

SECTION 5 CONTINUING CAP/C

CHAPTER 43 Monitoring of Care

SP
Service
Plans

HW
Health and
Welfare

The entire chapter relates to the assurances regarding Service Plans and Health and Welfare.

Plan monitoring activities in relation to a client's situation. Some clients may require more monitoring than others because of the intensity of needs, the support available from responsible parties, or other factors. The following describes the *minimum* monitoring requirements of the CAP/C program.

VERIFICATION OF MEDICAID ELIGIBILITY

The recipient's Medicaid eligibility should be confirmed monthly. See Chapter 39 for how to do this.

MONTHLY CONTACT WITH THE RECIPIENT/FAMILY

At least once every 30 calendar days, you should contact the recipient/family. This contact may be made in person or by telephone. Contact by email is permissible but not recommended. The main purpose of this contact is to assess the provision of services and the recipient's satisfaction with those services. Address any questions or concerns, and ask regarding updates to the child's condition and follow-ups on medical appointments and studies.

You may use the 'Note of Case Manager Contact with Recipient/Family/Caregiver/Legal Guardian' or a note similar to it to document your contact. This form can be found at http://www.ncdhhs.gov/dma/forms/CAPC_CMContact.doc.

QUARTERLY HOME VISIT WITH THE RECIPIENT/FAMILY

At least once every 90 calendar days, visit the recipient and family in their home. Both the recipient and the parent/caregiver must be present. If the child receives in-home attendant, aide, or nurse services, that staff should also be present at least annually.

The visit should be conducted in the recipient's home, so that you can assess the environment, equipment, etc. If you wish to do a visit somewhere else, such as the school, you are encouraged to do so but it may not take the place of the home visit. If the child receives care in two homes, alternate so that for example, the first and third visit occur in the mother's home and the second and fourth visit occur in the father's home.

The purpose of this monitoring visit is to get a complete update on the child's condition and needs and address any needs identified. Address any questions/concerns of the recipient/family. In addition to verifying Medicaid eligibility, assess for changes in private insurance or other payers. Update the child's health status, care needs, changes in treatment or medications, any new diagnoses, any physician visits, acute illnesses, emergency rooms visits, or hospitalizations. Assess for changes in caregiver availability or in the child's schedule. Assess the home environment, and assess the equipment/supplies including quantities. If in-home care is provided assess for any problems with staff including lack of staffing, attendance, or other concerns. Finally, assess whether the other services and supplies are being provided according to the Plan of

Care. Revise the Plan of Care as needed. You may use the 'CAP/C Case Manager Quarterly Visit Note' or one similar to it, to document your quarterly visits. This form can be found at

http://www.ncdhhs.gov/dma/forms/CAPC_CMQuarterVisit.doc.

QP
Qualified
Providers

QUARTERLY CONSULT WITH RN

If the Case Manager is ~~a Social Worker~~ not a nurse, the quarterly home visit should ideally be performed by the **SW/RN case management** team.

If this is not possible, the **SW Case Manager** conducts the home visit and has a consultation with the RN. If the RN is contracted, every effort should be made to consult with the same nurse each time, and for that nurse to be the one who performs the annual assessment. The RN should review any medically-related incident reports, case management notes, and any other documentation such as physician letters, discharge summaries, the CMS-485, or nurses'/aides' notes. Together, the RN and **SW Case Manager** should review the plan of care and revise it as needed.

The reverse process is **highly** recommended as well. If the Case Manager is an RN, regular contact with a Social Worker is beneficial, especially in recommending resources and sources of assistance. You may use the 'CAP/C Case Manager Quarterly Visit Note' or one similar to it, to document your quarterly visits. This form can be found at

http://www.ncdhhs.gov/dma/forms/CAPC_CMQuarterVisit.doc.

MONTHLY CONTACT WITH PROVIDERS OF WAIVER SERVICES

Each month contact the providers of waiver services. Assess the provision of the services; i.e, are the services being provided according to the plan of care? Are there problems staffing? Are there problems in working with

the family or recipient? Have they identified any needs you might need to address?

You may use the 'Note of Case Manager Contact with Provider', or one similar to it, to document your monthly contacts. This form can be found at

http://www.ncdhhs.gov/dma/forms/CAPC_NoteCMContProv.doc.

QUARTERLY CONTACT WITH PROVIDERS OF NON-WAIVER SERVICES

At least quarterly, contact the providers of non-waiver services. Perform the same type of assessment you did for providers of waiver services. Identify and address any discrepancies between the Participation Notice and the services/supplies provided.

You may use the 'Note of Case Manager Contact with Provider' or one similar to it, to document your quarterly contacts. This form can be found at http://www.ncdhhs.gov/dma/forms/CAPC_NoteCMContProv.doc.

QUARTERLY REVIEW OF IN-HOME CARE NOTES

If the recipient gets in-home care, request a random sample of notes each quarter. Review the notes to ensure that the appropriate level of staff is provided, medically related interventions are taking place, the service is being provided at appropriate times, the care needs match the assessment data, and there are no violations of Medicaid or CAP/C policy.

You may use the 'CAP/C Case Manager Supporting Documentation Review Note', or one similar to it, to document your review. This form can be found at

http://www.ncdhhs.gov/dma/forms/CAPC_CMQuarterSupportDocRev.doc.

FAFinancial
Accountability**REVIEW OF CLAIMS**

Claims for waiver services must be approved by ~~the Case Manager~~ CCME prior to the provider submitting them to the fiscal agent. CCME makes sure that services were coded appropriately, provided according to the service authorization, and that there are no patterns of caregiver refusal of services, lack of services, or misuse of services. When an agency sends CCME you their billing, they are supposed to send you a 'deviation notice' for each incidence in which a service did not match the authorization.

When reviewing a claim, Remember that provider agencies bill their usual and customary charges. There are controls in the payment system to restrict the amount that Medicaid pays. CCME compares the charge on the claim with the amount previously agreed upon with the provider agency, as per the Service Authorization.

CCME sends case managers a monthly report with the results of claims reviews for that case manager's recipients. The Case Manger should review this report, identify any issues that may exist, and address those issues.

You may use the 'CAP/C Case Manager Claims Review Note', or one similar to it, to document your review. This form can be found at http://www.ncdhhs.gov/dma/forms/CAPC_CMClaimsReview.doc.

ADDITIONAL CONTACTS WITH FAMILIES

- Contact the recipient's caregiver within 72 hours of discharge from a hospital or rehabilitation facility to assess the recipient's health status and changes in his or her needs.
- Contact the recipient's caregiver within 72 hours following construction or installation of home or vehicle modifications to confirm that the modification safely meets the recipient's needs.

COST REPORTS

~~To Be Determined~~

CHAPTER REVIEW**🔑 Key Points**

1. Monitoring is an individualized process based on the client's family's situation and needs.
2. CAP/C has minimum monitoring criteria which include
 - monthly verification of Medicaid eligibility
 - monthly contact with recipient/family
 - quarterly home visit with recipient/family
 - when there is a case management team, quarterly consult between the with RN and Case Manager for SW (or with SW for RN)
 - monthly contact with providers of waiver services
 - quarterly contact with providers of non-waiver services
 - quarterly review of supporting documentation
 - review of claims by CCME
 - follow-up after hospitalizations and home/vehicle modifications
 - ~~at some point in the near future, cost reports~~

 **Test Your Knowledge**

1. True or False: Home visits may only be done once every 90 days.
2. True or False: each recipient should receive the same amount of monitoring.

Match the activity with the frequency. You may use each letter more than once:

- | | |
|---|---------------------|
| 3. _____ home visit with recipient | a. monthly |
| 4. _____ telephone contact with recipient | b. quarterly |
| 5. _____ review of supporting documentation | c. as needed |
| 6. _____ contact with waiver provider | |
| 7. _____ contact with non-waiver provider | |
| 8. _____ review of claims | |

1. False, 2. false, 3. b, 4. a, 5. b, 6. a, 7. b, **8. c**

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SECTION 5

CONTINUING CAP/C

CHAPTER 44

Coordination of Care

This chapter contains information that the Case Manager will need to coordinate the family's services and prevent duplication of services.

GENERAL CONSIDERATIONS

No service is covered if it duplicates other Medicaid or non-Medicaid services.

Recipients are eligible to receive all Medicaid services according to Medicaid policies and procedures, except when those policies or procedures restrict participation.

CAP/C is not intended to replace or duplicate services and resources, such as health insurance benefits or services through the schools, which are available to the client. Help assure that the client gets the best available treatment and care by carefully coordinating the CAP/C services with the resources available in the community. For those clients with a broader array of needs than can be met with CAP/C, it is essential that you fully utilize all resources to allow the individual to stay in the community. Explore what the community has to offer, such as assistance from community groups, private individuals, public agencies and other entities. If the child has an IEP or IFSP, be sure to know what is included in the plan and coordinate services with the plan services.

WAIVERS

An individual can not be on two waiver programs at the same time. However, there is nothing that prohibits an individual on a waiver from being on a wait list for another waiver.

CASE MANAGEMENT

Medicaid will not pay for another Medicaid-reimbursed case management service in addition to CAP/C Case Management.

The agency providing case management services, including their subsidiary corporations, related partners, or closely allied entities may not also provide direct in home care services to the same recipient.

Exceptions to this criterion may be approved on a case-by-case basis when

- There is a lack of available providers such that the recipient would be unable to access services
- There is a written, signed statement by the recipient attesting to his or her free choice of the same agency for both purposes
- All of the normal requirements for both services are met independently; i.e., there is one file for the case management services, which meets all of the CAP/C case management criteria, and a second file for home health services which meets all of the home health criteria.

CAP/C PERSONAL CARE SERVICES

CAP/C Personal Care Services may not be provided at the same **day and** time as CAP/C Nursing Services or CAP/C Pediatric Nurse Aide Services.

~~CAP/C Personal Care Services may be provided on the same day but not during the same hours of the day as Attendant Care Services.~~

CAP/C Personal Care Services can not be provided at the same time as state plan Medicaid Personal Care Services.

CAP/C PEDIATRIC NURSE AIDE SERVICES

Pediatric Nurse Aide services may not be provided at the same **day and** time as CAP/C Nursing Service or CAP/C Personal Care Services.

~~Pediatric Nurse Aide services may be provided on the same day but not during the same hours of the day as Attendant Care Services.~~

CAP/C Pediatric Nurse Aide Services can not be provided at the same time as state plan Medicaid Personal Care Services.

CAP/C NURSING SERVICES

CAP/C Nursing may not be provided at the same **day and** time as CAP/C Personal Care Services or Pediatric Nurse Aide Services.

~~CAP/C Nursing may be provided on the same day, but not during the same hours of the day as Attendant Care Services.~~

CAP/C Nursing Services can not be provided at the same time as state plan Medicaid Private Duty Nursing.

Also see Respiratory Therapy Services and Home Infusion Therapy Services.

CAP/C ATTENDANT CARE

Recipients of CAP/C Attendant Care may not receive CAP/C Respite.

Attendant Care may be provided on the same day but not at the same time of day as CAP/C Personal Care Services, CAP/C Pediatric Nurse Aide Services, or CAP/C Nursing Services.

CAP/C RESPITE

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

Recipients of CAP/C Attendant Care may not receive CAP/C Respite.

PALLIATIVE CARE SERVICES

Palliative Care Service may not be provided at the same time as Hospice Services.

WAIVER SUPPLIES

Waiver Supplies may always be provided by the case management provider.

The reusable incontinence undergarments and disposable liners may also be provided by a DME company enrolled as a CAP provider.

MEDICAL SUPPLIES

Medical Supplies (non-durable medical equipment) may

- always be provided by a case management provider
- be provided by a Home Health agency, unless the recipient receives hourly nursing services

- be provided by a home care agency enrolled as a PDN provider
If the recipient receives private duty nursing services whether through CAP/C, state plan Medicaid PDN, or private insurance, the PDN provider is responsible for the medical supplies.

The home health agency may provide supplies when they are involved in the care of the recipient and there is no continuous nursing being provided.

Case Management providers enrolled for the service may always provide medical supplies.

Incontinence Supplies

Disposable Diapers				
provider	quantity limit		billing	coordination
	adults	children		
Case Management provider	Per assessment/plan of care	Per assessment/plan of care	Direct to DMA Can add 10% overhead to cost of diaper, up to Medicaid max	Can always provide and bill regardless of other services in the home
DME provider	192	192	Direct to DMA	Can always provide and bill regardless of other services in the home. If need to exceed limit, get from different provider type.
Home Health provider	Per assessment/plan of care	Per assessment/plan of care	Direct to DMA Includes one nurse visit every	Nurse visit every 60 days. If PDN is involved with the

			60 days billed as RC 589, rate per home health fee schedule for supply only visit	recipient, the diapers can not be provided by Home Health.
PDN provider	225	no limit	Direct to DMA Includes one nurse visit every 90 days billed as 99600, rate as per home care fee schedule, max of four 15 minute units per visit	Can provide to non-PDN recipients. Nurse visit every 90 days. If there is PDN already involved with the recipient, the diapers can not be provided by Home Health.

Re-usable Diapers and Liners

provider	quantity limit		billing	coordination
	adults	children		
Case Management provider	Per assessment/plan of care	Per assessment/plan of care	Direct to DMA	Can always provide and bill regardless of other services in the home
DME provider	Per service auth from CM	Per service auth from CM	Direct to DMA	Can always provide and bill regardless of other services in the home. Must send monthly invoice to CM.

HOME INFUSION THERAPY

Home Infusion Therapy services may not be billed at the same time as CAP/C Nursing. When an agency accepts a client for nursing care they must be able to meet all of the recipient's care needs. If the agency does not have personnel qualified to perform venipunctures, IV medications, etc, that agency must either subcontract with another agency or transfer the recipient to a different agency.

DURABLE MEDICAL EQUIPMENT, ORTHOTICS AND PROSTHETICS

Section 7.2.1 of the DME Policy and Section 7.3.1 of the Orthotics and Prosthetics Policy state

"Providers must notify the CAP case manager of all items (devices) they anticipate providing to a recipient who participates in a CAP program. The CAP case manager must be aware of all services being provided to a recipient to coordinate care and keep the cost of care within the CAP limit."

PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY

CAP/C recipients may receive therapy services from several different sources: the school system, home health agencies, and Independent Practitioners. Care must be taken to avoid duplication. It is sometimes appropriate for a child to receive therapies both in the home and in the school. However the purposes for/goals of the therapy should be different. The school system will help only with therapy that will affect the child's education. For instance, they may have a speech therapist see the child for communication needs, but would not have a Speech therapist working on swallowing issues. Or the child may have a gait disturbance for which he receives therapies outside of school, but the

school does not provide any therapy because the child can walk independently around the school. You should have a copy of the IEP (with the parent's permission) so that you can coordinate these services.

RESPIRATORY THERAPY

Respiratory Therapy services may not be billed at the same time as CAP/C Nursing. In the case of medically fragile children who are on life sustaining devices such as oxygen, mechanical ventilation, CPAP, etc an initial training of 1-2 hours with each nurse caring for the recipient with a follow-up each quarter may be provided if needed. The purpose of the respiratory therapy visit is to teach and train caregivers and licensed nursing staff, as needed, regarding the recipient's care. The nursing agency is responsible for ensuring the competency of nursing staff per Home Care Licensure rules.

MEDICAL APPOINTMENTS

CAP/C may accompany a patient and his/her caregiver to a medical appointment so that the staff can provide medical care for the patient while the caregiver drives. Under no circumstances may the staff drive, even if allowed by the agency policy. Once they reach the medical office, Medicaid will not reimburse for the staff time spent in the physician's office. The staff should defer to their agency policy and Standards of Practice regarding the provision of care while the staff is 'off the Medicaid clock'.

Medical appointments are an excellent opportunity for the case manager to coordinate care. If possible, have a 'well visit' scheduled with the coordinating care physician around the time of the CNR. You can have the FL-2 completed at that time, while everyone is there to discuss and resolve discrepancies. For caregivers with low health literacy, going to an

appointment with them will enable you to teach and reinforce the treatment plan. It also allows for more physician input into the plan of care and a greater understanding by the physician of the child's home situation and care.

SCHOOL SERVICES

No services are provided for exclusive use in the school.

Duplicate supplies, such as an extra feeding pump or pulse oximeter to keep in the school are not covered; the family is expected to transport these items to and from the school.

CAP/C may only pay for waiver services (nurse and nurse aide care) in the school under the following circumstances:

- The school's plan for meeting the child's identified IEP service needs is not adequate to ensure the child's health and welfare as determined by the child's waiver team.
- The school is developing a plan to meet the identified IEP service needs, but the plan is not yet in place.
- There is a discrepancy or difference of opinion regarding what is to be included on the IEP and how the IEP needs are to be met.
- The child is attending a private school, per parental preference, and the child needs a medically necessary service during school hours.

Please see Chapters 14, 15, and 16 for more detailed information regarding these requirements.

Also see the section earlier in this chapter regarding Physical, Occupational, and Speech therapy services.

PRIVATE INSURANCE

Private insurance is always billed prior to Medicaid.

If the recipient uses an out of network provider:

Medicaid will pay up to the Medicaid allowable if the recipient doesn't use an in network provider, but the insurance allows out of network benefits at a reduced rate. Medicaid will not pay if the insurance doesn't allow any out of network benefits and the recipient goes out of network for services. When the insurance carrier denies the claim with an EOB that states, provider not in network, non participating, etc. Medicaid cannot override the insurance and make payment.

WORKING WITH THE PHYSICIAN

A good working relationship with the client's physician and the physician's staff benefits all involved with the client's care. Some of the things you may do to develop and maintain such a relationship include:

- Help the physician understand how CAP/C will support the client as well as the physician's efforts to provide the best care for the client. Note that CAP/C may help reduce hospitalizations, allow earlier discharges, and permit clients to live at home. Briefly and clearly let the physician know what CAP/C offers the client.
- Keep the physician informed about the client's CAP/C plan of care. Provide the physician with a summary of the services the client is receiving or a copy of the current plan of care. For example, a note to the physician describing the services that the client will receive as a participant in CAP/C might say, "Sarah Jones has been approved to participate in CAP/C. The services authorized include eight hours of CAP/C Nursing daily,

construction of a wheelchair ramp, three cans of Pediasure daily and Case Management. Please let me know if you would like more information or have questions about the plan of care. My telephone number is (012) 345-6789."

- Let the physician know and periodically remind the physician of your role. As a case manager who knows what is available in the community, you will often be a "problem-solver" for the physician.
- Communicate in a clear and straightforward manner. Use short narratives with short sentences or phrases - something the physician can quickly and easily comprehend.
- Establish yourself as a provider of information and a source of help, not a sender of forms to sign. When you have to get a form signed, include a brief note that lets the physician know why you are making the request in terms of how it relates to the client. For example, when sending an FL-2 for the Continued Need Review, let the physician know why you need to have it completed.

HOW TO ACCESS FEE SCHEDULES AND LIFETIME EXPECTANCIES/QUANTITY LIMITATIONS FOR SUPPLIES

To access fee schedules for CAP/C DME Home Health Home Infusion Therapy Hospice Orthotics and Prosthetics Independent Practitioners (IPP), and all others:

Go to <http://www.ncdhhs.gov/dma>

Click 'For Providers'

On left side of screen, click on 'Fee Schedules/Cost Reports'.

Click on 'Fee Schedules'

Click on the desired fee schedule.

To access the 'Lifetime Expectancies and Quantity Limitations' for Durable Medical Equipment (DME) and Orthotics and Prosthetics (O&P)

Go to <http://www.ncdhhs.gov/dma>

Click "For Providers"

Under 'Quick Links' on the left side of the screen, click on "Medicaid Clinical Coverage Policies and Provider Manuals"

Scroll down to 'Medical Equipment'

Click on either 5A for DME, or 5B for O&P.

Go to 'Attachment D'

To access the "Enteral Nutrition Product Classification List":

Go to <https://www.dmepdac.com/dmecsapp/do/search>. Scroll down to the last item, 'Search fro DMEPOS Product Classification List'

To see the entire list: go to 'classification', select 'enteral nutrition', and click 'go'.

To find the code for a specific formula: enter the name of the formula under 'product name', select 'enteral nutrition' under 'classification', and click 'go'.

FEE SCHEDULES ARE NOT UPDATED ON A ROUTINE, SCHEDULED BASIS. YOU SHOULD READ YOUR MEDICAID BULLETINS AND ACCESS THE FEE SCHEDULES REGULARLY TO CHECK FOR UPDATES.

CHAPTER REVIEW

🔑 Key Points

1. Services must not duplicate each other.
2. Non-waiver services are subject to the policies and regulations for that particular service, and are not determined by CAP/C.
3. Services should be provided by multiple sources including personal and community supports, not just CAP/C.
4. Some services may not be provided at the same time as or during the same hours as other services.
5. Some programs can not be provided at the same time as another program.
6. As Case Manager, you coordinate all of the recipient's services and supplies according to both the CAP/C criteria and the criteria for the specific service or supply.



Test Your Knowledge

1. True or False: A recipient can be active on the CAP/C program while on the waiting list for the CAP **MR/DD IDD** program.
2. List the three types of providers who can provide physical, occupational, or speech therapy to children.

3. True or False: A recipient of CAP/C Nursing may also have a home health agency come out to draw labs if the agency providing the nurse is unable to do so.
4. Palliative care services may not be provided at the same time as
 - a. hospice services
 - b. CAP/C Attendant Care**
 - c. CAP/C Case Management
5. True or False: if a parent feels the child needs more physical therapy than Medicaid approved, the child can receive the additional therapy under CAP/C.

1. True; 2. school, home health, and independent practitioner; 3. False; 4. a; 5. False

**SECTION 5
CONTINUING CAP/C**

**CHAPTER 45
Revising the Plan of Care**

SP
Service
Plans

This entire chapter relates to the assurances regarding Service Plans.

WHAT IS A PLAN OF CARE REVISION?

A Plan of Care revision is a change to the goals, interventions, services and supplies, coverage schedule or other items on the Plan of Care that occurs at a time other than the change of waiver year.

WHEN IS A PLAN OF CARE REVISION DONE?

When monitoring reveals a change in the client's needs, situation or condition, do a plan of care revision. Discuss possible changes with the client/responsible party and others involved with the care and treatment of the client. You may also need to consult with other professionals. Also be alert to changes needed in services other than Medicaid services. You may assist the client/responsible party in considering and obtaining those changes. The revision should be done at the time of the change; do not wait until the next CNR or mid-year review.

WHEN SHOULD THE PLAN OF CARE BE SUBMITTED?

The revised Plan of Care should be submitted to DMA any time there is a change involving the type, amount, frequency, or duration of a waiver service or supply. The paperwork should be received by DMA no later than 30 days after the effective date of the revision.

Chapter 45 Revising the Plan of Care

OTHER SITUATIONS

Change in the Unit Rate of a Service or Supply

When the cost of a waiver service or supply changes, recompute the Cost Summary.

If the total cost to Medicaid remains within the annual cost limit, put a record of the provider's notification of the cost increase, the effective date of the cost increase, and the recomputed Cost Summary in the client's file. Do not submit anything to DMA.

If the total cost to Medicaid exceeds the annual cost limit, revise the Plan. Submit the plan of care revision to DMA. If it appears the cost cannot be kept within the limit, promptly notify the DMA CAP/C consultant.

Change in Provider Agencies

Obtain a signed and dated statement from the client/responsible party that contains the name of the new provider agency, the effective date of the change, and a statement of agreement to the change. For example: "I have selected Better Outcomes Home Care to provide CAP/C Personal Care Services to my child, Susie Jones (MID 999-99-9999Z) beginning on August 22, 2010."

Place the statement in the client's file and document the change on the plan of care. Do not submit anything to DMA.

Change in the Typical 24 Hour Coverage Schedule

When the schedule for 24 hour coverage changes, document the change.

If the change involves an increase or decrease in the number of hours per week provided, submit a plan of care revision to DMA.

If the new schedule is within the already approved allotment of weekly hours and meets the criteria for interventions taking place during that time, etc, document the change by completing a new 24

hour schedule. Note the effective date of the change and have the client/responsible party sign and date the item to indicate agreement to the change.

Variations within Estimate

The plan of care entry is an estimate. It is understood that the amount may vary from month to month due to the length of each month and the changing needs of the client. You do not have to revise the Plan if the pattern of use remains within the estimate on the Plan.

WHAT DOCUMENTATION IS NEEDED?

Submit the following documents with your Plan of Care revision:

- Cover letter
- Plan of Care form
- Supporting documentation

Please do not attach a revision to a CNR. CNRs are not reviewed and approved as quickly as revisions, so there is significant risk that your revision will not get approved in a timely manner.

Please mail the revision whenever possible; submitting the revision by fax is acceptable if the need is urgent. Please submit all of the information at the same time. Make sure that the recipient's name and MID are on every page.

APPROVAL OF THE REVISION

Plan revisions should be approved before a change is made; however, changes may be approved retroactively for up to 30 days prior to the date that the revised Plan is received by DMA's HCI Unit for approval.

Revisions will only be verbally approved in urgent situations. Both families and case managers should plan ahead and make requests in a timely manner. Verbal approvals will not be given for last minute requests of

foreseeable circumstances. Verbal approvals are usually only appropriate for requests for short-term-intensive in-home-care services that are needed because of an emergency situation. Examples include:

- A single-parent caregiver must travel out of town due to an unexpected death in the family; you need approval for 3 days of 24 hour short-term-intensive services for the child.
- A recipient's parent is suddenly hospitalized. You need approval for short-term-intensive services because of both the absence of the hospitalized parent, and the need for the other parent to be at the hospital at times

When requesting verbal approval, you should know specifically what you are requesting and how it will impact the budget. Phone approvals are always tentative, pending the final review of the written documents. If a phone request is approved, you must submit the written request to DMA within five workdays of the phone approval or the approval will be voided.

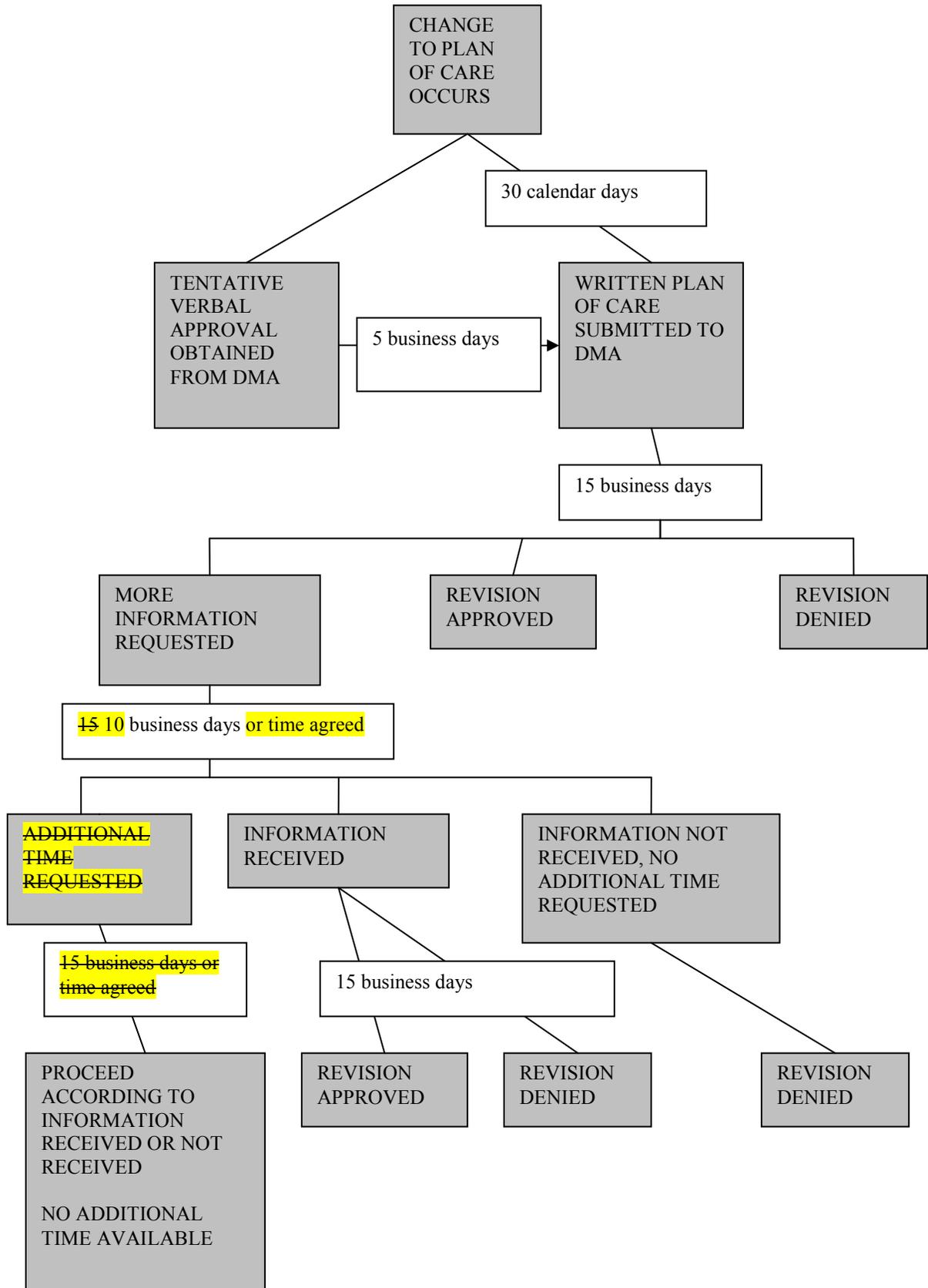
Revisions are reviewed in the order in which they are received. They receive higher priority than CNRs, but lower priority than initials.

Plan revisions must be approved to qualify the changes for Medicaid payment. If the revision is approved, you will receive a letter of approval from your CAP/C Nurse Consultant. Notify the client/responsible party of the approval; implement the change(s); and, if the client has a Medicaid deductible, send a copy of the revised Cost Summary to the Medicaid staff at the county DSS.

WHAT IF THE REVISION IS DENIED?

If the revision as requested is denied, the client/responsible party has the right to appeal the denial of reduction of services. They will receive a letter from DMA stating the reason for decision and giving instructions for requesting an appeal. The case manager is copied on this letter.

CAP/C REVISIONS PROCESS AND TIMELINES



CHAPTER REVIEW**🔑 Key Points**

1. A plan of care revision is needed when there is a change in the child's condition or situation that causes a need for a change to the approved plan of care.
2. Plan of care revisions need to be submitted to DMA when they involve a change in the type, amount, frequency, or duration of a waiver service or supply.
3. Approval of the revision should be granted before the change is implemented.
4. In emergency situations, a verbal approval may be granted. Verbal approval is tentative pending receipt and review of the written plan of care. The written plan of care must be submitted within 5 business days of the verbal approval. Approval may be granted for up to 30 days prior to the date the revision was received at DMA.
5. Submit the cover letter, plan of care form, and any supporting documentation.



Test Your Knowledge

1. Plan of care revisions are needed for
 - a. changes in waiver services
 - b. changes in non-waiver services
 - c. changes in cost
 - d. all changes

2. Plan of care revisions are submitted to DMA for approval when the revision is for
 - a. changes in waiver services
 - b. changes in non-waiver services
 - c. changes in cost
 - d. all changes

3. True or False: When you submit a plan of care revision, you must submit all of the documentation you would submit with a CNR.

1. d, 2. a, 3. False

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SECTION 5 CONTINUING CAP/C

CHAPTER 46 Mid-Year Review

FA
Financial
Accountability

This chapter relates to the assurance of Financial Accountability.

WHAT IS THE PURPOSE OF A MID-YEAR REVIEW?

The mid-year review helps to

- ensure that our most medically fragile and highest cost recipients are monitored more closely
- ensure that care and services is both effective and cost effective
- prevent instances of a child continuing to receive a service long after it should have been changed or stopped (i.e., due to a change in condition or caregiver availability)
- keep our assurance to CMS of cost neutrality

WHO NEEDS A MID-YEAR REVIEW?

- Recipients of CAP/C Pediatric Nurse Aide Care or CAP/C Personal Care whose waiver budget meets or exceeds \$30,000 per year
- Recipients of CAP/C Nursing whose waiver budget meets or exceeds \$135,000 per year

WHEN IS THE MID-YEAR REVIEW DONE?

This review occurs 6 months after the last CNR and before the next CNR.

Mid-year reviews on new patients in their first year of CAP/C participation are needed only if there is a lapse of greater than six

months between initial approval and first CNR due date. In these cases, the mid-year review will be due at the halfway date between initial approval and CNR due date. The same is true if a plan of care revision causes the recipient to meet the criteria for a review.

The date of the next mid-year review will be indicated on the initial or CNR approval letter, as is the next CNR date.

The review is due on the 5th of the month.

WHAT DOCUMENTATION IS NEEDED?

Please submit the following documents to your Nurse Consultant:

- The cover letter, indicating that this is a mid-year review
- The current CAP/C Plan of Care
- The CMS-485 or similar document
- 3-5 days of service notes (nurse's notes, nurse aide task sheets, medication administration records, and any other pertinent documentation, i.e., a seizure log.)
- Case management notes for the previous quarter (i.e., most recent two monthly phone calls, and most recent home visit)

IS THERE AN APPROVAL OR DENIAL?

The Consultant will review the documentation. If she determines that everything is as it should be, you will receive a letter to that effect.

If there are questions or something needs to be changed, your Consultant will contact you. Normal procedures for requests for additional information, plan of care revisions, or adverse decisions are followed.

CHAPTER REVIEW

Key Points

1. Mid-year reviews are done only on recipients who receive in-home nurse aide or nurse care and whose waiver budgets exceed certain amounts.
2. Mid-year refers to the CNR year; the halfway point between two annual initial/CNR reviews.
3. Mid-year review consists of submitting the cover letter, the plan of care, the CMS-485, nurse/nurse aide service notes, and case management notes.

**Test Your Knowledge**

1. Which of the following does not need to be submitted with a mid-year review?

a. the assessment

b. the plan of care

c. the CMS 485

d. nurse's notes

2. True or False: All CAP/C recipients get mid-year reviews.

1. a, 2. False

SECTION 5

CONTINUING CAP/C

CHAPTER 47

The Continued Need Review

Chapter 47 The Continued Need Review (CNR)

WHAT IS THE PURPOSE OF A CNR?

Every 12 months, the client's needs must be completely reassessed to determine if the client remains appropriate for CAP/C and for the CAP/C services he or she is receiving. This formal reassessment is called a Continued Need Review (CNR).

WHO NEEDS A CNR?

Each CAP/C participant must have an annual CNR completed. It is a requirement to remain on the program.

WHEN IS THE CNR DONE?

The CNR is performed at least annually. The due date is determined by the recipient's date of birth. The CNR must be received by the 5th day of the child's birth month.

The date the next CNR is due is noted on the DMA Initial or CNR approval letter. If the date does not correspond with your records, contact the DMA CAP consultant.

The CNR due date will never change for as long as the recipient is on the program.

If the CNR will be delayed, because for example, the child will be at an out of state feeding therapy program – notify your Nurse Consultant

as soon as you are aware. It is imperative that the FL-2 be done on time, even if the CNR must be late. You can not go longer than 12 months without an FL-2. Get the new FL-2 before the recipient becomes unavailable. (If the CNR can not be completed within 60 days, you will need to get another FL-2 when the CNR is done.) If the FL-2 is not completed on time, the client may be terminated from CAP/C. Claims for services provided after the FL-2 expires may be denied. DMA may take back payments for services provided after the FL-2 has expired. During the first year of a child's participation it will likely be less than one year before the next CNR is due. The CNR must still be submitted. If the child's birthday occurs soon after the initial approval, it is unlikely that much of the information will have changed. Get a new FL-2, update the forms as needed and submit the CNR as you would any other.

WHERE IS THE CNR DONE?

The CNR should be performed in the recipient's home so that the environment, family dynamics, and medical needs and resources can be assessed. If the recipient is hospitalized or otherwise not available in the home at the time of the CNR, please discuss with your Consultant.

WHAT TIMEFRAMES ARE ASSOCIATED WITH THE CNR?

- The dates during which the CNR is actually being done are referred to as the CNR month. The CNR month is the month before the recipient's birth month.
- The FL-2 must be completed within 60 days of the CNR, so the FL-2 may be obtained as early as the month before the CNR month.
- The completed CNR is due in to DMA by the 5th of the recipient's birth month.

- The approval is effective the first day of the month after the recipient's birth month and ends one year later on the last day of the recipient's birth month.

BIRTH MONTH	FL-2 MAY BE OBTAINED	CNR MONTH	CNR DUE TO DMA	APPROVAL EFFECTIVE
January	November	December	January 5	February 1 – January 31
February	December	January	February 5	March 1 – February 28
March	January	February	March 5	April 1 – March 31
April	February	March	April 5	May 1 – April 30
May	March	April	May 5	June 1 – May 31
June	April	May	June 5	July 1 – June 30
July	May	June	July 5	August 1 – July 31
August	June	July	August 5	September 1 – August 31
September	July	August	September 5	October 1 – September 30
October	August	September	October 5	November 1 – October 31
November	September	October	November 5	December 1 – November 30
December	October	November	December 5	January 1 – December 31

For example, Sally's birthday is July 12. Her CNR is due July 5. Her CNR month, during which you are completing the CNR is June. Her FL-2 may be obtained as early as May. The approval will be for August 1 through July 31.

The time spent on the assessment part of the CNR would be claimed within the six hours per rolling calendar year of T1016 SC. The system does a true 365 day look back, so consider that when you schedule your assessment activities.

Transitioning During the First Year

For active recipients whose CNR due date was based on the date of the first FL-2 approval, follow this procedure for transitioning the CNR to the recipient's birth month:

For October to December 2010, continue to do the CNRs based on the current (FL-2 based) CNR date.

Beginning January 1, 2011, all CNRs will be submitted based on birth month.

If the birth month occurs before your current CNR date, at the birth month due date, submit a new FL-2 and the documentation necessary for a mid-year review (even if the waiver expenses do not meet the criteria). Do not do anything on the FL-2 based CNR date. Complete a full CNR the next year during the birth month.

If the birth month occurs after your current CNR date, at the current CNR date, submit a new FL-2 and the documentation necessary for a mid-year review (even if the waiver expenses do not meet the criteria). At the birth month, submit a full CNR.

QP

Qualified Providers

WHO COMPLETES THE CNR?

The RN Case Manager or the RN/SW Case Management team are responsible for coordinating the information required for the CNR. The client/responsible party is responsible for cooperating in getting the information required to complete the CNR.

WHAT DOCUMENTATION IS NEEDED?

For CNRs, send the following items. Please submit everything at the same time, rather than sending in some and then sending other forms when they are ready. The CNR can not be reviewed until all of the documentation is received. Please do not fax a CNR (even if it will not arrive by mail until after the 5th) unless requested to do so by your Consultant. Never submit both a faxed and mailed copy of the CNR. Please send copies of your documents, not originals.

- Cover Letter
- A copy of a new FI-2 signed by the physician (needs to be approved by the fiscal agent only if there is a level of care change)
- The family-centered self-assessment
- ~~The case manager assessment~~
- The current Plan of Care (Please note your Plan of care is documented from July 1 to June 30. Send the Plan of Care in effect at the time of the CNR, including revisions to that plan based on your new assessment data. You do not need to start a new plan of care with the CNR.)
- The Physician's Request Form, if you have changed the Plan of Care to include CAP/C Nursing
- The employment verification form, if the family is requesting nurse aide or nurse hours to cover work time
- The Request Form for Documentation of Nurse or Nurse Aide Services in the School, if applicable. This form may be done annually at the time of the IEP meeting. It does not need to be repeated for the CNR. Just send the request that is in effect.
- The current CMS-485 or similar document, if the child receives CAP/C Nursing

- The current medication administration record, if the child receives CAP/C Nursing
- Three to five days of nurses' notes/nurse aide task sheets, if applicable. For recipients of CAP/C nursing, the notes should correspond to the dates on the CMS-485 form. It is best to select the days that the client required the most care. If the dates the client required the most care were not within the dates of the CMS-485 form, you may send additional notes for those days. For example, a 10 year old child with chronic lung disease has a CNR due in July. Your assessment indicates, however, that this child is always much sicker during the winter months, and during those months requires more frequent nebulizer treatments, oxygen, and suctioning. You would send in a CMS-485, MAR, and nurses notes for June-July, along with an additional 3-5 days of nurses notes from the previous winter.
- Any additional information that may be helpful, such as letters from physicians, discharge summaries, parent seizure logs...
- Other documentation may be requested on an individual basis.

WHAT IF THE CNR IS APPROVED?

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

When the CNR is approved, you will receive a letter from your Nurse Consultant. It will be copied to the local DSS to assist you in coordinating Medicaid eligibility and ensuring the correct CAP Indicator code is entered. The approval letter is not copied to the family.

Once you receive approval from DMA, proceed with notifying the family, coordinating with the DSS, and sending your service authorizations and participation notices.

Date

MEMORANDUM

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

FM: (Name & Agency of Case Manager)

RE: Approval of CAP/C for (Name and Medicaid ID no. of client)

The above individual has been approved to continue participating in the CAP/C program. The Continued Need Review was approved on _____.

A copy of the approved Plan of Care Cost Summary that shows what CAP services are authorized is attached. A copy of the DMA Plan approval letter is also attached.

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

Attachments (2)

If a CNR has not been reviewed by DMA prior to when your service authorization expires, you **should** ~~may, at the provider agency's request,~~ authorize an additional month of services, for as many months as it takes until you get DMA approval. The authorization shall be for the services listed on the most recently approved plan of care – not for the services listed on the CNR.

FH
Fair
Hearings

WHAT IF THE CNR IS DENIED?

If continued participation is denied, the procedures described in Section 6 and 7 will be followed.

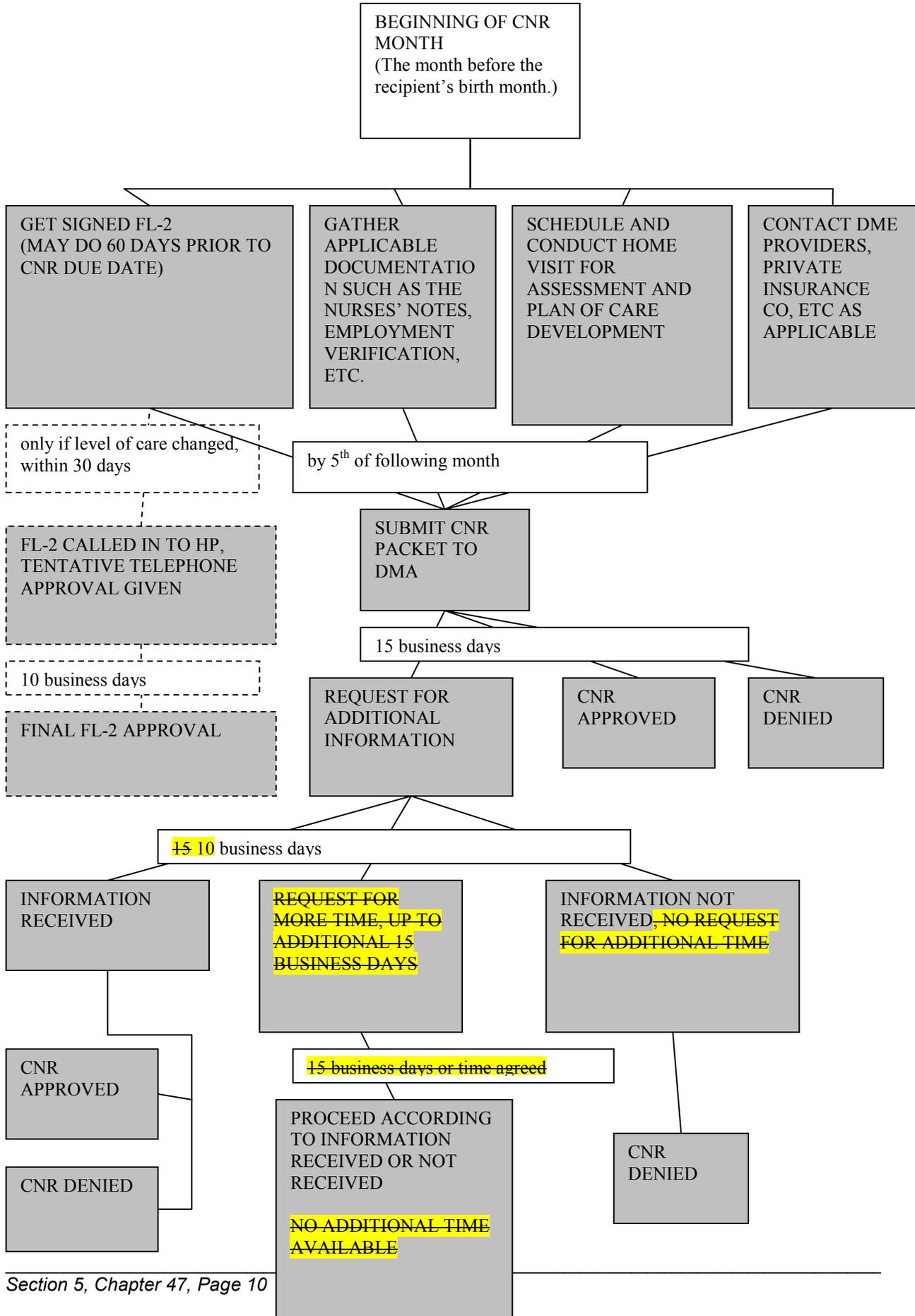
HOW IS THE CNR BILLED?

Your assessment time for the CNR is billed under code T1016 **SC**, at the rate on the CAP/C fee schedule located at

http://www.ncdhhs.gov/dma/fee/CAP_Child.pdf. **Remember that this time is**

limited to six hours per rolling calendar year. The remainder of the CNR activities are billed under code T1016, at the rate on the fee schedule listed above.

CAP/C CNR PROCESS AND TIMELINES



CHAPTER REVIEW

🔑 Key Points

1. The CNR is a requirement for continued participation in the CAP/C program.
2. The CNR is due to DMA by the 5th of the recipient's birth month.
3. The CNR month is the month before the recipient's birth month, when most of your CNR activities will take place.
4. The FL-2 can be **submitted obtained** up to 60 days prior to receipt by DMA.
5. The CNR Plan of Care is effective the first of the month following the recipient's birth month.

 **Test Your Knowledge**

1. The CNR is done
 - a. quarterly
 - b. annually
 - c. as needed
2. A CNR is needed for
 - a. all CAP/C recipients
 - b. high-cost CAP/C recipients
 - c. recipients with high medial needs
 - d. recipients receiving certain services
3. The CNR is due on the 5th of
 - a. the month in which they originally started CAP/C services
 - b. the month the original FL-2 was approved
 - c. the birth month
 - d. July
4. The CNR approval period begins _____ and ends _____.

1. b, 2. a, 3. c, 4. first day of month after birth month through last day of birth month

SECTION 5 CONTINUING CAP/C

CHAPTER 48 Absences

This Section provides guidance to the case manager on handling absences from CAP/C participation as well as breaks in services.

HOSPITALIZATIONS

When a client is admitted to a hospital, determine why the client was admitted, the prognosis and anticipated length of the absence from the home.

Anticipated Hospitalization of 30 Days Or Less

When the recipient enters the hospital

- Suspend all CAP/C services except for Case Management. Continue to provide Case Management that does not duplicate discharge planning. None of the other CAP/C services may be billed to Medicaid for a recipient who is in institutional care. Notify service providers that CAP/C services are suspended and let them know you will contact them when services need to be resumed. (Telephone contact is acceptable, although written contact is preferred.)
- Notify the discharge planner that the client is on CAP/C. Ask the discharge planner to coordinate his or her actions with you, including FL-2 actions.

While the recipient is in the hospital

- Monitor the recipient's situation through contacts with the discharge planner and other appropriate parties.
- Be alert to any changes that may extend the hospitalization beyond 30 days or result in a transfer to a nursing facility/rehabilitation center.
- If the recipient is transferred to a nursing facility/rehabilitation center, contact the HCI unit so that termination procedures may be initiated. You will be asked to coordinate this date in conjunction with the DSS Medicaid staff

When the recipient is expected to be discharged

- Determine the recipient's medical situation and related home care needs through contacts with the physician, discharge planner and other appropriate parties. Remember to document your findings in case management notes.
- Confirm that the recipient still meets nursing facility level of care. If there is possibility that he/she may not, obtain a new FL-2 from the physician and get the fiscal agent's approval.
- Determine whether the Plan of Care needs to be revised and take necessary action. If you find that the recipient's health, safety, and well-being can no longer be met with CAP/C assistance in the home setting, contact the HCI Unit. Remember, the recipient may need short-term intensive services to be included in the Plan.
- Alert CAP/C providers about when to resume care.

- Inform the DSS Medicaid staff that the recipient continues on CAP/C. Confirm that the recipient still has an active CAP indicator in the Eligibility Information System (EIS) – it should not have been removed during the recipient's hospitalization. If the recipient's level of care has changed from the level of care prior to hospitalization, **inform your Nurse Consultant and send in a plan of care revision if applicable. DMA will inform** DSS in writing of the effective date of the CAP indicator change (this is the effective date of the new level of care).

Note that because the absence does not exceed 30 days, it is not necessary to treat the recipient as a new applicant. You do not have to complete a new assessment and POC to reinstate the indicator code.

After the recipient returns home

- Verify that services have resumed and are appropriate for the recipient's situation.
- If Home Health services have been ordered, a RN from the home health agency will usually make a visit to the recipient's home shortly after the return home – contact the home health nurse to get an evaluation of the recipient's situation and to verify what Home Health services are planned.
- Revise the Plan of Care if needed and send to the HCI Unit for approval.
- Continue to use the same CNR schedule.

- Carefully document all your findings, decisions and actions in case management notes. Be careful that your actions do not duplicate the responsibilities of the discharge planner – you may not bill for Case Management for those activities that are the responsibility of the discharge planner.

Hospitalization for Over 30 Days

Hospital stays over 30 days affect Medicaid eligibility and CAP participation. If the recipient is hospitalized for over 30 days, contact the DSS Medicaid staff to learn when the recipient's Medicaid status will change. Convey that information to HCI Unit so that termination procedures can be initiated.

If the recipient is to be discharged to his/her home before the proposed effective date of termination, alert the DSS Medicaid staff and the HCI Unit about the client's return home. If the recipient's responsible party wishes to resume CAP/C, use the following procedures:

When the recipient is expected to be discharged

- Determine the recipient's medical situation and related home care needs through contacts with the physician, discharge planner and other appropriate parties. Remember to document your findings in case management notes.
- Confirm that the recipient still meets nursing facility level of care. If there is possibility that he/she may not, obtain a new FL-2 from the physician and get the fiscal agent's approval
- Determine whether the Plan of Care needs to be revised and take necessary action. If you find that the child no longer meets CAP/C criteria, notify the HCI Unit so that termination procedures may be initiated. Remember, the recipient may need short-term intensive services to be included in the Plan.

- Alert CAP/C providers about when to resume care.
- Inform the DSS Medicaid staff that the client continues on CAP/C. Confirm that the client still has an active CAP indicator in the Eligibility Information System (EIS) – it should not have been removed prior to the proposed effective date of the DSS Medicaid eligibility change. If the recipient's level of care has changed from the level of care prior to hospitalization, **inform your Nurse Consultant and send in a plan of care revision if applicable. DMA will inform** DSS in writing of the effective date of the CAP indicator change (this is the effective date of the new level of care).

After the recipient returns home

- Verify that services have resumed and are appropriate for the recipient's situation.
- If Home Health services have been ordered, a RN from the home health agency will usually make a visit to the client's home shortly after the return home – contact the home health nurse to get an evaluation of the recipient's situation and to verify what Home Health services are planned.
- Revise the Plan of Care if needed and send to the HCI Unit for approval.
- Continue to use the same CNR schedule.
- Carefully document all your findings, decisions and actions in case management notes. Be careful that your actions do not duplicate the responsibilities of the discharge planner – you may not bill for

Case Management for those activities that are the responsibility of the discharge planner.

If the recipient is discharged after the effective date and the recipient wishes to participate in CAP/C, consider the individual as you would any individual applying for the program.

STAYS IN REHABILITATION CENTERS AND NURSING FACILITIES

Admission to a nursing facility or a rehabilitation center that is billed to Medicaid as NF care affects Medicaid eligibility and CAP participation. If the client is admitted to a nursing facility/rehab center, contact DMA's HCI Unit so that termination may be initiated. Termination is effective the day of admission to the facility.

Anticipated Stay of 30 days or Less

Because many clients are in nursing facilities/rehabilitation centers for short-term rehabilitation stays that do not exceed thirty days, there is a simplified procedure for returning these individuals to CAP/C.

Remember, the client has already been terminated from CAP/C due to the admission. These procedures do not reverse that termination. The nature of this short absence allows the use of a simplified process to get the individual back on the program without requiring all the procedures used for considering a new participant. If the client is returning home from the nursing facility/rehab center in less than 31 days and wishes to resume CAP/C, proceed as follows:

When the recipient is expected to be discharged

- Determine the recipient's medical situation and related home care needs through contacts with the physician, discharge planner and other appropriate parties. Remember to document your findings in case management notes.
- If resuming CAP/C appears inappropriate, relay that information to the caregivers (without giving them the impression you are denying CAP/C).

Provide guidance on any known alternatives. If they are in agreement that CAP/C is no longer needed, the process ends here.

- If the family still wishes to pursue CAP/C, or if resumption of CAP/C seems appropriate, get a new FL-2, develop a new plan of care, and submit both to DMA.
- If the plan of care is approved, resume services, monitoring, etc as you would if the recipient were being discharged from the same length hospitalization (see above). If the plan of care is denied, it will be treated as a denial of an initial for due process purposes.

Anticipated Stay of More Than 30 Days

As with any stay in a nursing facility, CAP/C will be terminated effective the date of admission to the facility. If the recipient wishes to resume CAP/C services after discharge from an admission lasting longer than 30 days, you would treat it the same as any other initial application.

TEMPORARY ABSENCES FROM AREA

When a client temporarily leaves the county, suspend the delivery of CAP/C services by contacting the provider agencies. The length of the absence needs to be tracked, as an extended absence can affect Medicaid eligibility. If the absence is expected to be over 30 days, the local DSS Medicaid staff should be notified.

CHAPTER REVIEW**🔑 Key Points**

1. Any absence of more than 30 days must be reported to DSS as it can affect Medicaid eligibility.
2. CAP/C must be terminated anytime a recipient enters a long term care facility such as a nursing home or rehab center, even when they expect to be there less than 30 days.
3. Coordinate hospitalizations with the discharge planner. Call the discharge planner to let them know that the child is on CAP/C and that you are his/her case manager. Do not duplicate any activities of the discharge planner.
4. The procedure for resuming services after discharge depends on the length of admission and whether it was a hospital or a long-term care facility.

 **Test Your Knowledge**

1. If a CAP/C child is in the hospital, you may provide case management that does not duplicate the hospital's discharge planning, as long as it is within the ____ days prior to discharge.
2. When a child is admitted to a rehabilitation facility
 - a. They do not need to be terminated from CAP/C
 - b. They need to be terminated from CAP/C if the admission lasts longer than 30 days
 - c. They need to be terminated from CAP/C immediately
3. When a CAP/C child's custody arrangement states that the child spends six weeks during the summer with a parent in another state, you should
 - a. contact your CAP/C Nurse Consultant to terminate CAP/C
 - b. contact your local DSS eligibility person to inform them of the situation, then contact your CAP/C Nurse Consultant
 - c. do nothing except suspend services and then resume them once the child arrives home
4. True or False: A recipient returning to CAP/C after a stay in a rehab center lasting less than 30 days needs to start over again as a new initial applicant.

1. 30, 2. c, 3. b, 4. False

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SECTION 5

CONTINUING CAP/C

CHAPTER 49

Transfers

A transfer is a move without a break in participation.

TRANSFERS BETWEEN CASE MANAGEMENT AGENCIES

This type of transfer is usually caused by a move out of a case management agency's service area. Transfers may also occur within a county when multiple CAP/C case management agencies are available. The parent/responsible party works with your agency, the new agency and the HCI Unit to accomplish a transfer.

How to Accomplish a Transfer

Recipient Responsibilities

To initiate a transfer, the parent/responsible party:

- With the assistance of the current CAP/C case manager and the HCI Unit, locates a new CAP/C case management agency that agrees to provide the service and confirms with the new agency when it will be able to begin providing Case Management; and
- Gives a signed statement to both the current agency and the new agency in advance of the transfer that:
 - indicates the intent to change agencies,
 - shows the name of the current agency,

- shows the name of the new agency,
- states the date of the change, and
- gives permission for the current agency to release copies of the current FL-2, assessment, Plan of Care and related information to the new agency.

Current Agency Responsibilities

The current agency is the agency providing case management prior to the transfer.

The current agency

- works with the parent/responsible party and the HCI unit to help locate a new CAP/C case management agency (This is part of discharge planning and is a billable case management activity.),
- notifies the CAP/C Nurse Consultant of the transfer,
- calls the new case management agency to get the name of its contact person for handling the transfer,
- If the client is moving, work with the new agency to arrange for services to continue in the client's new home during the transition period. Authorize services from the new providers for a two week period beginning with the date of transfer.
- Send a notice to each current provider of CAP/C services that tells the provider
 - the transfer date,
 - the date that your authorization for services ends - the last day of the transition period,
 - If the client remains in the provider's service area, to expect an authorization from the new case management agency before your authorization ends;

- If the client is moving out of the provider's service area, the date to end CAP/C services – either the date of the move or an earlier date if desired by the parent(s)/responsible party;
 - The new case management agency may change or stop the services prior to the end of the transition period; and
 - The name, address and phone number of the new case management agency, plus the name of a contact at the agency.
- If the recipient is moving to a different county, notify DSS of the transfer.
 - Send a notice to each provider of the other community services, such as Home Health, that tells the provider that case management responsibilities are being transferred. Include the transfer date and the name, address, phone number and contact person for the new case management agency.
 - Send a copy of each of the above notices, plus a copy of the current FL-2, assessment, Plan of Care and service authorizations to the new agency.
 - The last day that the current agency may bill for Case Management is the day prior to the transfer date.

New Agency Responsibilities

Remember, according to the wait list policy, transfers should be given priority.

- When the new agency receives the client's signed transfer request, it informs the current agency of the contact person to handle the transfer. The new agency begins planning to complete its transfer activities.

- Immediately reviews the recipient's situation to determine if changes in services are needed. Conducts a home visit, reviews the most recent assessment and current Plan of Care, and contacts providers and caregivers as needed. Documents your findings in your case management notes.
- Revises the Plan of Care as needed and obtain the HCI Unit's approval. Initiates changes as soon as you see that they are needed. At a minimum, sends in to DMA the new demographic information and the new home environment assessment if applicable.
- Establishes working relationships with the CAP/C providers, the other community care services providers, the client's Medicaid worker at DSS, and the others involved in the client's care.
- The first day that the new agency may bill for Case Management is the transfer date.
- The recipient's CNR date remains the same after the transfer.
- All transfer activities, including issuing new Service Authorizations and Participation notices, must be completed within two calendar weeks of transfer.

Coordination with Medicaid Eligibility Staff

Notify the DSS Medicaid eligibility staff of the change in CAP/C case management agencies. Include the effective date and the name, address, contact person and phone number for the new case management agency.

If the change involves a move to another county, remember that the Medicaid eligibility staff must transfer Medicaid coverage to the new county. The CAP indicator code is no longer removed and reentered with transfers.

TRANSFERS BETWEEN SERVICE/SUPPLY PROVIDERS

Obtain a signed and dated statement from the client/responsible party that contains the name of the new provider agency, the effective date of the change, and a statement of agreement to the change. For example: "I have selected Better Outcomes Home Care to provide CAP/C Personal Care Services to my child, Susie Jones (MID 999-99-9999Z) beginning on August 22, 2010."

Place the statement in the client's file and document the change on the plan of care. Do not submit anything to DMA.

Notify the old provider to discontinue services. Issue a service authorization or participation notice as applicable to the new provider.

TRANSFERS BETWEEN PROGRAMS

When a CAP/C client is moving to another Medicaid program, CAP/C must be terminated before beginning participation in the other program. The transfer ideally should occur such that CAP/C ends on the last day of the month, and the new program begins the next day on the first day of the month (particularly if the new program also provides case management). The transfer must be carefully coordinated with the client, both programs, provider agencies and the DSS Medicaid worker.

Recipient Responsibilities

To initiate a transfer to a different program, the parent/responsible party:

- With the assistance of the current CAP/C case manager and the HCI Unit, locates a new program and completes the referral/approval process for that program
- If the recipient is transferring voluntarily, signs a Voluntary Withdrawal of CAP/C Participation form. (If the transfer is not voluntary (for example, the recipient must transfer to PDN because of turning 21 years of age, but would prefer to remain on CAP/C to get case

management and respite), notify your Nurse Consultant and she will begin the procedure for an involuntary adverse decision, as described in Chapter 53.)

Current Agency Responsibilities

The current agency is the agency providing case management prior to the transfer.

The current agency

- assists the recipient with locating and referring to another program,
- presents the Voluntary Withdrawal of CAP/C Participation form to the recipient for signature, or notifies the Nurse Consultant of the Involuntary transfer,
- notifies the CAP/C Nurse Consultant of the transfer, if not already done,
- calls the new case manager or program representative to get the name of its contact person for handling the transfer,
- sends a notice to each current provider of CAP/C services that tells the provider the date to end CAP/C services,
- notifies DSS of the transfer, and
- send a copy of any pertinent documentation to the new agency.
- The last day that the current agency may bill for Case Management is the day prior to the transfer date, which should be the last day of the month.
- You will receive a copy of the letter to the recipient confirming the termination of CAP/C. This letter is also copied to the DSS so that they know to take out the CAP/C Indicator Code.
- Follow up with the DSS to make sure that the CAP/C Indicator Code is removed.

New Agency Responsibilities

- Informs the current agency of the contact person to handle the transfer. The new agency begins planning to complete its transfer activities.

- The first day that the new agency may bill for Case Management is the transfer date, which should be the first day of the month.

Coordination with Medicaid Eligibility Staff

Notify the DSS Medicaid eligibility staff of the change. Include the effective date and the name, address, contact person and phone number for the new case management agency or program representative.

CHAPTER REVIEW**↳ Key Points**

1. By definition, a transfer means that there is no break in the recipient's services.
2. CAP Indicator codes are no longer removed and re-entered when a recipient moves to a different county.
3. Transfers ideally occur at the end of one month/beginning of the next month.
4. Transfers must be carefully coordinated among the recipient, old provider or program, new provide or program, supply and service providers, DSS, and the HCI Unit.

 **Test Your Knowledge**

1. You are receiving a CAP/C child who is moving into your county. You
 - a. Make the child a priority if you have a wait list
 - b. Assist the current case manager in getting services started in your county so that there is no break in services for the recipient
 - c. Review the assessment and plan of care
 - d. All of the above
2. The best time to submit the home environmental assessment for the above child is
 - a. As soon as the child moves to your county
 - b. Next CNR
 - c. Next time you need to submit something (such as a revision) to DMA
3. When transferring between case management agencies, who authorizes the first two weeks of services in the new county?
 - a. The current case manager
 - b. The new case manager

4. True or False: A transfer to a different DME supplier requires a plan of care revision to be submitted to DMA.

 5. What is the last responsibility that the CAP/C case manager has after transferring a recipient to a different Medicaid program? _____
-

1. d, 2. a, 3. a, 4. False, 5. make sure the CAP/C Indicator Code has been removed.

SECTION 5

CONTINUING CAP/C

CHAPTER 50

Documentation

The case management agency and other CAP/C providers must document services and keep records according to Medicaid requirements. A provider must document the provision of a service before seeking Medicaid payment. The provider's records must provide an audit trail for services billed to Medicaid.

This section provides the Medicaid requirements for client records maintained by the CAP/C case management agency, including those for the case management agency services – Case Management, Home ~~Mobility Aids-Modifications~~, Vehicle Modifications, Community Transition Funding, Caregiver Training and Education, CAP/C Waiver Supplies, and case management agency supplied Medicaid medical supplies. Case management agencies must also keep related personnel, financial and other management records as required by the Medicaid Provider Participation Agreement, the policies and procedures in this manual, Medicaid rules, and State and Federal law.

This section includes Medicaid's minimum requirements for client records and related information. Nothing in this section relieves a case management agency or other provider from the licensing rules and other applicable requirements.

INFORMATION COMMON TO ALL CLIENT RECORDS

All records (both case management agency and provider records) must contain the client's name and MID as on the Medicaid ID card. This information should be on each page. Service documentation must contain

- what service was provided,
- the date that the service was provided,
- where the service was provided; and
- the required documentation for the specific service.

ELECTRONIC SIGNATURES

Providers that maintain patient records by computer rather than hard copy may use electronic signatures on valid supporting documentation for Medicaid claims if such entries are appropriately authenticated and dated. The following requirements apply:

- Electronic entries must be dated and accompanied by the unique identifier of a primary author who has reviewed and approved the entry.
- Computer or other code signatures must be maintained under adequate safeguards.
- Entry of electronic signatures and codes must be made in a secure environment which prevents unauthorized access to records and which protects the security of patient information being electronically transmitted.
- Sanctions must be in place and imposed for improper or unauthorized use of stamp, computer key, or other code signatures.
- The provider agency must have a process for reconstruction of electronic records in the event of a system breakdown.

AVAILABILITY OF RECORDS

The provider must furnish information regarding its Medicaid payments that is requested by DMA and its agents, the Office of the Attorney General, the Department of Health and Human Services, the Center for Medicare and Medicaid Services, and any other entities specified in the Medicaid Provider Participation Agreement. In addition, the provider must allow the CAP/C case manager to review the documentation that supports a claim for CAP/C services. HIPAA Privacy regulations 45 CFR Part 164.502 and .508 allow for disclosure of this information without client authorization for payment activities including but not limited to review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges.

WHAT THE CASE MANAGEMENT AGENCY KEEPS

The case management agency maintains client records that contain:

- All FL-2's.
- CAP/C Assessments and Plans of Care, Plan revisions, and related correspondence.
- DMA Plan approval letter.
- Physicians' orders for **services or supplies** ~~Medicaid Medical Supplies~~ provided by **and/or billed by** the Case Management Agency.
- Service authorizations.
- **Notice of CAP/C participation to non-waiver service providers of Medicaid home and community care services.**
- Case management records.
- Other correspondence related to the client's participation in CAP/C.
- Copies of claims that it submits to Medicaid and third party payers as well as related correspondence.

- For CAP/C Waiver Supplies, the case management agency maintains an invoice from the supplier that shows the date the item was provided to the client, a description of the item, and the cost of the item, including charges for delivery and taxes. There must be a signed physician's order for the supply in the record.
- For Home and vehicle Modifications and Community Transition Funding, the case management agency maintains an invoice from the supplier/installer that shows the date the item was provided to the client, a description of the item, and the cost of the item and related charges (applicable charges for delivery, installation, and taxes). For modifications that require permits for construction or installation, a receipt for the permit is required if the cost is claimed.
- When Medicaid Medical Supplies are supplied by the case management agency, the agency maintains an invoice from the supplier that shows the date the item was provided to the client, a description of the item, and the cost of the item, including charges for delivery and taxes. The records must also include a signed physician order for all items billed.
- For Caregiver Training and Education, the case manager keeps registration information, proof of attendance, dates of training, topics presented, and who provided the training.
- For palliative care, the case manager keeps an invoice that shows the type of service, dates of service, and units of service provided.

If the case management agency provides other services, for instance Home Health, it follows the instructions of that program for documenting those services. When another CAP/C provider bills services, DMA does not expect the case management agency to maintain copies of the other agency's service documentation.

WHAT PROVIDERS OF THE OTHER CAP/C SERVICES KEEP

- Service authorizations from the CAP/C case manager, including any amendments to those authorizations, and related correspondence.
- Copies of claims submitted to Medicaid and third party payers, as well as related correspondence.
- Specific service documentation, such as nurse or nurse aide notes

WHAT THE CASE MANAGER DOCUMENTS

The case management agency keeps case management notes signed by the case manager that document client assessment and ongoing case management activities to plan, coordinate, and monitor care. They document the date of the case management activity; the time (in minutes) involved in the activity; and a description of the activity. Each entry must contain sufficient detail to support your claim for reimbursement. For example, if the activity involved a telephone call, the entry must briefly describe the purpose of the call.

Documentation templates for CAP/C Case Managers can be found with the other CAP/C forms at <http://www.ncdhhs.gov/dma/services/capc.htm>.

Templates include documentation of contacts with recipient/family, contacts with providers, quarterly home visits, documentation review, and claims review. It is not necessary to use these exact forms, but whatever type of note you use should contain the same information.

Notes may be handwritten or typed. If the notes are computer-generated or typed and the same case manager completed all of the activities that are documented on a single page, the case manager may sign once at the bottom of the page. The case manager also enters the date that the page was signed beside the signature. If the notes are handwritten, the case manager signs each entry.

HOW LONG RECORDS MUST BE KEPT

As a condition of participation, providers are required to keep records necessary to disclose the extent of services rendered to recipients and billed to the N.C. Medicaid program [Social Security Act 1902(a)(27) and 42 CFR 431.107]. Records must be retained for a period of at least six years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations, or agreements (10A NCAC 22F.0107). It is recommended that records be kept until six years from the recipient's 18th birthday OR six years from the last date of service, whichever is later.

CHAPTER REVIEW

🔑 Key Points

1. Documentation must contain name, MID, type of service, date of service, location of service, and applicable service noted.
2. The case management agency must keep only documentation that originates from their agency; i.e., they must keep their case management notes, but do not need to keep nurses' notes once they have been reviewed.
3. Case managers document their monitoring activities on or according to the templates located on the DMA website.

 **Test Your Knowledge**

1. Records must be kept for at least _____ years from the date of service.
2. It is recommended that records be kept for six years from _____.
3. True or False: Once you review your quarterly sample of in-home nursing notes, you should keep them in your case management record.
4. All records should contain this information on every page:
_____ and _____.

1. six; 2. six years from 18th birthday or six years from date of service, whichever is later; 3. False; 4. name and MID number

SECTION 5 CONTINUING CAP/C

CHAPTER 51 Claims



This chapter provides only limited and basic information. Please see the Basic Medicaid Billing Guide at <http://www.dhhs.state.nc.us/dma/prov.htm#pub> for further information regarding claims.

This chapter relates to the assurance of Financial Accountability.

CAP EFFECTIVE DATE

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

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

Medicaid payment is available for CAP/C services beginning on the CAP effective date if (1) the client is authorized for Medicaid on the date of service; and (2) the service is approved on the Plan of Care.

A provider agency that is willing to accept the payment risk may begin services before Plan of Care approval if the services are provided on and after the CAP Effective Date.

The CAP effective date is NOT the date that DMA approves the initial. The CAP effective date is when billing starts for that patient. This is done to allow you to claim your case management time for the assessment and plan of care development.

FA
Financial
Accountability

WHO MAY FILE A CLAIM

Providers may file a claim with Medicaid if they are enrolled with DMA to provide the service they are billing, and the service is provided according to Medicaid policies.

WHAT MAY BE BILLED

Providers may bill for the services that they provide to Medicaid recipients when the services are provided according to Medicaid policies and procedures. It must be provided as approved on the client's CAP/C Plan of Care and **as stated the ordered** by the client's CAP/C case manager **on the Service Authorization**. Remember, Case Managers may only authorize CAP/C **waiver services; the provision of non-waiver services is coordinated by the Case Manager via the Participation Notice**.

Providers bill their usual and customary rate, even when different from Medicaid's maximum allowable rate.

For services provided in 15 minute units,

- Total the amount of time spent providing the service during the day.
- Divide the total by 15 to get the number of full units.
- Add an additional unit if the remainder is 8 minutes or more.



MORE
INFORMATION

For specific information regarding what may or may not be billed for a particular service or supply (for instance, that the cost of the permit may be billed for home modifications), please refer to the appropriate chapter of this manual or to the Clinical Coverage Policy for the selected service or supply.

WHAT WILL BE PAID

The basis for payment depends on the specific service. The maximum payment for each service or supply is listed on the appropriate fee schedule, located at <http://www.ncdhhs.gov/dma/fee/index.htm>.

Medicaid will pay the amount billed or the amount listed on the fee schedule, whichever is less.

THIRD PARTY COVERAGE

Medicaid is the payer of last resort, unless there is an exemption from this requirement specifically included in federal law. The key points to remember are:

- Unless otherwise noted, you must pursue payment from other parties, such as Medicare and private insurers when a client has such coverage for the rendered service. In addition to the coverage identified on the Medicaid ID card, you must ask the client if other coverage exists and pursue that coverage.
- If a third party covers the service and pays less than Medicaid's allowable charge, you may bill Medicaid for the difference between the third party payment and the Medicaid maximum allowable.
- If the third party payment is more than the Medicaid allowable charge, you must accept that payment as payment in full. Medicaid will not pay the difference between the charge and the third party payment. You may not bill the client for the difference.
- State and Federal third party liability (TPL) laws mandate that Medicaid not pay for services denied by private health plans due to non-compliance with those private plan requirements. If the service would have been a covered service and payable by the private plan, but some requirement of the plan was not met, then Medicaid will not pay for this service.

MEDICAID TREATMENT OF INSURANCE PLAN PAYMENTS AND DENIALS

The recipient and the provider both have responsibility for complying with private plan requirements. If the recipient did not inform the provider of the existence of the recipient's private plan, and the plan's requirements were not met because the provider was unaware of them, the provider may bill the patient for those services if both the private plan and Medicaid deny payment due to noncompliance.

Similarly, if a recipient fails to cooperate in any way in meeting any private plan requirement, the provider may bill the recipient for the service(s). However, if the recipient presents the private payer information, and the provider is aware that the provider is not a participating provider in that plan or cannot meet any other private plan requirement, the provider must inform the recipient of that fact and that the recipient will be responsible for payment.

Medicaid will pay up to the Medicaid allowable if the recipient doesn't use an in network provider, but the insurance allows out of network benefits at a reduced rate. Medicaid will not pay if the insurance doesn't allow any out of network benefits and the recipient goes out of network for services. When the insurance carrier denies the claim with an EOB that states, provider not in network, non participating, etc. Medicaid cannot override the insurance and make payment.

THE BILLING PROCESS

Claims are processed through MMIS using the CMS-1500 form. A CAP indicator code shows waiver eligibility. Claims for CAP/C in-home nurse, nurse aide, and respite services are sent to the case manager CCME for approval before being sent to the fiscal agent. The payment system checks for eligibility on the date of service, looks for duplicate claims, verifies nursing facility level of care prior approval, verifies CAP/C eligibility, checks charges against maximum allowable rates and completes other operations to control payment. If a "detail" or line

item on a claim is "clean" - that is, the system detects no errors in relation to its controls, the fiscal agent processes it for payment.

DMA conducts post-payment reviews to look at the complete audit trail, the approval of the plan of care, the case manager's service authorization, service documentation, and the case manager's authorization for claims submission.

TIME FRAMES

The fiscal agent must receive your claim within 365 days of the date of service.

Payments are issued on a regular schedule referred to as the "Checkwrite Schedule." The schedule is printed in the monthly *Medicaid Bulletin*.

CLAIMS REVIEW

The provider (except for a DME provider billing waiver supplies) sends the paper claim or a printout of the electronic claim to ~~the CAP/C case manager~~ CCME for CAP/C Nursing, Pediatric Nurse Aide, Personal Care, and all in-home respite services for approval before sending it to the fiscal agent. ~~The case manager~~ CCME will review the claim to see if it accurately reflects authorized services.

The provider should not send a paper or an electronic claim to the fiscal agent before ~~the case manager~~ CCME approves the claim. Claims submitted and paid by Medicaid without ~~the case manager's~~ CCME's approval are subject to recoupment by DMA.

- ~~Accurate Claims: The case manager approves a "paper claim" by signing the bottom of the claim form. The case manager either returns the claim to the provider or sends it to the fiscal agent according to the agreement between the provider and case manager. The case manager approves an electronic claim by~~

signing the bottom of the printout and returning the printout to the provider agency.

- **Inaccurate Claims:** The case manager contacts the provider agency to resolve the discrepancy.

It is very important for case managers to promptly review claims, resolve any discrepancies and approve claims for payment. Case Managers and CAP/C providers are encouraged to work cooperatively to establish and maintain a good workflow for claims approval.

The Case Manager reviews the claims report from CCME and takes appropriate action regarding any identified issues. documents this claims review as per the documentation template for claims reviews.

PAYMENT REVIEW, FRAUD AND ABUSE

As a CAP/C case manager, you share responsibility with your agency, DMA, the fiscal agent, and others involved with CAP/C for assuring that Medicaid funds are properly used.

The Purpose of Prevention and Detection Efforts

DMA has policies and procedures to prevent and detect abuse, over utilization and fraudulent practices by providers, recipients or others involved with Medicaid. This is part of DMA's efforts to ensure the most effective use of Medicaid funds. The policies and procedures provide for due process in investigations, including applicable appeal and fair hearing rights. Within DMA, the Program Integrity Section is primarily responsible for detecting misuse of Medicaid funds. Additional information about Program Integrity is on DMA's website – wwhhs.state.nc.us/dma/pi.html.

Provider Education

To assist your agency in complying with Medicaid's requirements, DMA supplies a provider manual containing information on participation, coverage, limitations and reimbursement. DMA and the fiscal agent update this information through

monthly *Medicaid Bulletins*. They also offer provider seminars throughout the state. Each has staff to provide guidance and assistance, and help is available by phone or mail. The address and phone numbers of key contacts are listed in Appendix B.

Reporting Fraud, Abuse and Misuse of Funds

If you suspect misuse or abuse of Medicaid, contact DMA's Program Integrity Section at the number listed in Appendix B.

Quality of care and other concerns related to a provider's licensure or certification should also be reported to the appropriate licensing/certifying authority.

CHAPTER REVIEW

🔑 Key Points

1. Claims for waiver nurse, nurse aide, and respite services must go through the case manager CCME for approval before being submitted to the fiscal agent for payment.
2. DME companies providing waiver supplies are the exception to the above statement.
3. The case manager documents the claims review according to the documentation template.
4. Billing for CAP/C services begins with the CAP Effective Date.
5. Providers bill their usual and customary rate.
6. Providers are paid the lesser of the amount billed or the amount listed on the fee schedule.
7. Providers have one year from the date of service to submit the claim to the fiscal agent.
8. Medicaid is the payer of last resort; private insurance and other third party payers are billed first.
9. A Case Manager who suspects a provider of fraud or abuse should report that provider to Medicaid's Program Integrity Unit.

 **Test Your Knowledge**

1. The CAP Effective Date is the _____ of three dates.
 - a. earliest
 - b. latest
2. Those three dates are:

3. The CAP Effective Date is
 - a. the date that billing for CAP/C services and supplies may begin
 - b. the date the CNR is due
 - c. the date you receive the initial approved letter from DMA
4. **CCME Case Managers** must review claims for _____ prior to their submission to the fiscal agent for payment.
 - a. Non-waiver services/supplies
 - b. **Most waiver services/supplies-Nurse, Nurse Aide, and respite services**
 - c. Both of the above
 - d. None of the above
5. True or False: Providers should automatically bill the amount on the fee schedule.
6. The fiscal agent must receive the claim within _____ days of the date of service.
 - a. 10 days

- b. 30 days
- c. 90 days
- d. 365 days

1. b; 2. date of Medicaid application, date of FL-2 approval, date of de-institutionalization; 3. a, 4. b, 5. False; 6. d

SECTION 5 CONTINUING CAP/C

Section Review

Jenny has just been approved for CAP/C. She receives in-home nursing and her waiver expenses total about \$90,000 per year. Her date of birth is November 26. Today is July 2, 2010

1. Jenny's next CNR will be due
 - a. July 2, 2011
 - b. July 5, 2011
 - c. November 5, 2010
 - d. November 5, 2011

~~2. Jenny's next mid-year review would be due~~

- ~~a. January 2, 2011~~
- ~~b. January 5, 2011~~
- ~~c. September 5, 2010~~
- ~~d. May 5, 2011~~

3. Your first home visit at Jenny's should be done no later than
 - a. August 2
 - b. October 2
 - c. January 2
 - d. July 2 next year

4. You are making your monthly contact with Jenny's family. During this contact, in addition to getting updates regarding the child's health and care needs, you must ask specifically about _____.

5. Jenny's mother inquires about respiratory services for Jenny. You advise her that

- a. for the most part, the respiratory therapist would duplicate what the nurse is doing
- b. tell her that if she feels it is needed, you can have the respiratory therapist do a visit with the nurse to provide the nurse some training
- c. she can have daily respiratory therapy services, after all Jenny is on a ventilator
- d. she can not have respiratory therapy services
- e. a and b

6. Jenny needs 240 disposable diapers per month. She has both an agency providing her nursing services and a home health agency providing therapy services. Between the two, the best option for Jenny is

- a. the home health agency
- b. the nursing provider agency

7. Jenny has been in the emergency room twice in the last month because her GT button came out. List three actions you might take in this situation. _____

8. Jenny has pneumonia and is on a 10 day course of IV antibiotics at home. Her nursing agency tells you that they do not allow their nurses to do IV medications.
 - a. You get a home infusion therapy provider to do the antibiotics
 - b. You tell the agency that they are responsible for meeting all the recipient's needs and they should either get a nurse that can do the IV meds or transfer the recipient to a different agency

9. Jenny's brother is having some behavioral issues due to the effects of Jenny's illness on his life.
 - a. You are sympathetic, but can not do anything – he is not the recipient
 - b. You offer palliative care services for the brother

10. Jenny's mother must return to work to help the family financially. Jenny's father also works, and there are no other informal support persons available during the parents' work hours. You are revising Jenny's plan of care to add additional nursing hours. You need to submit all of the following except
 - a. Part A, the goals and interventions
 - b. Part B, the services/supplies
 - c. Part C, the 24 hour coverage schedule
 - d. The Letter of Understanding and Freedom of Choice.

11. Jenny has been admitted to the hospital again, and this time she has been hospitalized for over 30 days. You have notified the DSS. She is now going to be discharged.
- She can not get back on CAP/C
 - She must go through the referral and initial process just as if she were a new applicant
 - There is a procedure in place so that CAP/C services can be resumed quickly.
12. You are reviewing nurse notes, and notice that Jenny is not suctioned nearly as much as your assessment had indicated.
- You do nothing – she is still eligible for CAP/C nursing because she has a trach and a ventilator
 - Talk to the family and to the provider to ascertain the reason for the discrepancy (are the parents suctioning too often?, are the nurses not documenting adequately?) and resolve it
13. Jenny is about to turn 21 and is transferring to PDN. The ideal time for the transfer to take place is
- on her 21st birthday
 - on the last CNR due date before she turns 21
 - at the end of one month/beginning of the next
14. Assuming that Jenny's parents are comfortable with this transfer, what documentation should you get from them and submit to DMA? _____
15. How long should you keep Jenny's records?
- You may shred them immediately

- b. Until Jenny turns 24
- c. For six years after her last date of service
- d. For one year after her last date of service

Section 5 Review

1. c; 2. ~~a~~; 3. b; 4. the family's satisfaction with their services; 5. e; 6. b; 7. make sure there is a replacement tube in the home and the family knows how to put it in, discuss with the family the reasons the tube may be coming out and intervene as appropriate, consult with the RN for recommendations, consult with or make an appointment with the gastroenterologist, complete an incident report; 8. b; 9. b; 10. d; 11. c; 12. b; 13. c; 14. voluntary termination of cap/c participation; 15. c

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