SECTION 3
CAP/C SERVICES AND SUPPLIES

Chapter 13
Case Management

WHAT IS CASE MANAGEMENT?

A CAP/C Case Manager works with beneficiaries, families, physicians, other health care providers, natural support systems, and others to

HW Health and

- Enhance the beneficiary's safety, productivity, satisfaction, and quality of life,
- Assist beneficiaries to achieve an enhanced level of health and to maintain wellness and function by facilitating timely and appropriate health services,
- Assist beneficiaries to appropriately self-direct care, self-advocate, and make informed health care decisions to the degree possible,

FA Financial Accountabilit

- Maintain cost effectiveness in the provision of health services, and
- Facilitate appropriate and timely treatment decisions.

These outcomes are achieved through a process of

- Continual assessment and reassessment of the beneficiary's current status,
- Planning the beneficiary's care so that it takes into account all of the beneficiary's strengths, needs, and goals,

SP Service Plans

- Linking the beneficiary to other sources of help within the family and the community so that the burden of care is not solely on formal health and social agencies, and
- Monitoring the provision of care and revising the plan as needed.

WHAT IS INCLUDED?

CAP/C Case Management specifically includes:

- Responding to inquiries about the CAP/C program, explaining the benefits and limitations of the program to potential beneficiaries or referral sources, identifying and explaining other programs or sources of help that may be provided instead of or in addition to CAP/C, and providing the link to the CAP/C website and Parent Handbook.
  Please refer to Chapter 24 for information regarding inquiries

MORE INFORMATION

- Completing and submitting the referral form to DMA for approval.
  Please refer to Chapter 25 for more information about Referrals.

- Maintaining a wait list if necessary, making regular contact with the applicants on the wait list to assess their continued interest and inform them of their place on the list, and making efforts to avoid a wait list whenever possible
  Please refer to Chapter 27 for information regarding Wait Lists.

MORE INFORMATION

LOC
Level of Care

- Facilitating the determination of nursing facility level of care by getting a signed FL-2 and having it approved by CSC.
  Please refer to Chapter 29 for more information regarding the FL-2.

MORE INFORMATION

- Directing the family to DSS to make their Medicaid application and guiding them through that process as necessary.
  Please refer to Chapter 28 for more information regarding the Medicaid application.

MORE INFORMATION

- Coordinating with Medicaid income maintenance staff regarding the beneficiary's Medicaid eligibility and the meeting of applicable

deductibles. This includes planning with the income maintenance caseworkers, beneficiaries, and families/primary caregivers on how deductibles will be met.

SP
Service Plans

- Conducting an assessment which involves completion of the family-centered assessment form, and obtaining other relevant data such as the Physician's Request for Nursing Services, employment verification, or CMS-485. The assessment will include contact with many sources of formal and informal support, including CCNC.
  Please refer to Chapters 30, 31, and 33 for more information about these documents.

SP
Service Plans

- Assisting the beneficiary and family to develop a family-centered plan of care that addresses all of the beneficiary's strengths, needs, and goals; uses personal and natural supports rather than exclusively using formal support; and does not have services that duplicate one another.
  Please refer to Chapter 34 for more information regarding the Plan of Care, and Chapter 43 for information regarding duplication of services.

FC
Free Choice

- Reviewing the beneficiary's rights and responsibilities with them, and having them sign the Letter of Understanding and Freedom of Choice.
  Please see Chapter 35 for more information about the Letter of Understanding and Freedom of Choice.

- Submitting the appropriate documentation and working with the DMA Nurse Consultant to obtain approval for CAP/C participation.
  Please see Chapter 36 for information regarding DMA's evaluation for participation.

FC
Free
Choice

- Ensuring the beneficiary's right to free choice, referring to the providers of their choice, and authorizing services from those providers by completing a service authorization or a participation notice.

  MORE INFORMATION

  Please see Chapters 39 and 40 for more information regarding the Service Authorization and Participation Notice.

HW
Health
and
Welfare

- Monitoring of the beneficiary and his/her care via
  - Contact with the beneficiary each calendar month,
  - Contact with providers of waiver services each calendar month,
  - Quarterly (i.e. every third month) home visit with the beneficiary; one of those visits per year must include the in-home care staff if applicable,
  - Quarterly (i.e. every third month) contact with non-waiver service providers,
  - Quarterly review of a sample of nurses notes or nurse aide task sheets if applicable,
  - Quarterly assessment and documentation of progress toward plan of care goals,
  - Review and approval of claims for waiver services when applicable, and
  - Follow-up of hospitalizations, emergency room visits, and changes in the beneficiary's health or care needs.

SP
Service
Plans

FA
Financial
Accountabilit

Contacts can be made by telephone, e-mail, or visit, unless otherwise specified.

MORE INFORMATION

Please see Chapters 42 and 43 for information regarding monitoring and coordination of care.

SP
Service
Plans

- Revising the plan of care as needed and obtaining approval from DMA.

  MORE INFORMATION

  Please see Chapter 44 for information regarding plan of care revisions.

HW
Health and Welfare

LOC
Level of Care

FH
Fair Hearings

MORE INFORMATION

- Ensuring the policies and procedures of the program are upheld to maintain the health, safety, and well being of the beneficiary.
- Conducting the annual Continued Needs Review (CNR), or reassessment.
  Please see Chapter 45 for more information regarding the CNR.
- Discharging the beneficiary from a particular CAP/C service or from CAP/C participation in accordance with CAP/C policies and procedures as directed by DMA.
  Please see Chapters 50, 51, and 52 for more information regarding discharges and disenrollments.

WHAT IS NOT INCLUDED?

- Case management services must be prior-approved.
- CAP/C Case Managers may not provide direct care. This means that if a particular activity is offered as a distinct service under Medicaid, it can not be provided by a case manager. For example, a case manger can not be the in-home nurse or provide transportation to a medical appointment.

WHO CAN GET IT?

CAP/C Case Management is a requirement to participate in CAP/C. The provision of good case management is critical for the beneficiary to benefit from the program. Therefore, all CAP/C beneficiaries receive case management.

WHERE CAN THEY GET IT?

A Case Management agency is assigned to a beneficiary based on the beneficiary's current county of residence, even if the beneficiary's Medicaid or the beneficiary's legal guardian is in a different county.

CAP/C Case Management is normally provided while the beneficiary is in the home setting. However, there are three situations in which case management can be provided to a beneficiary in a hospital or nursing facility. In all three cases, the CAP/C case management activities may not duplicate the facility's discharge planning activities.

1. When assessing a potential beneficiary prior to discharge from the hospital or nursing facility. The case management activities must be performed within the 30 days prior to discharge.
2. When a current CAP/C beneficiary is hospitalized for 30 days or less.
3. When a CAP/C beneficiary is disenrolled from CAP/C for short-term (30 days or less) admission to a nursing facility or rehabilitation center, case management activities to get the beneficiary back on CAP/C after discharge may be provided.

HOW MUCH CAN THEY GET?

Beneficiaries normally receive a maximum of 72 hours per plan of care year for case management activities. Please see the end of this chapter for a list of billable case management activities.

Case managers are expected to perform all of the essential case management functions, in a timely manner, even if all of the allotted hours have been used.

MORE INFORMATION

Additional hours of case management may be approved when they meet EPSDT criteria. Please see Chapter 6 for more information regarding EPSDT.

QP
Qualified Providers

WHO CAN PROVIDE IT?

An agency must be enrolled as a CAP provider to provide CAP/C case management. In addition to the CSC conditions for provider enrollment, the following qualifications must be present:

- The agency must be capable of providing case management by both nursing and social work staff.
- The agency and their subsidiary corporations, related partners, or closely allied entities may not also provide direct care services to the same beneficiary. Exceptions to this criterion may be approved on a case-by-case basis when:
    - There is a lack of available providers such that the beneficiary would be unable to access services, or
    - There is a written statement, signed by the beneficiary, attesting that the individual has been offered choice among all qualified providers and that he or she has freely chosen the same agency for both purposes, and
    - There is an individual capable of and willing to advocate for the beneficiary, and that advocate can be present in planning meeting, and
    - All of the normal administrative requirements for both services are met independently; i.e., there is one beneficiary file for the case management services which meets all of the case management criteria, and a second beneficiary file for home health services which meets all of the home health criteria, and
    - The advocate is informed verbally and in writing about how to make a complaint to the State or request assistance with concerns about choice, quality, and outcomes.

- An agency employing or contracting a case manager who is the parent or family of a CAP/C beneficiary shall not provide case management to that beneficiary. Exceptions to this criterion may be approved on a case-by-case basis when there is no alternate agency or when free choice of that agency is documented as above.
- The agency must have capability for web based automation.
- The agency must be able to demonstrate experience with pediatric case management.
- The agency must conduct criminal background checks on case managers in accordance with GS131E-265.
- The agency must provide Care Advisement to beneficiaries in the CAP/C-Choice option.

Provider agencies are endorsed by the DMA CAP/C Supervisor prior to being approved by CSC Provider Enrollment. Endorsement is based on the ability of the agency to meet the conditions contained in the CAP/C policy, as well as its ability to meet the CMS waiver assurances and case management standards of practice. Any information available to the CAP/C Supervisor, including information requested by her, or information available from entities such as DHSR and Program Integrity will be factored into a decision regarding endorsement.

Typical CAP/C case management providers include Health Departments, Departments of Social Services, Councils on Aging, Home Health agencies, and private case management agencies.

Agencies are encouraged to serve a geographic area large enough to support a full CAP/C caseload.

An individual case manager must meet the following qualifications:

- Bachelor's degree in social work from an accredited school of social work, and one year of directly related experience, or
- Bachelor's degree in a human services or equivalent field (as set forth in "Guidelines for Evaluating Human Services Degrees, Prepared by Office of State Personnel Local Government Services, October 2003" located at http://www.osp.state.nc.us/Guide/LocalGovmt/HRManual/vi_humansrvcdegrees.pdf from an accredited college or university and one year directly related experience, or
- Bachelor's degree from an accredited college or university and two years directly related experience, or
- Registered nurses who hold a current North Carolina license, regardless of whether they have completed a two or four year educational program, must have one year of directly related experience.

Directly related experience is defined as human services experience in the areas of pediatrics, nursing, medical social work, case management, assessment and referral, intervention, and treatment planning. No trainee appointments are eligible.

New hires must meet minimum qualifications at the time of hiring.

In addition to meeting the minimum staff qualifications, provider agencies are responsible for ensuring that staff is competent in the following areas:

1. Assessment

Knowledge of:

a. Formal and informal assessment practices.

b. The population/disability/culture of the beneficiary being served

Skills and Abilities to:

a. Apply interviewing skills such as active listening, supportive responses, open-and closed-ended questions, summarizing, and giving options.
b. Develop a trusting relationship to engage beneficiary and natural supports
c. Engage beneficiaries and families to elicit, gather, evaluate, analyze and integrate pertinent information, and form assessment conclusions.
d. Recognize indicators of risk (health, safety, mental health/substance abuse).
e. Gather and review information through a holistic approach, giving balanced attention to individual, family, community, educational, work, leisure, cultural, contextual factors, and beneficiary preferences.
f. Consult other professionals and formal and natural supports in the assessment process.
g. Discuss findings and recommendations with the beneficiary in a clear and understandable manner.

2. Care Planning

Knowledge of:

a. The values that underlie a person-centered approach to providing service to improve beneficiary functioning within the context of the beneficiary's culture and community.
b. Models of wellness-management and recovery
c. Biopsychosocial theories of practice, evidenced-based standards of care, and practice guidelines.
d. Processes used in a variety of models for group meetings to promote beneficiary and family involvement in case planning and decision-making.

e. Services and interventions appropriate for assessed needs.

Skills and Abilities to:

a. Identity and evaluate a beneficiary's existing and accessible resources and support systems.
b. Develop an individualized care plan with a beneficiary and his or her supports based on assessment findings that include measurable goals and outcomes.

3. Linkage/Referral

Knowledge of:

a. Community resources such as medical and behavioral health programs, formal and informal supports, and social service, educational, employment, recreation, and housing resources.
b. Current laws, regulations, and policies surrounding medical and behavioral healthcare.

Skills and Abilities to:

a. Research, develop, maintain, and share information on community and other resources relevant to the needs of beneficiaries.
b. Maintain consistent, collaborative contact with other health care providers and community resources.
c. Initiate services in the care plan in order to achieve the outcomes derived for the beneficiary's goals.
d. Assist the beneficiary in accessing a variety of community resources.

4. Monitoring & Follow-Up

Knowledge of:

a. Outcome monitoring and quality management.
b. Wellness-management, recovery, and self-management.
c. Community beneficiary-advocacy and peer support groups.

Skills and Abilities to:

a. Collect, compile and evaluate data from multiple sources.
b. Modify care plans as needed with the input of beneficiaries, professionals, and natural supports.
c. Discuss quality-of-care and treatment concerns with the beneficiary, professionals, formal and natural supports.
d. Assess the motivation and engagement of the beneficiary and his or her supports.
e. Encourage and assist a beneficiary to be a self-advocate for quality care.

5. Professional Responsibility

Knowledge of:

a. Importance of professional ethical standards and the consequences of violating ethical standards.
b. Quality assurance practices and standards.
c. Confidentiality regulations.
d. Required performance standards and case management best practices
e. Definitions and fundamental concepts of culture and diversity.
f. Origins and tenets of one's personal value system, cultural background, and beliefs; and understanding of how this may influence actions and decisions in practice.
g. Beneficiary differences in culture and ethnicity.

Skills and Abilities to:

a. Use critical thinking skills and consultation with other professionals to make ethical decisions and conduct ethical case management.
b. Use initiative and creative problem solving to support people in accessing the community and developing socially valued roles.

c. Form constructive, collaborative relationships with beneficiaries of various cultures and use effective strategies for conducting culturally-competent case management.
d. Form constructive, collaborative relationships with medical and other service providers.
e. Discern with whom protected health information can be shared.
f. Communicate clearly, both verbally and in writing.
g. Discern when the severities of family problems are beyond the case manager's skill or responsibility, and when referrals to other professionals are necessary.
h. Identify areas for self improvement, pursue necessary education and training, and seeks appropriate supervision.

The agency is also responsible for ensuring and documenting that each individual case manager has the following:

- Bloodborne pathogen/infection control training
- HIPAA training
- Completion of the DMA-sponsored CAP/C training within 90 calendar days of employment and prior to billing any case management services.
- Completion of the "Training for Case Managers – Improving the Quality of Home and Community Based Waiver Services", within 90 calendar days of employment, located at http://www.hcbsassurances.org.
- One year of experience in pediatrics or completion of DMA-approved pediatric training curriculum.

DMA supports the use of one case manager with a full caseload rather than multiple case managers with partial caseloads when this is practical

for the case management agency. However, if there is only one CAP/C case manager, there must be someone knowledgeable enough to cover her caseload during vacations or absences.

CAP/C case management providers may contract with a qualified individual, agency, or other entity for individual case management. A contracted RN or SW should meet the same minimum qualifications of education and experience as case managers.

An nurse or agency providing direct care to a CAP/C beneficiary may not also be the RN Case Manager or person contracted to perform nursing functions of case management (for example, the annual assessment) for that CAP/C beneficiary.

In accordance with conflict free case management, case managers cannot be related by blood or marriage to the beneficiary or any of the beneficiary's paid caregivers, anyone financially responsible for the beneficiary, or anyone empowered to make financial or health-related decisions on behalf of the beneficiary.

For beneficiaries of CAP/C Nursing, it is recommended that the CAP/C case manager is an RN who meets the minimum standards set forth above. For all CAP/C beneficiaries, an RN is involved in the

- Initial and annual assessments,
- Joint home visits with the social work case manager every 6 months,
- Review of all incident reports regarding injury, death, or other medical issues, and
- Quarterly review of the beneficiary's file and consultation with the social work case manager.

A CAP/C Case Manager Supervisor shall meet the following qualifications:

All of the qualifications of the individual case manager, <u>and</u>

A. designation as one of the following:

1. Certified Case Manager (CCM) by the Commission for Case Manager Certification.
2. Certified Social Work Case Manager (CSWCM) by the National Association of Social Workers.
3. Certified Advanced Social Work Case Manager (CASWCM) by the National Association of Social Workers.
4. Case Management Administrator Certification (CMAC) by the Center for Case Management.
5. Licensed Medical Social Worker.
6. Registered Nurse - Board Certified (RN-BC) in case management nursing by the American Nurses Credentialing Center.

OR

B. the following *additional* experience (above what is required for the individual case manager)

1. Bachelor of Social Work (BSW), Bachelor of Science (BS) in a human services field, or RN with two years of directly related experience, one of those years to have been case management experience.
2. BS in a non-human services field and three years directly related experience, one of those years to have been case management experience.

The beneficiary has the right to choose from among enrolled case management provider agencies and among individuals within those agencies.

CAP/C Case Management can <u>not</u> be provided by

- The beneficiary's parent, stepparent, foster parent, custodial parent, or adoptive parent,
- Anyone who has legal responsibility for the minor beneficiary,

- Grandparents of the beneficiary,
- Siblings of the beneficiary,
- The spouse of an adult (18 and over) beneficiary, or
- Anyone who has legal responsibility for an adult (18 and over) beneficiary.

WHAT DOCUMENTATION DO I NEED?

Each Case Management agency should have written policies regarding

- Waiting list management,
- Charging for assessment-only visits,
- Documentation requirements (referrals, assessments, plans of care, changes in condition, contact notes),
- Monitoring visits,
- Quality management program (to include management of critical incident reports and clinical and financial oversight,
- Billing practices,
- Admission, transfer, and discharge policies,
- Communicable disease reporting and prevention,
- Beneficiary confidentiality,
- Provider choice,
- Record retention and safekeeping,
- Personnel policies (hiring, dismissal, validation of credentials, and continuing education if applicable), and
- Language access plan.

All agency policies should be consistent with Medicaid and CAP/C policies.

If you do not have any or all of these policies, some sample policies have been placed on the web for your reference. You can access them from http://www.ncdhhs.gov/dma/services/capc.htm

Each beneficiary record should contain the following:

- Confidentiality form/HIPAA release
- Referral form
- DMA authorization for assessment
- Most recent stamped FL-2
- Current FL-2 if not the same as above
- Letters of medical necessity, if applicable
- Assessment
- Plan of care, including cost summary
- Service authorizations
- Participation notices
- Physician orders for supplies provided by case management agency
- Correspondence from DMA regarding approvals, changes
- Copies of quotes or invoices and claims for items billed by the case management provider
- Case management notes

The current, active file should contain

- The signed HIPAA agreement
- The referral, and accompanying approval for assessment
- All other documents listed above dated from the second most recent CNR forward

More information regarding documentation can be found in Chapter 48.

FA
Financial Accountabilit

HOW IS IT BILLED?

Case Management is billed using codes T1016. The service is billed in 15 minute units at the rate indicated on the current CAP/C fee schedule located at http://www.ncdhhs.gov/dma/fee/.

There is no difference in reimbursement for case managers of different qualifications, such as RN and SW case managers. When a case management team is used, the time for both members is combined for billing purposes. For example, if during an assessment the RN spends 2 hours on her portion and the SW spends 3 hours on his portion on the same date of service, one claim for 5 hours is submitted.

If your time spent does not equal a full 15 minute unit, follow this procedure:

1. Total the amount of time providing the service for that day.
2. Divide the total by 15 to get the number of full units.
3. Add an additional unit if the remainder is 8 minutes or more.

Billing for CAP/C services begins with the CAP Effective Date and ends with the beneficiary's disenrollment or death. Generally, time spent doing things directly related to a specific beneficiary; i.e., time spent with the beneficiary, time spent talking with those involved in the beneficiary's care, time completing service authorizations and time spent completing other correspondence directly related to the beneficiary's care is billable.

The CAP Effective Date is the latest of the following three dates:

- The Medicaid application date,
- The date the FL-2 was approved, or
- The date of de-institutionalization.

While case managers are usually involved in other tasks as part of their daily activities and as part of their employee responsibilities, those tasks are not billable time. Activities such as attending training; completing time sheets; recruiting, training, scheduling and supervising staff; billing

Medicaid; documenting case management activities; and gathering information to respond to quality assurance requests are a few examples of non-billable activities.

Specifically, the following activities are billable under codes T1016 as applicable:

- Assessing the beneficiary for CAP/C participation.
  Completing or reviewing the family assessment; doing the case manager assessment; gathering and reviewing documentation such as physician letters of medical necessity, nurses notes, and DME supplies provided; except in the case of a new beneficiary, obtaining the FL-2.
- Completing the plan of care and revising the plan as needed.
  Developing the family –centered plan of care, reviewing it quarterly, revising it as needed, obtaining approval from DMA.
- Locating service providers for approved CAP/C services and ordering the services from those providers.
  Helping the beneficiary/family to choose from available providers, contacting those providers, completing service authorizations and participation notices.
- Locating and arranging non-CAP/C and/or non-Medicaid support to meet the beneficiary's needs.
  Arranging for volunteer help to make the beneficiary's environment safe, finding funding sources for items that Medicaid does not cover.
- Coordinating the provision of all services.
  Attending IEP meetings, arranging for or attending care conferences, coordinating with the home care agency regarding physician orders, arranging to discontinue duplicative services.

- Monitoring services, including the delivery of the service and reviewing claims and related documentation.
  Monthly contact with waiver service providers, quarterly contact with non-waiver service providers, approving claims.
- Monitoring the beneficiary's situation including the continuing need for CAP participation, the level of care, and the appropriateness of services as well as taking action on your findings.
  Monthly contact with the family, quarterly home visit, follow-up on hospitalizations, making and implementing revisions to the plan of care based on findings from these activities.
- Working with the beneficiary, family, and others involved in the beneficiary's care to assure the beneficiary's health, safety, and well-being.
  Locating resources for food, electricity, or transportation; working with Child Protective Services, assessing for and intervening as needed for issues of domestic violence, substance abuse, etc.
- Coordinating Medicaid eligibility issues with DSS.
  Assisting the family with their Medicaid application and reviews, with submitting documentation of meeting their spend-down amount, and with updating DSS of changes of address or private insurance; correcting incorrect CAP Indicator Codes.
- Arranging and coordinating activities related to the disenrollment of CAP/C that occur prior to the disenrollment date.
  Referral to other program, assisting with transition to that program, coordinating the transfer with the new case manager, notifying providers of the disenrollment date.
- Assisting the family and/or DMA or participating in the mediation and appeals process.

Gathering information, advising the family, attending the mediation.

The following activities are not billed separately; the cost of these activities is built into the reimbursement rate:

- Responding to inquiries, completing and submitting the referral form, managing a wait list
- Obtaining the FL-2 on a new beneficiary
- Documenting case management 'contact notes' and critical incident reports. (Documenting your assessment, plan of care, and quarterly review of the plan of care is billable. Documentation of a phone call to/from a provider, family member, or DMA is not billable.)
- Travel time
- Delivering supplies
- Completion of county-mandated or agency mandated forms not required by CAP/C
- Completing and submitting claims to Medicaid
- Any activities that occur after the beneficiary's disenrollment or death
- Attending/completing training
- Consultations in which general information is obtained as opposed to information about a specific beneficiary's circumstance
- Staff recruiting, training, scheduling, and supervision
- Quality assurance/improvement activities

If you are billing for case management that was provided to assess a new beneficiary while the individual was still in a hospital or long term care

facility, wait until the beneficiary is discharged home and the DSS has entered the CAP indicator code in the claims reimbursement system.

MORE INFORMATION

Please refer to Chapter 26 for instructions for billing an 'assessment anyway' claim.

Remember that your case management documentation must support the time you billed.

CHAPTER REVIEW

🗝Key Points

1. Case Management is required for all CAP/C beneficiaries.
2. CAP/C Case Management is provided by RNs and qualified non-nurse case mangers.
3. Case Managers assess the beneficiary and family, plan care that meets their needs and is quality cost effective care, link the family to the appropriate resources, monitor the provision of those resources and the outcomes, and revise the plan of care when needed.
4. Case Managers may not provide direct care.
5. CAP/C Case Management is normally provided while the beneficiary is in the home setting, but under certain specific circumstances, can be provided while the beneficiary is in a hospital or nursing facility.
6. Case Management is limited to 72 hours per waiver year. Additional hours may be provided if they meet EPSDT criteria.
7. Case Management is billed in 15 minute units, using code T1016.
8. All case management activities must be documented, and the documentation must support the time billed.
9. Time spent in non-patient related activities such as completing time sheets or attending training is not billable. Documentation is not billable.

Test Your Knowledge

1. Which of the following is not a case management activity?
    a. referring a family to a charitable organization that can provide equipment that Medicaid will not cover
    b. picking up the beneficiary's prescriptions
    c. getting a physician order to decrease the beneficiary's respiratory therapy services because they duplicate the nursing care that is being provided
    d. providing resources to the family to assist them in coping with the needs of the beneficiary
2. Which of the following activities can a case manager bill for?
    a. taking a referral
    b. getting the initial FL-2 signed by the physician
    c. calling the home care agency to see if they have found staff to care for the beneficiary
    d. assisting the family with funeral arrangements after the beneficiary's death
3. True or False: If there is more than one case management agency available in a certain area, the beneficiary will be assigned to whoever can serve the beneficiary first so as not to create a wait list
4. If the case manager is a social worker, what is the role of the RN?
    a. conducting the annual assessment for the CNR
    b. consulting with the social worker quarterly and reviewing the beneficiary's history and status
    c. reviewing the critical incident report for a visit to the emergency room
    d. all of the above

5. When can case management be provided when the beneficiary is in a hospital or nursing home?
    a. never
    b. always
    c. within 30 days prior to discharge
    d. when requested by the facility's discharge planner

1. b. 2. c, 3. false, 4. d, 5. c

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SECTION 3
CAP/C SERVICES AND SUPPLIES

CHAPTER 14
In-Home Nursing Care

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Substantial

CONT
Continuous

WHAT ARE IN-HOME NURSING SERVICES?

Skilled Nursing, as it applies to CAP/C, is defined as assessment, judgment, intervention, and evaluation of interventions that require the education, training, and experience of a registered (RN) or licensed practical (LPN) nurse who holds a current valid license issued by the N.C. Board of Nursing to practice nursing as under NCGS 90-171, and 21 NCAC 36. Skilled CAP/C nursing does not include those tasks that can be delegated to unlicensed personnel (21 NCAC 36) or accomplished during the course of a home health visit.

WHAT IS INCLUDED?

The service provides an RN or LPN to provide continuous care in the home to a medically fragile child in order to support the family in caring for the child at home. The service may include performance of specialized procedures, preparation of equipment and material for treatment, assistance in learning appropriate self-care techniques, and other medical tasks performed on an ongoing, daily basis. The nurse may also assist the child with eating or feeding, transferring, ambulating, and performing other personal care tasks when needed as an integral part of the child's day-to-day treatment plan.

Nursing services are available under EPSDT.

WHAT IS *NOT* INCLUDED?

Limitations of this service include:

- CAP/C Nursing services are not approved exclusively for services in the school or home school.
- CAP/C nursing services must be prior-approved.
- CAP/C nursing services (RN or LPN) are not covered if any of the following apply:
  - A task can be delegated to a Nurse Aide (21 NCAC 36 .0221).
  - A provider agency does not have a Nurse Aide available to provide services.
  - A provider agency will not allow unlicensed personnel to perform a Nurse Aide task that meets the North Carolina Board of Nursing's delegation criteria.

SUB
Substantial

FA
Financial Accountability

MN
Medically Necessary

- CAP/C nursing is limited to a maximum of $265,000 per fiscal year. There is no entitlement of services up to this limit.
- CAP/C nursing is not covered if the beneficiary has third-party insurance coverage for nursing services at 100% coverage of hours for the approval period. Only the number of hours provided by insurance compared to the number of hours approvable by CAP/C are considered. The presence of copays or deductibles for those hours, or differences in reimbursement rates, do not apply. The approval period is the dates on the service authorization.
- CAP/C nursing is not covered if within one year of requesting CAP/C nursing services, the responsible party voluntarily discontinues private insurance that would have covered nursing in order to become eligible for the waiver.
- CAP/C Nursing Services are generally not provided on the same day and time as CAP/C Pediatric Nurse Aide Services or CAP/C Personal

MN
Medically Necessary

Care Services. CAP/C Nursing Services may not be provided if it duplicates other Medicaid or non-Medicaid nursing services.

- Respiratory therapy services may not be billed at the same time as CAP/C Nursing. 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 beneficiary 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 beneficiary's care. Ongoing respiratory therapy visits during nursing services is considered duplication of care. The nursing agency is responsible for ensuring the competency of nursing staff.
- Home Infusion therapy services may not be billed at the same time as CAP/C Nursing. When an agency accepts a client for nursing care, they must be able to meet all of the beneficiary's care needs. If the agency does not have personnel qualified to do blood draws, IV medications, etc, that agency must either subcontract with another agency or transfer the beneficiary to a different agency. Please refer to the home care licensure rules for more information regarding infusion nursing.

MORE INFORMATION

- A nurse may accompany a patient and his/her caregiver to a medical appointment (or to/from school or other activities) so that the nurse can provide medical care (i.e., tracheal suctioning) for the patient while the caregiver drives. Under no circumstances may the nurse drive, even if allowed by the nursing agency policy. A nurse can not attend to a medically fragile client while driving. CAP/C services are provided to meet the unmet needs of the beneficiary, not the needs or preferences of caregivers, provider agencies, or others involved in the

HW
Health and Welfare

MN
Medically Necessary

child's care. For example, a request for a nurse will not be authorized when unlicensed personnel can provide the needed services.

- In-home nursing services will be discontinued if the service is not required and used within a 90 consecutive day time period.

WHO CAN GET IT?

To qualify for admission to and continuance of CAP/C skilled nursing services, all of the following components shall be present:

- All criteria for CAP/C participation, such as age, medical diagnosis, and Medicaid eligibility are met.

LOC
Level of Care

- The beneficiary qualifies for nursing facility level of care or hospital level of care.

SUB
Substantial

- The beneficiary requires interventions that can be performed only by a licensed nurse in accordance with the North Carolina Nurse Practice Act (NCGS 90-171; 21 NCAC 36).

COMP
Complex

- There are actual assessments and nursing interventions to be performed. Nursing care that does not require intervention and is only for observation in case an intervention is required will not be covered by Medicaid as medically necessary CAP/C skilled nursing services. Monitoring, which involves active assessment and judgment rather than passive observation, is coverable if the criteria for substantial and continuous are also met.

CONT
Continuous

- Skilled nursing assessment, interventions, or both are performed by a licensed nurse usually at least every 2–4 hours during the hours that Medicaid-covered CAP/C nursing services are provided. The care cannot be provided as an intermittent home health nursing visit. Required interventions exclude routine orders for medications.

MN
Medically Necessary

- There is a signed Physician's Request Form (DMA 3063) on file, and physician order for nursing services. Authorized services are

documented on an established plan of care (for example, the CMS-485) signed by the physician.

MORE INFORMATION

See Chapter 30 for more information regarding the Physician's Request Form.

HW Health and Welfare

- The beneficiary has a caregiver available to provide needed services during the planned and unplanned absences of the nurse. There is a back-up plan for when the usual caregiver is unavailable. This plan includes a person able to physically be with the beneficiary and make judgments as designated by the parent.

WHERE CAN THEY GET IT?

HW Health and Welfare

The location of service is normally the beneficiary's home; however, if care is to be provided on a consistent basis in another location, such as another relative's home, the setting is assessed and approved by the case manager prior to the delivery of the service. Case managers do not need to assess private schools, daycares licensed by the Division of Child Development (DCD), or church daycares with a letter of compliance from DCD. Waiver funding may NOT be used to pay for any services, including nursing, that are provided in the public school.

HOW MUCH CAN THEY GET?

MN Medically Necessary

- The number of hours of nursing care authorized for a beneficiary is based on medical necessity, caregiver availability, and other available resources. The case manager assesses the child's care needs and caregiver availability.
- The standard method for determining amount of services is:

Work Time + Sleep Time + Personal Time = Hours Approved

Work Time

actual hours worked

+ ½ to 1 hour lunch per day

+ ½ to 2 hours commute per day

X number of days per week worked

– number of hours other support available

work time per week

employment verification required

50 hours per week maximum

Personal Time

time for caregiver ADLs and IADLs =

20 hours per week maximum

Sleep Time

based on 8 hours per night, 7 nights per week

sleep interventions required

56 hours per week maximum

The Case Manager verifies the caregiver's employment schedule. Verification consists of a written statement on employer letterhead, verifying that the caregiver is employed, and detailing the hours and schedule of employment. If this statement is difficult to obtain or obtaining it would create a hardship, there is a substitute form developed by DMA and located on the website with the other CAP/C forms at http://www.ncdhhs.gov/dma/services/capc.htm. The form should only be used as a last resort. Please do not send anything that indicates salary information, a social security number, or other private information; we only need employment status and schedule.

CONT
Continuous

The approval of hours is based on the care needs of the child. All of the hours authorized are contingent upon interventions being provided for the child every 2–4 hours during that time or lasting for the duration of the shift. For example, a child may have interventions done during the day, but sleeps through the night with no interventions needed; that family will not

COMP
Complex

FA
Financial Accountability

MN
Medically Necessary

be given sleep time. Hours are only authorized when there are medically necessary interventions taking place.

The approval of hours is based on the needs of the child and the caregiver's availability to meet those needs, not on the maximum hours allowed. For example, a caregiver may not need a full 20 hours per week for personal time. A working parent, according to the above formula, may need only 40 hours per week for work time; in that case, they will not be authorized for 50 hours per week. There is no entitlement of services up to the maximum allowed. The decision is based on medical necessity and availability of informal caregivers.

The hours will be authorized on a weekly basis and may be scheduled at the caregiver's discretion as long as there are medically necessary interventions taking place. It is the shared responsibility of the family, case manager, and provider agency to ensure that hours are used appropriately.

Total formal support does not exceed 126 hours per week. These hours includes those hours during which the beneficiary attends school or daycare (even if not paid by Medicaid) and those hours paid by private insurance or another payer source.

Short-term-intensive care is used to approve extra hours that are needed due to

- A change in the beneficiary's condition resulting in additional or increased medical needs,
- Caregiver crisis (illness or death in the family),
- Occasional, intermittent work obligations of the caregiver when no other caregiver is available, or
- For beneficiaries with an alternate plan for school days off, school sick days or adverse weather days, up to sixty hours per school year. Hours above the sixty hour limit are submitted on a plan of care revision as

additional short-term-intensive services and approved by a DMA Nurse Consultant.

The cost of this care is managed within the annual monetary allocation for the service.

The CAP/C Nurse Consultant approves 24-hour nursing care for a maximum period of two weeks. An additional two weeks may be granted to allow caregivers time to be trained or supports to be put into place so that the beneficiary/family does not need to rely on 24 hour formal support. No more than four weeks may be approved for any significant change in condition.

Supporting documentation may be requested by the DMA Consultant in order to approve any short-term-intensive hours.

MN
Medically Necessary

Unused hours of services are not "banked" or "carried over" to another week. Hours are approved for a per-week schedule based on unmet needs.

Once the hours for that week are used, there are no more available hours until the following week. If the family should need more hours, they may choose to use their respite hours to meet that need. If a family uses their hours unwisely such that there is a threat to the child's health, safety, or well-being (i.e., there are no hours left at the end of the week, and no caregivers available for the child), the Case Manager has the discretion to place the family on a daily schedule with the need for changes to be approved by the Case Manager. Repeated occurrences place the family at risk for termination of the service.

HW
Health and Welfare

For caregivers working at home, caregiver availability will be assessed on a case-by-case basis according to the caregiver's physical proximity to the child and the caregiver's flexibility in being able to address care needs during work hours or to arrange work hours around care needs.

CAP/C hours will not be authorized to cover caregiver's overtime hours in excess of the maximum allowed per program and budget limitations.

CAP/C hours will not be authorized to cover caregiver's on-call time. However, if the caregiver is actually called to work, the actual hours worked and commute time may be authorized in accordance with program and budget limitations.

Caregivers attending school in pursuit of a diploma or a degree for purposes of employment may count their school time as work time. Time will be calculated as follows: actual time spent in class per week plus 2 hours study time per credit hour per week, plus commute time if applicable, up to a maximum of 50 hours per week.

A maximum of 50 hours per week will be authorized for school or work or a combination of both. Exceptions to the maximum hours allowed will not be made based on co-occurrence of work and school, or on multiple jobs. If both are part-time, the total, up to 50 hours per week, will be allowed if otherwise eligible. If more than 50 hours per week are used, the parent will need to make other arrangements for the remaining time.

Additional assistance cannot be provided by CAP/C because of the presence of siblings in the home. The hours approved are based on the medical needs of the CAP/C beneficiary. If a parent desires more hours because of the demands of other siblings, then arrangements should be sought for the siblings.

Congregate Care

Congregate services are allowed when more than one Medicaid hourly nursing beneficiary resides in the same home. Congregate care means that one nurse cares for more than one beneficiary simultaneously. Ratios are determined by the combined needs of the beneficiaries. Services are billed to each beneficiary using a special code and rate that allows the nurse to be reimbursed a rate higher than that of a single beneficiary.

WHO CAN PROVIDE IT?

QP
Qualified Providers

An agency providing this service must be licensed by the North Carolina Division of Health Services Regulation under 10A NCAC 13J as a home care agency and enrolled with N.C. Medicaid to provide in-home nursing services. If an agency is not enrolled as a CAP/C provider, they can not provide care to CAP/C clients. If an agency wishes to become a CAP/C provider, they should contact CSC at 866-844-1113.

Special care must be taken to avoid a conflict of interest when the case management agency is a home care agency. Generally, an agency may not provide both case management and direct care to the same beneficiary. Exceptions can be made on a case-by-case basis when

- There is a lack of available providers such that the beneficiary would be unable to access services, or
- There is a written statement, signed by the beneficiary, attesting that the individual has been offered choice among all qualified providers and that he or she has freely chosen the same agency for both purposes, and
- There is an individual capable of and willing to advocate for the beneficiary, and that advocate can be present in planning meeting, and
- All of the normal administrative requirements for both services are met independently; i.e., there is one beneficiary file for the case management services, which meets all of the CAP/C case management criteria, and a second beneficiary file for home health services which meets all of the home health criteria, and
- The advocate is informed verbally and in writing about how to make a complaint to the State or request assistance with concerns about choice, quality, and outcomes.

Individual nurses who provide care must be qualified and supervised according to the N.C. Home Care Licensure Rules (10A NCAC 13J), the N.C. Nurse Practice Act (NCGS 90-171), and N.C. Board of Nursing rules and regulations (21 NCAC 36).

The provider agency is responsible for verifying the nurses' qualifications as follows:

- Verification of current licensure as a LPN or RN by the North Carolina Board of Nursing or a compact state. Verification is completed at hire and with each renewal date (every two years)
- Criminal background checks in accordance with GS 131E-265 and 10 NCAC 27G.0202. It is recommended that the nurse not begin providing services until the check has come back satisfactorily. It is further recommended that state criminal background checks be repeated every two years at time of licensure renewal.
- Verification of CPR certification at hire and every two years coinciding with expiration dates
- Review of trainings and beneficiary-specific competencies upon hire and at each job performance review as per agency policy
- One year full time equivalent pediatric nursing experience preferred or completion of the DMA pediatric training located at http://www.ncdhhs.gov/dma/services/capc.htm.
- Supervision of the LPN and RN at least every 60 calendar days, in the home, by the RN Supervisor.

Services may not be reimbursed if provided by a member of the beneficiary's family, defined as:

- The beneficiary's parent, stepparent, foster parent, custodial parent, or adoptive parent,
- Anyone who has legal responsibility for the minor beneficiary,
- Grandparents of the beneficiary,

- Siblings of the beneficiary,
- The spouse of an adult (18 and over) beneficiary, or
- Anyone who has legal responsibility for an adult (18 and over) beneficiary even if the family member meets the qualifications of RN or licensed practical nurse (LPN).

In addition, nursing services are not covered if they are performed in the home of any paid caregiver.

FC
Free Choice

The beneficiary/family has the right to choose from among any enrolled Medicaid provider. The family should be given a list of providers to choose from. The list may include information regarding the agency such as geographic region served, private insurances accepted, or the availability of first-aid certified aides. The case manager may not however, make a recommendation to the family.

RN or LPN?

It is the responsibility of the agency to provide staff with the appropriate scope of practice to meet the beneficiary's needs. Most CAP/C beneficiaries could be cared for by either an LPN or an RN, and the agency will provide whomever is available, and may interchange.

The agency should consider the following factors:

- Qualifications of the LPN in relation to client 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 LPN role in teaching and counseling to reinforcing activities planned and initiated by the RN
- Continuous RN availability, on site when necessary, for direct participation in nursing care and supervision of the LPN
- RN accountability for evaluation of client's response to care provided and subsequent modification to plan of care or discharge of client from service
- 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 RN maintains accountability for nursing care given by all personnel to whom that care is delegated.

WHAT DOCUMENTATION DO I NEED?

The decision for initial admission to CAP/C nursing services and continuation at this level of service is made following a review of the

- Plan of care (POC) records that have similar requirements as Form CMS-485, Home Health Certification and Plan of Care (as applicable),
- Physician's orders,
- FL-2,
- CAP/C assessment and POC,
- Physician's Request Form (DMA 3063),
- Nursing documentation,
- Medication administration records , and
- Treatment records

AA
Administrative Authority

FH
Fair Hearings

as applicable.

This decision is made by a CAP/C Nurse Consultant who evaluates the information to determine if the beneficiary meets the criteria specified above. The DMA Nurse Consultant sends a written notice in accordance with DMA's beneficiary notices to the parent if a service is denied or reduced, or if the beneficiary is disenrolled from CAP/C.

HOW IS IT BILLED?

Nursing care is billed by the provider agency. Regular nursing care is billed as code T1000. Congregate care is billed as G0154. The service is billed in 15 minute units at the rate indicated on the current CAP/C fee schedule located at http://www.ncdhhs.gov/dma/fee/.

DMA will conduct post-payment reviews of billing claims until prior approval is done automatically in eCAP.

The case manager reviews a sample of nursing notes each quarter. The Case Manager will review these in part to make sure that services were provided only when there were actual interventions taking place (other review criteria are described in Chapter 43).

MORE INFORMATION

CHAPTER REVIEW

🗝Key Points

1. To receive on-home nursing care, the beneficiary's needs must be:
   - Substantial – requires the scope of practice of an RN or LPN; could not be delegated to a NA or lower level of care
   - Complex – involve assessments and interventions; is not simply for observation in case something happens
   - Continuous – assessments and interventions must occur at least every 2-4 hours while the nurse is there.
2. The nurse may also perform ADLs and other NA tasks, but they should be secondary to the purpose for which the nurse is there.
3. Nurses may not transport beneficiaries (they may accompany during transport if there are care needs).
4. The amount of services authorized is determined by a combination of personal time, work time, and sleep time according to the established criteria for each, and may not exceed 126 hours per week of total formal support. Hours are approved on a weekly basis and must be provided when there are medically-related care needs. No more than 4 weeks of 24 hour care may be given.
5. Nursing services are not covered if the beneficiary has private insurance which pays for 100% of the Medicaid approvable hours, regardless of copay, deductible, or reimbursement rate for the authorization period.
6. Nursing services may not be provided exclusively in the school; there must be home care needs as well. Nursing services may be provided only in private schools. Services in public schools are the responsibility of the LEA.
7. Congregate nursing care may be provided when there is more than one Medicaid nursing beneficiary in the home.

8. An agency providing case management services generally may not also provide nursing services to the same beneficiary. Some exceptions can be made when there is an issue of access to services.
9. Certain family members are prohibited from being the CAP/C beneficiary's paid nurse. Services may not be provided in the home of any paid caregiver.
10. The annual limit for nursing services per fiscal year is $265,000, which includes regular hours and short-term-intensive hours.
11. The Case Manager reviews samples of nursing notes to make sure that services are provided according to the plan of care and service authorization.

Test Your Knowledge

Match the term with its definition:

1. _____ Continuous
2. _____ Complex
3. _____ Substantial

a. Requires the scope of practice of an RN or LPN.
b. Interventions occur every 2-4 hours
c. Is not for observation

4. When may CAP/C provide services in the school?
   a. When the services are included in the IEP.
   b. When the services are not included in the IEP.
   c. When the services are included in the IEP and certain criteria are met.
   d. Only when the child attends a private school.

5. The maximum number of hours per week of formal support that a CAP/C beneficiary can receive is _____.

6. If your agency provides case management for a CAP/C beneficiary, it can also provide CAP/C Nursing services to that beneficiary.
   a. Yes
   b. Yes, but only if you carefully document that you gave the beneficiary freedom of choice
   c. No, except in certain cases approved by DMA because of issues with access to services

7. The $265,000. annual limit includes
   a. Regularly scheduled weekly hours
   b. Regularly scheduled weekly hours plus short-term-intensive hours
   c. Regularly scheduled weekly hours plus short-term-intensive hours and in-home nursing respite hours

1. b, 2. c, 3. a, 4. d, 5.126, 6. c, 7. b

SECTION 3
CAP/C SERVICES AND SUPPLIES

CHAPTER 15
CAP/C Pediatric Nurse Aide Care

WHAT ARE CAP/C PEDIATRIC NURSE AIDE SERVICES?

Pediatric Nurse Aide is a level of service that, during the hours of service provision, provides hands-on (not merely set-up or cueing) assistance with a minimum of two ADL needs, at least one of which falls into the NA I+ or NA II scope of practice, for beneficiaries who are unable to perform these tasks independently due to a medical condition named and documented on an assessment. The Nurse Aide providing the care is qualified as an NA 1+ or NA II, and has undergone additional pediatric, home care, and CAP/C training.

Pediatric Nurse Aide services (NA I+4 or NA II) are provided as defined by the N.C. Board of Nursing (http://www.ncbon.com) and DHSR.

WHAT IS INCLUDED?

The service provides an NA I+ or NA II to provide continuous care in the home to a medically fragile child in order to support the family in caring for the child at home. The aide may assist the child with activities of daily living as specified in the plan of care.

Pediatric Nurse Aide services may also include home management tasks that are essential, although secondary, to the personal care tasks furnished, and that are essential to the health and safety of the beneficiary (rather than the beneficiary's family). These tasks can only be assigned when the aide is in the

home to perform the higher level personal care tasks, and those tasks have been completed. Home management tasks may not be provided as a separate service. The tasks must be specified in the plan of care.

EXAMPLES OF HOME MANAGEMENT TASKS THAT CAN BE PERFORMED BY THE NURSE AIDE

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

Pediatric Nurse Aid services are available under EPSDT.

WHAT IS *NOT* INCLUDED?

Limitations of this service include:

- Pediatric Nurse Aide services must be prior-approved.
- The need for assistance with ADLs must relate directly to the beneficiary's physical medical condition, and not only to another psychosocial, cognitive, behavioral, or developmental diagnosis that, in and of itself, would not qualify a beneficiary for the CAP/C program.

MN
Medically Necessary

- Pediatric Nurse Aide services are not provided to meet only age-appropriate needs; this is considered parental responsibility.

- Children whose only age-inappropriate medical need is GT feeding, and who have a caregiver available to provide those feedings, are not eligible for CAP/C in-home care services.
- Pediatric Nurse Aide services are not approved exclusively for services in the school or home school.
- Pediatric Nurse Aide services are not approved in order to assist a child with homework for school.
- CAP/C Nurse Aide services (any combination of Pediatric Nurse Aide services and/or Personal Care services) are limited to a maximum of $75,000 per waiver year. There is no entitlement of services up to this limit.

  FA Financial Accountability

  Pediatric Nurse Aide services are not covered if the beneficiary has third-party insurance coverage for aide services at 100% coverage for the approval period. The approval period is the dates on the service authorization.

  MN Medically Necessary
- Pediatric Nurse Aide Services may not be provided at the same day and time as CAP/C Nursing services or CAP/C Personal Care services. Pediatric Nurse Aide services may not be provided if it duplicates other Medicaid or non-Medicaid nursing services.

  MN Medically Necessary
- A Pediatric Nurse Aide may accompany a patient and his/her caregiver to a medical appointment (or to/from school or other activities) so that the aide can provide medical care (i.e., oral suctioning, positioning) for the patient while the caregiver drives. Under no circumstances may the aide drive, even if allowed by agency policy. An aide can not attend to a medically fragile client while driving.

  FA Financial

  HW Health and Welfare
- CAP/C services are provided to meet the unmet needs of the beneficiary, not the needs or preferences of caregivers, provider agencies, or others involved in the child's care. For example, a request for a Pediatric Nurse Aide will not be authorized when an NA I can provide the needed services.

  MN Medically Necessary

- Pediatric nurse aid services will be discontinued if the service is not required and used within a 90 consecutive day time period.

WHO CAN GET IT?

To qualify for admission to and continuance of CAP/C skilled nursing services, all of the following components shall be present:

- All criteria for CAP/C participation, such as age, medical diagnosis, and Medicaid eligibility are met

LOC Level of Care

- The beneficiary qualifies for nursing facility (NF) level of care.

SUB Substantial

- The beneficiary's care needs requires the scope of practice of an NA I+ or NA II. The care could not be provided by a personal care aide or home health aide not registered with DHSR, or by NA I personnel without the additional training in up to four NA II tasks.

COMP Complex

CONT Continuous

- There are actual interventions to be performed. Nurse Aide care that is only for observation in case an intervention is required will not be covered by Medicaid as medically necessary CAP/C Pediatric Nurse Aide services. The beneficiary requires interventions throughout the Nurse Aide's shift or lasting the duration of the NA's shift. The care cannot be provided as an intermittent home health visit.

MN Medically Necessary

- The care is not for normal age-appropriate functioning, which is considered parental responsibility. The care needs must relate directly to a medical diagnosis identified in the assessment.

MN Medically Necessary

- There is a signed physician's order for Pediatric Nurse Aide services as under 10A NCAN 13J.1302. Authorized services are documented on an established plan of care signed by the physician.

HW Health and Welfare

- The beneficiary has a caregiver available to provide needed services during the planned and unplanned absences of the aide. There is a back-up plan for when the usual caregiver is unavailable. This plan includes a person able

to physically be with the beneficiary and make judgments as designated by the parent.

WHERE CAN THEY GET IT?

HW
Health and Welfare

The location of service is normally the beneficiary's home; however, if care is to be provided on a consistent basis in another location, such as another relative's home, the setting is assessed and approved by the case manager prior to the delivery of the service. Case managers do not need to assess private schools, daycares licensed by the Division of Child Development (DCD), or church daycares with a letter of compliance from DCD.

Pediatric Nurse Aide services can not be approved exclusively for services in the school; there must be a need for care in the home as well.

Waiver funding may NOT be used to pay for any services, including Pediatric Nurse Aide services, that are provided in the public school.

HOW MUCH CAN THEY GET?

The number of hours of nurse aide care authorized for a beneficiary is based on medical necessity, caregiver availability, and other available resources. The case manager assesses the child's care needs and caregiver availability. The standard method for determining amount of services is:

Work Time + Personal Time = Hours Approved

Work Time

actual hours worked

+ ½ to 1 hour lunch per day

+ ½ to 2 hours commute per day

X number of days per week worked

– number of hours other support available

work time per week

employment verification required

50 hours per week maximum

Personal Time

time for caregiver ADLs and IADLs =

20 hours per week maximum

Sleep Time

Sleep time is generally not medically necessary, and therefore not available, for beneficiaries at a nurse aide level of care. Sleep time may be granted when it meets EPSDT criteria.

The Case Manager verifies the caregiver's employment schedule. Verification consists of a written statement on employer letterhead, verifying that the caregiver is employed, and detailing the hours and schedule of employment. If this statement is difficult to obtain or obtaining it would create a hardship, there is a substitute form developed by DMA and located on the website with the other CAP/C forms at http://www.ncdhhs.gov/dma/services/capc.htm. The form should only be used as a last resort. Please do not send anything that indicates salary information, a social security number, or other private information; we only need employment status and schedule.

CONT
Continuous

COMP
Complex

FA
Financial Accountability

MN
Medically Necessary

The approval of hours is based on the care needs of the beneficiary. All of the hours authorized are contingent upon interventions being provided for the child every 2–4 hours during that time or lasting for the duration of the shift. Hours are only authorized when there are medically necessary interventions taking place. The approval of hours is based on the needs of the child and the caregiver's availability to meet those needs, not on the maximum hours allowed. For example, a caregiver may not need a full 20 hours per week for personal time. A working parent, according to the above formula, may need only 40 hours per week for work time; in that case, they will not be authorized for 50 hours per week. There is no entitlement of services up to the maximum allowed. The decision is based on medical necessity and availability of informal caregivers. The hours will be authorized on a weekly basis and may be scheduled at the caregiver's discretion as long as there are medically necessary interventions taking place (the interventions indicated on the service authorization task sheet). It is the shared responsibility of the family, case manager, and provider agency to ensure that hours are used appropriately.

Total formal support does not exceed 126 hours per week. These hours include those hours during which the beneficiary attends school or daycare (even if not paid by Medicaid) and those hours paid by private insurance or another payer source. A maximum of 70 of those hours per week can be provided by CAP/C. Short-term-intensive care is used to approve extra hours that are needed due to

- A change in the beneficiary's condition resulting in additional or increased medical needs
- Caregiver crisis (illness or death in the family)
- Occasional, intermittent work obligations of the caregiver when no other caregiver is available
- For beneficiaries with an alternate plan for school days off, school sick days or adverse weather days, up to sixty hours per school year. Hours above the

sixty hour limit are submitted on a plan of care revision as short-term-intensive services and approved by a DMA Nurse Consultant.

The cost of this care is managed within the annual monetary allocation for the service.

The CAP/C Nurse Consultant approves 24-hour care for a maximum period of two weeks. An additional two weeks may be granted to allow caregivers time to be trained or supports to be put into place so that the beneficiary/family does not need to rely on 24 hour formal support. No more than four weeks may be approved for any significant change in condition.

Supporting documentation may be requested by the DMA Consultant in order to approve any short-term-intensive hours.

MN
Medically Necessary

Unused hours of services are not "banked" or "carried over" to another week. Hours are approved for a per-week schedule based on unmet needs.

Once the hours for that week are used, there are no more available hours until the following week. If the family should need more hours, they may choose to use their respite hours to meet that need. If a family uses their hours unwisely such that there is a threat to the child's health, safety, or well-being (i.e., there are no hours left at the end of the week, and no caregivers available for the child), the Case Manager has the discretion to place the family on a daily schedule with the need for changes to be approved by the Case Manager. Repeated occurrences place the family at risk for termination of the service.

HW
Health and Welfare

For caregivers working at home, caregiver availability will be assessed on a case-by-case basis according to the caregiver's physical proximity to the child and the caregiver's flexibility in being able to address care needs during work hours or to arrange work hours around care needs.

CAP/C hours will not be authorized to cover caregiver's overtime hours in excess of the maximum allowed per program and budget limitations.

CAP/C hours will not be authorized to cover caregiver's on-call time. However, if the caregiver is actually called to work, the actual hours worked and commute time may be authorized in accordance with program and budget limitations. Caregivers attending school in pursuit of a diploma or a degree for purposes of employment may count their school time as work time. Time will be calculated as follows: actual time spent in class per week plus 2 hours study time per credit hour per week, plus commute time if applicable, up to a maximum of 50 hours per week.

A maximum of 50 hours per week will be authorized for school or work or a combination of both. Exceptions to the maximum hours allowed will not be made based on co-occurrence of work and school, or on multiple jobs. If both are part-time, the total, up to 50 hours per week, will be allowed if otherwise eligible. If more than 50 hours per week are used, the parent will need to make other arrangements for the remaining time.

Additional assistance cannot be provided by CAP/C because of the presence of siblings in the home. The hours approved are based on the medical needs of the CAP/C beneficiary. If a parent desires more hours because of the demands of other siblings, then arrangements should be sought for the siblings.

QP
Qualified Providers

WHO CAN PROVIDE IT?

An agency providing this service must be licensed by the North Carolina Division of Health Services Regulation under 10A NCAC 13J as a home care agency and enrolled with N.C. Medicaid to provide in-home nurse aide services. If an agency is not enrolled as a CAP/C provider, they can not provide care to CAP/C clients. If an agency wishes to become a CAP/C provider, they should contact CSC at 866-844-1113.

Special care must be taken to avoid a conflict of interest when the case management agency is a home care agency. Generally, an agency may not provide both case management and direct care to the same beneficiary. Exceptions can be made on a case-by-case basis when

- There is a lack of available providers such that the beneficiary would be unable to access services, or
- There is a written statement, signed by the beneficiary, attesting that the individual has been offered choice among all qualified providers and that he or she has freely chosen the same agency for both purposes, and
- There is an individual capable of and willing to advocate for the beneficiary, and that advocate can be present in planning meeting, and
- All of the normal administrative requirements for both services are met independently; i.e., there is one beneficiary file for the case management services, which meets all of the CAP/C case management criteria, and a second beneficiary file for nurse aide services which meets all of the home care criteria, and
- The advocate is informed verbally and in writing about how to make a complaint to the State or request assistance with concerns about choice, quality, and outcomes.

The aide providing direct care is trained, listed, and supervised as a Nurse Aide I with the Healthcare Personnel Registry at DHSR or listed as a Nurse Aide II in accordance with the Nurse Practice Act (NCGS 90-171) and N.C. Home Care Licensure Rules (10A NCAC 13J). Nurse Aide I personnel providing Pediatric Nurse Aide services must have additional training in up to four NA II tasks.
The Nurse Aide providing Pediatric Nurse Aide services completes DMA approved training regarding pediatric growth and development, pediatric client interactions, and home care of pediatric clients. This training is completed prior to billing for Pediatric Nurse Aide services. Nurse Aides currently functioning in the role of an NA I+ or NA II must complete this additional training by March 31, 2011. The provider agency is responsible for verifying the aide's qualifications as follows:

- Check of Health Care Personnel Registry (10NCAC27G.0202) at hire and with each renewal date (every two years)
- Criminal background check in accordance with GS 131E-265. It is recommended that the nurse aide not begin providing services until the check has come back satisfactorily. It is further recommended that state criminal background checks be repeated every two years at time of registry renewal.
- Verification of CPR certification at hire and every two years coinciding with expiration dates. It is recommended that First Aid certification also be maintained and verified.
- Review of trainings and beneficiary-specific competencies upon hire at each job performance review as per agency policy.

The RN supervises the nurse aide in the beneficiary's home at least every three months, as specified in 10A NCAC 13J .1110. This supervisory visit is not billable. The licensed nurse maintains accountability and responsibility for the delivery of safe and competent care (NC Board of Nursing). Decisions regarding the delegation of any nurse aide tasks are made by the licensed nurse on a beneficiary-by-beneficiary basis according to the NC Board of Nursing's delegation criteria.

Services may not be reimbursed if provided by a member of the beneficiary's family, defined as

- The beneficiary's parent, stepparent, foster parent, custodial parent, or adoptive parent,
- Anyone who has legal responsibility for the minor beneficiary,
- Grandparents of the beneficiary,
- Siblings of the beneficiary,
- The spouse of an adult (18 and over) beneficiary, or
- Anyone who has legal responsibility for an adult (18 and over) beneficiary even if the family member meets the qualifications of NA I+ or NA II.

In addition, nurse aide services are not covered if they are performed in the home of any paid caregiver.

FC
Free Choice

The beneficiary/family has the right to choose from among any enrolled Medicaid provider. The family should be given a list of providers to choose from. The list may include information regarding the agency such as geographic region served, private insurances accepted, or the availability of first-aid certified aides. The case manager may not however, make a recommendation to the family.

WHAT DOCUMENTATION DO I NEED?

The decision for initial admission to CAP/C Pediatric Nurse Aide services and continuation at this level of service is made following a review of the

- FL-2
- CAP/C assessment and POC
- Nurse Aide flowsheets

FH
Fair Hearings

as applicable. This decision is made by a CAP/C Nurse Consultant who evaluates the information to determine if the beneficiary meets the criteria specified above. The DMA Nurse Consultant sends a written notice in accordance with DMA's beneficiary notices to the parent if a service is denied, reduced, or suspended, or if the beneficiary is disenrolled from CAP/C.

HOW IS IT BILLED?

- Pediatric Nurse Aide care is billed by the provider agency. The service is billed as code T1019 for regular services and G0156 TG for congregate services, in 15 minute units at the rate indicated on the current CAP/C fee schedule located at http://www.ncdhhs.gov/dma/fee.

DMA will conduct post-payment reviews of billing claims until prior approval is done automatically in eCAP.

The case manager reviews a sample of nurse aide notes each quarter. The Case Manager will review these in part to make sure that services were

provided only when there were actual interventions taking place (other review criteria are described in Chapters 43).

CHAPTER REVIEW

Key Points

1. Pediatric Nurse Aide services are for children who require the scope of practice of a Nurse Aide I + or Nurse Aide II.
2. Pediatric Nurse Aides have also received additional training in pediatrics, home care, and the CAP/C program.
3. To receive Pediatric Nurse Aide care, the beneficiary's needs must be:
   - Substantial – requires the scope of practice of an NA I+ or NA II, and could not be delegated to a lower level of care.
   - Complex – involve hands-on interventions; is not simply for observation in case something happens.
   - Continuous –interventions must occur at least every 2-4 hours while the aide is there or last the duration of the aide's shift.
4. The aide may also perform home management tasks when they are for the beneficiary (rather than the beneficiary's family), are part of the plan of care, and personal care tasks have been completed.
5. Aides may not transport beneficiaries (they may accompany during transport if there are care needs).
6. The amount of services authorized is determined by a combination of personal time and work time according to the established criteria for each. Formal support may not exceed 126 hours per week. Hours are approved on a weekly basis and must be provided when there are medically-related care needs. No more than 4 weeks of 24 hour care may be given.
   - CAP/C aide services in the school are available only when the child attends a private school

7. An agency providing case management services may not also provide nurse aide services to the same beneficiary. Exceptions may be approved by DMA when there are issues with access to care.
8. Certain family members are prohibited from being the CAP/C beneficiary's paid nurse. Services may not be provided in the home of any paid caregiver.
9. The annual limit for Pediatric Nurse Aide services (including the combination of Pediatric Nurse Aide services and CAP/C Personal Care services) per fiscal year is $75,000, which includes regular hours and short-term-intensive hours.
10. The case manager reviews samples of nursing notes to make sure that services are provided according to the plan of care and service authorization

Test Your Knowledge

Match the term with its definition:

1. _____ Continuous
2. _____ Complex
3. _____ Substantial

a. Requires the scope of practice of a Pediatric Nurse Aide.
b. Interventions occur every 2-4 hours or last the duration of the NA's shift
c. Is not for observation

4. How may aide services be provided in the school?
   a. When the services are included in the IEP and the school pays for the service.
   b. When the child attends a private school and CAP/C pays for the service.
   c. When the services are provided by Medicaid Personal Care services.
   d. All of the above
   e. None of the above

5. True or False: Pediatric Nurse Aide services are normally available for sleep hours.

6. The $75,000 annual limit includes
   a. Pediatric Nurse Aide services only, regularly scheduled and short-term-intensive hours

b. Pediatric Nurse Aide and CAP/C Personal Care services regularly scheduled weekly hours
c. Pediatric Nurse Aide and CAP/C Personal Care services, regularly scheduled weekly hours and short-term-intensive hours

1. b, 2. c, 3. a, 4. d , 5. f, 6. c

SECTION 3
CAP/C SERVICES AND SUPPLIES

CHAPTER 16
CAP/C Personal Care Services

WHAT ARE CAP/C PERSONAL CARE SERVICES?

CAP/C Personal Care is a level of service that, during the hours of service provision, provides hands-on (not merely set-up or cueing) assistance with a minimum of two ADL needs, for beneficiaries who are unable to perform these tasks independently due to a medical condition named and documented on an assessment. The Nurse Aide providing the care is qualified as an NAI. CAP/C Personal Care services are provided as defined by the N.C. Board of Nursing (http://www.ncbon.com) and DHSR.

WHAT IS INCLUDED?

The service provides an NAI to provide continuous care in the home to a medically fragile child in order to support the family in caring for the child at home. The aide may assist the child with activities of daily living as specified in the plan of care.

CAP/C Personal Care services may also include home management tasks that are essential, although secondary, to the personal care tasks furnished, and that are essential to the health and safety of the beneficiary (rather than the beneficiary's family). These tasks can only be assigned when the aide is in the home to perform the higher level personal care tasks, and those tasks have been completed. Home management tasks may not be provided as a separate service. The tasks must be specified in the plan of care.

EXAMPLES OF HOME MANAGEMENT TASKS THAT CAN BE PERFORMED BY THE NURSE AIDE

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

Personal Care services are available under EPSDT.

WHAT IS *NOT* INCLUDED?

Limitations of this service include:

- Personal Care Services must be prior-approved.
- The need for assistance with ADLs must relate directly to the beneficiary's physical medical condition, and not only to another psychosocial, cognitive, behavioral, or developmental diagnosis that, in and of itself, would not qualify a beneficiary for the CAP/C program.

MN
Medically Necessary

- CAP/C Personal Care services are not provided to meet only age-appropriate needs; this is considered parental responsibility.
- CAP/C Personal Care services are not approved exclusively for services in the school, home school, pre-school, or daycare.
- CAP/C Personal Care Services are not approved in order to provide assistance with homework for school.

FA Financial Accountability

- CAP/C nurse aide services are limited to a maximum of $60,000 per waiver year. If the beneficiary has used a combination of Pediatric Nurse Aide Services and Personal Care Services within the year, the limit is $75,000. There is no entitlement of services up to this limit.

FA Financial Accountability

- CAP/C Personal Care services are not covered if the beneficiary has third-party insurance coverage for aide services at 100% coverage for the approval period. The approval period is the dates on the service authorization.

MN Medically Necessary

- CAP/C Personal Care services may not be provided at the same day and time as CAP/C Nursing services or CAP/C Pediatric Nurse Aide services. CAP/C Personal Care services may not be provided if it duplicates other Medicaid or non-Medicaid nursing services.

HW Health and Welfare

- A CAP/C Personal Care Nurse Aide may accompany a beneficiary and his/her caregiver to a medical appointment (or to/from school or other activities) so that the aide can provide medical care (i.e., oral suctioning, positioning) for the patient while the caregiver drives. Under no circumstances may the aide drive, even if allowed by agency policy. An aide can not attend to a medically fragile client while driving.
- CAP/C services are provided to meet the unmet needs of the beneficiary, not the needs or preferences of caregivers, provider agencies, or others involved in the child's care.

MN Medically Necessary

- Personal Care services will be discontinued if the service is not required and used within a 90 consecutive day time period.

WHO CAN GET IT?

To qualify for admission to and continuance of CAP/C Personal Care services, all of the following components shall be present:

- All criteria for CAP/C participation, such as age, medical diagnosis, and Medicaid eligibility are met

LOC
Level of Care

- The beneficiary qualifies for nursing facility (NF) level of care.

COMP
Complex

- There are actual interventions to be performed. Nurse Aide care that is only for observation in case an intervention is required will not be covered by Medicaid as medically necessary CAP/C Personal Care services.

CONT
Continuous

- The beneficiary requires interventions throughout the Nurse Aide's shift or lasting the duration of the NA's shift. The care cannot be provided as an intermittent home health visit.

SUB
Substantial

- The care requires the scope of practice of a Nurse Aide I and can not be delegated to a lower level of staff.

MN
Medically Necessary

- The care is not for normal age-appropriate functioning, which is considered parental responsibility. The care needs must relate directly to a medical diagnosis identified in the assessment.

MN
Medically Necessary

- There is a signed physician's order for CAP/C Personal Care services as under 10A NCAN 13J.1302. Authorized services are documented on an established plan of care signed by the physician.

HW
Health and Welfare

- The beneficiary has a caregiver available to provide needed services during the planned and unplanned absences of the aide. There is a back-up plan for when the usual caregiver is unavailable. This plan includes a person able to physically be with the beneficiary and make judgments as designated by the parent.

WHERE CAN THEY GET IT?

HW
Health and Welfare

The location of service is normally the beneficiary's home; however, if care is to be provided on a consistent basis in another location, such as another relative's home, the setting is assessed and approved by the case manager prior to the delivery of the service. Case managers do not need to assess schools, daycares licensed by the Division of Child Development (DCD), or church daycares with a letter of compliance from DCD.

CAP/C Personal Care services can not be approved exclusively for services in the school; there must be a need for care in the home as well.

Waiver funding may NOT be used to pay for any services, including nursing, that are provided in the public school.

HOW MUCH CAN THEY GET?

- The number of hours of nurse aide care authorized for a beneficiary is based on medical necessity, caregiver availability, and other available resources. The case manager assesses the child's care needs and caregiver availability.
- The standard method for determining amount of services is:

Work Time + Personal Time = Hours Approved

Work Time

actual hours worked
+ ½ to 1 hour lunch per day
+ ½ to 2 hours commute per day
X number of days per week worked
– number of hours other support available
work time per week
employment verification required
50 hours per week maximum

Personal Time

time for caregiver ADLs and IADLs =
20 hours per week maximum

Sleep Time

Sleep time is generally not medically necessary, and therefore not available, for beneficiaries at a nurse aide level of care. Sleep time may be granted when it meets EPSDT criteria.

The Case Manager verifies the caregiver's employment schedule. Verification consists of a written statement on employer letterhead, verifying that the caregiver is employed, and detailing the hours and schedule of employment. If this statement is difficult to obtain or obtaining it would create a hardship, there is a substitute form developed by DMA and located on the website with the other CAP/C forms at http://www.ncdhhs.gov/dma/services/capc.htm. The

form should only be used as a last resort. Please do not send anything that indicates salary information, a social security number, or other private information; we only need employment status and schedule.

CONT
Continuous

The approval of hours is based on the care needs of the beneficiary. All of the hours authorized are contingent upon interventions being provided for the child every 2–4 hours during that time or lasting for the duration of the shift. Hours are only authorized when there are medically necessary interventions taking place.

COMP
Complex

The approval of hours is based on the needs of the child and the caregiver's availability to meet those needs, not on the maximum hours allowed. For example, a caregiver may not need a full 20 hours per week for personal time.

FA
Financial Accountability

A working parent, according to the above formula, may need only 40 hours per week for work time; in that case, they will not be authorized for 50 hours per week. There is no entitlement of services up to the maximum allowed. The decision is based on medical necessity and availability of informal caregivers.

MN
Medically Necessary

The hours will be authorized on a weekly basis and may be scheduled at the caregiver's discretion as long as there are medically necessary interventions taking place (the interventions indicated on the service authorization task sheet). It is the shared responsibility of the family, case manager, and provider agency to ensure that hours are used appropriately.

Total formal support does not exceed 126 hours per week. These hours include those hours during which the beneficiary attends school or daycare (even if not paid by Medicaid) and those hours paid by private insurance or another payer source. A maximum of 70 of these hours may be provided by CAP/C.

Short-term-intensive care is used to approve extra hours that are needed due to

- A change in the beneficiary's condition resulting in additional or increased medical needs
- Caregiver crisis (illness or death in the family)
- Occasional, intermittent work obligations of the caregiver when no other caregiver is available

- For beneficiaries with an alternate plan for school days off, school sick days or adverse weather days, up to sixty hours per school year. Hours above the sixty hour limit are submitted on a plan of care revision as short-term-intensive services and approved by a DMA Nurse Consultant.

The cost of this care is managed within the annual monetary allocation for the service.

The CAP/C Nurse Consultant approves 24-hour care for a maximum period of two weeks. An additional two weeks may be granted to allow caregivers time to be trained or supports to be put into place so that the beneficiary/family does not need to rely on 24 hour formal support. No more than four weeks may be approved for any significant change in condition.

Supporting documentation may be requested by the DMA Consultant in order to approve any short-term-intensive hours.

MN
Medically Necessary

Unused hours of services are not "banked" or "carried over" to another week. Hours are approved for a per-week schedule based on unmet needs.

Once the hours for that week are used, there are no more available hours until the following week. If the family should need more hours, they may choose to use their respite hours to meet that need. If a family uses their hours unwisely such that there is a threat to the child's health, safety, or well-being (i.e., there are no hours left at the end of the week, and no caregivers available for the child), the Case Manager has the discretion to place the family on a daily schedule with the need for changes to be approved by the Case Manager. Repeated occurrences place the family at risk for termination of the service.

HW
Health and Welfare

For caregivers working at home, caregiver availability will be assessed on a case-by-case basis according to the caregiver's physical proximity to the child and the caregiver's flexibility in being able to address care needs during work hours or to arrange work hours around care needs.

CAP/C hours will not be authorized to cover caregiver's overtime hours in excess of the maximum allowed per program and budget limitations.

CAP/C hours will not be authorized to cover caregiver's on-call time. However, if the caregiver is actually called to work, the actual hours worked and commute time may be authorized in accordance with program and budget limitations.

Caregivers attending school in pursuit of a diploma or a degree for purposes of employment may count their school time as work time. Time will be calculated as follows: actual time spent in class per week plus 2 hours study time per credit hour per week, plus commute time if applicable, up to a maximum of 50 hours per week.

A maximum of 50 hours per week will be authorized for school or work or a combination of both. Exceptions to the maximum hours allowed will not be made based on co-occurrence of work and school, or on multiple jobs. If both are part-time, the total, up to 50 hours per week, will be allowed if otherwise eligible. If more than 50 hours per week are used, the parent will need to make other arrangements for the remaining time.

Additional assistance cannot be provided by CAP/C because of the presence of siblings in the home. The hours approved are based on the medical needs of the CAP/C beneficiary. If a parent desires more hours because of the demands of other siblings, then arrangements should be sought for the siblings.

WHO CAN PROVIDE IT?

QP
Qualified Providers

An agency providing this service must be licensed by the North Carolina Division of Health Services Regulation under 10A NCAC 13J as a home care agency and enrolled with N.C. Medicaid to provide in-home nurse aide services. If an agency is not enrolled as a CAP/C provider, they can not provide care to CAP/C clients. If an agency wishes to become a CAP/C provider, they should contact CSC at 866-844-1113.

Special care must be taken to avoid a conflict of interest when the case management agency is a home care agency. Generally, an agency may not

provide both case management and direct care to the same beneficiary. Exceptions can be made on a case-by-case basis when

- There is a lack of available providers such that the beneficiary would be unable to access services, or
- There is a written statement, signed by the beneficiary, attesting that the individual has been offered choice among all qualified providers and that he or she has freely chosen the same agency for both purposes, and
- There is an individual capable of and willing to advocate for the beneficiary, and that advocate can be present in planning meeting, and
- All of the normal administrative requirements for both services are met independently; i.e., there is one beneficiary file for the case management services, which meets all of the CAP/C case management criteria, and a second beneficiary file for nurse aide services which meets all of the home care criteria, and
- The advocate is informed verbally and in writing about how to make a complaint to the State or request assistance with concerns about choice, quality, and outcomes.

The aide providing direct care is trained, listed, and supervised as a Nurse Aide I with the Healthcare Personnel Registry at DHSR. The provider agency is responsible for verifying the aide's qualifications as follows:

- Check of Health Care Personnel Registry (10NCAC27G.0202) at hire and with each renewal date (every two years)
- Criminal background check in accordance with GS 131E-265. It is recommended that the nurse aide not begin providing services until the check has come back satisfactorily. It is further recommended that state criminal background checks be repeated every two years at time of registry renewal.

- Verification of CPR certification at hire and every two years coinciding with expiration dates. It is recommended that First Aid certification also be maintained and verified.
- Review of trainings and beneficiary-specific competencies upon hire at each job performance review as per agency policy.

The agency RN supervises the nurse aide in the beneficiary's home at least every three months, as specified in 10A NCAC 13J .1110. This supervisory visit is not billable. The licensed nurse maintains accountability and responsibility for the delivery of safe and competent care (NC Board of Nursing). Decisions regarding the delegation of any nurse aide tasks are made by the licensed nurse on a beneficiary-by-beneficiary basis according to the NC Board of Nursing's delegation criteria.

Services may not be reimbursed if provided by a member of the beneficiary's family, defined as

- The beneficiary's parent, stepparent, foster parent, custodial parent, or adoptive parent
- Anyone who has legal responsibility for the minor beneficiary
- Grandparents of the beneficiary
- Siblings of the beneficiary
- The spouse of an adult (18 and over) beneficiary, or
- Anyone who has legal responsibility for an adult (18 and over) beneficiary even if the family member meets the qualifications of a Nurse Aide I.

In addition, nurse aide services are not covered when the services are performed in the home of any paid.

FC
Free Choice

The beneficiary/family has the right to choose from among any enrolled Medicaid provider. The family should be given a list of providers to choose from. The list may include information regarding the agency such as geographic region served, private insurances accepted, or the availability of first-aid

certified aides. The case manager may not however, make a recommendation to the family.

WHAT DOCUMENTATION DO I NEED?

The decision for initial admission to CAP/C Personal Care Services and continuation at this level of service is made following a review of the

- FL-2
- CAP/C assessment and POC
- Nurse Aide flowsheets

as applicable. This decision is made by a CAP/C Nurse Consultant who evaluates the information to determine if the beneficiary meets the criteria specified above. The DMA Nurse Consultant sends a written notice in accordance with DMA's beneficiary notices to the parent if a service is denied, reduced, or suspended, or if the beneficiary is disenrolled from CAP/C.

FH
Fair Hearings

HOW IS IT BILLED?

CAP/C Personal Care Services are billed by the provider agency. The service is billed as code S5125 for regular services and G0156 TF for congregate services, in 15 minute units at the rate indicated on the current CAP/C fee schedule located at http://www.ncdhhs.gov/dma/fee/.

DMA will conduct post-payment reviews of billing claims until prior approval is done automatically in eCAP.

The case manager reviews a sample of nurse aide notes each quarter. The Case Manager will review these in part to make sure that services were provided only when there were actual interventions taking place (other review criteria are described in Chapters 42).

CHAPTER REVIEW

Key Points

1. CAP/C Personal Care Services are for children who require the scope of practice of a Nurse Aide I.
2. To receive CAP/C Personal Care Services, the care must be:
   - Complex – involve hands-on interventions; is not simply for observation in case something happens
   - Continuous –interventions must occur at least every 2-4 hours while the aide is there or last the duration of the aide's shift.
   - Substantial - requiring the scope of practice of a NA I; can not be delegated to a lower level of staff.
3. The aide may also perform home management tasks when they are for the beneficiary (rather than the beneficiary's family), are part of the plan of care, and personal care tasks have been completed.
4. Aides may not transport beneficiaries (they may accompany during transport if there are care needs).
5. The amount of services authorized is determined by a combination of personal time and work time according to the established criteria for each. Formal support may not exceed 126 hours per week. Hours are approved on a weekly basis and must be provided when there are medically-related care needs. No more than 4 weeks of 24 hour care may be given.

- Aide services may not be provided in public schools; only in private schools.

6. An agency providing case management services may not also provide nurse aide services to the same beneficiary. Exceptions may be approved by DMA.
7. Certain family members are prohibited from being the CAP/C beneficiary's paid nurse aide. Services may not be provided in the home of any paid caregiver.

8. The annual limit for CAP/C Personal Care Services per fiscal year is $60,000, which includes regular hours and short-term-intensive hours. If Personal Care Services were provided in combination with Pediatric Nurse Aide Services, the limit is $75,000.
9. The Case Manger reviews samples of notes/task sheets to make sure that services are provided according to the plan of care and service authorization.

Test Your Knowledge

Match the service with the level of staff:

1. _____ CAP/C Personal Care Services a. NA I+, NA II
2. _____ Pediatric Nurse Aide Services b. NA I
3. True or False: A child's grandparent can be her paid CAP/C Nurse Aide.

1. b, 2. a, 3. false

SECTION 3
CAP/C SERVICES AND SUPPLIES

CHAPTER 17
Respite Care and Short-Term-Intensive Services

WHAT IS RESPITE?

Respite care is care that is furnished on a short-term basis to beneficiaries unable to care for themselves because of the absence or need for relief of those persons who normally provide care for the beneficiary. Respite care is not available under EPSDT.

WHAT IS INCLUDED?

There are four types of respite care:

- In-home nurse aide respite
- In-home pediatric nurse aid respite
- In-home nurse respite
- Institutional respite

WHAT IS NOT INCLUDED?

Limitations of this service include:

- Respite services must be prior-approved.
- Respite services are not approved to provide oversight of additional minor children.
- Respite services are not approved to relieve other paid providers.
- The cost of room and board is not covered for in-home respite services.

- Respite services are not provided when they are the only waiver service besides case management. The beneficiary must use case management plus one other waiver service at least quarterly in order to receive respite services.

WHO CAN GET IT?

CAP/C beneficiaries who are receiving case management plus at least one other waiver service per quarter may receive respite care.

HOW MUCH CAN THEY GET?

The chart below shows the maximum number of hours that can be provided (actual hours provided may be fewer).

Hours of Formal Support Provided Each Week	Hours of Respite Available Each Fiscal Year (July 1–June 30)
0–30	720
31–60	540
61–90	360
91 or more	180

'Formal support' is paid support, regardless of the payer source or place of service. For example, daycare, school, CAP/C services, and services provided through private insurance are all considered formal support.

Each day of institutional respite counts as 24 hours toward the allotted total. The 'day' is defined by the particular facility's admission and discharge times.

When hours of formal support vary; for example, school year versus summer vacation, respite hours are determined by the amount of formal support provided for the majority of the year.

In-home respite hours are counted as the amount of time over the normal scheduled hours. For instance, if a family that normally receives 18 hours of care on Friday, asks for 24 hours of care that day, it is counted as six hours of respite.

Respite hours are assigned per household. Families with more than one CAP/C beneficiary in the home will be given respite hours according to the child with

the least amount of scheduled support per week. Those services will normally be provided as simultaneous care. Other situations may be approved on a case-by-case basis.

Once the yearly allotment of respite hours is used, there are no more available hours until the beginning of the next fiscal year (July through June). Additional respite hours cannot be approved. Short-term-intensive hours will not be approved for respite purposes.

Any hours not used at the end of the fiscal year are lost. Hours may not be carried over into the next year.

Please note that there is a program limit of two weeks of 24 hour per day in-home care at a time.

Within the above parameters, respite care can be used entirely at the family's discretion. It may be used as needed, or it may be used on a scheduled basis. It can be used as many hours one month and none the next month. It may be used in place of short-term-intensive hours that do not get approved, or in place of a regular increase in hours that did not get approved. However, families should not be made to use respite for a non-leisure need in lieu of applying for short-term-intensive hours.

The cost of respite services does not count against the annual fiscal limit for nurse or nurse aide services.

QP
Qualified Providers

WHO CAN PROVIDE IT?

A Medicaid-certified nursing facility or a hospital with swing beds provides institutional respite. The facility or hospital is licensed under 10A NCAC 13 and certified by DHSR.

In-home respite is subject to the same provider qualifications listed in Chapter 14 for In-Home Nursing, Chapter 15 for CAP/C Pediatric Nurse Aide care, and Chapter 16 for CAP/C Personal Care.

FC
Free Choice

The beneficiary/family has the right to choose from among any enrolled Medicaid provider. The family should be given a list of providers to choose from.

The list may include information regarding the agency such as geographic region served, private insurances accepted, or the availability of first-aid certified aides. The case manager may not however, make a recommendation to the family.

Multiple agencies can be used if needed. However, if multiple agencies are used, each should provide care regularly enough that they are knowledgeable regarding the child's needs.

HW Health and Welfare

If the caregivers are going to be unavailable (such as out of town), there must be a back-up caregiver available that can assume care of the child in the event of a staffing problem or emergency.

WHAT DOCUMENTATION DO I NEED?

The Case Manager will need to send a service authorization to the provider agency detailing the type and amount of respite to be used. This form is available at http://www.dhhs.state.nc.us/dma/services/capc.htm and is titled CAP/C Respite Service Authorization Notice. Service authorizations are also generated in eCAP when a plan of care is approved and acknowledged.

It is the joint responsibility of the family, the Case Manager, and the provider agency to track the family's respite use. There is a worksheet available on the back of the Respite Service Authorization that can assist. The use of this worksheet for tracking respite hours is optional; however, the actual tracking of respite hours is not.

HOW IS IT BILLED?

Respite hours are billed by the provider agency according to the codes and unit limits on the CAP/C fee schedule located at http://www.ncdhhs.gov/dma/fee/.

Congregate respite care is not available. In such case, the cost of respite provide by one staff member may be divided equally among the beneficiaries. Documentation will be according to agency standards.

Foster care services are not billed during the period that respite is furnished for the relief of the foster care provider.

Therapy services provided during institutionalization are included in the per day cost of the respite.

WHAT IS THE DIFFERENCE BETWEEN RESPTE AND SHORT-TERM-INTENSIVE SERVICES?

	Respite	Short-Term-Intensive
Definition	Extra hours provided so that caregivers can have some leisure time away from their care giving responsibilities.	Extra hours provided because of an acute increase in medical need or because of lack of caregiver availability during family emergencies, work obligations, or school holidays – anything that is not leisure.
Example	The caregiver(s) want to go to a movie, or take a weekend vacation.	The child has a respiratory infection and is requiring more suctioning at night, or the caregiver is absent due to a business trip, due to his/her own illness, or due to a family emergency. There must be care needs occurring during the time the short-term-intensive hours are requested.
Approval	An allotment of hours may be approved once by DMA and then used as needed throughout the fiscal year.	Each occurrence must be approved by DMA. Except in the case of a truly unpredictable emergency, it must be prior-approved. Documentation, such as a physician's note in the case of caregiver illness, may be requested by the Consultant.
Limit	There is a limit to the number of hours that can be provided. Yearly hours are prorated if the beneficiary will not be in the program the full year. 24 hour care will be given only for a two week duration. The cost does not count toward the annual limit for nurse or nurse aide services.	There is no numeric limit to the number of hours that may be used or to the number of occurrences; it is based on medical necessity and/or caregiver availability. 24 hour care will be given only for a two-week duration. In the event that the need for 24 hour care continues, at the discretion of the DMA Nurse Consultant, a second two-week period may be approved in order to give the family and Case Manager time to make alternate arrangements. After the second period, no additional 24 hour care will be provided. The cost of STI services counts toward the annual budget limit for nurse or nurse aide services.

CHAPTER REVIEW

Key Points

1. Respite care is intended to provide informal caregivers an opportunity for leisure time and relief from the stress of caregiving.
2. Respite care can be provided in the beneficiary's home or in a nursing facility or hospital.
3. The amount of respite approved depends upon the amount of formal support the beneficiary already receives.
4. Respite hours are approved for use during a fiscal year. If all hours are used prior to the end of that year, there are no more available until the next fiscal year. If there are unused hours at the end of that year, they are lost – they do not roll over into the next year.
5. Case Managers are required to track each beneficiary's respite use to ensure that they stay within their approved limit.
6. Respite is different from short-term-intensive in that short-term-intensive is for non-leisure activities, must be approved at each occurrence, and has no maximum number of hours.

Test Your Knowledge

1. A beneficiary who gets 20 hours per week of Pediatric Personal Care and has no other formal support in place would be entitled to how much respite per waiver year?
    a. 720 hours
    b. 540 hours
    c. 360 hours
    d. 180 hours
2. When a child needs extra care because of an acute illness, that care should be provided as:
    a. respite services
    b. short-term-intensive services
3. 24 hour per day respite will be approved for a maximum of _____ when there is a responsible back-up caregiver available.
    a. three days
    b. one week
    c. two weeks
    d. there is no maximum as long as they don't exceed their maximum number of respite hours for the year
4. All respite hours must be used by _____ (date) and a new allotment of hours begins on _____ (date).

1. a, 2. b, 3. c, 4. June 30, July 1

SECTION 3
CAP/C SERVICES AND SUPPLIES

CHAPTER 18
Waiver Supplies

WHAT ARE WAIVER SUPPLIES?

Waiver supplies, also called specialized medical equipment and supplies, are, as defined by CMS:

- Devices, controls, or appliances specified in the plan of care that enable beneficiaries to increase their ability to perform activities of daily living;
- Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
- Other durable and non-durable medical equipment not available under the State plan that is necessary to address beneficiary functional limitations; and
- Necessary medical supplies not available under the state plan or under EPSDT.

These supplies are not part of the State Plan and are not available under EPSDT.

WHAT IS INCLUDED?

The following specific waiver supplies are included in this CAP/C service.

- Reusable incontinence undergarments
- Disposable liners for the reusable undergarments

- Adaptive tricycles when prescribed by a physical or occupational therapist and used for the development of gross motor skills, range of motion, improved endurance, improved circulation, trunk stabilization and balance, or as an adjunct to gait training, and when it is not a tricycle that would normally be used by non-disabled children.

This service also includes

- The performance of assessments by an appropriate professional to identify the type of equipment needed by the beneficiary,
- Training the beneficiary or caregiver in the operation or maintenance of the equipment or use of the supply, and
- Repair of equipment as long as the cost of the repair does not exceed the cost of purchasing a new piece of equipment.

WHAT IS *NOT* INCLUDED?

- Other items which meet the definition of waiver supplies as described in "What are Waiver Supplies?" section above, but are not listed under "What Is Included?" are not covered.
- Items for which there is not a physician's signature certifying medical necessity for the supply are not covered.
- Waiver supplies must be prior-approved.
- Equipment or supplies purchased for exclusive use at school or home school are not covered. (Garments and liners may be sent from home to school with the child for use during the school day.)
- The waiver is the payer of last resort for items that are covered through Durable Medical Equipment (DME), Home Health supplies, and EPSDT. All items covered through the respective programs must be requested through the respective programs. The waiver does not cover items that could be covered by one of these programs but were denied for the particular beneficiary for lack of

FA
Financial Accountability

medical necessity. (Medicaid does not currently cover this supply under any of these programs; however, if Medicaid did for example start supplying these under Home Health, you would be expected to obtain them through Home Health.)

- Replacement of equipment that has not been properly used, has been lost, or has been purposely damaged is not covered.
- Service agreements, maintenance contracts, and extended warranties are not covered.
- Reusable incontinence undergarments and disposable liners may not be the only waiver service besides case management.

WHO CAN GET IT?

MN
Medically Necessary

The beneficiary may receive reusable incontinence garments and the disposable liners for them when the beneficiary is age 3 years or older and the incontinence is due to a medical issue.

Eligible beneficiaries may receive waiver supplies when all of the criteria are met and proper procedures have been followed.

HOW MUCH OF IT CAN THEY GET?

No more than $500 per waiver year may be spent on reusable undergarments.

No more than $1000 per waiver year may be spent on disposable liners.

No more than $600 per waiver year may be spent on an adaptive tricycle.

As always, Medicaid is the payer of last resort. Medicaid will allow payment up to these maximums, inclusive of third-party and Medicaid funds.

It is the responsibility of the case manager to track the cost of the supplies to avoid exceeding the limit.

Approval of waiver supplies is based upon medical need; there is no entitlement of services up to the program limit.

QP
Qualified Providers

WHO CAN PROVIDE IT?

Waiver Supplies are provided by a Durable Medical Equipment company that has enrolled with Medicaid to provide CAP waiver supplies, or directly by the case management provider.

The DME provider receives a Service Authorization from the Case Manager and bills directly for the item. The DME provider must have a CAP/C provider number. If an agency wishes to become a CAP/C provider, they should contact the EVC Call Center at 866-844-1113. The beneficiary has the right to choose a particular DME provider from among those enrolled.

The Case Manager must meet the qualifications listed in Chapters 11 and 13. In the case of incontinence supplies, if the Case Manager is not an RN, the need for the supplies must be based upon an RN assessment.

A licensed physical or occupational therapist assesses the patient and recommends the adaptive tricycle and its particular features.

A licensed physician orders or cosigns for all waiver supplies.

FC
Free Choice

The beneficiary/family has the right to choose from among Medicaid-enrolled DME/CAP providers, or from other providers if the case manager will be providing the supply. The family should be given a list of providers from which to choose. The list may include information regarding the agency such as geographic region served or types of private insurance accepted. The case manager may not however, make a recommendation to the family.

WHAT DOCUMENTATION DO I NEED?

There must be a physician's order certifying medical necessity for the item. The order should be kept in the case manager's files; it needs to be submitted to your Nurse Consultant only if requested. Except for the adaptive tricycle, the order must be renewed annually. An order for reusable incontinence supplies should include the type and amount of the incontinence supplies to be provided. For amount, a range is acceptable. The signed FL-2 or CMS-485 is acceptable documentation of the physician's order as long as it contains all of the above components.

The CAP/C assessment should document the need for the supply.

SP
Service Plans

The CAP/C Plan of Care should include outcomes and goals related to the use of the supplies, including training needs associated with the beneficiary's/family's use of the requested supply.

HOW IS IT BILLED?

The provider bills Medicaid for the items using codes T2029 for adaptive tricycles, T4539 for reusable undergarments, and T4535 for liners according to the unit rates on the CAP/C fee schedule located at http://www.ncdhhs.gov/dma/fee/.

MORE INFORMATION

Please refer to the Basic Medicaid Billing Guide for additional information. It can be located at http://www.ncdhhs.gov/dma/basicmed/index.htm.

CHAPTER REVIEW

Key Points

1. Reusable diapers and disposable liners for those diapers may be approved for children age three and over who are incontinent due to a medical issue. There must be a physician's order, and the CAP/C assessment should support the need for the item. The item should be part of the plan of care with goals and outcomes related to use of the item. A beneficiary may spend up to $500 per fiscal year on reusable undergarments and up to $1000 per fiscal year on disposable liners. These items may not be the only waiver service besides case management.
2. Adaptive tricycles may be provided when used to achieve specific physical or occupational therapy goals. The physician orders the item based upon the PT's or OT's recommendations. The CAP/C assessment should support the need for the item. The item should be part of the plan of care with goals and outcomes related to use of the item. A beneficiary may spend up to $600 per fiscal year on an adaptive tricycle.
3. These items may be provided by
   - A DME company that has enrolled with Medicaid as a provider of CAP waiver supplies, based upon a service authorization provided by the Case Manager. The DME company bills for the item, or
   - The case management provider agency, based on RN assessment. The case management provider bills for the item.

Test Your Knowledge

1. Incontinence supplies may be provided to children aged ____ and older.
2. True or False: disposable diapers are a waiver supply.
3. Up to $_____ per fiscal year may be spent on reusable incontinence undergarments.
4. Up to $_____ per fiscal year may be spent on an adaptive tricycle.
5. Waiver supplies are obtained through
   a. DME agencies
   b. Home Health agencies
   c. Case Management agencies
   d. a and c

1. 3 years, 2. False, 3. 500, 4. 600, 5. d

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SECTION 3
CAP/C SERVICES AND SUPPLIES

CHAPTER 19
Home Modifications

WHAT ARE HOME MODIFICATIONS?

Home modifications include equipment and physical adaptations to the beneficiary's home that are required by his/her needs for health, safety, and welfare, and are contained in the approved plan of care. They are intended to give the beneficiary mobility, safety, and independence in the home, thus avoiding institutionalization. These services are not part of the State Plan and are not available under EPSDT.

WHAT IS INCLUDED?

The following specific home modifications are included in this CAP/C service:

- Wheelchair ramps, stationary or portable
- Threshhold ramps, used to allow wheelchairs to move over small rises such as doorways or raised landings
- Grab bars or safety rails mounted to wall
- Modification of bathroom facilities to improve accessibility for a disabled individual, including : roll in shower, sink modifications, water faucet controls, tub modifications (excluding handheld showers which are covered by EPSDT), toilet modifications, floor urinal adaptations, and plumbing modifications

- Widening of doorways for wheelchair access, turnaround space modifications for wheelchair access
- Bedroom modifications other than doorway widening to accommodate hospital beds and wheelchairs
- Lifts, elevators, manual, hydraulic, or other electronic lifts, including portable lifts or lift systems that are used inside a beneficiary's home.
- Porch stair lifts
- Floor coverings for ease of ambulation when existing floor coverings are in disrepair and pose increased risk to a beneficiary with documented fall risk, or when those floor coverings are contributing to asthma exacerbations requiring repeated emergency room or hospital treatment
- Portable or whole house air filtration system and filters under the following circumstances:

    1. For beneficiaries with severe allergies or asthma, when all other preventive measures such as removal of the allergen or irritant, removal of carpeting and drapes have been attempted, and the beneficiary's asthma remains classified as moderate persistent or severe persistent, and a physician has certified that air filtration will be of benefit. Ozone generators and electronic or electrostatic or other air filters which produce ozone or ≤50 parts per billion ozone byproduct will not be covered.
    2. For beneficiaries susceptible to infection, when adequate infection control measures are already in place yet the beneficiary continues to acquire airborne infections, and when a physician has certified that air filtration will be of

benefit in preventing infection, a germicidal air filter (with UV light) may be provided.

3. The smallest unit that will meet the beneficiary's needs is covered; i.e., if a beneficiary spends most of his or her time confined to a specific area of the house, then a whole-house system will not be approved.

- Back-up generator for ventilators, when the beneficiary uses the ventilator more than eight hours per day and in the event of a power outage~~,~~ would require the beneficiary to be hospitalized if not for the presence of the generator.

This is an exhaustive list.

This service also includes

- Technical assistance in device selection,
- Training in device use by a qualified assistive technology professional,
- Purchase, including necessary permits and inspections, taxes, and delivery charges,
- Installation,
- Assessment of the modification by the case manager and by any applicable inspectors to verify safety and ability to meet beneficiary's needs, and
- Repair of equipment, as long as the cost of the repair does not exceed the cost of purchasing a new piece of equipment, and only when not covered by warranty. The waiver beneficiary or his or her family shall own any equipment that is repaired.

WHAT IS *NOT* INCLUDED?

Limitations of this service include

- Other items which may be home modifications but which are not contained in the above list.

- Service agreements, maintenance contracts, and extended warranties are not covered.
- Roof repair, central air conditioning, swimming pools, hot-tubs, and locks are not covered.
- The service is limited to those modifications needed to adapt the individual's home environment to his/her specific disabilities, and does not include items that have general utility to non-disabled individuals.
- This service is available only to modify an existing home. It is not available for new construction.
- Home modifications that add to the total square footage of the home are excluded.
- Home modifications must be prior-approved.
- Modifications for the exclusive use in a home school are not covered.
- Home modifications may be provided only in the following settings:
    - A dwelling where the beneficiary resides and that is owned by the beneficiary's family (natural, adoptive, or foster)
    - A rented residence, when the modifications are allowed by the owner.
- Waiver funding will not be used to replace equipment that has not been properly used, has been lost, or has been purposely damaged.
- This service is not to be used for major home renovations and repairs.
- The waiver is the payer of last resort for items that are covered through the Durable Medical Equipment (DME), Orthotics and

Prosthetics, Home Health supplies, or EPSDT. All items covered by these programs must be requested through the respective programs. The waiver does not cover items that could be covered under one of these programs but were denied for the particular beneficiary for lack of medical necessity.

WHO CAN GET IT?

Eligible beneficiaries may receive home modifications when all of the criteria are met and proper procedures have been followed.

FA
Financial Accountability

HOW MUCH CAN THEY GET?

The total cost of home modifications may not exceed $10,000 over the life of the waiver. It is the responsibility of the Case Manager to track the cost of home modifications billed and paid in order to avoid exceeding the limit. Beneficiaries not in the waiver for the full five years will receive this benefit prorated to $2000 for each year of participation, the total amount to be used over the duration of participation.

A beneficiary who enters the waiver between	May receive _____ to use prior to June 30, 2015
prior to June 30, 2011	$10,000
July 1, 2011 and June 30, 2012	$8000
July 1, 2012 and June 30, 2013	$6000
July 1, 2013 and June 30, 2014	$4000
July 1, 2014 and June 30, 2015	$2000

Funding for home modifications is assigned on a per-home and per beneficiary basis. In other words, if there are two CAP/C beneficiaries residing in the home, that family does not receive $20,000 – there is one home to be modified, so there is one allotment of funds. If one

beneficiary resides in two homes, the $10,000 limit also stands, although the funds may be used for either home.

A beneficiary who leaves and then re-enters CAP/C within the same waiver period will not receive additional funds upon re-entering. For example, a beneficiary was receiving CAP/C prior to June 30, 2011, and so was eligible to receive $10,000 in home modifications. The beneficiary spent all of this money and then withdrew from the CAP/C program. In August 2012 he reapplied and was approved for CAP/C. This beneficiary would not get $6,000 at this time; he would get no money until the next waiver period because he had already spent his allotment for this waiver period.

Approval for home modifications is based upon medical need; there is no entitlement of services up to the program limit.

Beneficiaries receiving Home (and/or Vehicle) Modifications as their only waiver service besides case management will be approved for CAP/C participation for 90 days, as most modifications can be completed within that time, and the requirement is for use of the waiver service at least every 90 calendar days. At the end of the 90 days, CAP/C participation may be voluntarily withdrawn, the beneficiary may be involuntarily disenrolled from CAP/C, or a plan of care revision may be submitted if the beneficiary requires a new service. If the plan of care revision is approved, CAP/C participation may be extended for up to the remainder of the CNR year.

QP
Qualified Providers

WHO CAN PROVIDE IT?

Approval for home modifications is based on an assessment by a physical therapist (PT), occupational therapist (OT), or Rehabilitation Engineer and accompanying MD certification of medical necessity, with the exception of generators, air filters, and floor coverings, which are based on RN assessment and MD certification (written order).

The Home Modifications are provided through a CAP/C case management agency.

The Case Manager arranges to obtain the modification from an appropriate vendor; for example, a licensed contractor. The items must be provided by individuals capable of constructing and installing the needed apparatus, with any construction/installation completed in accordance with state and local building codes.

FC
Free Choice

The beneficiary has the right to choose the vendor.

WHAT DOCUMENTATION DO I NEED?

A physician's signature certifying medical necessity for the modification is required. The physician may sign a statement on the assessment or recommendation, certifying that the requested adaptation is medically necessary or may sign a separate document. This document should be kept in the case manager's files; it needs to be submitted to your Nurse Consultant only if requested.

The CAP/C assessment should document the need for the modification.

The CAP/C assessment needs to be completed in full, even if Home (and/or Vehicle) Modifications is the only service requested.

SP
Service Plans

The CAP/C Plan of Care should include outcomes and goals related to the modification, including training needs associated with the beneficiary's/family's use of it. The plan of care, with three itemized quotes for the modifications, must be submitted to DMA for approval prior to the work being started. For modifications involving equipment for which there is a Manufacturer's Suggested Retail Price (MSRP) (for example, a portable ramp), documentation of the MSRP may be submitted in lieu of quotes. If the modification is on a rented residence, a statement signed by the owner allowing the modification is also needed.

The Case Manger should keep copies of all bids and invoices.

FA
Financial Accountability

HOW IS IT BILLED?

The CAP/C waiver utilizes a bid or competitive invoice process to ensure the most efficient use of Medicaid funds.

Three quotes or a manufacturer's suggested retail price are required. The amount of funding approved will be based on the lowest quoted price, which the beneficiary may then use for the qualified provider of their choice. The case manager determines if the beneficiary's home modification budget can accommodate the cost of the modification(s). The Case Manager uses all potential funding sources, not just Medicaid, to cover the cost.

The case management agency bills Medicaid for these items. The service is billed using code S5165. The case management works out a payment agreement with the vendor. Either the vendor must wait for Medicaid to reimburse the case management agency and the case management agency in turn reimburse the vendor, or the case management agency may pay the vendor and then reimburse itself.

HW
Health and Welfare

Once the item is installed, the Case Manager needs to assess the modification (to the best of his/her ability) for safety and effectiveness. When the beneficiary and Case Manager are satisfied with the modification, the item is then billed by the Case Management Agency using the code S5165 according to the CAP/C fee schedule.

MORE INFORMATION

Please refer to the Basic Medicaid Billing Guide for additional information. It can be located at http://www.ncdhhs.gov/dma/basicmed/index.htm.

CHAPTER REVIEW

Key Points

1. Only those home modifications listed under "What Is Included?" are covered by CAP/C. Other items which are home modifications but are not included in this list are not covered.
2. Home modifications must be ordered by the physician.
3. The CAP/C assessment must support the need for the home modification.
4. The CAP/C Plan of Care must contain goals and outcomes related to the use of and training about the modification.
5. The cost of home modifications is limited to $2,000 per year of participation in the current waiver cycle, up to a max of $10,000. All money must be used during the current waiver cycle which ends June 30, 2015.
6. Home modifications are billed by the case management agency. A bid or competitive invoice process is used.

Test Your Knowledge

1. Which of he following is not a covered home modification?
   a. wheelchair ramp
   b. stair lift
   c. central air conditioning
   d. generator
2. A beneficiary participating in the waiver for the entire waiver period may receive up to $_____ to spend on home modifications until the end of the waiver period.
3. Home modifications are billed by:
   a. the case management agency
   b. the contractor or supplier
4. If a home is rented, modifications may only be made if:
   a. _____
   b. _____

1. c, 2. 10000, 3. a, 4. the landlord gives permission, the modifications are portable

SECTION 3
CAP/C SERVICES AND SUPPLIES

CHAPTER 20
Motor Vehicle Modifications

WHAT ARE MOTOR VEHICLE MODIFICATIONS?

Motor vehicle modifications are adaptations or alterations to a motor vehicle such as an automobile or van that is the waiver beneficiary's primary means of transportation in order to accommodate the special needs of the beneficiary. Vehicle adaptations are specified by the service plan as necessary to enable the beneficiary to integrate more fully into the community and to ensure the health, safety, and well-being of the beneficiary.

WHAT IS INCLUDED?

The specific vehicle adaptations which are covered include

- Door handle modifications
- Door modifications
- Electric door openers
- Installation of raised roof or related alterations to existing raised roof system to improve head clearance
- Lifting devices or ramps
- Devices for securing wheelchairs or scooters inside the vehicle, including the portion of the device that is attached to the wheelchair (i.e., an EZ Lock system).
- Devices for securing oxygen tanks.
- Devices for transporting mobility devices such as Rooftop Wheelchair Carriers, Trailers, and Trunk Lifts.

- Adapted steering, acceleration, signaling, and breaking devices only when recommended by a physician and a certified driving evaluator for people with disabilities, and when training in the installed device is provided by certified personnel
  - Handrails and grab bars
  - Seating modifications
  - Lowering of the floor of the vehicle
  - Safety and security modifications including additional mirrors and pedal guards
  - Adaptive car seats or vehicular transport vests for beneficiaries weighing over 30 pounds or with a seat to crown height that is longer than the back height of the largest safety car seat if the beneficiary weighs less than the upper weight limit of the current car seat, who are unable to be transported safely with a seat belt or standard child car safety seat.

This is an exhaustive list.

This service also includes

- Installation,
- Repair, as long as the repair does not exceed the cost of purchasing a new piece of equipment, and the beneficiary or family own the equipment being repaired, and
- Training in care and use.

WHAT IS *NOT* INCLUDED?

Limitations of this service include:

- Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the beneficiary are excluded.
- The waiver is the payer of last resort for items that are covered through the Durable Medical (DME), Orthotics and Prosthetics, and Home Health Supply

FA
Financial Accountability

Programs and EPSDT prior to requesting from the Waiver. All items covered through the respective programs must be requested through the respective programs. The waiver does not cover items that would be covered by these programs, but were denied for a particular beneficiary because of lack of medical necessity.

- The vehicle that is adapted must belong to the individual, to a family member with whom the individual lives or has consistent and on-going contact, or non-relative who provides primary long-term support to the individual and is not a paid provider of such services.
- Payment may not be made to adapt the vehicles that are owned or leased by paid providers of waiver services.
- This service does not include the purchase or lease of the vehicle itself.
- Vehicle modifications must be prior-approved.
- Vehicle Modifications may in some cases be used to pay for a modification on a pre-modified vehicle. These modification requests are reviewed as follows:
    - The asking price of the vehicle is compared to the Kelly Blue Book (http://www.kbb.com) value for that vehicle. The difference between the two is the asking price for the modifications.
    - The average cost of the modifications as determined by the Division of Vocational Rehabilitation is used as a starting point and then 10% depreciation per year for each year since the modification was new is subtracted.
    - The lower value of these two is approved.
- Items not covered include: the cost of renting a vehicle with adaptations; service and maintenance contracts and extended warranties; and adaptations purchased for exclusive use at the school/home school.
- Regularly scheduled upkeep and maintenance of a vehicle is excluded.

- Waiver funding will not be approved to replace a vehicle adaptation if the beneficiary/family fails to keep their automobile insurance policy current when the repair would have been covered by the insurance.
- All items shall meet applicable standards of manufacture, design, and installation.
- Vehicle modifications must be provided and installed in accordance with the manufacturer's installation instructions, and national Mobility Equipment Dealer's Association, Society of Automotive Engineers, and National Highway and Traffic Safety Administration guidelines.
- Only the modifications related to the child's disability will be approved. For instance, adapted brakes will not be approved for a child who will not be able to drive or for whom the vehicle and modification will not last until driving age.
- Medicaid will not pay for modifications on a used vehicle if Medicaid was the original payer for those modifications.

HW
Health and Welfare

WHO CAN GET IT?

Eligible beneficiaries may receive motor vehicle modifications when all of the criteria are met and proper procedures have been followed.

FA
Financial Accountability

HOW MUCH OF IT CAN THEY GET?

The total cost of vehicle modifications may not exceed $15,000 over the life of the waiver. It is the responsibility of the Case Manager to track the cost of vehicle modifications billed and paid in order to avoid exceeding the limit. Beneficiaries not in the waiver for the full five years will receive this benefit prorated to $3000 for each year of participation, the total amount to be used over the duration of participation.

A beneficiary who enters the waiver between	may receive _____ to use prior to June 30, 2015
prior to June 30, 2011	$15,000
July 1, 2011 and June 30, 2012	$12,000
July 1, 2012 and June 30, 2013	$9000
July 1, 2013 and June 30, 2014	$6000
July 1, 2014 and June 30, 2015	$3000

A beneficiary who leaves and then re-enters CAP/C within the same waiver period will not receive additional funds upon re-entering. For example, a beneficiary was receiving CAP/C prior to June 30, 20111, and so was eligible to receive $15,000 in home modifications. The beneficiary spent all of this money and then withdrew from the CAP/C program. In August 2012 he reapplied and was approved for CAP/C. This beneficiary would not get $9000 at this time; he would get no money until the next waiver period because he had already spent his allotment for this waiver period.

MN
Medically Necessary

Approval for vehicle modifications is based upon medical need; there is no entitlement of services up to the program limit.

Beneficiaries receiving Vehicle (and/or Home) Modifications as their only waiver service besides case management will be approved for CAP/C participation for 90 days, as most modifications can be completed within that time, and the requirement is for use of the waiver service at least every 90 calendar days. At the end of the 90 days, CAP/C participation may be voluntarily withdrawn, the beneficiary may be involuntarily disenrolled from CAP/C, or a plan of care revision may be submitted if the beneficiary requires a new service. If the plan of care revision is approved, CAP/C participation may be extended for up to the remainder of the CNR year.

QP
Qualified Providers

WHO CAN PROVIDE IT?

Recommended equipment or modification shall be justified by an assessment by a Physical Therapist, or Occupational Therapist specializing in vehicle modifications, or a Rehabilitation Engineer or Vehicle Adaptation Specialist, and accompanied by a physician's signature certifying medical necessity for the person. Adaptive car seats require assessment by a Physical or Occupational Therapist and accompanying physician signature.

The case management provider arranges for the Motor Vehicle Modifications to be made.

All vehicles are evaluated by an adapted vehicle supplier with an emphasis on the safety and "life expectancy" of the vehicle in relationship to the modifications.

FC
Free Choice

The beneficiary has the right to choose the provider.

WHAT DOCUMENTATION DO I NEED?

A physician's signature certifying medical necessity is required. The physician may sign a statement on the assessment or recommendation, certifying that the requested adaptation is medically necessary or may sign a separate document.

The CAP/C assessment should document the need for the modification.

The CAP/C assessment needs to be completed in full, even if Vehicle (and/or Home) Modifications is the only service requested.

The assessment by the adapted vehicle supplier should contain information regarding the rationale for selected modification, condition of the vehicle to be modified, insurance on the vehicle to be modified, and training plan for the use of the prescribed modification.

The CAP/C Plan of Care should include outcomes and goals related to the modification, including training needs associated with the beneficiary's/family's use of it. The plan of care should be submitted, with the three itemized quotes for the modifications, to DMA for approval prior to the work being started. For modifications involving equipment for which there is a Manufacturer's

SP
Service Plans

Suggested Retail Price (MSRP) (for example, an adaptive car seat), documentation of the MSRP may be submitted in lieu of quotes.

The Case Manger should keep copies of all bids and invoices. The completed Request for Vehicle Modification Form (see below) must also be submitted. The form can be found at http://www.ncdhhs.gov/dma/services/capc.htm.

In addition, for pre-modified vehicles, submit the asking price of the vehicle and modification and the age of the modification.

North Carolina Division of Medical Assistance
REQUEST FOR VEHICLE MODIFICATION

Vehicle to be Modified	Modification For
Make:	Beneficiary Name:
Model:	MID Number:
VIN#:	Program: ☐ CAP/C ☐ CAP-IDD

Case Manager

Name: Agency: Phone: Fax: E-mail:

I hereby request assistance for a modification to the above vehicle to improve accessibility for the above-named beneficiary with a disability. I have received, read, and understand the "DMA Clinical Policy for Vehicle Modifications" distributed by the Case Manager assigned to my case.
I understand that this vehicle has features that impede its use by a person with a disability. Modifications will include:

I have reviewed the plans and specifications prepared by the vehicle modification specialist, approve them, and agree that the North Carolina Division of Medical Assistance may have the modifications completed in accordance with these plans. I understand that there shall be no deviation from these plans without prior consultation with and written approval from the Division of Medical Assistance.

I agree that these modifications represent a permanent structural change to the vehicle and that the North Carolina Division of Medical Assistance will not be responsible for removing the planned modifications from the vehicle or for restoring the property to its original condition.

I understand that the Division of Medical Assistance may at its discretion, remove certain Agency-purchased, free-standing equipment when it is no longer needed by the individual with a disability.

I agree to fully indemnify the North Carolina Division of Medical Assistance should I incur any loss, damage, or hurt as a result of this modification.

I understand that for vehicle modifications, I am required to submit a certificate of insurance showing collision and comprehensive coverage for the vehicle and if applicable the vehicle conversion and adaptive equipment being provided. Without this certificate of insurance at or prior to vehicle delivery, the North Carolina Division of Medical Assistance will not authorize the dealer to release the modified vehicle. The Division considers insurance to be a comparable benefit in sponsoring repairs or replacements.

Signature of person whose name is on the vehicle registration	Signature of beneficiary or legal representative, if different
Date	Date
Signature of Witness	Signature of Witness

FA
Financial
ccountability

HOW IS IT BILLED?

The CAP/C waiver utilizes a bid or competitive invoice process to ensure the most efficient use of Medicaid funds.

Three quotes or a manufacturer's suggested retail price are required. The amount of funding approved will be based on the lowest quoted price, which the beneficiary may then use for the qualified provider of their choice The case manager determines if the beneficiary's motor vehicle modification budget can accommodate the cost of the modification(s). The Case Manager uses all potential funding sources, not just Medicaid to cover the cost.

The case management agency bills Medicaid for these items. The service is billed using code T2039. The case management works out a payment agreement with the vendor. Either the vendor must wait for Medicaid to reimburse the case management agency and the case management agency in turn reimburses the vendor, or the case management agency may pay the vendor and then reimburse itself.

HW
Health
and
Welfare

Once the item is installed, the Case Manager needs to assess the modification (to the best of his/her ability) for safety and effectiveness. When the beneficiary and Case Manager are satisfied with the modification, the item is then billed by the Case Management Agency using code T2039.

ⓘ
MORE
INFORMATION

Please refer to the Basic Medicaid Billing Guide for additional information. It can be located at http://www.ncdhhs.gov/dma/basicmed/index.htm.

CHAPTER REVIEW

Key Points

1. Only those vehicle modifications listed under "What Is Included?" are covered by CAP/C. Other items which are vehicle modifications but are not included in this list are not covered.
2. Adaptive car seats are included in vehicle modifications.
3. Vehicle modifications must be ordered by the physician.
4. The CAP/C assessment must support the need for the vehicle modifications.
5. The CAP/C Plan of Care must contain goals and outcomes related to the use of and training about the modification.
6. The cost of vehicle modifications is limited to $3000 per year of participation in the current waiver cycle, up to a max of $15000. All money must be used during the current waiver cycle which ends June 30, 2015.
7. Vehicle modifications are billed by the case management agency. A bid or competitive invoice process is used.

Test Your Knowledge

1. A beneficiary participating in the waiver for the entire waiver period will receive up to $_____ to spend on vehicle modifications until the end of the waiver period.
2. Vehicle modifications are billed by:
   a. the case management agency
   b. the vehicle adaptation supplier
3. True or False: Adaptive care seats are included in vehicle modifications.
4. True or False: Case Managers do not need to keep bids and invoices.

1, $15000, 2. a, 3. True, 4. False

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SECTION 3
CAP/C SERVICES AND SUPPLIES

CHAPTER 21
Community Transition Funding

WHAT ARE COMMUNITY TRANSITION SERVICES?

Community Transition Funding is a non-recurring set-up expense for individuals who are transitioning from an institution to a living arrangement in a private residence. It is available when needed to supplement the prorated cost of home modifications and vehicle adaptations to which the beneficiary would otherwise be entitled. Allowable expenses include necessary home accessibility modifications and vehicle adaptations according to the definition of home modifications and vehicle adaptations.

Community transition funding is not available under EPSDT.

WHAT IS INCLUDED?

Everything included for home modifications and vehicle adaptations apply.

WHAT IS *NOT* INCLUDED?

- Community transition services must be prior-approved.
- This service is available only as a one time expense to facilitate transition from an institutional setting to a private residence. This service is not available to beneficiaries who change their place of residence.

- All limitations for home modifications and for vehicle modifications apply.

WHO CAN GET IT?

Eligible beneficiaries may receive community transition funding when all of the criteria are met and proper procedures have been followed.
The beneficiary must be institutionalized and require the service in order to transition to a home setting.

HOW MUCH OF IT CAN THEY GET?

Community transition funds are limited to the difference between the maximum allowed amount for home or vehicle modification ($10,000 for home modifications and $15,000 for vehicle modifications) and the prorated amount already available to the beneficiary for the same service, such that:

Home Modifications	
A beneficiary who enters the waiver between	may receive _____ in community transition funding to use prior to June 30, 2015
prior to June 30, 2011	$0
July 1, 2011 and June 30, 2012	$2000
July 1, 2012 and June 30, 2013	$4000
July 1, 2013 and June 30, 2014	$6000
July 1, 2014 and June 30, 2015	$8000
Vehicle Modifications	
A beneficiary who enters the waiver between	may receive _____ in community transition funding to use prior to June 30, 2015
prior to June 30, 2011	$0

July 1, 2011 and June 30, 2012	$3000
July 1, 2012 and June 30, 2013	$6000
July 1, 2013 and June 30, 2014	$9000
July 1, 2014 and June 30, 2015	$12,000

MN
Medically Necessary

The maximum limits for home and vehicle modifications still apply. For example, a beneficiary being deinstitutionalized and entering the waiver August 8, 2011, who needs both home and vehicle modifications, is eligible for $2000 community transition funding for home modifications and $3000 community transition funding for vehicle modifications. The beneficiary may not apply unused money for vehicle modifications toward home modifications.

A beneficiary that exits and then returns to the waiver within the same waiver cycle will have only the amount remaining that he/she had left when he/she exited the waiver. However, this amount would only apply if the child was being deinstitutionalized with the return to CAP/C and needed these services to return home.

MORE INFORMATION

The amount of money approved is based upon medical need; there is no entitlement of funding up to the program limit.

QP
Qualified Providers

WHO CAN PROVIDE IT?

All of the provider qualifications listed for home modifications and for vehicle adaptations apply.

WHAT DOCUMENTATION DO I NEED?

All of the documentation required for home modifications and for vehicle adaptations apply.

HOW IS IT BILLED?

Billing is done through the case management agency the same way as for home modifications or vehicle adaptations, but using code T2038.

CHAPTER REVIEW

Key Points

1. Community transition funding is for beneficiaries transitioning out of an institution into a private residence, to allow them to make that transition.
2. Community transition funding provides the difference between the maximum amount allowable for modifications ($10,000 for home modifications, and $15,000 for vehicle modifications) and the prorated amount for which the child is eligible for home modifications and vehicle adaptations.
3. All of the inclusions, limitations, provider qualifications, documentation, and billing requirements for home modifications and vehicle adaptations apply.

Test Your Knowledge

1. Community Transition Funding allows the difference between _____ and _____ to be provided for home modifications and vehicle adaptations for a person going from an institution to a home.
2. True or False: Community Transition Funding can be used for someone who has moved to a new residence and needs modifications made to the new residence.

1. the maximum amount of money per waiver cycle that can be provided for home modifications and vehicle adaptations; the prorated amount of money for home modifications and vehicle adaptations that the beneficiary is entitled to based on the year he or she entered the waiver, 2. False

SECTION 3
CAP/C SERVICES AND SUPPLIES

CHAPTER 22
Caregiver Education and Training

WHAT IS CAREGIVER TRAINING AND EDUCATION?

Caregiver Training and Education is training for family members, neighbors, friends, or companions who provide unpaid care, support, training, companionship, or supervision to a waiver beneficiary. The purpose of training is to enhance the decision making capacity of the beneficiary's support system. Training will provide orientation regarding the nature of the illness or disability and its impact on the child and family, treatment regimens, and equipment. Caregiver Training and Education will also include updates as necessary to maintain the child safely at home.

Caregiver training and education is not available under EPSDT.

WHAT IS INCLUDED?

This service includes registration and enrollment fees associated with formal instruction/workshops/seminars.

WHAT IS *NOT* INCLUDED?

Limitations of this service include:

- Caregiver training and education must be prior-approved.
- Travel, meals, or overnight lodging to attend a training event or conference is not covered.
- Individuals who are paid service providers are excluded from this service.

- Training must be directly related to the individual's role in supporting the beneficiary in areas specified in the service plan.

WHO CAN GET IT?

Any informal support person, including family, neighbors, friends, or companions, who provides the CAP/C beneficiary unpaid care, support, training, companionship, or supervision, and needs training in order to support the beneficiary as written in the beneficiary's Plan of Care.

FA
Financial Accountability

HOW MUCH CAN THEY GET?

The service is limited to a maximum expenditure of $500 per waiver year (July 1 through June 30).

QP
Qualified Providers

WHO CAN PROVIDE IT?

Colleges, universities, AHECS, and other organizations with expertise in the field in which the training is being provided. The Case Manager, in conjunction with DMA, evaluates the provider and the curriculum prior to the event.

WHAT DOCUMENTATION DO I NEED?

- A brochure or similar information regarding the event, which describes what the content of the event will be, and who will be presenting it.
- A copy of the registration form with payment information or a receipt of payment (the receipt does not need to be submitted to DMA unless requested; just keep on file).
- A copy of the certificate or other proof of attendance (does not need to be submitted to DMA; just keep on file).
- All caregiver training and outcomes must be included in the beneficiary's Plan of Care.

SP
Service Plans

HOW IS IT BILLED?

The Case Manager bills for this service using code S5110 and the unit rate specified on the CAP/C fee schedule located at http://www.ncdhhs.gov/dma/fee/. The case management works out a payment agreement with the educator. Either the educator must wait for Medicaid to reimburse the case management agency and the case management agency in turn reimburses the educator, or the case management agency may pay the educator and then reimburse themselves.

Please note that this service is billed in 15 minute units. Therefore, you will bill for the number of units that add up to the cost of the registration or enrollment.

MORE INFORMATION

Please refer to the Basic Medicaid Billing Guide for additional information. It can be located at http://www.ncdhhs.gov/dma/basicmed/index.htm.

CHAPTER REVIEW

Key Points

1. Caregiver Training and Education is only for informal support persons. It may not be used to train the nurse aide, nurse, or other paid staff.
2. The training must be related to the Plan of Care in that it will help the informal support person provide the type of care that the plan of care says he/she will provide.
3. The Plan of Care must contain goals or outcomes related to the training.
4. This service covers only the enrollment/registration fee; not mileage, meals, lodging, or other expenses.
5. This service is limited to $500 per waiver year, billed by the case manager in 15 minute increments to equal the amount of the registration/enrollment fee.

. **Test Your Knowledge**

1. True or False: Caregiver Training and Education may be used to train a nurse aide to do a certain task for a beneficiary.

2. True or False: If the training session takes all day, you would bill for 8 hours (32 units) of Caregiver Training and Education.

3. The Caregiver Training and Education must be indicated on the
   a. goals and interventions
   b. cost summary
   c. both
   d. neither

4. It is the joint responsibility of _____ and _____ to review the presenters and content of the training to be sure the information will be accurate and not jeopardize the beneficiary's health or welfare.

1. False, 2. False, 3. c, 4. the Case Manager and the DMA Nurse Consultant

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SECTION 3
CAP/C SERVICES AND SUPPLIES

CHAPTER 23
Palliative Care

WHAT IS PALLIATIVE CARE?

Palliative care services assist children with life-threatening illnesses to live as normally as possible, by providing their families access to a continuum of care, with the objectives of alleviating suffering and keeping the children at home during the course of their disease. They support the independence, integrity, caregiving and other functions of the families and guardians of these children, including parents, siblings, and other significant adults, by providing full access to services and resources that sustain effective coping and positive family dynamics.

Palliative care is provided to decrease a beneficiary's feelings of isolation, improve communications skills, decrease emotional suffering due to health status, and develop coping skills. Palliative care is provided for the beneficiary and the caregiver and family members to alleviate the feelings of devastation and loss related to a diagnosis and prognosis for limited lifespan, surrounding the failing health status of the client, and impending death of a child.

Palliative care services are not available under EPSDT.

WHAT IS INCLUDED?

- Counseling by a Clinical Social Worker, Licensed Professional Counselor (LPC), or Licensed Psychologist with experience working with clients with life-limiting illnesses and their families, provided to the beneficiary

and family members in order to guide and help them cope with the beneficiary's illness and the related stress that accompanies the continuous, daily care required by caring for a chronically disabled child.

- Expressive Therapy. Expressive Therapy is defined as provision of creative art, music or play therapy i.e., book writing, painting, music therapy, scrap-book making, which gives children the ability to creatively and kinesthetically express their medical situation. Use of these therapies can decrease a beneficiary's feelings of isolation, improve communications skills, decrease emotional suffering due to health status, and develop coping skills. Expressive therapy is activity which is not for recreation but related to the care and treatment of the patient's disabling health problems. Expressive therapy may be provided in an individual or group setting.
- Bereavement activities and opportunities for dialogue offer the family a mechanism for expressing emotion and asking questions about death and grieving in a safe environment thereby potentially decreasing complications for the family after the child dies.

WHAT IS NOT INCLUDED?

Limitations of this service include:

- Palliative care services must be prior-approved.
- This service is not available to beneficiaries of Medicaid or Medicare Hospice services.
- Approval for this service is based upon need; there is no entitlement of services up to the program limit.
- As always, Medicaid is the payer of last resort. Medicaid will allow payment up to this maximum, that payment inclusive of third party and Medicaid payments.

- Palliative Care Services will be discontinued if not required and used within a 90 consecutive day time period.

WHO CAN GET IT?

Eligible beneficiaries may receive palliative care services when all of the criteria are met and proper procedures have been followed.

WHERE CAN THEY GET IT?

Services may be provided in the home or in an outpatient setting as determined by the Plan of Care.

FA
Financial Accountability

HOW MUCH CAN THEY GET?

Counseling services are limited to 98 visits per year. Expressive therapy is limited to 39 hours (156 units) per year. Bereavement is limited to a one time visit, which must be billed on or before the beneficiary's last date of service.

Beneficiary, Family, or Caregiver Counseling will be provided according to the assessment of the beneficiary in the continuum of care after a diagnosis of a life-limiting illness or condition. When a child is first diagnosed with the illness, the child and family might need a significant amount of anticipatory grief and loss counseling that may taper off during the treatment phase when the child has some improvement or remission of symptoms. As the child's health deteriorates counseling services may be required at an intensive level.

QP
Qualified Providers

WHO CAN PROVIDE IT?

This service is provided by a certified Hospice agency as according to 10A NCAC 13J.1005, a Home Health Agency, or an independent provider. The hospice or home health agency must be enrolled with Medicaid as a CAP/C provider.

Counseling is provided by a Clinical Social Worker, Licensed Professional Counselor (LPC), or Licensed Psychologist with experience working with clients with life-limiting illnesses and their families.

Expressive therapies are provided by

- Art Therapist: Master's degree in art therapy or art education or psychology with major coursework in art or art therapy, including an approved clinical internship in art therapy. Registered or eligible for registration with the American Art Therapy Association.
- Music Therapist: Bachelor's degree in music therapy and current certification with the Certification Board for Music Therapists.

FC
Free Choice

The beneficiary/family has the right to choose from among any enrolled Medicaid provider. The family should be given a list of providers to choose from. The list may include information regarding the agency such as geographic region served or private insurances accepted. The case manager may not however, make a recommendation to the family.

WHAT DOCUMENTATION DO I NEED?

MN
Medically Necessary

There must be a copy of signed physician's order for the service on file with the case management agency.

The CAP/C assessment should document the need for the service.

The CAP/C Plan of Care should include outcomes and goals related to the use of the services.

FA
Financial Accountability

The Case Manager should receive copies of the monthly invoices and should track the amount of service to make sure the annual limits are not exceeded.

FA
Financial Accountability

HOW IS IT BILLED?

Palliative care services are billed directly to Medicaid by the provider agency. If an independent provider is used, the cases management agency bills Medicaid on behalf of the provider. The case management

MORE INFORMATION

works out a payment agreement with the provider. Either the provider must wait for Medicaid to reimburse the case management agency and the case management agency in turn reimburses the provider, or the case management agency may pay the vendor and then reimburse themselves. Counseling services are billed per visit using code 99510. Bereavement counseling is billed as a one-time event using code S5111. It must be billed prior to the beneficiary's death. Expressive therapies are billed in 15 minute units using code S5108. All are billed using the unit rate on the current CAP/C fee schedule located at http://www.ncdhhs.gov/dma/fee/. Please refer to the Basic Medicaid Billing Guide for additional information. It can be located at http://www.ncdhhs.gov/dma/basicmed/index.htm.

CHAPTER REVIEW

Key Points

1. Palliative care services include counseling, bereavement counseling, and expressive therapies.
2. Counseling services are limited to 98 sessions per year. Bereavement counseling is a one-time event. Expressive therapies are limited to 39 hours per year billed in 15 minute units.
3. Palliative care services are provided by a hospice or home health agency enrolled as a CAP/C provider, or by an independent practitioner.
4. Palliative Care services may not be approved at the same time as Hospice services.

Test Your Knowledge

1. True or False: Palliative care services can be used to provide counseling for a member of the child's family.
2. True or False: Bereavement counseling is billed on the date of service.
3. True or False: An independent outpatient psychologist may provide palliative care counseling.
4. Expressive therapies are limited to _____ hours per year.

1.True, 2. False, 3.True, 4. 39

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SECTION 3
CAP/C SERVICES AND SUPPLIES

Section Review

1. Abigail has been receiving regular Medicaid state plan Personal Care Services. Her mother mentioned to the pediatrician that she really needs Abigail's nurse aide for more time because of Abigail's increase in seizure activity. The pediatrician suggested a referral to the CAP/C program. When you explain the program to Abigail's mother, she states the family values their privacy and it has been hard enough to have a nurse aide in their home; they don't want a case manager as well. The appropriate course of action would be:
    a. Tell her it's not a problem; she is not required to use any services she doesn't want.
    b. Suggest that she stay on PCS and have an EPSDT request for the additional hours submitted.
2. Thomas has cerebral palsy. He is completely dependent for ADLs, incontinent, has seizures that require observation and safety precautions, and he receives bolus GT feedings. Which CAP/C service should provide Thomas' in-home care?
    a. Nurse
    b. Pediatric Nurse Aide
    c. Personal Care
3. Samuel is 15 years old and is quadriplegic as a result of a car accident. Samuel's mother does not work outside the home so that she can provide care for Samuel. He is incontinent and he needs to

be fed orally. Mom needs help in providing his ADLs and incontinence care and she is unable to transfer him by herself. She also needs to occasionally leave him with a competent caregiver so that she can attend to the grocery shopping and other errands. Which CAP/C service should provide Samuel's in home care?

a. Nurse
b. Pediatric Nurse Aide
c. Personal Care

4. Margaret is 3 years old. She has a history of prematurity. She has BPD (bronchopulmonary dysplasia), failure to thrive, and developmental delays. She receives bolus GT feedings during the day as well as ADL and incontinence care, and scheduled nebulizer treatments. She sleeps through the night with no nursing care requirements. Margaret's mother works and is absent from the home from 8:30AM to 5:30 PM. Her father works and is absent 7:00AM to 4:30PM. What is the maximum number of in-home care hours per week that Margaret can receive?

a. 20
b. 50
c. 60
d. 70

5. What is the maximum number of hours per year of respite that Margaret (above question) can receive?

a. 720
b. 540
c. 360
d. 180

6. Margaret's mother needs to go out of town to a business conference. They will need to change their hours to cover Dad's work schedule.
    a. They cannot do this.
    b. They can do this, and no action is needed.
    c. They can use short-term-intensive hours for this.
    d. They can use respite hours for this.
7. Christopher is wheelchair dependent. He is admitted to CAP/C in October 2012, when his family moves here from Virginia. For now, they are making do carrying Christopher in and out of the house, but he needs a wheelchair ramp. They also need to modify the bathroom to put in a roll-in shower. How much money can CAP/C pay for these modifications?
    a. $10,000
    b. $7,500
    c. $6000
    d. $4500
8. Hannah's mother is having difficulty coping with Hannah's medical needs. She is very anxious and is reluctant to make even simple decisions regarding Hannah's care. Hannah's mother is a stay at home parent, but she is afraid to be left alone with Hannah because something might happen and she wouldn't know what to do. She is asking for 16 hours per day of an RN so that the nurse will be there whenever her husband is not. You are considering palliative care services to provide counseling for the mother, and think
    a. This is appropriate.
    b. Palliative care services can only be used for the child, not the family.

c. She is not eligible for palliative care because she has longer than six months to live.

9. You get a phone call from a parent who wants to make a CAP/C referral so that her child can get disposable diapers. Her child is four years old and receiving Medicaid PCS services. Your best response is
   a. CAP/C does provide diapers, and you will be happy to take her referral.
   b. You can not get CAP/C just to get disposable diapers.
   c. CAP/C covers re-usable diapers. If she wants disposable diapers, she doesn't need CAP/C to get them; they are available through Medicaid and she should contact her PCS agency and they will assist her in obtaining them.
10. Brian has Duchenne's muscular dystrophy. There is a conference coming up, which is targeted for caregivers. It presents basic information about the disease, the latest treatments, resources, how to advocate, how to care for a family member who has the disease, and care for the caregiver. It is presented by a major hospital, but it is a 4 hour drive each way. The mother would like to attend the conference and would need to stay overnight. You explain that
    a. CAP/C will pay for all of the expenses of the conference up to $500.
    b. CAP/C will pay only for the cost of the conference; not for the travel, lodging, and meals.
    c. CAP/C will pay $34.12 per hour of the conference.
11. Brian will need some additional hours of in-home care while his mother is gone overnight. Assuming that there is an emergency back-up caregiver available,

a. This can be provided as respite.
b. This should be provided as short-term-intensive.
c. Extra hours can not be approved for this purpose.

12. Laura's mother calls to inquire about CAP/C. Laura has GT feedings, and most of the time they are able to handle her care on their own. They have difficulty finding babysitters though, and would like some occasional respite services. You explain that
    a. Respite is only available if you also have regularly scheduled in-home care.
    b. Respite is only available if you also have one other waiver service.
13. Matthew is on a ventilator 24 hours per day. He requires suctioning at least hourly during the day and usually 3-4 times during the night. His parents work full-time, and Mark is receiving the maximum of 126 hours per week of CAP/C nursing. The family has broken this time down into 18 hours per day, every day. Mark was recently hospitalized for pneumonia, and upon discharge the physician wrote an order for respiratory therapy once per day for trach care, nebulizer treatment, chest PT, suctioning, care of the vent, and assessment. You notify the doctor that
    a. You will start respiratory therapy services as ordered immediately.
    b. Since Mark has nursing care in the home, Medicaid will only pay for a respiratory therapist for some initial teaching and quarterly follow-up.
    c. Since Mark has nursing care in the home, Medicaid will not pay for a respiratory therapist.
14. Catherine's family is moving into a one-level home, but it will need some modifications to make it fully accessible to Catherine. Based

on when Catherine entered the waiver, she can receive up to $6000 for home modifications. Her family states that this will not be enough, and asks you why they can't use community transition funding.

a. They can use community transition funding.
b. Community transition funding is only available to people transitioning from an institutional setting to a home.
c. Additional Community transition funding may be available through EPSDT.

1. b, 2. b, 3. c, 4. c, 5. b, 6. c, 7. c, 8. a, 9. c, 10. b, 11. b, 12. b, 13. b, 14. b