* must be: (1) written; (2) signed by you while you are still able to make and communicate health care decisions; (3) witnessed by two qualified adults; and (4) notarized.

WHO IS A QUALIFIED WITNESS?

A qualified witness is a competent adult who sees you sign, is not a relative, and will not inherit anything from you upon your death. The witness cannot be your physician, a licensed employee of your physician or mental health providers, or any paid employee of a health care facility where you live or that is treating you.



MEDICAL CARE DECISIONS AND ADVANCE DIRECTIVES: What You Should Know

Yes. Forms for *living wills*, *health care powers of attorney*, and *advance instructions for mental health treatment* may be obtained from the North Carolina Secretary of State website, at: www.secretary.state.nc.us/ahcdr. These forms meet all the rules for a formal advance directive. For more information, visit the website, or call 919-807-2167, or write to:

Advance Health Care Directive Registry
 Department of the Secretary of State
 PO Box 29622
 Raleigh, NC 27626-0622



- You can cancel your *living will* anytime by communicating your intent to cancel it in any way. You should inform your physician and those closest to you about your decision. It is also a good idea to destroy copies of it.
- You can cancel or change your *health care power of attorney* while you are able to make and communicate your decisions. You can do this by executing another one and telling your physician and each health care agent you named of your intent to cancel the previous one and make a new one, or by communicating your intent to cancel it to the named health care agents and the attending physician or eligible psychologist.

**ARE THERE
 FORMS I
 CAN USE
 TO MAKE
 AN ADVANCE
 DIRECTIVE?**

**WHAT
 HAPPENS IF
 I CHANGE
 MY MIND?**

MEDICAL CARE DECISIONS AND ADVANCE DIRECTIVES: What You Should Know

7

- You can cancel your *advance instruction for mental health treatment* while you are able to make and communicate your decisions by telling your physician or mental health provider that you want to cancel it.

WHO SHOULD I TALK TO ABOUT AN ADVANCE DIRECTIVE?

You should talk to those closest to you about an advance directive and your feelings about the health care you would like to receive. Your physician or health care provider can answer medical questions. A lawyer can answer questions about the law. A trusted advisor or clergy member might be able to help with more personal questions.



WHERE SHOULD I KEEP MY ADVANCE DIRECTIVE?

Keep a copy in a safe place where your family members can get it. Give copies to your family, your physician or mental health providers, your health care agent(s), and any family members or close friends who might be asked about your care should you become unable to make decisions. Always remember to take a copy of your Advance Directive with you for hospital admissions, emergency room visits, clinic visits for cardiac procedures, etc. so it can be put into your chart. Also, consider registering your advance directives with the North Carolina Advance Health Care Directive Registry: www.secretary.state.nc.us/ahcdr.

A living will or health care power of attorney created outside North Carolina is valid in North Carolina if it appears to have been executed in accordance with the applicable requirements of the place where it was created or of this State.



Contact your health care provider or attorney, or visit the North Carolina Department of the Secretary of State Advance Health Care Directive Registry website at: www.secretary.state.nc.us/ahcdr.

WHAT IF I HAVE AN ADVANCE DIRECTIVE FROM ANOTHER STATE?

WHERE CAN I GET MORE INFORMATION?

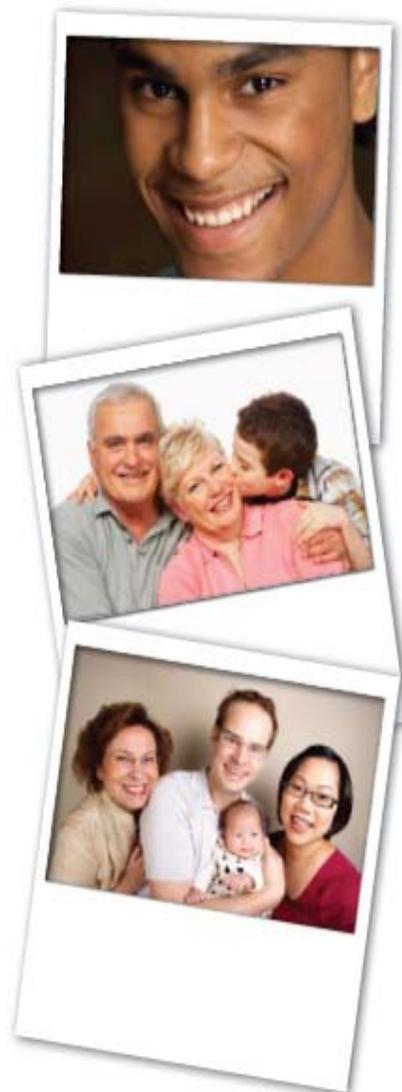
ARE THERE OTHER FORMS AVAILABLE THAT WILL HELP ENSURE MY HEALTH CARE DECISIONS ARE KNOWN AND FOLLOWED?

Other forms that you may want to be aware of include: *Authorization to Consent to Health Care for a Minor*, *Organ Donor Card*, *Portable Do Not Resuscitate (DNR) Orders*, and *Medical Orders for Scope of Treatment (MOST)*.

- An *authorization to consent to health care* for a **minor** is a legal document that allows parents with sole or joint legal custody of a minor (under 18) to authorize another adult to make certain health care decisions for their child or children in their absence. For more information, go to: www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_32A/GS_32A-34.html.
- An *Organ Donor Card* is a document that allows you to donate your organs. You can become an organ donor by expressing your desire to donate in your will, by authorizing the NC Division of Motor Vehicles to put an organ donor symbol on your driver's license or identification card, by completing an *organ donor card* or other document, or by authorizing that a statement or symbol be included on the NC Organ Donor Registry. You also may authorize an agent to make an anatomical gift of organs under a *health care power of attorney*. To make sure your wishes are honored, you should discuss organ donation with your family, friends, and health care providers so they know and can carry out your wishes. You can get an *organ donor card* from the North Carolina Department of the Secretary of State Advance Health Care Directive Registry at: www.secretary.state.nc.us/ahcdr.
- A *Portable Do Not Resuscitate (DNR) Order* is a medical order that can be followed by emergency medical responders or other health care providers that tells them not to attempt cardiopulmonary resuscitation (CPR) if your heart and

breathing stop (cardiopulmonary arrest). Because it is portable, it can be followed in different settings (for example, in your home, in a nursing home, or in a hospital). Since a *Portable DNR Order* is a physician or medical order it must be signed by your physician (in NC, physician assistants and nurse practitioners also may issue these orders). It is effective when it is completed and signed by your physician (or physician assistant or nurse practitioner). It can be cancelled by destroying or writing "void" on the original form. *Portable DNR Orders* must be obtained from your physician. For more information, be sure to talk to your physician or other health care provider.

- A *Medical Order for Scope of Treatment*, called a *MOST form*, like a *Portable DNR Order*, is a medical order that can be followed in different settings such as in the home, nursing home, hospital, etc. A *MOST form* contains instructions for CPR and also addresses other end-of-life treatments that you may or may not want to receive. For example, a *MOST* can tell emergency medical responders and other health care providers what level of treatment you would like to receive, whether you would like to receive antibiotics, and artificial nutrition and hydration through tubes. While a *MOST* is a medical order that must be signed by your physician (or physician assistant or nurse practitioner), it also must be signed by you or, if you are not able to make or communicate your health care decisions, by someone who is legally recognized to speak for you. A *MOST* can be cancelled by destroying the original form or indicating on the form that it is void. A *MOST form* must be obtained from your physician. For more information, be sure to talk to your physician or other health care provider.



MEDICAL CARE DECISIONS AND ADVANCE DIRECTIVES: What You Should Know

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on Advance Directives 1991.

Revised 1999.

Revised 2009



State of North Carolina Department of Health and Human Services Division of Medical Assistance
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