

## **SECTION 4 INITIATING CAP/C**

### **CHAPTER 24 Inquiries**

#### **WHAT IS AN INQUIRY?**

An "inquiry" occurs when someone contacts a CAP/C case manager to gather information about CAP/C. As a case manager, you should respond to these inquiries.

#### **HOW TO HANDLE AN INQUIRY**

During this discussion, you should

1. Find out who you are taking to, and what their relationship is to the child. If you are not speaking with the parent/legal guardian:
  - determine if the parent/legal guardian is aware of the referral
  - speak only in general terms, avoiding any potential HIPAA violation
  - ask the caller to give you the contact information for the parent/legal guardian or have the parent/legal guardian call you to complete the referral form
2. Ask the caller what they want or expect CAP/C to be able to do for them. It is important to do this because the following misunderstandings commonly occur:
  - They move from another state and expect the program to be the same.

- They don't realize there are three CAP programs, and they are all different. Many times they are making a CAP/C referral for CAP-IDD service.
- They have Medicaid already, and want a certain service or supply or more of a certain service or supply and they think they need CAP to get it.
- They have a need that CAP/C can not meet, such as providing transportation or mentoring a child.
- They are on a waiting list for another program, and want CAP/C even though they don't qualify, so they can have some services while waiting.
- They see CAP/C as a way of obtaining Medicaid if their income is too high, rather than seeing it as services to support keeping the child at home.

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3. Inquire about the general needs of the child. Determine if

- The primary diagnosis is medical in nature
- The needs relate directly to that diagnosis, and are not age-appropriate
- The needs occur in the home
- The needs are currently unmet, or the family is having difficulty or anticipates having difficulty meeting them

4. Discuss the benefits and limitations of the CAP/C program in terms of this particular child's needs, being careful not to dissuade the inquirer from making the referral.

- Discuss what CAP/C can and can not do for the child.
- Refer the caller to the CAP/C Parent Handbook.
- Inform the caller of options instead of or in addition to CAP/C.

The CAP/C parent Handbook is available at

<http://www.ncdhhs.gov/dma/capc/capcparenthandbook.pdf>. There



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is information for case managers regarding other programs and resources in Appendix A of this manual.

5. Determine if the caller wants to make a referral.

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Even if you think the referral is inappropriate, you may not go against the caller's wishes and refuse to send in a referral if the caller still wants to apply. Denials must be issued by DMA so that the potential beneficiary/responsible party can receive their due process rights.

6. Complete the referral form, if applicable.

See Chapter 25 for instructions regarding the referral form.

7. Complete the inquiry log

Your agency should keep a record of all inquiries. The record should note, at a minimum, the date, name of the caller, name of the child, and result of the inquiry. This information should be made available to DMA upon request for quality assurance purposes.

Please see the next page for one example of an inquiry log.



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<b>Date/Time</b> 7/1/2010 10:00AM-10:15AM	<b>Caller's Name</b> John Doe
<b>Child's Name</b> Jane Doe	<b>Caller's Relationship</b> father
	<b>Caller's Contact Info.</b> (555) 555-5555
<b>Reason for Inquiry</b> 10 year old with CP, getting too heavy to lift, requests IHA assist	
<b>Result</b> Referral submitted to DMA	
<i>Ima Case Manager, SW</i>	
<b>Date/Time</b> 7/2/2010 10:00AM-11:10AM	<b>Caller's Name</b> Florence Nightingale, RN
<b>Child's Name</b> Mary Doe	<b>Caller's Relationship</b> Discharge Planner, Healthy Hospital
	<b>Caller's Contact Info.</b> (555) 555-5555
<b>Reason for Inquiry</b> 3 month old, coming out of NICU 24 week preemie, vent and GT dependent, anticipated discharge date 7/31/10	
<b>Result</b> Discharge planner to complete referral form with family and forward to me	
<i>Ima Case Manager, SW</i>	
<b>Date/Time</b> 7/3/2010 11:15AM-12:00PM	<b>Caller's Name</b> Ann Doe
<b>Child's Name</b> Jim Doe	<b>Caller's Relationship</b> mother
	<b>Caller's Contact Info.</b> (555) 555-5555
<b>Reason for Inquiry</b> 4 year old, autism, on CAP- IDD waiting list but will be years, wants services in the meantime	
<b>Result</b> Informed parent that child would probably not qualify for CAP/C, suggested referral to PCS, but referral submitted to DMA anyway per parent's request.	
<i>Ima Case Manager, SW</i>	
<b>Date/Time</b> 7/5/2010 11:15AM-2:00PM	<b>Caller's Name</b> Dorothy Doe
<b>Child's Name</b> David Doe	<b>Caller's Relationship</b> mother
	<b>Caller's Contact Info.</b> (555) 555-5555
<b>Reason for Inquiry</b> 12 year old, spina bifida, currently on waiver program in New York, planning to move to NC	
<b>Result</b> Discussed NC's program as well as other resources; parent will call back if she decides on CAP/C and once she has an address in NC.	
<i>Ima Case Manager, SW</i>	

**Example of an Inquiry Log**

## **CHAPTER REVIEW**

### **🔑 Key Points**

1. An inquiry is when a person asks for information about the CAP/C program or wants to make a referral.
2. The steps in the process include:
  - a. Find out who you are taking to, and what their relationship is to the child.
  - b. Ask the caller what they want or expect CAP/C to be able to do for them.
  - c. Inquire about the general needs of the child.
  - d. Discuss the benefits and limitations of the CAP/C program in terms of this particular child's needs.
  - e. Determine if the caller wants to make a referral.
  - f. Complete the referral form, if applicable.
  - g. Complete the inquiry log.

 **Test Your Knowledge**

1. True or False: All inquiries result in referrals.
2. You should provide the CAP/C Parent Handbook
  - a. at the time of the inquiry
  - b. only if the inquiry results in a referral
3. True or False: A Case Manger may deny a referral or refuse to submit a referral to DMA.
4. True or False: A Case Manager may only advise a caller regarding CAP/C; he or she may not offer information regarding other programs.
5. If an inquiry does not result in a referral, the case manager should:
  - a. do nothing
  - b. log the inquiry on the agency's form.

1. False; 2. a; 3. False; 4. False; 5. b

## **SECTION 4**

### **APPLYING FOR CAP/C**

## **CHAPTER 25**

### **The Referral**

#### **WHO CAN MAKE A REFERRAL?**

Anyone can make a referral to the CAP/C program. Potential CAP/C clients are identified through a variety of sources: the family themselves, a hospital discharge planner, an Early Intervention worker, a physician, or a teacher, to name a few. Although there is no rule against these people filling out the referral form themselves, it is usually much more effective for the Case Manager to fill it out. The Case Manager is much more knowledgeable about the CAP/C program, the type of information DMA needs to have on the referral, and other available resources. It is a good idea to establish and maintain contacts with the public and private agencies, interest groups, service organizations that work with children with special medical needs, and other potential referral sources in your area. That way, when someone identifies a potential CAP/C beneficiary, they can call you to make the referral.

Referrals should not be made by discharge planners, Early Intervention workers, home care agencies, or anyone else without the parent's knowledge and consent. This is a violation of HIPAA regulations



**Child's Primary Care Physician**

Physician First Name  
 Physician Last Name  
 Physician Practice  
 Physician Mailing  
 Address 1  
 Physician Mailing  
 Address 2  
 City State Zip -  
 Office Phone - -

**CAP/C Details**

Has the child ever been referred to CAP/C before?  no  yes, referral date / /  
 Result  
 What services, if any, does the child currently have?  
 In their own words, why does the recipient/family want CAP/C?  
 What services are the recipient/family requesting from CAP/C?  
 Case Management  Nurse or Nurse Aide Care  Home and/or Vehicle  
 Modifications, type  
 Palliative Care  Waiver Supplies, type  Caregiver Training and  
 Education  Respite  
 Is the child being referred to other services as well?  no  yes, specify  
 Is the child awaiting services in order to be deinstitutionalized? \*  yes  no  
 Is the child receiving another Medicaid program about to end? \*  yes  no  
 I certify that the parent/legal guardian is aware of and has consented to this referral. \*  yes  
 no  
 The parent/legal guardian has been given a copy of or the link to the CAP/C Parent Handbook  
 and the CAP/C for Consumers webpage. \*  yes  no  
 The recipient has been notified of their choice of case management providers. \*  yes  no  
 N/A  
 If applicable,  the recipient has not chosen  the recipient has chosen, specify agency

**Referring Details**

Submitter  Submitter Name* Date Agency Address* City* State* Zip* - Phone - - extension Fax - -	Referring Source <input type="checkbox"/> referrer same as submitter Referrer Name Last Name Address 1 Address 2 City State Zip - Phone - - extension Fax - -
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**If CAP/C Nursing, Pediatric Nurse Aide, or Personal Care Services are Requested:**

In their own words, what does the caregiver want the nurse or nurse aide to do?

ADL Needs	
Describe the child's ability to bathe him/herself.*	<input type="checkbox"/> age appropriate <input type="checkbox"/> independent <input type="checkbox"/> set-up help only <input type="checkbox"/> supervision/cueing <input type="checkbox"/> limited assistance <input type="checkbox"/> extensive assistance <input type="checkbox"/> maximal assistance <input type="checkbox"/> total dependence Further Information/Comments
Describe the child's ability to dress him/herself.*	<input type="checkbox"/> age appropriate <input type="checkbox"/> independent <input type="checkbox"/> set-up help only <input type="checkbox"/> supervision/cueing <input type="checkbox"/> limited assistance <input type="checkbox"/> extensive assistance <input type="checkbox"/> maximal assistance <input type="checkbox"/> total dependence Further Information/Comments
Describe the child's ability to groom him/herself (personal hygiene).*	<input type="checkbox"/> age appropriate <input type="checkbox"/> independent <input type="checkbox"/> set-up help only <input type="checkbox"/> supervision/cueing <input type="checkbox"/> limited assistance <input type="checkbox"/> extensive assistance <input type="checkbox"/> maximal assistance <input type="checkbox"/> total dependence Further Information/Comments
Describe the child's ability to move (locomotion/ambulation).*	<input type="checkbox"/> age appropriate <input type="checkbox"/> independent <input type="checkbox"/> set-up help only <input type="checkbox"/> supervision/cueing <input type="checkbox"/> limited assistance <input type="checkbox"/> extensive assistance <input type="checkbox"/> maximal assistance <input type="checkbox"/> total dependence Further Information/Comments
Describe the child's ability to eat by mouth.*	<input type="checkbox"/> age appropriate <input type="checkbox"/> independent <input type="checkbox"/> set-up help only <input type="checkbox"/> supervision/cueing <input type="checkbox"/> limited assistance <input type="checkbox"/> extensive assistance <input type="checkbox"/> maximal assistance <input type="checkbox"/> total dependence Further Information/Comments
Describe the child's ability to toilet by him/herself.*	<input type="checkbox"/> age appropriate <input type="checkbox"/> independent <input type="checkbox"/> set-up help only <input type="checkbox"/> supervision/cueing <input type="checkbox"/> limited assistance <input type="checkbox"/> extensive assistance <input type="checkbox"/> maximal assistance <input type="checkbox"/> total dependence Further Information/Comments
Describe the child's ability to be bed mobile by him/herself.*	<input type="checkbox"/> age appropriate <input type="checkbox"/> independent <input type="checkbox"/> set-up help only <input type="checkbox"/> supervision/cueing <input type="checkbox"/> limited assistance <input type="checkbox"/> extensive assistance <input type="checkbox"/> maximal assistance <input type="checkbox"/> total dependence Further Information/Comments
Describe the child's ability to transfer by him/herself.*	<input type="checkbox"/> age appropriate <input type="checkbox"/> independent <input type="checkbox"/> set-up help only <input type="checkbox"/> supervision/cueing <input type="checkbox"/> limited assistance <input type="checkbox"/> extensive assistance <input type="checkbox"/> maximal assistance <input type="checkbox"/> total dependence Further Information/Comments
Is the child continent?*	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> age appropriate
Describe the child's ability to communicate.*	<input type="checkbox"/> understood <input type="checkbox"/> usually understood <input type="checkbox"/> often understood <input type="checkbox"/> sometimes understood <input type="checkbox"/> rarely/never understood Further Information/Comments

Other ADL needs?	
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Other Needs	
None	<input type="checkbox"/>
Feeding Tube	<input type="checkbox"/> continuous <input type="checkbox"/> bolus, frequency type of tube
ventilator	<input type="checkbox"/> , hours per day
CPAP/BiPAP	<input type="checkbox"/> , hours per day
suctioning	<input type="checkbox"/> tracheal, times per <input type="checkbox"/> other suctioning, times per
oxygen	<input type="checkbox"/> continuous <input type="checkbox"/> PRN, times per <input type="checkbox"/> stable rate <input type="checkbox"/> requires rate adjustments times per
catheterizations	<input type="checkbox"/> indwelling <input type="checkbox"/> intermittent, times per Self-cath? <input type="checkbox"/> yes <input type="checkbox"/> no
seizures	<input type="checkbox"/> oxygen <input type="checkbox"/> activation of VNS device <input type="checkbox"/> administration of PRN medication <input type="checkbox"/> safety precautions and monitoring frequency of seizures frequency of interventions needed other than safety/monitoring

Private Insurance	
Does private insurance cover any in-home nurse or nurse aide care?*	<input type="checkbox"/> yes <input type="checkbox"/> no
Please indicate how much.	
Comments	

**HOW IS THE REFERRAL FORM COMPLETED?**

Case managers should submit all referrals in eCAP. Please see eCAP's Knowledge Exchange, User Guidelines for Referrals Processing at <https://www.ncecap.net/a4e9f7d8-43f6-4eb4-be25-c576aa381107.GUID?db=ECAPCProd&download=true> for more information about how to complete referrals in eCAP.

The referral form for parents or other sources, as seen above, is on the CAP/C website at [http://www.ncdhhs.gov/dma/services/CAPC\\_referral.doc](http://www.ncdhhs.gov/dma/services/CAPC_referral.doc). This version of the form may be filled out on the computer, but it can not be submitted via computer. The referrer must print the completed form and mail or fax it to DMA. The CAP/C mailing address is Division of Medical Assistance, HCI Unit, CAP/C, 2501 Mail Service Center, Raleigh, NC 27699-2501. The fax number is 919-715- 9025.

To ensure that the family understands the CAP/C program as well as their other options and has made an informed consent to participate in CAP/C, at the time of referral the parent should be given a copy or link to the CAP/C Parent Handbook and the CAP/C for Consumers webpage.

For counties in which there is more than one case management agency available, the beneficiary has the freedom to use the agency of their choice. Please ensure that they are aware of this choice

**WHAT IF I DON'T THINK THE REFERRAL IS APPROPRIATE?**

If you don't feel a referral is appropriate, you should explain to the referral source/family why you think that and what resources you do believe are

appropriate. If they are in agreement, give them the information needed to link to the other resources. If they are not in agreement, or they say they still want to make the referral, you *must* submit the referral. An important part of Medicaid's patient rights is that any type of denial, or anything that the beneficiary or family could interpret as being a denial, must come from DMA and include appeal rights. *Under no circumstances may a case manager tell a beneficiary or family member that they can not or should not submit a referral.*

#### **WHAT IF THE CHILD HAS ALREADY BEEN REFERRED IN THE PAST?**

There are no restrictions regarding the number of times a child may be referred or the length of time that is needed between referrals. It is helpful to indicate on the referral form that the child has been referred in the past; oftentimes DMA will look at the previous referral and decision. Even if the previous referral was denied for some reason, there may be a change in the child's care needs or even in CAP/C policy that would reverse that decision.

If the previous referral was more than 60 days ago, you will need to submit a new/updated referral form.

#### **WHO REVIEWS THE REFERRAL AND WHEN?**

Within 15 business days of the date DMA receives the referral, whether submitted in eCAP by a case manager, or on paper by another source, the Case Manager will receive notice of approval or denial, or a request for more information. DMA will also copy the referral source (if applicable) on the approval or denial decision.

If more information is requested, you must submit the information within 10 business days. If you are unable to do so, please inform your Consultant.

If the requested information is not received by the end of that time, the referral will be denied. If the requested information is received on time, DMA will respond to that information within 15 business days.

### **WHAT ARE THE CRITERIA USED TO APPROVE OR DENY A REFERRAL?**

- Is the primary diagnosis medical, as opposed to mental, developmental, behavioral, or cognitive? For example, children with diagnoses of autism, mental retardation, developmental delay, and Down's syndrome, without any accompanying medical diagnosis, would not be appropriate for CAP/C.
- Is the child under 21 years of age?
- Does the child live in a non-institutional setting?
- Is there a need (and request) for case management services? There must be a need for a case manager to assess, plan care, monitor, and coordinate services. The family must agree to this service and participate in it.
- Is the client at risk of institutionalization? The client's care needs must be such that the client could reasonably be expected to be admitted to a nursing home if CAP/C services were not available. There must be a lack of other resources such as informal caregivers or formal daycare services that would be able to meet the child's needs.
- What resources does the child currently have to meet his/her needs? Existing formal and informal supports are considered. CAP/C can only be approved to supplement, not replace, these resources. Reasons for any change in existing services are considered. CAP/C is approved only to meet unmet medical needs of the child, not for the convenience of the caregivers. If

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existing resources can meet the child's needs, there is no reason for CAP/C to supplement these resources.

- What other potential resources, formal or informal, are available to meet the child's needs? Other programs that could meet the child's needs are considered to ensure that CAP/C is the most appropriate service for the child.

For any Medicaid service to be approved, there must be no other as effective and less costly option available statewide. This means that if a state plan service can meet a beneficiary's needs as effectively, then that program is the one that must be provided.

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#### **WHEN AND HOW WILL I AND THE FAMILY BE NOTIFIED OF THE DECISION?**

If the referral is approved, the case manager will be notified via eCAP and the family and referral source (as applicable) will be notified via mail.

The case manager should contact the family within two weeks of receiving this notification, even if the child will be placed on a wait list.

If the referral is denied, the case manager, the referral source (as applicable), and the family will be notified via mail.

The decision will be made within 15 business days of DMA receiving all of the information needed.

#### **WHAT DOES THE DECISION MEAN?**

*The referral is a screening; it is not a final decision.* A letter saying that the referral has been approved does NOT mean that CAP/C participation has been approved. Conversely, a letter saying that the referral has been denied does NOT mean that CAP/C participation has been denied. It is important for Case Managers and families to understand this.

The referral process is an opportunity to have a discussion with the parent(s)/responsible party about the eligibility requirements, services, and

limitations of CAP/C as well as the needs of the child and their expectations of CAP/C. The discussion is an opportunity to explain what the program can and cannot be expected to provide in relation to the child's needs. The Case Manager and DMA use this information to determine if CAP/C is the most effective and appropriate program to meet the child's needs, or if the child should be referred to other programs or services instead of or in addition to CAP/C. It also assists in making the best use of the resources available for CAP/C assessments.

An approved referral means that DMA thinks the child will be a good fit for the program, and we are authorizing the case management agency to perform the complete initial assessment and plan of care development process. It is only after this complete initial process that a final decision will be made. It is possible for a referral to be approved, but then CAP/C participation be denied.

A denied referral means that DMA does not think that CAP/C will be able to meet the child's/family's needs. More information about this in the section below titled 'What If The Referral Is Denied And I Or The Family Disagree?' Again, it is possible for a referral to be denied, but then CAP/C participation be approved. The referral decision is not a final decision; a final decision is made only after review of the complete initial assessment and plan of care.



### **WHAT IF THE REFERRAL HAS ALREADY BEEN SUBMITTED, BUT THE FAMILY CHANGED THEIR MIND, MOVES, OR NO LONGER NEEDS OR WANTS THE REFERRAL?**

Have the family complete the 'CAP/C Notice of Voluntary Withdrawal of Referral' form, and submit it to DMA through eCAP, in the referrals section, supporting documents. Notify your nurse consultant, and DMA will follow

up with a letter to the family and to the case manager confirming that the referral has been closed.

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### **WHAT IF THE REFERRAL IS DENIED AND I OR THE FAMILY DISAGREE?**

The family always has the right to request an 'assessment anyway'.

Please see Chapter 26 for complete information regarding the 'assessment anyway'.



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### **WHAT KIND OF DOCUMENTATION IS NEEDED FOR THE REFERRAL PROCESS?**

Inquiries should be documented as described in Chapter 24. If the inquiry results in a referral, eCAP will maintain a permanent record of the referral and of DMA's decision. If the referral is approved and the child is placed on a wait list, document as described in Chapter 27.



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### **HOW DO I BILL FOR MY CASE MANAGEMENT TIME FOR THE REFERRAL?**

You cannot bill for referral activities. Time spent on non-billable activities such as referrals is built into the case management rate. Please refer to the Basic Medicaid Billing Guide for more information.

## **CHAPTER REVIEW**

### **🔑 Key Points**

1. Anyone can make a referral, but it is preferred that the Case Manager do so.
2. A Case Manager may not refuse to submit a referral when the client wants it submitted.
3. Referrals are approved by DMA.
4. The referral is a screening process. It is not the final determining factor in CAP/C participation.

**Test Your Knowledge**

1. What is the correct course of action if you feel that a referral to CAP/C is not appropriate?
  - a. submit the referral
  - b. do not submit the referral
  - c. discuss it with the family and let them decide whether or not to submit the referral.
  
2. What is the correct first course of action if you receive a referral form from someone other than the family?
  - a. Refuse the referral
  - b. Submit the referral
  - c. Contact the family because you can not accept a form from someone else; it must be completed by the case manager
  - d. Ensure that the family is aware of and has consented to the referral.
  
3. True or False: if a child was disenrolled from CAP/C six months ago, they may not complete a new referral now.

1. c, 2. d, 3. False

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## **SECTION 4 APPLYING FOR CAP/C**

### **Chapter 26 Assessment Anyway**

#### **WHAT IS AN ASSESSMENT ANYWAY?**

An 'assessment anyway' is the term used to denote the beneficiary's due process right at the referral stage. If a referral for CAP/C is denied, the parent may request an 'assessment anyway'. It is essentially a way for the parent to say 'You denied this referral, but I believe that if you had all of the information, you would approve my child for participation.' DMA then authorizes the 'assessment anyway', and the case managers proceed with the initial application for CAP/C much as they would if the referral had been approved.

#### **HOW IS THE FAMILY NOTIFIED OF THEIR RIGHT TO AN ASSESSMENT ANYWAY?**

When the referral is denied, the family will receive a letter explaining the reason for the denial, other options, and their right to have an assessment anyway. The letter states:

If you still wish to pursue CAP/C, you have the right to request that a full CAP/C assessment be completed. You should know that if you make this request, and your participation in CAP/C is still denied, you may be required by the case management agency to pay for the assessment. If you wish to have the assessment, please contact me within sixty days of the date of this letter at 919-855-4380 and I will contact the CAP/C case management agency serving your area to inform them of your request. The local case manager will then contact you directly.

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Fair  
Hearings

**WHAT IS THE PROCEDURE FOR AN ASSESSMENT ANYWAY?**

1. The parent receives the denial letter. They review the reasons for the denial and research the other options that were given to them. They may seek information or advice from you during this process.
2. The parent calls DMA to request the assessment anyway. This must be done within sixty days of the letter. If it is longer than 60 days, a new referral will need to be completed. The assessment anyway is automatically granted; the consultant does not ask any questions or attempt to gather any additional information. If the parent has questions, they will be answered to the best of the consultant's ability.
3. DMA generates an 'assessment anyway' letter, similar to an approved referral letter. This letter is sent to the family, and is visible by the case manager in eCAP. If a choice of agencies has been made by the family, or if no choice is available, the child enters the case management agency's queue as an approved referral would, and the child is ready for assessment assignment and to begin the application process. If the family has not chosen a case management agency, they will need to submit the choice form included in their letter to DMA, and the child will be assigned to the agency chosen.
4. The case manager contacts the family. She explains the agency's policy concerning payment if the child still is not approved for CAP/C. She determines if the parent is still interested in having the assessment anyway.
5. If the parent is not still interested, the case manager obtains a voluntary withdrawal of referral and uploads into eCAP.

If the parent is still interested, the case manager proceeds with the Medicaid application, FL-2, assessment, and plan of care development same as for any other initial application.

Note that even though this process is referred to as an 'assessment anyway', it is not just the assessment that is completed – it is the entire application.

Information regarding the entire application is found in Chapters 28-35.

There is no need to prioritize someone on the wait list just because of the assessment anyway. Follow your normal wait list procedures. For complete information about wait lists, please see Chapter 27.

- If the child is approved for CAP/C, bill for the assessment as you would normally. If the child is not approved for CAP/C, bill according to the instructions for Billing for Non-Beneficiaries in Chapter 33 of this Manual.

#### **WHAT DOES THE POLICY NEED TO SAY?**

The assessment anyway policy outlines your agency's practices regarding payment and any other related information.

How your agency chooses to handle payment is up to each individual agency. You may decide to:

- Charge the entire case management unit rate for as much time as the assessment takes
- Offer a discounted fee or a sliding scale fee
- Not charge the family at all for the assessment anyway.

Whatever decision is made, it must be written in policy and applied uniformly to all beneficiaries in your agency.

The policy should include the following information:

- Does your agency charge the beneficiary for 'assessment anyway' activities?
- What is the fee based on; i.e, normal case management rate and units, flat fee determined by..., sliding scale based on income, other?
- How and when is the family informed of these costs, and by whom?
- Do you require the family to sign something agreeing to the charges?
- What happens if the family does not agree to the charges?
- When is payment expected?
- What forms of payment are accepted?
- Do you allow a payment plan?
- Who is responsible for sending invoices and monitoring payments?
- What happens if the family doesn't pay? Do you absorb the cost or send it to collections? At what point do you make that decision?
- What documentation do you require for your agency?

## CHAPTER REVIEW

### 🔑 Key Points

1. An assessment anyway is the beneficiary's due process right if the referral is denied.
2. An assessment anyway means that the initial application is completed even though the referral was denied.
3. Agencies need to have a written policy regarding billing for assessment only if the initial is also denied and the beneficiary does not have Medicaid in a CAP/C category.

 **Test Your Knowledge**

1. An assessment anyway is the beneficiary's \_\_\_\_\_ right when their referral is denied.
2. Who must request the assessment anyway?
  - a. the case manager
  - b. the beneficiary/responsible party
3. What needs to be submitted to DMA for an assessment anyway?
  - a. the assessment only
  - b. the assessment and the FL-2
  - c. everything except the plan of care
  - d. everything that you would submit with any other initial CAP/C application
4. True or False: You may charge a beneficiary for the assessment anyway if the initial is denied and the beneficiary does not have Medicaid
5. True or False: You may determine whether or not to charge a beneficiary on a case by case basis.
6. What happens if the beneficiary requests the assessment anyway three months after they get the denial letter?
  - a. It is too late; they can not participate in CAP/C
  - b. It doesn't matter; they can always request the assessment anyway
  - c. rather than having an assessment anyway, they will need to re-refer.

1. due process, 2. b, 3. d, 4. True, 5. False, 6. c

## **SECTION 4 INITIATING CAP/C**

### **CHAPTER 27 Wait Lists**

#### **OCCURRENCE OF CAP/C WAIT LISTS**

CAP/C does not have “slots” as do other waiver programs. The CAP/C waiver determines the number of beneficiaries who can be served by the program in any given year. That number is managed statewide; in other words, it is not divided into a certain amount of slots for each county.

CAP/C has not reached its capacity, and plans that if it ever does so, DMA will submit a waiver amendment to increase the capacity. Waiting lists therefore do not occur in CAP/C at the State level. They occur only when an individual case management provider becomes unable to serve more beneficiaries because of staffing or other internal issues.

Under EPSDT regulations, CAP/C may not have any wait lists. This means that if an agency does not have adequate staffing or other resources to serve the CAP/C need in their area, DMA will need to find a second case management provider to meet the need. If a beneficiary chooses to stay with the provider that has a wait list, that is their choice, but DMA must ensure that there is an alternative available so that any applicant or beneficiary can be served immediately at any time.

#### **DEFINITION OF CAP/C WAIT LIST**

A wait list is defined as a list of CAP/C applicants who

- Have had their referral reviewed and have been approved for an assessment or assessment anyway, AND

- The case management agency cannot serve that applicant within two weeks of receiving the CAP/C referral approved letter.

Examples:

1. You receive the referral approval letter from DMA. The family has not yet moved to the area, so you can not send the family to apply for Medicaid or send the FL-2. If the family was here, you could start that process – you have the capacity, but you are on hold until the family moves here. Although you would certainly want to track that patient, for DMA purposes that patient is not considered to be on a wait list. For the time being, you will still need to enter them as a wait list patient in e-CAP, but in the future you will be able to distinguish these applicants versus true wait list applicants in e-CAP.
2. You receive the referral approved letter from DMA. You have a case manager out on maternity leave, and everyone else has a full caseload already. You will not be able to begin working on this patient's initial until your case manager comes back in six weeks. This patient is considered to be on a wait list.
3. You receive the referral approved letter from DMA. You contacted the family immediately to begin the application, but they did not return your call. It has been two weeks, and you have been unable to reach them. You are now going to send a certified letter. This patient is not considered to be on a wait list.

So, it is not the inability of the beneficiary to be served for two weeks that determines wait list; it is the reason the beneficiary can not be served. If it is that the case management agency cannot serve the client, the client is on a wait list. If the case manager could serve the client but is prevented from doing so, the client is not on a wait list.

### **STARTING A WAIT LIST**

All efforts should be made to avoid a wait list. If your agency is getting ready to start a wait list, please contact your CAP/C Nurse Consultant. We will work with you to try to find an alternate solution; i.e., help from a neighboring county, or a second agency in your county, to comply with EPSDT regulations.

### **MANAGING THE WAIT LIST**

Applicants should be contacted upon your receipt of the approved referral letter, and no later than two calendar weeks from receipt of that letter. At this time, they should be

- Informed that they are on a wait list, and where on the wait list they are/how long the wait is.
- Informed about how the wait list is managed; for instance, they should be told about the possibility of someone being placed on the wait list ahead of them.
- Given your contact information so that they can inform you of changes or check on their status.
- Linked to other resources for which they may be eligible while on the wait list.

Applicants on the wait list should then be contacted on a regular basis (at least every 60 days)

- To determine if they are still interested in CAP/C
- To determine if the referral information is still accurate or has changed significantly
- To inform them of their place on the wait list.

If anyone is removed from the wait list, because for example they got a slot on CAP- IDD or they have moved to a different state, please obtain a voluntary withdrawal of referral form and submit it to DMA.

A referral does not 'expire' while a beneficiary is on a wait list, even if they are on the wait list longer than 60 days. However, as stated above, when you contact families on the wait list, you should update the referral information.

Efforts should be made to move people off of the wait list. If you are not able to move at least one patient per county off the wait list at least every 90 days, please contact DMA so that another agency may be found to assist you.

### **REPORTING YOUR WAIT LIST TO DMA**

Wait lists are now generated in eCAP, so case managers no longer need to submit a monthly wait list report to DMA. However, case managers are responsible for assigning children to the wait list in eCAP if they are not going to be able to begin the assessment within two weeks of the referral approval. Wait list assignment includes assigning an expected release date. DMA uses the wait list to record the number of beneficiaries on the list and the length of time of the wait for both Quality Management purposes and to be able to provide data to other agencies that require this information

### **WAIT LIST POLICY**

Each case management agency should have a written wait list policy, even if it doesn't currently have a wait list. The policy must be in accordance with the following two CAP/C and Medicaid regulations:

- Priority must be given to CAP/C beneficiaries
  - Transferring from another county, or
  - Transferring from another Medicaid program, and
  - New applicants requiring home care in order to be discharged from current institutionalization.

- Applicants must be linked to other available services while on the wait list. For example, an applicant who already has Medicaid should be able to receive PCS services and physical therapy while on the wait list for CAP/C.

Other than these two requirements, the agency may choose how to manage the wait list, as long as it is on accordance with their written policy. For example, you may choose to order your wait list chronologically so that the person waiting the longest is first on the list, or you may order it by level of need, prioritizing the family with the highest level need.

Your policy should include the following components:

- Who decides when the case management provider can not immediately serve an applicant?
- What is that decision based on (caseload numbers, individual case manager report, other)?
- What steps are taken to avoid placing the child on a wait list (refer patient to another case management provider, hire temporary assistance, other)?
- How does your agency determine wait list priority on the 1-5 scale in eCAP?
- How does your agency determine the target date for removal from wait list?
- How is the patient notified that they are on a wait list, where they place on that list, and their target date for being assessed?
- Who is responsible for referring the patient to other resources while they are on the wait list?
- Who is responsible for the monitoring the wait list? How often, by whom, and by what method are patients contacted?

- If it is determined during this contact that needs have changed, who is responsible for re-prioritizing the patient on the wait list and referring the patient to new resources?
- Are patients on your wait list served chronologically by referral date, by level of acuity, some combination of both, other?
- Are 'assessment anyway' referrals prioritized differently from above?
- How does the agency handle applicants who can not be served but are not truly wait list patients (i.e, they have not yet moved here from another state, they are still hospitalized, they are receiving other services and don't want CAP/C now, but want to be on the wait list, other)

## **CHAPTER REVIEW**

### **🔑 Key Points**

1. A child placed on a waiting list is one that the case management agency can not serve, because of their own staffing or other issues, within two weeks of receiving notice of the referral approved or transfer.
2. A wait list should be avoided whenever possible.
3. Each case management agency should have a written wait list policy.
4. Children who are becoming de-institutionalized or who are transferring from another county or another program should receive priority status on the wait list.
5. Children on the wait list should be linked to other services that they can receive while waiting.

 **Test Your Knowledge**

1. If a case management agency is not able to serve a child within \_\_\_\_\_ of referral approval, the child should be assigned to the wait list in eCAP.
  
2. These people should be given priority on a wait list:
  - a. \_\_\_\_\_.
  - b. \_\_\_\_\_.
  - c. \_\_\_\_\_.
  
3. All applicants, but especially those who already have Medicaid as per EPSDT regulations, should \_\_\_\_\_.
  
4. With the exception of the children noted in question 2, a case management agency may organize their wait list either chronologically or by level of need, as long as it is in accordance with their agency's \_\_\_\_\_.

*1. two weeks 2. children becoming de-institutionalized, children transferring from another county or agency, children transferring from another Medicaid program, 3. be linked to other services they are eligible for while they wait, 4. written policy*

## **SECTION 4 INITIATING CAP/C**

### **Chapter 28 Applying for Medicaid**

## **Chapter 28 Applying for Medicaid**

Once you have received approval for assessment, your first step will be to get the Medicaid eligibility determination started.

For children who already receive Medicaid, this involves ensuring that the child has the right type of Medicaid to participate in CAP/C (MAD, MAB, I-AS, or H-SF). Individuals receiving SSI (Supplemental Security Income, or disability) are automatically Medicaid eligible.

For children who do not currently have Medicaid, this involves completing a Medicaid application at the county DSS.

#### **REFERRING THE APPLICANT TO DSS**

If the child receives Medicaid, notify the DSS that the individual is being considered for CAP/C. The DSS must be aware of the possibility of CAP/C to assure that any changes in coverage are processed. Because changes may affect the child, it is important that the parents/ responsible party have the opportunity to discuss the implications of a change with DSS.

If the child does not currently receive Medicaid, refer the child's parents or responsible party to the county DSS Medicaid staff. You may wish to use a memo like the one below. Give a copy of the memo to whomever will be making the Medicaid application, and send a copy to the Medicaid staff member who is the contact for CAP/C.

	(Date)
<b>MEMORANDUM</b>	
<b>TO:</b>	(Name of DSS Medicaid Contact) (County) Department of Social Services
<b>FROM:</b>	(Name & Agency of Case Manager)
<b>RE:</b>	Referral of Potential CAP/C Beneficiary for Medicaid
I am referring _____ to apply for Medicaid on behalf of _____. The applicant is a potential CAP/C beneficiary.	
Thank you for your assistance. If there are any questions or problems please call me at _____.	

### **WHEN TO BEGIN THE APPLICATION**

Medicaid applications are open for a certain period of time: 45, 60, or 90 days depending upon the type of Medicaid and whether disability needs to be established. Approval of the CAP/C Plan of Care may be necessary for Medicaid to be approved. Be sure that your plan of care can be developed and approved before the Medicaid application expires. If the application expires, it will have to be completed again.

### **INFORMING THE PARENT WHAT TO EXPECT**

The Medicaid staff will ask for the income and resources of the parents when the potential CAP/C beneficiary applies for Medicaid. Many families who know that the parents' income does not count towards eligibility for CAP/C are confused by this and unprepared for it. The DSS is required to look at all ways that a person may be eligible for Medicaid. In some instances, this will be advantageous for the individual, as it will allow the individual to have regular Medicaid before the CAP/C Plan of Care is approved. The Case Manager should inform parents that DSS may ask them about income and resources.

When applying for Medicaid, the individual should present:

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

In addition, if the SSI or Medicaid eligibility is to be based on disability and the applicant is not receiving Social Security disability benefits, the applicant will have to provide medical information and may need to have an examination by a physician. The examination will be paid for by the state. The Disability Determination Services Section of the North Carolina Division of Vocational Rehabilitation determines disability. Once approved for Medicaid, the beneficiary will receive a gray Medicaid identification card which is good for one year. This card is not proof of eligibility, and does not indicate CAP participation. See Chapter 38 for information about verifying eligibility.

Depending upon the particular type of Medicaid the child receives, Medicaid will re-determine eligibility either every six or every twelve months.



Cut along dotted lines

**ANNUAL MEDICAID IDENTIFICATION CARD**

CASEHEAD NAME  
 CASEHEAD ADDRESS LINE 1  
 CASEHEAD ADDRESS LINE 2  
 CASEHEAD ADDRESS LINE 3  
 CASEHEAD ADDRESS LINE 4  
 CASEHEAD ADDRESS LINE 5

FOLD HERE

RECIPIENT I.D.      RECIPIENT NAME      ISSUE DATE  
 000.00.0000.N      JONNXXXXX Q. PUBLIC      SEPT. 8, 2009

PRIMARY CARE PROVIDER NAME  
 PRIMARY CARE PROVIDER ADDRESS LINE 1  
 PRIMARY CARE PROVIDER ADDRESS LINE 2  
 PRIMARY CARE PHONE NO. AND AFTER HOURS NO.

Recipient Signature \_\_\_\_\_  
 (Not valid unless signed)

USE OF THIS CARD BY ANYONE NOT LISTED ON THE CARD IS FRAUD  
 AND IS PUNISHABLE BY A FINE, IMPRISONMENT OR BOTH

For questions about your Medicaid coverage and/or to report  
 Medicaid fraud, waste or program abuse, please contact  
 CARE-LINE at 1-800-662-7030 or locally call 919-855-4400.

Cut along dotted lines

Cut along dotted lines

**NOTICE TO PROVIDERS**

The Medicaid Identification card is not proof of medicaid eligibility. It is the responsibility of the medical provider to verify the identity of the individual, the Medicaid covered services, medical home/ primary care physician with whom the recipient is enrolled, and to obtain authorization from the primary care physician as required Refer to the Basic Medicaid Billing Guide at <http://www.ncdhhs.gov/dma/basicmed/> for information on how to verify eligibility for Medicaid covered services and to obtain authorization.

**Eligible Provider:** A provider must be enrolled in the NC Medicaid program to be paid for services rendered to NC Medicaid recipients. If not enrolled, go to [www.netracks.nc.gov](http://www.netracks.nc.gov) to find enrollment information and forms or call the CSC Enrollment Verification and Credentialing (EVC) Center at 1-866-844-1113.

- **Prior Approval:** Some Medicaid services must be approved in advance. Refer to the Basic Medicaid Billing Guide for prior approval requirements. Changes are published the first of each month in Medicaid Provider bulletins.
- <http://www.ncdhhs.gov/dma/bulletin/>.
- Out of state providers must obtain approval prior to delivering Medicaid services unless there is a medical emergency as defined in the Social Security Act, Section 1923(b)(2)(B)(i-iii) and (C)(i-iii). In cases of medical emergency that result in patient hospitalization, out of state providers must notify North Carolina Medicaid within 72 hours (three business days) of the admission date.
- **Claim Filing:** Bill other insurance first; Medicaid is last payor. Medicaid payment is full payment even if charges exceed the payment. Refer to the Basic Medicaid Billing Guide for additional information regarding claim filing.

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Cut Along Dotted Lines

Medicaid Card

DMA-5005A (Rev. 08/09) Yearly

## CHAPTER REVIEW

### 🔑 Key Points

1. Be careful of the timing of the Medicaid application. You can not discourage a family from applying for Medicaid whenever they wish, but you should make them aware that if approval is dependent on CAP/C approval, and you can not get the initial assessment done before the Medicaid application expires, they will have to apply again.
2. Send the family to the DSS even if they already have Medicaid. They may not have the right type of Medicaid or changes may need to be made.
3. Even though the parents' income doesn't count for CAP/C Medicaid eligibility, the DSS will ask the family for income and resource information.
4. Children who receive SSI automatically qualify for Medicaid.
5. The family will receive one annual gray Medicaid ID card.
6. Medicaid eligibility will be re-determined every six to twelve months.

 **Test Your Knowledge**

1. If a child is going to be on a wait list for six months, you
  - a. Tell the family to apply for Medicaid so at least that part will be done when their turn comes up
  - b. Tell the family not to apply for Medicaid until you tell them; you will not be able to meet the deadline and they will have to reapply.
  - c. Tell the family they can apply if they wish, but if they are not eligible without CAP and are denied, they will have to reapply when their turn comes up on the wait list.
2. If a child who already has Medicaid applies for CAP/C,
  - a. they still need to go to the DSS and inform the worker that they are applying for CAP
  - b. there is no need to go to DSS – they already have Medicaid
3. True or False: If the parents inform the Medicaid worker that they are applying for CAP/C, they will not be asked anything about their income or finances.
4. The beneficiary will receive a Medicaid card
  - a. monthly
  - b. quarterly
  - c. annually

1. c, 2. a, 3. False, 4. c

## **SECTION 4**

### **APPLYING FOR CAP/C**

## **CHAPTER 29**

### **The FL-2 and Level of Care**

**LOC**  
Level of  
Care

This entire chapter relates to the assurance of Level of Care.

#### **WHAT IS THE PURPOSE OF THE FL-2?**

CAP/C is an alternative to placement in a nursing facility, so in order to be approved for CAP/C the child must require the same level of care as a nursing facility requires.

The FL-2 is the way in which this is done. Since the FL-2 is used by nursing facilities, approval of the FL-2 is a sure indication that the child meets the nursing facility level of care.

#### **WHEN IS THE FL-2 COMPLETED?**

The FL-2 must be completed prior to initial approval for CAP/C, and annually thereafter. It must also be completed any time there is a significant change in the child's condition.

The person must be a Medicaid applicant or beneficiary for the FL-2 to be processed. So for initial approval, the CAP/C applicant will need to apply for Medicaid while you obtain the FL-2 from the physician. Once the applicant has a Medicaid number, and within 30 days of the date the physician signs the form, you may submit the form to the fiscal agent for approval.

The FL-2 must be approved by the fiscal agent before you begin the assessment and plan of care process.

For the annual Continued Needs Review, the FL-2 must be completed during the same month that it was approved the prior year. It does not need to be called in to the fiscal agent each year. If the previous FL-2 was evaluated by the fiscal agent, the approval date is the date of the telephone approval. If it was not reviewed by the fiscal agent, the approval date is the date of the physician's signature. There are no written criteria on how often a FL-2 needs to be called in to the fiscal agent if there are no significant changes in condition. It is recommended that it be called in every other year.

A significant change in condition is defined as

- Start or discontinuation of a ventilator
- Start or discontinuation of a tracheostomy tube
- Change in level of staff between nurse aide level and nurse level
- Start or discontinuation of tube feedings
- Increase or decrease in seizure activity such that a revision to the plan of care is needed
- Increase or decrease in need for ADL assistance such that a revision to the plan of care is needed
- Other changes as determined by the Case Manager and/or by the DMA CAP/C Nurse Consultant

For active CAP/C beneficiaries who have had a significant change in condition for the worse, the FL-2 must be completed and signed by the physician but does not need to be called in to the fiscal agent. For beneficiaries whose change in condition is a significant improvement, the FL-2 should be called in the fiscal agent to determine if the beneficiary still meets nursing facility level of care criteria.

An FL-2 must always be completed as part of the annual Continued Needs Review, even if the previous FL-2 was completed less than one year ago.

### **GETTING THE FL-2 DONE ON TIME**

It is very important that the FL-2 is completed on time. CMS, the federal authority over CAP/C, mandates that level of care is reevaluated annually.

If you can foresee your FL-2 being done late (for example, at the time of the CNR, the child is out of state in a treatment program or because of a custody arrangement), please get the FL-2 approved or signed prior to the child's departure. A copy of this FL-2 should be uploaded into eCAP along with an explanation of why it was obtained. Upload it when you obtain it; do not wait for the next CNR.

The same applies if the child is hospitalized. Get an FL-2 from the doctors at the hospital if you need to. The discharge planner may be able to assist in this process.

### **WHO COMPLETES THE FL-2?**

The FL-2 should ideally be completed by the physician. The case manager's and family's assessment is found on the assessment form and plan of care; the FL-2 is supposed to reflect the physician's assessment. It also helps to ensure our clients' health, safety, and well-being by noting any discrepancies between the physician's, case managers', and families' information, and resolving those discrepancies.

If, however, the physician will not complete the FL-2, the case manager may complete it and submit it to the physician for review and signature. Please explain to the physician the importance of a complete and accurate FL-2 form and the need for his/her thoughtful consideration of the information and recommendations contained in it.

If the Case Manager documents additional information on the FL2 form, it should be initialed and dated so it is known that it is a Case Manager's

amendment/clarification, and not the physician's.

### **WHERE DO I GET THE FL-2 FORM?**

The DMA372-124, NC DMA Long Term Care FL2 Form is located at the following link: <http://info.dhhs.state.nc.us/olm/forms/dma/dma-372-124-ia.pdf>. This is the paper version of the FL-2 form.

The electronic version of the form is located in NC Tracks, under Prior Approval Entry, PA Type A31-LTC-CAP.

### **HOW IS THE FORM COMPLETED?**

#### The Paper Form

The NC DMA Long Term Care FL2 Form (DMA372-124) is the printable, paper version of the FL2 form.

Each section on the FL-2 form must be completed to its entirety in order for the request to be complete.

#### Recipient Information Section

Items 1 and 2	Recipient Last Name and First Name	Enter the child's name as it is recorded for Medicaid.
Item 3	Recipient DOB	Enter the month, day, year of the child's birth.
Item 4	Recipient ID	Enter the Medicaid ID number
Item 5	Recipient Gender	Enter F for female or M for male.
Item 6	SSN	Enter the child's Social Security Number.
Item 7	Admission Date	If the child is at home, enter N/A. If the child is in a hospital or other facility, enter the admission date.
Items 8, 10,	Facility Name, Facility Address, and Provider	If the child is at home, enter the information of the CAP/C case

and 11	Number	management provider. If the child is in a hospital or other facility, enter the facility's information. Provider Number refers to your NPI number.
Item 9	PASRR #	Enter 99999
Item 13	Relative Name/Address	Enter the information of the person responsible for the child
Item 14	Current Level of Care	If a new CAP/C applicant who lives at home, enter N/A. If the client is on CAP/C, check "Other" and write "CAP/CH SNF" or "CAP/CH Hosp".
Item 15	Requested Level of Care	Enter "CAP/CH SNF" or "CAP/CH Hosp".
Item 16	Discharge Plan	Enter other and write CAP/CH

#### Diagnosis Information Section

An attachment may be used for this section. Clearly indicate that an attachment is being used. For example, "Please see the attached diagnosis list as supporting documentation to use for a LOC determination".

You will need to enter the diagnosis code, not just the name.

#### Patient Information Section

This section must be completed to its entirety; the use of an attachment for this section is not appropriate.

Check the blocks applicable to this patient under the designated heading. If may be necessary to check more than one block under a heading or write additional information in blanks. Make information as specific as possible to support the recommended level of care.

Note that for CAP/C, PT and Speech Therapy are not used in determining level of care.

CAP/C does not allow the use of restraints.

#### Medication Section

An attachment may be used for this section. Clearly indicate that an attachment is being used. For example: "Please see the attached current medication list as supporting documentation to use for a LOC determination".

List current medications, with their dosages and routes of administration. Include all prescription and over-the-counter medications.

#### The Physician's Signature and Date

The physician must validate by signature the care needs presented on this patient. The signature must be that of the physician indicated in item 12 of the Recipient Information. FL-2s that are signed by a Physician Assistant or Nurse Practitioner must be cosigned and dated by the attending physician, and both names should be in item 12. An FL-2 signed by a physician in the same practice as the physician in item 12 is acceptable as long as the physician writes "in practice with" and his/her name in item 12 next to the first physician's name. An out-of-state physician may sign the FL-2.

The FL-2 must be dated by the physician who signs the form. The fiscal agent must receive the form within 30 days of this date.

#### The Electronic Form

Guidance regarding completing the form electronically may be obtained at <http://www.NCTracks.com/PAformhep> or through the NCTracks Call Center at 1-800-688-6696.

NCTracks has implemented a physician signature form that can be used to attest for the physician signature on the FL-2. This form can be retrieved from the NCTracks web portal. The customer service department at NCTracks can assist you in obtaining this form.

### **HOW IS THE FL-2 SUBMITTED?**

There are three ways to make a prior approval request for a LOC determination utilizing the NCTracks web portal: electronic, mail or telephone.

All individuals who make LOC requests and who have a valid NCID will be assigned a pin number to use when making a LOC request. This assigned pin number must be used each time a LOC request is made electronically, by mail or telephone.

The NCID user who is making a LOC request is the only assigned individual who can obtain the official results (LOC approval and prior approval number) for the LOC decision. However, a provider entity can conduct a recipient inquiry within their assigned NPI and taxonomy coverage area to assess information about the prior approval status of beneficiaries assigned to that Lead Agency.

The FL-2 must be submitted for approval within 30 days of the physician's signature.

The FL-2 information should also be entered into e-CAP supporting documents.

### **HOW IS AN-FL-2 PROCESSED?**

The following procedure is used to process the FL-2 for prior approval:

The fiscal agent's nurse analyst, applying the N.C. Medicaid nursing facility LOC criteria (see 'What are The Criteria For Approval?', below) reviews the FL-2. When the decision is made, the approval or denial notice will be

available to the submitter in NC Tracks. When you receive approval in NC Tracks, record that number and upload the paper FL-2 form into eCAP supporting documents.

The case manager submits the entire initial application or Continued Needs Review to DMA within 60 calendar days of the FL-2 approval date. If the assessment, POC, and FL-2 are not received by DMA within the time limit, a new FL-2 is obtained and the assessment and plan of care are updated.

### **What If The FL-2 Is Denied?**

If the nursing facility LOC is not evident upon review of the FL-2, a denial decision will be visible in NC Tracks.

If the nursing facility level of care is denied, residents/responsible parties must be notified that they have the right to an appeal of the denial in accordance with Medicaid's beneficiary notices procedures

**FH**  
Fair  
Hearings

### **WHAT IF THERE IS A PROBLEM WITH PROCESSING OF THE FL-2?**

If prior approval is delayed or voided due to a processing problem that is beyond the control of the case manager, call DMA's HCI Unit for guidance. A new FL-2 may have to be obtained; however, in some instances, DMA may be able to get approval retroactive to the original FL-2 approval date.

### **WHAT ARE THE CRITERIA FOR APPROVAL?**

The following information is taken from Clinical Coverage Policy 2B-1, Nursing Facilities, located at <http://www.ncdhhs.gov/dma/mp/2B1.pdf>.

The following criteria are not intended to be the only determinants of the resident's or beneficiary's need for nursing facility level of care. Professional judgment and a thorough valuation of the resident's or beneficiary's medical condition and psychosocial needs are necessary, as well as an understanding of and the ability to differentiate between the need for

nursing facility care and other health care alternatives. All professional services that are provided to the resident or beneficiary to maintain, monitor, and/or enhance the resident's or beneficiary's level of health must be addressed in the medical records and reflected on the medical eligibility assessment form.

### Qualifying Conditions

Conditions that are considered when assessing a beneficiary for nursing facility level of care include the following:

- a. Need for services that, by physician judgment, require
  1. a registered nurse for a minimum of 8 hours daily and
  2. other personnel working under the supervision of a licensed nurse
- b. Need for daily licensed nurse observation and assessment of resident needs
- c. Need for administration and/or control of medications that, according to state law, are to be the exclusive responsibility of licensed nurses, requiring daily observation for drug effectiveness and side effects (as defined in 10A NCAC 13O.0202, medications may be administered by medication aides with appropriate facility policies and procedures and following the North Carolina board of nursing requirement for supervision)
- d. Need for restorative nursing measures to maintain or restore maximum function or to prevent the advancement of progressive disabilities as much as possible; such measures may include, but are not limited to, the following:
  1. Encouraging residents to achieve independence in activities of daily living (such as bathing, eating, toileting, dressing, transfer/ambulation)
  2. Using preventive measures and devices, such as positioning and alignment, range of motion, handrolls, and positioning pillows, to prevent or retard the development of contractures
  3. Training in ambulation and gait, with or without assistive devices
- e. Special therapeutic diets: nutritional needs under the supervision and monitoring of a registered dietician
- f. Nasogastric/gastrostomy tubes: requiring supervision and observation by licensed nurses
  1. Tube with flushes
  2. Medications administered through the tube
  3. Supplemental bolus feedings
- g. Respiratory therapy: oxygen as a temporary or intermittent therapy or for residents who receive oxygen therapy continuously as a component of a stable treatment plan
  1. Nebulizer usage

2. Pulse oximetry
3. Oral suctioning
- h. Wounds and care of decubitus ulcers or open areas
- i. Dialysis: hemodialysis or peritoneal dialysis as part of a maintenance treatment plan
- j. Rehabilitative services by a licensed therapist or assistant as part of maintenance treatment plan
- k. Diabetes, when daily observation of dietary intake and/or medication administration is required for proper physiological control

### **Conditions That Must be Present in Combination to Justify Nursing Facility Level of Care**

The following conditions when in combination may justify nursing facility level of care placement:

- a. **Need for teaching and counseling** related to a disease process, disability, diet, or medication
- b. **Adaptive programs:** training the resident to reach his or her maximum potential (such as bowel and bladder training or restorative feeding); documentation must include the purpose of the resident's participation in the program and the resident's progress
- c. **Ancillary therapies:** supervision of resident performance of procedures taught by a physical, occupational, or speech therapist, including care of braces or prostheses and general care of plaster casts
- d. **Injections:** requiring administration and/or professional judgment by a licensed nurse
- e. **Treatments:** temporary cast, braces, splint, hot or cold applications, or other applications requiring nursing care and direction
- f. **Psychosocial considerations:** psychosocial condition of each resident will be evaluated in relation to his or her medical condition when determining the need for nursing facility level of care; factors to consider along with the resident's medical needs include
  1. Acute psychological symptoms (these symptoms and the need for appropriate services and supervision must have been documented by physician's orders or progress notes and/or by nursing or therapy notes)
  2. Age
  3. Length of stay in current placement
  4. Location and condition of spouse
  5. Proximity of social support
  6. Effect of transfer on resident, understanding that there can always be, to a greater or lesser degree, some trauma with transfer (proper and timely discharge planning will help alleviate the fear and worry of transfer)
- g. **Blindness**
- h. **Behavioral problems** such as

1. Wandering
  2. Verbal disruptiveness
  3. Combativeness
  4. Verbal or physical abusiveness
  5. Inappropriate behavior (when it can be properly managed at the nursing facility level of care)
- i. **Frequent falls**
  - j. **Chronic recurrent medical problems** that require daily observation by licensed personnel for prevention and/or treatment

Note that for CAP/C, the criteria related to therapies (PT, OT, ST, RT) don't apply.

Remember that approval of an FL-2 does not automatically mean approval for CAP/C. For instance, an FL-2 may be approved for cognitive or behavioral problems; these conditions by themselves would not qualify a beneficiary for CAP/C.

#### **Critical Dates and Time Limits Related to FL-2**

1. The FL-2 must be submitted to the fiscal agent within 30 calendar days of the physician's signature.
2. The effective date is the date of approval.
3. The complete set of paperwork including assessment and plan of care must be received by DMA within 60 days of the approval.
4. The next year's FL-2 must be completed in or before the same month as this year's FL-2 approval date.
5. The effective date of the approval for all subsequent FL-2s becomes
  - a. If submitted to the fiscal agent for review, the date of approval
  - b. If not submitted to the fiscal agent for review, the date of the physician signature

## **HOSPITAL LEVEL OF CARE**

Hospital level of care is approved by DMA's HCI Unit for children with medical conditions who require continuous, complex and substantial skilled nursing care that could not otherwise be provided in a skilled nursing facility. These children typically have multiple serious illnesses, medical conditions and/or injuries.

Hospital level of care requires that the beneficiary meet at least one of the following additional criteria:

- Ventilator dependency, for all or part of the day
- A tracheostomy requiring suctioning more often than every four hours
- Oxygen dependency when the flow rate requires adjustment based on oxygen saturation
- PRN medications, excluding routine topical meds such as those for diaper rash, administered more often than every four hours
- More than two unplanned hospitalizations within the last year, or more than three total hospitalizations within the last year
- Interventions that occur at least every two hours AND require the scope of practice of an RN or LPN

The two levels of care in CAP/C:	
<b>Nursing Facility</b>	<b>Hospital</b>
approved by DMA's fiscal agent	approved by DMA after DMA's fiscal agent's approval of Nursing Facility
based on FL-2	based on FL-2, assessment, and other supporting data
Indicator Code: SC	Indicator Code: HC
Nurse Aide or Nurse level of in-home care	Nurse Aide or Nurse level of in-home care

The designation of hospital level of care is only used by DMA for financial reports related to cost neutrality: making sure that CAP/C costs less than institutionalization. It has no bearing on the type or amount of services or supplies the beneficiary can have. There is no added benefit to the child, the family, or the case manager of having hospital versus nursing facility level of care.

## **CHAPTER REVIEW**

### **🔑 Key Points**

1. There are two levels of care in CAP/C: Nursing Facility and Hospital.
2. Nursing Facility level of care is approved by DMA's fiscal agent based on the FL-2.
3. A subset of Nursing Facility-approved beneficiaries who meet certain criteria will be approved by DMA for Hospital level of care.
4. Nursing Facility level of care is designated as SC. Hospital level of care is designated as HC.
5. There is no benefit to the beneficiary of being or not being Hospital level of care.
6. The FL-2 must be completed annually at the time of the CNR.
7. The FL-2 must also be completed any time there is a significant change in condition.
8. Important FL-2 deadlines:
  - Must be submitted for approval within 30 days of MD signature
  - Initial/CNR must be received by DMA within 60 days of level of care approval
  - FL-2 must be completed during or before the month it was completed the previous year.

 **Test Your Knowledge**

1. What are the two levels of care in CAP/C?
  - a. Intermediate and Skilled
  - b. Skilled and Hospital
  - c. Nursing Facility and Hospital
  - d. Nursing Facility and Skilled
2. True or False: A hospital level child can receive more hours of in-home nursing than a nursing facility level child.
3. True or False: The frequency of physical, speech, and occupational therapy can be used to meet nursing facility level of care for CAP/C.

1. c, 2. False, 3. False,

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## **SECTION 4 APPLYING FOR CAP/C**

### **CHAPTER 30 The Physician's Request Form**

#### **WHEN IS THE PHYSICIAN'S REQUEST FORM NEEDED?**

The physician's request form must be completed at the time of the initial request for CAP/C Nursing. This may be during the initial application, or when a beneficiary changes from nurse aide level to nurse level care. Your CAP/C Nurse Consultant may also request that the form be completed at other times as part of the determination of appropriateness of services.

The form does not need to be completed for patients receiving nurse aide care.

The form does not need to be completed for beneficiaries who do not receive in-home care.

The form does not need to be completed for skilled nursing visits.

#### **HOW IS THE PHYSICIAN'S REQUEST FORM COMPLETED?**

It is recommended that this form be given to the physician at the same time as the FL-2.

Complete the form as follows:

**North Carolina Division of Medical Assistance  
Community Alternatives Program for Children  
PHYSICIAN'S REQUEST FORM FOR IN-HOME NURSING SERVICES**

Name \_\_\_\_\_ Medicaid ID# \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

---

This section may be completed by the Case Manger. The information refers to the beneficiary. Enter the child's name, MID, address, phone, and date of birth.

Diagnoses \_\_\_\_\_

Prognosis and expectations of specific disease process \_\_\_\_\_

Date last seen \_\_\_\_\_

This section should be completed by the physician.  
The physician should enter all of the current diagnoses, same as on the FL-2 form.  
Next, he/she should indicate the course of the beneficiary's condition: Will the child's condition improve, stay the same, or worsen? What specific changes are expected: is the physician expecting that a GT will be needed within the next six months? Or that the trach can be removed in the spring? Or that soon the child's muscle weakness will deteriorate to the point where he will lose the ability to walk?  
Finally, the physician should indicate when he or she last saw the beneficiary for a medical appointment.

**TECHNOLOGY REQUIREMENTS AND CARE NEEDS**

**1. Ventilator**

NO  YES, type \_\_\_\_\_ and hours per day \_\_\_\_\_

**2. Tracheostomy**

NO  YES, actual frequency of suctioning including PRN use  
\_\_\_\_\_

**3. Oxygen**

NO  YES, continuous stable rate  
 YES, continuous, rate adjusted daily/ more often  
 YES, PRN for \_\_\_\_\_; the actual frequency of PRN use is \_\_\_\_\_

This section also should be completed by the physician. Each question should be answered with a yes or no.

For ventilator, indicate the type and how many hours per day the child uses it. For a trach, indicate how often the child is *actually* suctioned. For example, the order may state 'Q4H and PRN', but the child may need PRN suctioning quite often such that the child actually gets suctioned hourly.

For oxygen, if it is used continuously, indicate whether the rate is stable or requires adjustments (for instance based on pulse oximetry readings). If it is ordered PRN, indicate when/for what reason it is used, and how often that happens.

**4. Other Needs for a Nurse**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This section should also be completed by the physician.

The physician should indicate here why he/she wants a nurse in the child's home. What will the nurse need to do? Why is a nurse required, and not a lower level of staff?

**5A. Family/home dynamics influencing in-home care**

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**5B. Caregiver availability**

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**5C. Caregiver competency with in-home care**

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This section should also be completed by the physician.

He should indicate any home or family issues he is aware of that would influence the child’s care. Some examples might be: cultural practices, influence of grandparents, relationship between parents, financial needs, language barriers, siblings providing care...

Next the physician should indicate to the best of her knowledge the caregivers that child has available to him/her. Are the parents generally available? Is there extended family that helps? Who brings the child in for appointments? Finally, he should indicate the caregiver’s ability to provide in-home care: Are they knowledgeable and involved? Do they seem unable to understand some aspect of the child’s care? Are they generally adherent to diet, medications, treatments, and keeping appointments? Are they very anxious? Do they understand what to look for and when to seek medical attention?

**6. What other resources have been used to assist this child/family?**

---

---

This section should be completed by the physician.

She should indicate what type of assistance the child has or has tried; for example, home health visits, developmental daycare, or another Medicaid program.

MD Name \_\_\_\_\_ Name of Practice \_\_\_\_\_  
MD Signature \_\_\_\_\_ Date \_\_\_\_\_

DMA-3063  
9/10

Finally, the MD should write and sign his/her name, indicate the date of the signature, and indicate the name of the practice in which he or she works. This form must be signed by an MD. It can be signed by a Nurse Practitioner or Physician Assistant, but must be cosigned by the physician. The rules for signatures on this form are the same as those for the FL-2. See Chapter 29 for this information.

#### **WHY IS THIS FORM NEEDED? FOR WHAT IS IT USED?**

This form supplements the information given to us on the FL-2 form. The FL-2 serves two purposes: it determines level of care, and it allows the physician's input into the care of these medically fragile children. However, the FL-2 is often not detailed. For instance, the FL-2 may indicate "oxygen" but rarely indicates the amount or the frequency of adjustments. The amount and frequency of adjustments is important because a nurse aide can handle continuous, stable oxygen, but a nurse is needed for PRN or variable rates. The Physician's Request Form also asks questions that are not on the FL-2, such as the child's prognosis and expected disease course.

As these children have a higher level of need, they require a higher level of physician input. The information on the combination of the two forms gives that input. It also helps ensure that the higher-level, higher-cost nursing services are medically necessary.

North Carolina Division of Medical Assistance
Community Alternatives Program for Children
PHYSICIAN'S REQUEST FORM FOR IN-HOME NURSING SERVICES

Name \_\_\_\_\_ Medicaid ID# \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Diagnoses \_\_\_\_\_

Prognosis and expectations of specific disease process \_\_\_\_\_

Date last seen \_\_\_\_\_

TECHNOLOGY REQUIREMENTS AND CARE NEEDS

1. Ventilator

[ ] NO [ ] YES, type \_\_\_\_\_ and hours per day \_\_\_\_\_

2. Tracheostomy

[ ] NO [ ] YES, actual frequency of suctioning including PRN use \_\_\_\_\_

3. Oxygen

[ ] NO [ ] YES, continuous stable rate
[ ] YES, continuous, rate adjusted daily/ more often
[ ] YES, PRN for \_\_\_\_\_; the actual frequency of PRN use is \_\_\_\_\_

4. Other Needs for a Nurse

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5A. Family/home dynamics influencing in-home care

\_\_\_\_\_  
\_\_\_\_\_

5B. Caregiver availability

\_\_\_\_\_  
\_\_\_\_\_

5C. Caregiver competency with in-home care

\_\_\_\_\_  
\_\_\_\_\_

6. What other resources have been used to assist this child/family?

\_\_\_\_\_  
\_\_\_\_\_

MD Name \_\_\_\_\_ Name of Practice \_\_\_\_\_
MD Signature \_\_\_\_\_ Date \_\_\_\_\_

A Blank Physician's Request Form

## **CHAPTER REVIEW**

### **Key Points**

1. The Physician's Request Form is completed only for beneficiaries who need CAP/C Nursing.
2. The form is completed only at the initial request for CAP/C Nursing.
3. The form supplements the information obtained on the FL-2 form.



## Test Your Knowledge

1. True or False: The Physician's Request Form needs to be submitted every year with the CNR.
2. True or False: The Physician's request form needs to be submitted for any patient receiving in-home care.
3. Who must sign the Physician's request form?
  - a. MD
  - b. NP (Nurse Practitioner)
  - c. PA (Physician's Assistant)
  - d. all of the above

1. False, 2. False, 3. a

**SECTION 4  
APPLYING FOR CAP/C**

**CHAPTER 31  
Employment Verification**

**Chapter 31 Employment Verification**

**WHAT IS EMPLOYMENT VERIFICATION?**

Employment verification is written documentation of the caregivers' work status and typical work schedule. It does not include salary information, social security number, performance evaluations, length of employment or anything else. It is simply a verification of the caregiver's availability.

**WHEN IS EMPLOYMENT VERIFICATION NEEDED?**

Employment verification is needed when the plan of care involves in-home attendant, nurse aide, or nurse care, and the requested number of hours includes the up to 50 hours per week for work time.

**HOW OFTEN IS IT COMPLETED?**

Employment verification is completed at the initial and at least annually at the time of the CNR, and more often as needed with changes in employment.

**WHO COMPLETES IT?**

The parent is ultimately responsible for providing you with this information. Depending upon the type of documentation provided (see below), either the employer or the parent will complete it.

**WHAT DOCUMENTATION IS NEEDED?**

There are two acceptable forms of documentation: a letter from the employer, or a completed Employment Verification Form.

**The Letter from the Employer**

This is the preferred method of employment verification. It is simply a statement on the employer's letterhead which details

- The employment status; i.e. permanent full-time, temporary, currently on maternity leave or family leave, etc.
- The employee's typical work hours, including the times of day and the days per week.

**The Employment Verification Form**

The Employment Verification Form is to be used only as a last resort when it is impractical to obtain a letter. An example would be when a parent cleans houses, but does not work for an agency, it would be impractical to obtain a letter from each household for whom she works. Another example would be a parent who is self-employed.

**How Is The Employment Verification Form Completed?**

The form is located at <http://www.ncdhhs.gov/dma/services/capc.htm> and is titled 'Verification of Employment for CAP/C'. It should be completed for all of the working caregivers when work time is being included in the number of hours of care per week and employer verification is not possible. The form itself is self-explanatory; see the illustration on the next page.

**WHAT IF I AM UNABLE TO OBTAIN VERIFICATION OF EMPLOYMENT?**

Work hours will not be authorized for any child whose caregivers can not provide verification of employment.

VERIFICATION OF EMPLOYMENT FOR CAP/C

Child's Name: \_\_\_\_\_ Child's Medicaid ID Number \_\_\_\_\_

Caregiver Name \_\_\_\_\_

- 1. Attach letter from employer which includes hours and status of employment. You need not indicate salary information or social security number.

OR

- 2. Answer the following questions:

- A.  I am self-employed.
- I am an independent contractor.
- I am an employee of \_\_\_\_\_.

B. I work as a \_\_\_\_\_.

- C.  I do most of my work outside the home.
- I do most of my work at my home.

- D. If I do most of my work at my home,
  - I have a separate, dedicated work space in my home.
  - I do not have a separate, dedicated work space in my home.

- E. If I do most of my work at my home,
  - I can arrange my hours, interrupt my work, or be otherwise available for care of my child.
  - I can not be available to care for my child; I would need to seek daycare or babysitter/nanny services for my child.

- F. My typical work hours are (do not include on-call hours):
  - Monday \_\_\_\_\_
  - Tuesday \_\_\_\_\_
  - Wednesday \_\_\_\_\_
  - Thursday \_\_\_\_\_
  - Friday \_\_\_\_\_
  - Saturday \_\_\_\_\_
  - Sunday \_\_\_\_\_

- G. My typical work schedule:
  - never or rarely varies.
  - varies sometimes.
  - varies a lot.

- H. My typical work hours are:
  - very flexible.
  - somewhat flexible.
  - not flexible.

- I. Please elaborate on any of the above or include any additional relevant information on the back of this form.

**An individual who certifies a material and false statement in this assessment will be subject to investigation for Medicaid fraud and, if applicable, will be referred to the appropriate professional licensing agency for investigation.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

**WHAT IF THE INITIAL OR CNR IS DUE AND EMPLOYMENT VERIFICATION IS THE ONLY DOCUMENTATION I AM MISSING?**

Do not submit your initial or CNR until you have all of the documentation. You can not develop your plan of care without knowing whether the family is or is not eligible for work hours. Notify the parent(s) well in advance that you will need this information. If the paperwork is due and you have not received verification, submit the plan of care without work hours, and complete a plan of care revision once you receive the verification. Contact your Consultant for guidance as needed.

## CHAPTER REVIEW

### **Key Points**

1. Employment verification is necessary when in-home care includes coverage for work hours.
2. The preferred method of employment verification is a statement on the employer's letterhead.
3. There is also a form that can be used when getting a letter is a hardship or not possible.
4. The employment verification is verification only of work status and work schedule. No other information is needed.
5. Hours of care to cover work time will not be authorized without verification of employment.

 **Test Your Knowledge**

1. Which of the following is acceptable documentation of verification of employment?
  - a. A statement on employer letterhead.
  - b. A copy of a pay stub.
  - c. A copy of the W-2 form.
  - d. All of the above.
2. In which of the following situations is employment verification needed?
  - a. There is a stay-home caregiver, and only personal time and sleep time are being requested.
  - b. There is a single working parent who needs care for her child while she works.
  - c. There is no request for in-home care; only for home modifications and palliative care services.
3. If there are two parents in the home, and both work, and work hours are being requested on the plan of care, you need:
  - a. No verification.
  - b. Verification from one parent.
  - c. Verification from both parents.
4. If a caregiver changes jobs in between CNRs, you should obtain employment verification
  - a. At the time of the job change.
  - b. At the next CNR.

1. a, 2. b, 3. c, 4. a

**SECTION 4  
APPLYING FOR CAP/C**

**CHAPTER 32  
Request for Nurse or Nurse Aide Services In  
The School**

The Request for Nurse or Nurse Aid Services in the School form is no longer used.

As stated in Chapters 14, 15, and 16, waiver funding may not be used to pay for any services provided in a public school, as this is the responsibility of the state and local education agencies.

Waiver funding may only be used to pay for services in private schools. Please document within your assessment or plan of care revision that the service is being provided in a private school. This Request Form is not needed.

## SECTION 4 INITIATING CAP/C

### CHAPTER 33 The Assessment

## Chapter 33 The Assessment

#### WHAT IS THE PURPOSE OF THE ASSESSMENT?

An assessment is used to obtain information about the child and family, including

- The child's current health status
- The child's/family's abilities
- The help the child/family needs
- The help available from informal and formal supports
- The client's/family's preferences regarding care

This information is used to

- Determine whether or not waiver services are required
- Determine whether or not waiver services can meet/are meeting the child's/family's needs
- Develop the family-centered Plan of Care.

QP  
Qualified  
Providers

#### WHO CONDUCTS THE ASSESSMENT?

There are two options for who may conduct the assessment:

- A registered nurse who meets the case manager qualifications may conduct the entire assessment,
- or
- A team consisting of a registered nurse and a social worker who both meet the case manager qualifications may each conduct parts of the assessment.

Please see chapters 11 and 13 for information regarding case manager

qualifications.

If a CAP/C case management agency employs only social workers, it may contract for the RN to do all or some of the assessment. Likewise, if the CAP/C case management agency employs only nurse, it may contract for the SW to do parts of the assessment. The contract may be with a qualified individual or with an agency that then provides that individual. To avoid any conflict of interest, the case managers that conduct the assessment should not be employed by the agency providing the direct care to the child. The agency(ies) should also not conduct an assessment of a child when they employ that child's parent or caregiver.

### **WHEN IS THE ASSESSMENT DONE?**

#### For Potential New Beneficiaries

Do not begin a CAP/C assessment of a potential new client unless approved to do so by a DMA CAP/C Nurse Consultant. The referral must be reviewed first. If approved, you will receive a letter from your CAP/C Nurse Consultant authorizing you to proceed with the assessment. If the referral is denied, the client has the right to have the assessment done anyway (see Chapter 26). If they exercise that right, you will receive a letter of notification and approval for assessment from your CAP/C Nurse Consultant.

#### For Continuing Clients Who Have Been Residing In Your Service Area

For continuing cases, annually reassess the individual's need for CAP/C. The annual reassessment is called the Continued Need Review (CNR). Complete the CNR during the two months prior to the beneficiary's birth month. Submit the CNR Assessment and other documentation in eCAP no later than the fifth day of the beneficiary's birth month.

You must also reassess after any significant change in condition (see Chapter 29 for definition of a Significant Change in Condition). There is a version of the assessment in eCAP specifically for this purpose. If a revision of the Plan of Care



MORE  
INFORMATION



MORE  
INFORMATION

AA  
Admin.  
Authority



MORE  
INFORMATION

is needed, include enough information to support the request for change in services.

### For Continuing Clients Who Have Just Moved Into Your Service Area

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

- Complete a Significant Change In Condition assessment in eCAP. Update the demographic information (Recipient Profile), home environment assessment (Housing/Finance), and providers list (Profile: Professional Providers and Plan of Care).

(If any of the providers have changed, you will also need to print new service authorizations and participation notices after you have updated the assessment and Plan of Care as applicable.)

For all clients, complete the assessment after approval of the FL-2 and before you develop the Plan of Care. Submit all of your documentation so that it will be received by DMA no later than 60 days after the FL-2 completion date (the date of telephone approval if it was called in, or the date of MD signature if it was not called in). The assessment may be done up to 60 days in advance. If the assessment, POC, and FL-2 are not received by DMA within 60 days of the FL-2 completion date, a new FL-2 is obtained and the assessment and plan of care are updated.

In addition to the formal assessments, you are continually informally assessing the client's situation. The information that you gather enables you to adjust services, develop resources and perform other case management activities to support the client. It also helps you know when a client is no longer appropriate for the program or for a particular service within the program.

### **WHERE IS THE ASSESSMENT DONE?**

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

MORE  
INFORMATION

- For the initial assessment of a child at home, conduct the assessment where the person resides.
- For the initial assessment of a child in a hospital/nursing facility, who can not be discharged until CAP/C is in place, please refer to Chapter 41.
- For the initial assessment of a child in a hospital or nursing facility, who can be discharged at least for a short period of time without CAP/C, you may perform most of your assessment at the facility as long as it is done within 30 days of the beneficiary's discharge date. You will need to make arrangements to do the home environment assessment or do it once the child arrives home.
- For a CNR, conduct the assessment at the child's home. If the child is temporarily hospitalized or otherwise unavailable when the CNR is due, contact the DMA HCI Unit for guidance.

You may also want to assess the client in other settings where CAP/C care is or will be provided. You are encouraged to do so, but this must supplement, not replace, the assessment in the home.

### **HOW IS THE ASSESSMENT CONDUCTED?**

If there is an assessment team conducting the assessment, both members of the team ideally should visit the home at the same time. However, if scheduling conflicts don't permit this, then each person's portion of the assessment may be conducted individually. If separate assessments are done, they should each be shared and discussed with the other team member, with each team member giving input into the subsequent plan of care development.

Assessment involves consultation with other natural and paid supports such as family members, medical and behavioral health providers, and educators.

The scope of the physical assessment conducted by the RN is determined by liability insurance coverage for that nurse's activities. If the nurse is insured, a complete hands-on assessment is permitted and encouraged. If not, the

assessment will be limited to subjective data, medical records, and nurse observation.

As you complete and document your assessment, keep in mind the following:

- Be individualized
- Be detailed
- Be thorough
- Any need that is identified must have a corresponding goal on the Plan of Care.
- Address all of the following client-specific components
  - Personal goals
  - Physical/functional
  - Medical history
  - Psychosocial behavioral
  - Mental health
  - Cognitive
  - Client's strengths and abilities
  - Environmental and residential
  - Family or support system dynamics
  - Spiritual
  - Cultural
  - Financial
  - Health insurance status
  - History of substance abuse
  - History of abuse, violence, or trauma
  - Vocational and/or educational
  - Recreational/leisure pursuits
  - Caregiver (s) capability and availability
  - Learning and technology capabilities
  - Self-care capability
  - Health literacy and illiteracy
  - Health status expectations and goals

- Transitional or discharge plan
- Advance care planning
- Legal
- Transportation capability and constraints
- Readiness to change
- Assess resource utilization and cost management

### **HOW IS THE ASSESSMENT DOCUMENTED?**

The assessment is completed in eCAP at [www.ncecap.net](http://www.ncecap.net). Printable copies of the assessment form are located in the eCAP Knowledge Exchange, Category: Case Management. However, if the assessment is completed on paper, it must be entered into eCAP. Assessments must be submitted to DMA electronically through eCAP.

For instructions regarding how to complete the assessment or what information is needed in each section or field, please refer to the eCAP Knowledge Exchange, under the category Case Management Assessments.

### **When Completing the Assessment:**

Make sure that the information contained in the assessment is consistent with the FL-2 and the CMS-485 (if applicable). There should be no discrepancies between what the family understands, what the case manager understands (assessment), what the physician understands (the FL-2), and what the nurse or nurse aide agency understands (the CMS-485) regarding the child's health status and care needs. If any discrepancies exist, you must coordinate having the discrepancy resolved. If the discrepancy is with the CMS-485, you will need to communicate closely with the home care agency and share the results of your/their actions (such as a new MD order) with each other. Document these activities in eCAP under FL2 Diagnosis Reconciliation/Comments, the comments section under the Meds/Precautions section, or other appropriate comments boxes within the assessment. A form or note resolving the discrepancy can also be uploaded.

Note: There is a form on the CAP/C website, <http://www.ncdhhs.gov/dma/services/capc.htm>, that you may use to assist with resolving these discrepancies. You are not required to use this particular form; it is just available to you if you find it helpful. Resolving the discrepancy is required; how you go about doing so is up to you.

### **HOW IS THIS INFORMATION USED FOR CAP/C APPROVAL AND FOR DEVELOPING THE PLAN OF CARE?**

The case manager reviews the assessment findings looking for problems requiring case management intervention, including

- Lack of an established evidence-based plan of care with specific goals
- Compromised client safety
- Over-utilization or under-utilization of services
- Use of multiple providers/agencies
- Use of inappropriate services or level of care
- High-cost injuries or illnesses
- Non-adherence to plan of care (e.g. medication adherence)
- Complications related to medical, psychosocial or functional issues
- Lack of education or understanding of the disease process, the current condition(s) and/or the medication list
- Lack of a support system or presence of a support system under stress
- Financial barriers to adherence of the plan of care
- Medical, psychosocial, mental health and/or functional limitations
- Determination of patterns of care or behavior that may be associated with increased severity of condition
- Inappropriate discharge or delay from other levels of care
- Frequent transitions between settings

FOR EVERY NEED YOU IDENTIFY DURING THE ASSESSMENT, THERE MUST BE A CORRESPONDING GOAL AND INTERVENTIONS ON THE PLAN OF CARE.

**FH**  
Fair  
Hearing

If during the course of an initial assessment, you feel the child is inappropriate for the program, discuss that with the client/responsible party as above. If the client is in agreement with you, have them sign a Notice of Voluntary Withdrawal of Referral form. This form is available on the web at <http://www.ncdhhs.gov/dma/provider/forms.htm>. If you do not get this form signed, you must submit the initial. Assessment only claims will not be approved for assessments that were not submitted and do not have a voluntary withdrawal form signed.

**FA**  
Financial  
Accountability

### **HOW IS THE ASSESSMENT BILLED?**

#### What May Be Billed

The amount billed may include the CAP/C case manager's time to arrange the assessment activities, the time spent for team members' visit(s) with the client, the time gathering needed information and the time completing the assessment form. Travel time is not billable.

#### Who Bills

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

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

#### Date of Service

Assessment activities usually stretch over several days. Document and bill for the time involved each day for assessment activities by showing the date of service as the date that the activities occur. If both members of the team do

billable assessment activities on the same date, combine the time of both members and enter it as one line item on the claim.

Except when conducting an initial assessment for a potential beneficiary in a hospital or nursing facility, the assessment activities must be accomplished on or after the CAP effective date to be billed to Medicaid. Initial assessment activities for a potential beneficiary in a hospital or nursing facility must occur on or after the FL-2 approval date.

Medicaid payment is available only if the client is authorized for Medicaid in a Medicaid category eligible for CAP coverage on the date of the service.

#### Billing for Non-Beneficiaries

Each Case Management agency should have a written policy in place regarding payment for assessments of individuals who do not become CAP/C beneficiaries. This policy should be explained to the family before the assessment is performed.

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

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

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

Assessment only claims are an option only for beneficiaries who have Medicaid in a Medicaid category eligible for CAP/C coverage. For beneficiaries who do not have this or any Medicaid coverage, the agency may choose to bill the beneficiary for the assessment. You may bill at the full case management rate or at a sliding scale or discounted rate, or may

choose to provide this service free of charge. This decision should be put into written policy and applied to all beneficiaries.

To submit an "assessment only" claim:

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

HCI Unit

ATTN.: Administrative Officer

N. C. Division of Medical Assistance

2501 Mail Service Center

Raleigh NC 27699-2501



MORE  
INFORMATION

Please see Chapter 26 for complete info regarding the 'assessment anyway'.

## CHAPTER REVIEW

### 🔑 Key Points

1. The assessment is the basis for development and approval of the plan of care.
2. The assessment may either be conducted by an RN or by a RN/SW team. If done by a team, it is expected that each member will communicate with the other and that both members will be involved in plan of care development.
3. The assessment is conducted after the referral has been approved by DMA and the FL-2 has been approved by the fiscal agent. It is conducted at least annually thereafter.
4. Assessment is a continual process.
5. The assessment is normally conducted at the beneficiary's home, but in certain cases may be done while the child is hospitalized.
6. Assessment involves everyone who is involved in the child's care: family, teachers, therapists, etc.
7. FOR EVERY NEED YOU IDENTIFY DURING THE ASSESSMENT, THERE MUST BE A CORRESPONDING GOAL AND INTERVENTIONS ON THE PLAN OF CARE.

 **Test Your Knowledge**

1. True or False: The assessment should be of the family, not just the child.
2. True or False: There must be a goal and intervention(s) for every need identified, even if the family doesn't wish to address it at the time.
3. True or False: The assessment may be submitted to your consultant by email.

1. True, 2. True, 3. False

## **SECTION 4 APPLYING FOR CAP/C**

### **CHAPTER 34 The Plan of Care**

#### **WHAT IS THE PURPOSE OF THE PLAN OF CARE?**

The plan describes the medical and other services and activities put into place to meet the family's needs. It includes documentation of goals, interventions, and progress toward goals; documentation of services and supplies, the amount provided, who provides it, and the cost of the waiver services; and the child's family's typical use of in-home care hours if applicable.

The plan of care provides evidence that all needs identified in the assessment are being addressed, that the provision of care is family-centered, and that there is continual reassessment and re-evaluation of the plan of care.

#### **WHO DEVELOPS THE PLAN OF CARE?**

The Plan of Care is family-centered, and is therefore developed by the family with assistance and input from the Case Manager and any other parties the parent requested be involved. Both the Case Manager and the Registered Nurse if not the Case Manager should be involved in Plan of Care development and review.

#### **WHEN IS THE PLAN OF CARE DEVELOPED?**

The Plan of Care is developed after the initial assessment is completed. It is reviewed at least quarterly and progress toward goals is documented in eCAP.

It is reviewed and updated any time there has been a hospitalization, a significant change in condition, or a change in caregiver availability. It is thoroughly reviewed and updated annually at the time of the CNR based upon the new assessment data. The initial Plan of Care and the CNR Plans of Care must be completed so that they are received by DMA no later than 60 days after the FL-2 completion date (the date of fiscal agent approval if applicable, or the date of MD signature if not). If the assessment, POC, and FL-2 are not received by DMA within 60 days of the FL-2 completion date, a new FL-2 is obtained and the assessment and plan of care are updated.

### **WHAT DO I NEED TO KNOW IN ORDER TO DEVELOP THE PLAN OF CARE?**

In order to develop the Plan of Care, you will need:

- All of your assessment data
- Knowledge of the child's condition including symptoms, treatments, complications, equipment, and prognosis
- The CAP/C fee schedule (see <http://www.ncdhhs.gov/dma/fee/index.htm> )
- Knowledge of the eligibility criteria for CAP/C services (see sections 2 and 3)
- Knowledge of other Medicaid programs and criteria (see Appendix A)
- Knowledge of which CAP/C services and regular Medicaid services can or can not be provided together (see Chapter 43)
- Knowledge of community resources that can be used instead of or in addition to Medicaid services (see Appendix A)
- Knowledge of the Medicaid quantity limitations and lifetime expectancies for certain items of Durable Medical Equipment and Orthotics and Prosthetics (see <http://www.ncdhhs.gov/dma/mp/index.htm>, Policy 5A, Attachment E for DME and Policy 5B, Attachment E for Orthotics and Prosthetics)
- Knowledge of when and how to request EPSDT consideration for a service or supply (see Chapter 6)

- To remember that the Plan of Care must address all of the needs identified through the assessment
- To remember that beneficiaries have freedom of choice of providers
- To remember that the Plan must include case management and one other waiver service excluding respite and waiver incontinence supplies

### **WHAT IS MEANT BY 'REVIEWED'?**

A Plan of Care review means that:

- Progress toward the goals on the plan of care is reviewed: Has the goal been met? Have some or all of the interventions been implemented? Has there been difficulty in implementing the interventions or meeting the goal?
- The goals themselves are reviewed: Are they still appropriate to the beneficiary's needs? Are they consistent with the child's level of disability? Are there needs of the child or family that are not being met with these goals? If there has been difficulty meeting a goal, does it need to be changed?
- Does the plan meet ALL of the client's needs identified in the assessment?
- Is the client receiving all the services and supplies in the plan of care? If not, why not? Develop a plan to address the issue.

### **HOW IS THE PLAN OF CARE DOCUMENTED?**

The Plan of Care is completed electronically in eCAP at [www.ncecap.net](http://www.ncecap.net). The Goals, and applicable Service Plan View sections must be completed. Each service requested in the POC should help meet a need expressed in the assessment, and all needs expressed in the assessment should be appropriately addressed somewhere in the POC. Instructions and guidance for completing

the Plan of Care are available in the eCAP Knowledge Exchange under the category of Case Management Plans of Care.

Note that the dates on the plan of care are effective for the CNR year, not the waiver year (i.e. the first day of the month following the child's birth month to the last day of the child's birth month the following year). If the plan of care is an initial, enter the CAP effective date as the POC start date. The CAP effective date is the latest of the following:

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

The POC end date will be the last day of the child's birth month. If this date is too close to allow for a CNR to be completed on time (within 60 days), contact the Viebridge Help Desk for assistance with changing the POC end date to the following year. For a revision, the plan of care start date should be the date that the change is needed, and must be within 30 days of the revision submission date. The end date of the revision will be the same end date as the plan of care that it is revising.

### **Plan Narrative**

The Plan Narrative should be a very brief summary of the child, family, situation, and/or services requested that provides an overall picture of the needs and request. Include any important details not included elsewhere. Provide reasons for EPSDT or other requests above policy guidelines as well as any areas that need focused attention.

### **Goals**

ECAP will automatically transfer the goals entered in the assessment to the POC. In the goals section of the POC, describe the child's/family's goals and how they will be accomplished with more detail. Goals should be specific, measurable, achievable, relevant, and time sensitive (SMART goals). For more information on

goals entry, please see the knowledge exchange in eCAP under the categories Case Management Assessment and Case Management Plans of Care.

List the activities or interventions that will help the child meet that goal. Then list whom is responsible for each of the interventions and the status (e.g. started 6/1/13, ongoing, completed). Interventions should be patient-specific and based on the data in your assessment. Even if the case manager is not the responsible party, you should be available to answer questions and assist the person responsible, and follow-up with that person to make sure their task has been done

On at least a quarterly basis, review the goals and interventions and document their progress in the monitoring section of eCAP. If upon your review, you and the family determine that the goal has been met, discuss with the child/family what other goals they would like to address, and update eCAP with the status of the completed goal and any new goals.

### **Service Plan Views**

The service plan views are where all needed CAP/C services requested are entered. Plans of care should contain a request for, in the least, case management and one other waiver services besides respite and waiver incontinence supplies, as having a need for at least these services is a program requirement.

#### **Nurse/Aid View**

The Nurse/Aid section should include any regular, weekly in-home care provided by a nurse, Pediatric Nurse Aide, or In-home aide, and the schedule for that care. Multiple types of care can be entered if needed, and multiple agencies can also be used as needed. For more information on Nurse/Aide entry, please see the knowledge exchange in eCAP under the category Case Management Plans of Care.

### Alt Nurse/Aide View

In the Alt Nurse/Aide section, enter an alternate schedule if one is needed. Not all plans of care require an alternate schedule, even if nursing or aide services are provided. An alternate schedule is needed when hours change on a known, regular basis; for instance school year versus summer, or when the caregiver works rotating shifts. Think ahead, and if an alternate schedule is needed, for example, for summer, put it on the CNR, even if it will not be needed until later on in the year. For more information on Alt Nurse/Aide entry, please see the knowledge exchange in eCAP under the category Case Management Plans of Care.

### Other Waiver View

The Other Waiver section is for all waiver services besides in-home care. Case management, respite, short-term intensive, home and vehicle mods, community transition funding, caregiver training, waiver supplies, and palliative care services are entered under this section. For more information on Other Waiver services entry, please see the knowledge exchange in eCAP under the category Case Management Plans of Care.

### Non-Waiver View

State Plan Medicaid (non-waiver) services are entered in the Non-Waiver section. Examples include home health nursing, physical therapy, occupational therapy, feeding therapy, and developmental therapy. These services are not approved by the CAP/C program, but are important information for the plan of care. For more information on Non-Waiver services entry, please see the knowledge exchange in eCAP under the category Case Management Plans of Care.

### Equipment/Supplies View

State Plan (non-waiver) equipment and supplies are entered in the Equipment/Supplies section. Items owned by the beneficiary, rented items, and disposable items are included. For instructions on how to complete the Equipment/Supplies section of the plan of care, see the knowledge exchange in eCAP under the category Case Management Plans of Care.

### **Plan Budget Summary**

The Plan Budget Summary is a spreadsheet format listing of all services, units, and dollars requested on the plan of care from start date to end date. After entering all services requested in the Service Plan Views, click on the Plan Budget Summary and check it for accuracy. Are all the services that were requested listed and with appropriate units and dollar amounts? Are any additional services listed that should not be? Does the budget make sense with what was requested? The Plan Budget Summary is where you can catch errors in service entry or in computer error.

### **Recipient Summary Report**

After the Plan of Care has been completed, the Budget Summary checked, and any necessary correction made, click on the Recipient summary report and print it for the parent or legal guardian to sign. This document's purpose is to ensure that the family knows what is being requested and agrees with it. Upload the signed recipient summary report in the Assessment's supporting documents section.

### **Service Limits**

For any services requested above the policy limits, you will need to write a justification of the excess in the Service Limits section of the plan of care before submitting it to DMA. This is meant to be a brief description; if you need to submit additional documentation to support the request, submit this in the Assessment's Supporting Documents section.

## CHAPTER REVIEW

### 🔑 Key Points

1. The Plan of Care must address all of the needs identified in the assessment.
2. The Plan of Care includes goals and interventions, as well as information regarding services, supplies, and costs.
3. Progress toward the goals in the Plan of Care must be documented quarterly.
4. Plan of Care development is a family-centered process.
5. The same plan is used throughout the year, with all changes documented as revisions on that plan.



### Test Your Knowledge

1. Progress toward goals must be documented
  - a. monthly
  - b. quarterly
  - c. annually
  - d. as needed
  
2. The Plan of care is developed mainly by the \_\_\_\_\_, with input from the case managers and other formal and informal supports.
  
3. The Plan of Care is written for
  - a. the waiver year (July through June)
  - b. the CNR year
  
4. True or False: The most important needs identified in the assessment are incorporated into the Plan of Care.

1. b, 2. family, 3. b, 4. False

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**SECTION 4  
APPLYING FOR CAP/C**

**CHAPTER 35  
The Letter of Understanding and Freedom of  
Choice**

**FC**  
Free  
Choice

**SP**  
Service  
Plans

**WHAT IS THE LETTER OF UNDERSTANDING AND FREEDOM OF CHOICE?**

The Letter of Understanding and Freedom of Choice is a document that informs caregivers regarding certain important points about the CAP/C program and documents their understanding of those points. It provides an opportunity for discussion between the case manager and caregiver, ensures that the caregiver is making informed decisions, and provides documentation of meeting waiver assurances such as freedom of choice.

**WHO COMPLETES THE LETTER OF UNDERSTANDING AND FREEDOM OF CHOICE?**

The Case Manager reviews the document with the caregivers. Both the caregiver and the Case Manager sign it. All CAP/C beneficiaries are required to have this document.

**WHEN IS THE LETTER OF UNDERSTANDING AND FREEDOM OF CHOICE COMPLETED?**

The Letter of Understanding and Freedom of Choice is completed during the initial application and then annually during the CNR.

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

**Letter of Understanding and Freedom of Choice**

By signing this form, I, as the primary caregiver (parent or legally responsible party) for \_\_\_\_\_, acknowledge my understanding of the CAP/C policies stated below.

I understand that:

1. I have a choice between A) placing my child in a nursing home or hospital and B) receiving in-home care for my child through CAP/C services. I have chosen for my child to receive CAP/C services.
2. I understand that I have the freedom to choose from among any enrolled Medicaid provider to provide care or services for my child.
3. My child, the recipient, must require skilled nursing care equivalent to care received in an institutional setting to be eligible for this program.
4. CAP/C is designed to supplement, not replace, the formal and informal services already available to my child.
5. As the primary caregiver, I will actively participate in planning for my child's care, and will comply with the mutually agreed upon Plan of Care and will provide or make arrangements for needed care to be provided to my child during the planned and unplanned absences of the CAP/C provided nurses or nurse aides.
6. Skilled nursing hours and other services may be reduced over time based on the medical needs of my child.
7. The level of care needs of my child may change over time, thus requiring a change to the amount, frequency, or type of services.
8. CAP/C services will be terminated when my child meets any of the following criteria:
  - The recipient's Medicaid is terminated.
  - The recipient's physician does not recommend CAP/C participation.
  - The recipient's physician does not recommend nursing facility level of care.
  - Nursing facility level of care is not approved.
  - The recipient is admitted to a facility for 30 or more calendar days (including admission to inpatient facilities, including but not limited to a hospital, nursing facility, or rehabilitation facility).
  - The recipient moves out of his/her primary residence to a hospital, nursing facility, or adult care home for long-term care.
  - The CAP/C case manager has been unable to establish contact with the recipient and/or his/her parent or legally responsible party for more than 60 days.
  - The recipient fails to qualify for program participation based on medical needs; that is, the recipient does not require CAP/C services to remain safely at home.
  - The recipient does not need and use at least one waiver service besides case management and respite each quarter.
  - The recipient's health, safety, and well-being cannot be reasonably assured.
  - The recipient is over 20 years of age.
9. The recipient, recipient's parent, or legally responsible party does not participate in development of or sign the recipient's plan of care.
10. Case management services are not available.
9. If a waiver service is denied, reduced, or terminated, I will be notified in writing and be told how to appeal the denial.
10. Decisions made by my child's physician or home care provider agency cannot be appealed to DMA.
11. The providers I choose may have certain requirements regarding my participation in my child's treatment and enrollment with their agency.
12. The Case Manager is responsible for coordinating the assessment, plan of care, and monitoring CAP/C services to ensure that my child's needs are met within program guidelines. I understand that I must maintain communication with my Case Manager by returning telephone calls, being available for home visits, and informing him/her of
  - o Changes in my child's condition
  - o Hospitalizations, emergency room visits, and physician appointments
  - o Absences from the county
  - o New equipment or supplies
13. The Division of Medical Assistance has sole approval authority over the plan of care. My Case Manager is unable to approve or deny any services or supplies.

I have been given a copy of or provided access to the CAP/C Parent Handbook.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Signature of Case Manager

\_\_\_\_\_  
Date

## CHAPTER REVIEW

### **Key Points**

1. The Letter of Understanding and Freedom of Choice should be reviewed and discussed with the family, not just given to them for signature.
2. The legal guardian or representative also needs to understand and sign the form.
3. The Letter of Understanding and Freedom of Choice is done annually, at the initial and with each CNR.

**Test Your Knowledge**

1. The letter of Understanding and Freedom of Choice is submitted
  - a. Once, at the initial.
  - b. Quarterly, with the home visits
  - c. Annually, at the initial and CNRs.
  - d. With each Plan of Care submission.
  
2. The Letter of Understanding and Freedom of choice is used
  - a. For all CAP/C beneficiaries.
  - b. For CAP/C beneficiaries receiving in-home care services.
  - c. When the case manager is having or anticipates having a problem with the family's cooperation or acceptance of a change in the plan of care.

1. c, 2. a

## **SECTION 4 APPLYING FOR CAP/C**

### **CHAPTER 36 DMA Evaluation and Approval**

## **Chapter 36 DMA Evaluation and Approval**

#### **WHAT DOCUMENTATION IS NEEDED?**

For initial approvals, upload the following items to your CAP/C consultant so that they will be received by DMA no later than 60 days after the FL-2 approval date:

- A copy of the FL-2.
- The assessment
- A signed letter of understanding
- The assessment signature page
- A signed recipient summary report
- The employment verification form, if applicable
- The physician's request for nursing services, if applicable
- The plan of care, including goals, nurse/aide, alt nurse/aide, other waiver, non-waiver, and equipment/supplies sections
- Any additional information that may be helpful, such as medical reports, nursing notes, seizure logs, etc.

#### **VERBAL APPROVAL OF INITIALS**

Initials will NOT be verbally approved prior to the DMA Nurse Consultant's complete review of the written assessment, plan of care, and other required documentation.

Please be sure to submit an initial in plenty of time to have it reviewed and approved before the Medicaid application deadline. DMA gives

review of initials priority over review of CNRs and revisions; however, the process does take time, particularly if we have questions or need additional information.

### **DMA'S EVALUATION**

DMA is responsible for approving CAP/C participation and the CAP/C services the client may receive.

For Medicaid to pay for a CAP/C service, the service must be approved in a Plan of Care according to Medicaid policies and procedures.

### **What Are The Evaluation Criteria?**

The decision on whether an individual may participate in CAP/C and the services the individual may receive is based on the requirements listed in Sections 2 and 3 of this manual. Basically, those requirements are:

- Age under 21 years
- Medically Fragile
- At Risk for Institutionalization
- Lives in a private residence while on the program
- Requires one waiver service (excluding respite and waiver incontinence supplies) in addition to case management at least once per 90 calendar days
- Requires the service to supplement, not replace, existing resources
- Requires the service to meet specific unmet needs of the child
- Is not requesting CAP/C solely to become eligible for Medicaid or other Medicaid services.
- Meets the Medicaid eligibility criteria for CAP/C including approval for disability by the Social Security Administration if applicable
- Can have his or her health, safety, and well being maintained at home

- Can have his or her healthcare needs met within the CAP/C cost limit for the selected services, and there is no other as effective and less costly treatment available statewide.
- Has family/caregivers that participate in the child's care and in the CAP/C program.
- Meets the medical necessity and other criteria for the specific services or supplies requested.
- Has a plan of care signed by the caregiver and legal guardian.
- The goals, interventions, services, and supplies on the plan of care meet all of the needs identified in the assessment.

#### **How and When Will I Be Notified of Approval?**

Once your consultant (and other parties such as a peer reviewer, the CAP/C Supervisor or the Medical Director, as deemed necessary by the Consultant) has reviewed all of the information, including any requests for additional information, a notification and then an 'initial approval letter' will be available to you in eCAP. The letter is also sent via courier to the local DSS Medicaid Eligibility Supervisor to ensure that they are aware that the CAP/C plan of care has been approved and can enter the CAP Indicator Code into the system.

If your Consultant asks for additional information, you have 10 business days (or other previously negotiated time period) to provide that information. However, keep in mind that you must have approval before the Medicaid application deadline passes.

Initials are approved within 15 business days of receipt of all the information necessary to make a decision. Every effort is made to approve the family for participation before the Medicaid application deadline, and this is almost always possible. However it requires careful and prompt communication and coordination between the Case Manager and the Consultant.

Remember, approval of a CAP/C Plan of Care means that CAP/C participation has been approved and the CAP/C services in the Plan are approved. CAP/C Plan of Care approval does not constitute approval of regular Medicaid services. Providers of regular Medicaid services must follow Medicaid policies and procedures for those services.

**HOW AND WHEN WILL I BE NOTIFIED OF AN ADVERSE DECISION?**

A decision to deny a family's participation is never made by a single person. All possible adverse decisions are subject to review by other Consultants, the CAP/C Supervisor, and/or the Medical Director.

If the decision is to deny, you and the family will be notified in accordance with the processes and procedures in Sections 6 and 7 of this Manual.

## CHAPTER REVIEW

### Key Points

1. Initial assessments may not be verbally approved prior to review of all the written information.
2. Written information consists of the following as applicable: the FL-2, letter of understanding, assessment signature page, signed recipient summary report, assessment, employment verification form, physician's request for nursing services, the complete plan of care, and other medical documentation as appropriate.
3. DMA evaluates the initial assessment/according to program criteria.
4. Careful coordination between the Consultant and Case Manager is necessary in order to get the initial approved before the Medicaid application expires.
5. The Consultant's approval of the initial does not mean that Medicaid has been approved.

 **Test Your Knowledge**

1. The initial paperwork must be received at DMA within \_\_\_\_\_ days of the FL-2 approval date.
2. The initial must be approved
  - a. prior to the Medicaid application deadline
  - b. within 15 business days of receipt of all of the information at DMA
  - c. both of the above
  - d. none of the above
3. True or False: You must submit the stamped pink copy of the FL-2 with your initial paperwork.
4. True or False: CAP/C can be approved when the caregiver and legal guardian if applicable have not signed the Plan of care.
5. True or False: An initial approval letter from your Consultant means that you can go ahead and start services.

1. 60, 2. d, 3. False, 4. False, 5. False

## **SECTION 4**

### **APPLYING FOR CAP/C**

## **CHAPTER 37**

### **Notifying DSS**

Once a child has been approved for participation, and at each CNR, you will receive a letter from your Nurse Consultant informing you of the approval. This letter is also copied to the Medicaid Eligibility Supervisor at the county DSS. However, you will need to follow up as well.

Notify the DSS Medicaid worker in writing of CAP/C approval. Send a memo such as the one on the next page along with a copy of the Plan of Care and a copy of DMA's approval letter. (Your local county DSS may ask for additional items as well.) Follow-up with DSS to assure that the notification was received. Verify Medicaid eligibility and check to see if the CAP Indicator code was entered correctly.

Remember, the letter from your consultant is only one aspect of CAP/C approval. The other is approval of the Medicaid application. You and other providers will need to verify Medicaid eligibility before beginning and billing for services. For providers of CAP/C specific services, the CAP Indicator Code also needs to be present before billing will go through. Taking the above actions to notify DSS of the plan of care approval will help in getting services started promptly and in providers being able to bill without difficulty.

(Date)

**MEMORANDUM**

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

**FM:** (Name & Agency of Case Manager)

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

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

Please enter the CAP indicator and the effective date in the Eligibility Information System. The CAP indicator is SC (for Nursing Facility level of care) or HC (for hospital level of care) (circle one). The effective date is \_\_\_\_\_.

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

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

Attachments (2)

Please note that effective 7/1/10, the IC code is no longer used. SC denotes nursing facility level of care (formerly intermediate and skilled levels of care). HC continues to denote hospital level of care.

## CHAPTER REVIEW

### Key Points

1. Once you receive plan of care approval from DMA, send the following to DSS:
  - a. A memo
  - b. A copy of the plan of care
  - c. A copy of the approval from DMA.
2. Verify Medicaid approval before beginning and billing for services.  
Verify the CAP Indicator Code before billing for CAP specific services.

 **Test Your Knowledge**

1. True or False; CAP/C approval means Medicaid approval.
2. When CAP/C is approved, notify DSS by sending all of the following except
  - a. The assessment
  - b. The cost summary portion of the plan of care (Part B)
  - c. The approval letter
  - d. A memo or letter of explanation.

1. False, 2. a

## **SECTION 4**

### **APPLYING FOR CAP/C**

## **CHAPTER 38**

### **Verifying Medicaid Eligibility**

#### **MEDICAID ELIGIBILITY**

Medicaid eligibility is separate but related to CAP/C eligibility. To participate in CAP/C, you must have the approval of the plan of care from your DMA Consultant as well as approval of Medicaid from the DSS.

It is the provider's responsibility to verify Medicaid eligibility before services are rendered. An initial or CNR approval letter says only that the beneficiary meets the medical/program criteria for the CAP/C. It is not a statement of Medicaid approval. The service authorization and participation notice also remind providers to verify Medicaid eligibility.

Case Managers should verify Medicaid eligibility monthly. Eligibility status may change from month to month if financial and household circumstances change. You can not do this by looking at the Medicaid card, as Medicaid ID cards are issued annually and not considered proof of eligibility. Medicaid eligibility can be verified through the NC Tracks system.

#### **THE CAP INDICATOR CODE**

Each active CAP/C beneficiary should have a CAP Indicator Code. The CAP Indicator Code will be SC for most beneficiaries. SC denotes nursing facility level of care. HC is used for hospital level of care beneficiaries. These Indicator Codes show providers that the child is eligible for CAP/C.

Your agency and other providers will not be paid for CAP/C services unless the eligibility system shows the client is on CAP/C by showing one of these codes. Also, the client will not receive co-payment exemptions.

The SC or HC shows that the system contains the information needed to process claims and allow the co-payment exemptions.

As you verify Medicaid eligibility, you should also check the CAP Indicator Code. If the code is

- Not entered when a patient is active on the program,
- Incorrect, or
- Left in when the beneficiary has been disenrolled from the program,

Please notify the DSS and your CAP/C Nurse Consultant.

Having the correct CAP Indicator Code is also important financially when we are monitoring to ensure cost neutrality.

**DIFFERENT CAP PROGRAMS HAVE DIFFERENT INDICATOR CODES.  
CONTINUALLY FOLLOW UP WITH AND EDUCATE YOUR DSS**

## **CHAPTER REVIEW**

### **Key Points**

1. Medicaid approval and approval from the CAP/C Nurse Consultant are two separate but related types of eligibility.
2. Approval from the nurse consultant does not mean approval for Medicaid.
3. Medicaid eligibility should be verified monthly.
4. The CAP Indicator code allows billing for CAP/C services and exemption from copays for the beneficiary. It is also important in demonstrating cost neutrality.
5. The CAP Indicator Code should be verified along with the Medicaid eligibility.

**Test Your Knowledge**

1. True or False: Once you receive the initial approval letter from your CAP/C Consultant, you may begin services.
2. Who is ultimately responsible for verifying Medicaid eligibility prior to the delivery of nurse aide services?
  - a. The CAP/C Nurse Consultant
  - b. The case manager
  - c. The nurse aide's agency
3. True or False: Seeing the beneficiary's MID card proves Medicaid eligibility.
4. The CAP Indicator Codes for the CAP/C Program are \_\_\_\_\_ and \_\_\_\_\_.
5. Case Managers should verify Medicaid eligibility
  - a. Monthly
  - b. Quarterly
  - c. Every 6 months
  - d. Annually.

1. False, 2. c, 3. False, 4. SC and HC, 5. a

## **SECTION 4**

### **APPLYING FOR CAP/C**

## **CHAPTER 39**

### **The Service Authorization**

#### **WHAT IS THE SERVICE AUTHORIZATION?**

The service authorization is a form used to instruct providers of waiver services, what service to provide, how much to provide, and how to provide them.

#### **WHO COMPLETES THE SERVICE AUTHORIZATION?**

The service authorization is generated automatically in eCAP once a POC is approved and all providers have been entered. The Case Manger verifies that the service authorization is correct, adds any information needed (e.g. respite balance), and signs it before sending it to the CAP/C provider(s). Please see the knowledge exchange in eCAP, or call the Viebridge helpdesk at 888-705-0970 for problems or questions regarding service authorizations in eCAP.

#### **WHEN IS THE SERVICE AUTHORIZATION COMPLETED?**

The service authorization is generated after the initial plan of care is approved and the beneficiary has selected the provider(s) they wish to use. It is updated at least annually at the time of the Continued Needs Review (CNR), and each time the plan of care involving a waiver service change.

#### **WHAT IS THE PURPOSE OF THE SERVICE AUTHORIZATION?**

The service authorization ensures that services are provided according to the plan of care, which is an important waiver assurance. The service authorization is a binding document; the provider is obligated to follow the terms of the service authorization. If they do not, they are subject to review by Program Integrity and recoupment of

payment for any services provided incorrectly.

### **WHAT HAPPENS IF THE PROVIDER IS UNABLE TO PROVIDE SERVICES ACCORDING TO THE AUTHORIZATION?**

The services received by the client are expected to match the Plan of Care. If there are delays in starting services, consider alternative sources of care. The client's record must show the reason for any delays and document the actions taken to assure proper care.

If services cannot be promptly implemented, consider if a revised service package will meet the client's needs. If so, submit a plan of care revision. If not, notify your nurse consultant.

### **HOW IS THE FORM COMPLETED?**

The service authorization is used only for waiver services. Do not send service authorizations for regular Medicaid services. CAP/C Case Managers do not authorize regular Medicaid services. The service authorization is not necessary for items provided by the Case Manager.

For the CNR, the service authorization is valid and begins the first day of the month after the beneficiary's birth month and ends one year later. For example, a beneficiary whose birthday is July 3 would have the CNR due July 5, and the service authorization would be valid from August 1 to July 31. However, other dates may apply; for example, you may be authorizing short-term-intensive services and the service authorization dates would span just one week. Any service authorizations issued mid-year are valid only until the next CNR.

The provider is cautioned that the dates are no longer valid if you instruct them otherwise or if the child loses Medicaid eligibility.

The provider is instructed to notify you if there are any problems delivering the service; for example, they can't find qualified staff. They are also instructed to notify you if the service needs to be changed. This means that the provider shares the responsibility, along with the case manager and the family, of using Medicaid resources appropriately. For example, if the child has been eating by mouth and not via the feeding tube, the agency should notify you to decrease to a NA I or to disenroll the child from services as applicable.

The service authorization cautions the provider that the authorization does not guarantee Medicaid payment. The provider must verify the beneficiary's Medicaid eligibility, and they must ensure that as a provider they are in compliance with Medicaid policies and regulations.

The in-home care service authorization provides detailed instructions for those services. It consists of two parts:

- The type, schedule, and reimbursement for the service, and
- The task sheet.

When there are issues with staffing, you may use two provider agencies. The service authorizations must clearly delineate which agency provides service at which times. The agencies may not interchange without approval and a service authorization from you.

The service authorization should indicate the particular tasks that the in-home nurse or nurse aide is expected to perform, how often the task is to be performed, and any special instructions for it. This task and schedule information is taken from corresponding sections of the assessment, so it is important that those sections were completed fully. Remember the CMS assurance that the service plan must meet all of the beneficiary's needs. It is the responsibility of the agency to find qualified staff to meet the beneficiary's needs. You do not change the service authorization (i.e., take off the tube feeding) in order to accommodate the staff. If the agency can not provide staff to complete all of the tasks indicated, they should not accept that child as a client. If the child is a current client and becomes unable to meet all of the child's needs, the agency should notify you.

For the respite service authorization, until eCAP tracks respite balances, write in the number of respite hours available to the family. Since respite hours are counted on the waiver year (July 1-June 30), and you will be filling this out with the CNR, you will need to indicate how many hours are left in the waiver year and then how many hours are available after that. For example, if your service authorization is for November 1,

calculate how many hours have been used between July 1 and October 31. Subtract that from the total annual amount allowed to determine the remainder until June 30. The full annual amount will then be available starting July 1. The provider is reminded that those hours need to last until the following June, so they should not use them all within this authorization period.

Finally, sign the bottom of the page.

Good communication and coordination among the family, the provider, and the case manager is essential to the tracking of respite hours. It is the joint responsibility of all three to track respite use so that it does not exceed the limits on the plan of care.

### **DISCONTINUE SERVICES AUTHORIZATION**

Service Provider Termination Notifications are also automatically generated in eCAP when there is a change in services provided. Like with service authorizations, the case manager should print these, determine that they are correct, and sign them before sending them to providers. There is also a form on the website at <http://www.ncdhhs.gov/dma/services/capc.htm> called the 'CAP/C Service Authorization Discontinuation Notice'. This form is optional for you to use when suspending services or disenrolling a child from services. The Service Authorization is mandatory; the discontinuation form is not.

## CHAPTER REVIEW

### Key Points

1. The service authorization is the agency's instructions for providing a waiver service.
2. The service authorization is completed at least annually; more often when there are changes in the waiver service.
3. The service authorization is binding; the agency must provide services according to the service authorization.
4. The task sheet should be completed according to the plan of care. The agency is responsible for providing staff that can meet those needs.
5. It is the joint responsibility of the case manager, provider, and family to track respite hours.
6. The agency should notify you if there are problems providing the service or if the service needs to be changed or stopped.

 **Test Your Knowledge**

1. The service authorization is valid from September 1, 2010 through August 31, 2011. In December, a plan of care for more hours of in-home care is approved. Your new service authorization is valid
  - a. Until November 30, 2010
  - b. Until August 31, 2011
2. The agency is unable to provide a NA I+ or NA II to provide the child's tube feedings. The correct course of action is to
  - a. Authorize an NA I to provide the ADL care
  - b. Work with the family to choose a different provider
3. Who's responsibility is it to track use of respite hours?
  - a. The case manager
  - b. The family
  - c. The provider agency
  - d. All of the above

1. b, 2. b, 3. d

## **SECTION 4 APPLYING FOR CAP/C**

### **CHAPTER 40 The Participation Notice**

#### **WHAT IS THE PARTICIPATION NOTICE?**

The participation notice is a form used to coordinate with providers of non-waiver services. It informs the provider of the non-waiver services and supplies that are on the beneficiary's plan of care, and the amount, frequency, or duration of those supplies. Note that the Participation Notice is not an authorization; CAP/C does not authorize non-CAP/C services.

#### **WHO COMPLETES THE PARTICIPATION NOTICE?**

The participation notices is not currently generated in eCAP. It is completed by the Case Manager.

#### **WHEN IS THE PARTICIPATION NOTICE COMPLETED?**

The participation notice is completed when the plan of care is approved and the beneficiary has selected the provider(s) they wish to use. It is updated at least annually at the time of the Continued Needs Review (CNR), and at other times if the plan of care changes.

#### **WHAT IS THE PURPOSE OF THE PARTICIPATION NOTICE?**

You need to be aware of all Home Health services and medical supplies, DME, home infusion therapy and hospice services, and therapy services the client is receiving. When the CAP/C Plan is approved, send written

notification to the agency or agencies providing these services to let them know that CAP/C participation has been approved or is continuing. The notice documents and verifies the non-CAP/C home and community care services the client is receiving and reminds the provider to coordinate any changes with you.

**WHAT HAPPENS IF THE PROVIDER IS UNABLE TO PROVIDE SERVICES ACCORDING TO THE PARTICIPATION NOTICE?**

The services received by the client are expected to match the Plan of Care. If there are delays in starting services, consider alternative sources of care. The client's record must show the reason for any delays and document the actions taken to assure proper care.

If services cannot be promptly implemented, consider if a revised service package will meet the client's needs. If so, submit a plan of care revision. If not, notify your nurse consultant.

**HOW IS THE FORM COMPLETED?**

Unlike the service authorization, this is a one-page form with no attachments. The CAP/C Participation Notice form can be found on the CAP/C website at <http://www.ncdhhs.gov/dma/services/capc.htm>.

**NORTH CAROLINA COMMUNITY ALTERNATIVES PROGRAM FOR CHILDREN  
PARTICIPATION NOTICE**

DATE: \_\_/\_\_/\_\_

**TO: Provider**

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_

**FROM: Case Manager**

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Indicate the **date** on which the participation notice is completed. Fill in the **provider agency's name and contact information** on the left. Fill in **your name and contact information** on the right.

**RE: BENEFICIARY'S NAME:** \_\_\_\_\_

**MID:** \_\_\_\_\_

Parent/Responsible Party Name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Address: \_\_\_\_\_

This beneficiary -SELECT- have insurance other than Medicaid.

This beneficiary -SELECT- have a monthly deductible that has to be met before being authorized for Medicaid coverage.

Please begin these services on \_\_/\_\_/\_\_\_\_ and continue until A) \_\_/\_\_/\_\_\_\_, B) otherwise notified, or C) the beneficiary is disenrolled from Medicaid, whichever occurs first.

Enter the child's **name** and **Medicaid number**.

Enter the **parents' names and contact information**.

Select whether the child 'does' or 'does not' have **other insurance**.

Select whether the child 'does' or 'does not' have a **Medicaid deductible**.

Indicate the **dates** for which the participation notice is valid. This normally corresponds to the CNR and begins the first day of the month after the beneficiary's birth month and ends one year later. For example, a beneficiary whose birthday is July 3 would have the CNR due July 5, and the participation notice would be valid from August 1 through July 31. Any service authorizations issued mid-year are valid only until the next CNR.

The provider is cautioned in this section that these dates are subject to change upon your notification or upon the child's disenrollment from Medicaid.

The following services/supplies/equipment from your agency are included on this beneficiary's CAP/C Plan of Care.

If there are any changes in the type, amount, frequency or funding source of any of these services, or if any items are added or deleted, please notify me. My contact information is above.

CODE	ITEM	AMOUNT/FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Attach additional page if necessary.)

**IMPORTANT:** This is not an authorization for or approval of services from your agency. The purpose of this notice is to coordinate the beneficiary's home and community care services. Your services are provided and paid according to Medicaid policies and procedures. You are responsible for verifying Medicaid eligibility and the beneficiary's eligibility for the service.

Thank You, \_\_\_\_\_ **Insert Case Manager Name**, CAP/C Case Manager

In this section, list the services, supplies, or equipment provided by the particular agency you are sending this to. List the item by code, item, and amount; for example, RC 420, Physical Therapy visit, once per week. The codes can be found on the appropriate fee schedules, located at <http://www.ncdhhs.gov/dma/fee/index.htm>. The codes are important in ensuring proper and non-wasteful billing. For example, if you are listing a G tube, it is to everyone's benefit to understand that it is the W4211 tubing for \$9.82, rather than the B4087 tubing for \$18.08.

The provider is then reminded that this form is a means of coordinating care. It is not an authorization, and does not negate any need for prior approval, Medicaid eligibility, or any other regulation. As always, it is the provider of the service who is ultimately responsible for verifying Medicaid eligibility prior to the start of service.

Finally, sign the bottom of the form.

**DISCONTINUE PARTICIPATION NOTICE**

There is a form on the website at <http://www.ncdhhs.gov/dma/services/capc.htm> called the 'CAP/C Participation Discontinuation Notice'. This form is optional for you to use when suspending services or disenrolling the child from services. The Participation Notice is mandatory; the discontinuation form is not.

## CHAPTER REVIEW

### Key Points

1. The participation notice is a tool used for coordination of care for non-waiver services and supplies.
2. The participation notice is not an authorization.
3. The participation notice is completed at least annually; more often when there are changes to the plan of care involving one of the services or supplies listed.

 **Test Your Knowledge**

1. True or False: The participation notice is used for expressive therapy services.
2. True or False: CAP/C beneficiaries are automatically authorized for any non-waiver service or supply that is on their plan of care.
3. True or False: The provider should notify you when a beneficiary's services, supplies, or equipment vary from what is on the participation notice.

1. *False*, 2. *False*, 3. *True*

## **SECTION 4 APPLYING FOR CAP/C**

### **CHAPTER 41 Expedited Initial**

#### **WHAT IS AN EXPEDITED INITIAL?**

An expedited initial is a process used in certain situations to get services in the home started more quickly. This enables earlier de-institutionalization, and prevents children from having to be admitted to PDN and then transfer to CAP/C. By coming directly onto CAP/C, they have case management at a time when they most need it, and there is less disruption for the family.

#### **WHO CAN HAVE AN EXPEDITED INITIAL?**

Applicants who will be receiving in-home nursing services and who need those services in place immediately upon arrival to the home can have an expedited initial. For instance, a previously healthy child who was in a car accident and is now on a ventilator and coming home for the first time since the accident would use this process.

This process would not be used for children in the hospital who have already been getting cared for in the home and have no significant change in their condition. It also would not be used if private insurance approved services upon discharge that safely meet the beneficiary's needs; the need must also be for Medicaid –reimbursement of the expedited services and supplies.

To use this process, the child must be awaiting arrival to the home and have a condition in which the child would not be safe at home even for a

short time unless services and equipment was in place. He/she may also be receiving services from another Medicaid program which is ending.

## WHAT IS THE PROCESS?

The expedited initial application process includes the following:

- The Case Manager submits a referral in eCAP indicating that the child is awaiting services in order to be deinstitutionalized, or that he/she is receiving another Medicaid program about to end.
- The Nurse Consultant reviews the referral and marks it for expedited review.
- The Case Manager shall submit as much information as he or she is able,
  - The approved FL-2
  - The anticipated discharge/start of service date
  - The eCAP assessment including all fields required for an expedited initial (below)
    - Face Sheet (17) *Required Fields:*
      - *Medicaid County*
      - *Mailing address 1*
      - *Mailing City*
      - *Zip*
      - *Home Phone*
      - *Caregivers/Contacts*
      - Plan for Caring for the Recipient in an Emergency:  
*When Staffing Agency is unable to provide a nurse or nurse aide?*
      - Plan for Caring for the Recipient in an Emergency:  
*When there is a natural disaster?*
      - Plan for Caring for the Recipient in an Emergency:  
*When the power goes out?*
      - Plan for Caring for the Recipient in an Emergency:  
*When the caregiver is ill and unable to care for the child?*

- Plan for Caring for the Recipient in an Emergency: *If family had to immediately leave their home in case of emergency, where they stay?*
- Payer Source-Medicaid-Medicaid Eligible w/o CAP?
- Payer Source-Medicaid-Does deductible/spenddown apply?
- Payer Source-Medicaid- CAP Medicaid Type
- Payer Source-Medicaid- CAP Level of In-Home Care
- Payer Source-Third Party-Is there a third party payer?
- Diagnoses/History (6)
  - Diagnosis History *The information in this section was collected by: (Check at least one item.)*
  - Diagnosis Entry
  - Medical History *Is there medical history to document?*
  - Resource Utilization *# of hospitalizations last year*
  - Resource Utilization *# of hospitalizations last year related to primary diagnosis*
  - Resource Utilization *# of hospitalizations last year preventable and unplanned*
- Meds/Precautions (1)
  - Medications *Does recipient take medications?*
- Skin (6)
  - Skin details- *Skin condition-(Check at least one item.)*
  - Skin details- *Skin condition- Skin Turgor*
  - Skin details- *Skin condition-Skin Sensitivity*
  - Skin details- *Skin color-(Check at least one item.)*
  - Abnormal Findings?
  - Wounds-*Does the recipient have any wounds?*
- Neurological (3)
  - Seizures- *Does child have seizures?*
  - Thermoregulation Disorder-*Does child have thermoregulation disorder?*
  - Sleep Disorder- *Does child have a sleep disorder?*
- Sensory-Comm (8)
  - Visual- *Visual Acuity Rating*

- Visual- Assistive Devices Used (check at least one item.)
- Speech-Speech Ability/Making Self Understood Rating
- Speech-Assistive Devices Used (check at least one item.)
- Hearing-Hearing ability rating
- Hearing- Assistive Devices Used (check at least one item.)
- Communication Details-Primary language spoken in HH
- Communication Details-Is interpreter needed?
- Pain
  - Pain Details-Does the child have any recurrent/persistent pain?
- Musculoskeletal (16)
  - Ambulatory status-(Check at least one item.)
  - Strength - (Check at least one item.)
  - Appearance/Posture/Position-(Check at least one item.)
  - Fall Risk-Fall Risk
  - ADL Profiling- Bathing-Ability Rating
  - ADL Profiling Bathing- Functional deficit due to
  - ADL Profiling- Personal Hygiene-Ability Rating
  - ADL Profiling Personal Hygiene- Functional deficit due to
  - ADL Profiling Dressing- Ability Rating
  - ADL Profiling Dressing- Functional deficit due to
  - ADL Profiling Bed Mobility- Ability Rating
  - ADL Profiling Bed Mobility- Functional deficit due to
  - ADL Profiling Mobility- Ability Rating
  - ADL Profiling Mobility- Functional deficit due to
  - ADL Profiling Transfer- Ability Rating
  - ADL Profiling Transfer-Functional deficit due to
- Cardio-Respiratory (19)
  - Respirations (Check at least one item.)
  - Does anyone in household smoke tobacco?
  - Deep breathing assistance required?
  - Respiration monitoring required?
  - Pulse
  - BP

- Blood Pressure actual/reported
- Blood pressure measurement required?
- Treatments-Nebulizer
- Treatments-Chest Physiotherapy
- Treatments-Pulse Oximetry
- Treatments-Apnea Monitor
- Treatments-Cardiac Monitor
- Treatments-Oxygen
- Treatments-Sanctioning
- Treatments-Trach
- Treatments- CPAP, BiPAP
- Treatments- Ventilator
- CV Endurance
- Nutrition (5)
  - Weight Details-Fluid use management required?
  - Enteral Feeding
  - Parenteral Feeding
  - Testing/Measurement
  - ADL Profiling-Eating
- Elimination (5)
  - Bladder Continence- Bladder Continence Rating
  - Bladder Continence- Method (Check at least one item.)
  - Bowel Continence Rating
  - Bowel Continence- Method (Check at least one item.)
  - ADL Profiling Elimination- Ability Rating
- Supporting Docs
  - Signed Recipient Summary Report
  - FL-2
  - Assessment signature page
  - Letter of Understanding
- Housing/Finances (3)
  - Recipient/Child's Living Area in Primary Residence- Living arrangement
  - Housing Structure and Safety Review- Is the whole hose safe?

- Finances- Are there needed items or services that the child does without each month due to the lack of funds?
  
- A preliminary plan of care listing the services the beneficiary will need
- A preliminary Nurse/Aide schedule
- The Case Manager verifies the beneficiary's Medicaid eligibility.
- The Consultant prioritizes these reviews. If approved, approval is granted for a maximum of six weeks of service. There is no guarantee that services will continue beyond the six weeks.
- The Case Manager may issue service authorizations and participation notices as needed for the six weeks.
- The nurse case manager or social worker and nurse case management team should plan to be at the patient's home upon arrival to ensure that all equipment, caregivers, etc. are in place and that caregivers are adequately trained regarding care and equipment, so that the child can be safely cared for in the home. Any issues regarding health, safety, or well-being should be addressed.
- The case manager follows up by phone or visit approximately one week after start of services. The purpose of this follow-up is to assess the provision of services and address any needs or issues that have arisen related to caring for the beneficiary at home.
- No later than 30 days after start of services, the entire assessment and plan of care, including review and changes to the previously submitted information, shall be received at DMA.
- The consultant prioritizes these reviews. If approved, the approval will be for the remainder of the CNR year. If denied, services will end at the end of the six weeks.

## CHAPTER REVIEW

### **Key Points**

1. The expedited initial is only for children who need Medicaid-reimbursed nursing services and equipment in place immediately upon their arrival in the home in order to be safe in the home.
2. Preliminary documentation is submitted.
3. Approval is for six weeks.
4. Within 30 days, submit the complete application.
5. If the complete application is approved, services continue until the CNR. If denied, services stop at the end of the six weeks.

**Test Your Knowledge**

1. True or False: Every child coming out of the hospital needs an expedited initial.

Match the event with the time frame

2. 30 days \_\_\_\_\_ a. first follow-up with family
3. 6 weeks \_\_\_\_\_ b. complete application due
4. 1 week \_\_\_\_\_ c. initial approval period

1. *False, 2. b, 3. c, 4. a*

## **SECTION 4 INITIATING CAP/C**

### **Section Review**

1. You receive a phone call from Joey's mother. Someone in her church told her she should apply for 'CAPS' for Joey. Your first course of action is to
  - a. take the referral
  - b. determine the age and diagnosis of the child to determine if CAP/C is the appropriate 'CAPS' program
  - c. give her the CAP/C Parent Handbook
  
2. It turns out that Joey is 25 years old and is paralyzed from the waist down secondary to a motor vehicle accident. Your next course of action is to
  - a. tell her you can not help her; she has called the wrong program
  - b. give her information about CAP-DA
  - c. proceed with taking the CAP/C referral
  
3. Joey's mother decides not to apply for CAP/C. You
  - a. take no further action
  - b. log the inquiry in your agency's records.
  
4. A child's special education teacher calls you to get some information about CAP/C and possibly make a referral. You ask the

- teacher if the family is aware that she is calling, and she states they are not.
- a. You refuse to speak to her.
  - b. You tell her that without the parent's consent, you can only provide general information about the program and you can not take the referral
  - c. You answer her questions and take the referral
5. Now the parent calls you directly. After discussing the child's needs, you determine that CAP/C is not an appropriate program for the child.
- a. You thank her for her interest and inform her that the child is not eligible
  - b. You thank her for her interest, inform her that the child is not eligible, and refer her to the program you do think is appropriate
  - c. You explain to her why you feel CAP/C is not appropriate and what her options are. You follow through with either assisting her with the referral to a different program or submitting the CAP/C referral, depending on her wishes.
6. Joanne's mother submitted a CAP/C referral, and has been notified that it has been approved. She asks you when services will begin.
- a. You tell her that services can begin as soon as she selects a provider.
  - b. You tell her that you need to develop the plan of care, and then services can begin.
  - c. You tell her that approval of the referral is not approval for participation; it is just the first step – DMA must approve the

plan of care for participation to be approved and services to begin

7. Peter was disenrolled from CAP/C six months ago when he entered a rehab facility. Now he is home and wants to resume CAP/C.
  - a. He can not resume CAP/C, because once you come off the program you are ineligible to go back on it.
  - b. He can resume CAP/C; you will need to do a home visit and review/revise the Plan of Care
  - c. He needs to have the complete initial application done, but is guaranteed approval because he was on the program previously
  - d. He needs to have the complete initial application done, and it is reviewed the same as any other initial application
  
8. The 'assessment anyway' is an example of \_\_\_\_\_ rights.
  
9. Your agency is starting a wait list for the first time.
  - a. You notify DMA and work with them to find an alternative to having a wait list
  - b. You keep your wait list up to date in eCAP.
  - c. Both of the above
  
10. There are three children on your CAP/C wait list. You receive a referral for a child who has a new trach and needs services set up so that he can be discharged from the hospital.
  - a. You place the child at the bottom of the wait list; the other three children have been waiting longer

- b. You consider the level of need of all the children on the wait list, and place this child on the list in order of acuity/priority
- c. You admit the child with the new trach first.

11. Your agency has an extensive waiting list. The wait is several months long.

- a. You do nothing for the child while on the wait list; you can't bill for it
- b. You keep in regular contact with each person on the wait list
- c. You arrange for any other services they may be eligible for while they are waiting
- d. Both b and c
- e. None of the above

12. Jessica will be on your waiting list for about six months. You know that her parents' income is too high to meet normal Medicaid eligibility requirements.

- a. You instruct them to go ahead and apply for Medicaid, so at least that part can be done
- b. You instruct them it is best to not apply for Medicaid until you instruct them to do so
- c. They do not need to apply for Medicaid, they will be automatically eligible once CAP is approved

Jimmy's FL-2 was signed by the physician on June 10.

13. What is the latest date the FL-2 can be called in to HP? \_\_\_\_\_

14. What is the latest date that HP can receive the hard copy of the FL-2? \_\_\_\_\_

15. In the above example, suppose the FL-2 was approved the same day it was signed. What is the latest date that the initial/CNR can be received at DMA? \_\_\_\_\_
16. Cathy is on a ventilator, and she receives in-home nursing care while her parents work. You are doing her CNR. Which of the following documents does not need to be obtained?
- FL-2
  - physician's request from
  - employment verification
  - letter of understanding and freedom of choice
17. You are completing Cathy's plan of care. She currently receives 126 hours per week of CAP/C Nursing, but her parents want ongoing 24 hour per day nursing care. You explain that the CAP/C program doesn't allow that. You are exploring the issue and other options, but the CNR is due. Which of the following is your best course of action?
- You do not submit the CNR until the issue is resolved
  - You submit the plan of care for the number of hours she would ordinarily be eligible for, but instruct the parents not to sign it as they are not in agreement with it
  - You submit the plan of care for the number of hours she is asking for.
18. You are attending an IEP meeting. The school thinks that Samantha should have a 1:1 nurse with her during the day, but states that they don't have the funds to pay for it. You and the parents also agree regarding the need for the nurse. You

- a. Get the request for nursing services in the school form completed
- b. Tell the school CAP/C can pay for the services
- c. Tell the school that CAP/C can not pay for the services

Carol's parents are applying for CAP/C for Carol. Carol's father works full-time, and her mother stays home full-time.

19. Is Carol eligible for the up to 50 hours per week of work time?

- a. Yes
- b. No

20. Do you need to obtain employment verification from Carol's father?

- a. Yes
- b. No

21. Bob is in a wheelchair. His parents are applying to CAP/C in order to get home and vehicle modifications. They don't need or want any other waiver services.

- a. CAP/C will not be approved just for home and vehicle modifications
- b. CAP/C will be approved for three months
- c. CAP/C will be approved for one year

22. You have just received notification from your Nurse Consultant that Terry's initial has been approved. You can begin immediately to start setting up services.

- a. True
- b. False



1. b, 2. b, 3. b, 4. b, 5. c, 6. c, 7. d, 8. due process, 9. c, 10. c, 11. d, 12. b, 13. July 10, 14. July 20, 15. August 10, 16. b, 17. c, 18. c, 19. b, 20. b, 21. b, 22. b, 23. b, 24. a, 25. b, 26. b, 27. a, 28. f

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