SECTION 6
STOPPING OR REDUCING SERVICES

CHAPTER 52
Voluntary Reductions and Withdrawals

WHAT IS A VOLUNTARY REDUCTION OR WITHDRAWAL?

A voluntary reduction or withdrawal is one in which the decision was made by *the family, not by DMA,* to

- not apply for CAP/C services even though the referral has been approved, or
- reduce the type or amount of services they receive, or
- stop participation in the CAP/C program entirely.

WHO MAY MAKE A VOLUNTARY REDUCTION OR WITHDRAWAL?

Only the recipient or the recipient's representative may make a voluntary reduction or withdrawal.

WHAT ARE SOME REASONS FOR A VOLUNTARY REDUCTION OR WITHDRAWAL?

A family may decide not to receive CAP/C services for many reasons. Some of these reasons are:

- They learn that the CAP/C program does not offer the type of assistance they are seeking.
- They move out of the state of North Carolina.
- They transfer to a different program, such as CAP-MR/DD or CAP-DA.
- The child's health improves, or more informal caregivers become available, and the family feels their current level of services is not needed anymore.

- The family has received the services they needed; i.e., the home modifications have been completed and the family does not need or want other CAP/C services.

WHAT IS THE PROCEDURE FOR A VOLUNTARY REDUCTION OR WITHDRAWAL?

Make sure the family has made a fully informed and voluntary decision.

If it is a decision to not participate in the CAP/C program at all:

1. Have the parent complete and sign the CAP/C Notice of Voluntary Withdrawal of Referral form or the CAP/C Notice of Voluntary Termination of Participation form as applicable. Both notices are available at http://www.dhhs.state.nc.us/dma/services/capc.htm.
2. Submit a copy of the form to your DMA Nurse Consultant. Keep the original in your file.
3. The DMA Nurse Consultant will issue a letter to the family which confirms the withdrawal/termination and the date it is effective. This letter is copied to the case manager. If it is a termination of participation, it is also copied to the Medicaid Eligibility Supervisor at the County DSS.
4. Notify service providers to discontinue services. There are two forms on the website (http://www.dhhs.state.nc.us/dma/services/capc.htm) for this purpose: CAP/C Service Authorization Discontinue Notice and CAP/C Participation Discontinue Notice. Use of these two forms is optional. Also notify CCME of discontinuation of CAP/C if the recipient was receiving nurse, nurse aide, or respite services.

MORE INFORMATION

5. Assist the family with linkages or transitions to new services if applicable. Information about other resources can be found in Appendix A.
6. Remember that you will be unable to bill for any case management activities occurring after the termination date. Linkage to other resources,

transition procedures, etc should be completed as much as possible prior to the termination date.

MORE INFORMATION

More information regarding billable and non-billable case management activities can be found in Chapter 51.

If it is a decision to reduce or stop a particular CAP/C service:

1. If the family will still be receiving at least one service besides case management at least once per month: Submit a signed plan of care revision to DMA.

   MORE INFORMATION

   Please see Chapter 45 for instructions for how to do a plan of care revision.
2. If the family will not be receiving at least one service besides case management (excluding respite) at least once per quarter: Proceed with a voluntary termination as described above, or an involuntary termination as described in the next chapter, as applicable.

WHEN DO THE SERVICES STOP OR CHANGE?

If the recipient is withdrawing due to acceptance into a different Medicaid program:

- The last day of CAP/C services is the last day of the month
- The first day of the new services is the first day of the next month

If the recipient is reducing a service, or withdrawing from the program without transferring to a different Medicaid program:

- The services will stop or change on whatever date the family requests, as long as
  - The recipient is not age 21 or over
  - The recipient is still eligible for both Medicaid and CAP/C up until the effective date.

If the family does not request a particular date, services will stop or change the

last day of the month in which the change is requested (or the last day the recipient is 20 years old).

Even though you may end CAP/C participation at any time, usually the recipient will still be eligible for Medicaid until the last day of the month.

FH
Fair Hearing

IF A RECIPIENT WITHDRAWS VOLUNTARILY, DO THEY GET APPEAL RIGHTS?

No. Only decisions made by DMA are appealable. In this case, the decision was made by the family; DMA is simply following through with the family's request. The family may change their mind and withdraw that request at any time.

It is very important however, to ensure that the family's decision is truly voluntary. For example, you may seek a voluntary withdrawal from a recipient who is 'aging out' of CAP/C and transferring to PDN. If the family is happy with PDN and is in agreement with the transfer, then a voluntary withdrawal is appropriate. However, if the family does not want to make the change and is only doing so because policy says they have to, that is not considered a voluntary withdrawal. A family should never feel forced to sign a voluntary withdrawal form. Instead, you should notify your DMA Nurse Consultant and it should be treated as an involuntary termination, with notices with appeal rights issued.

IF A RECIPIENT WITHDRAWS VOLUNTARILY, CAN HE OR SHE EVER GET CAP/C AGAIN?

Absolutely. There is nothing that prohibits a family from reapplying any time they wish. Nor is there any period of time they must wait before they reapply. However, each application will be reviewed on its own merit. In other words, having received CAP/C in the past is not a guarantee of receiving it in the future. The child must meet all of the usual CAP/C and Medicaid eligibility requirements.

CHAPTER REVIEW

Key Points

1. A voluntary reduction or withdrawal is when the family, not DMA, makes a decision to withdraw their application for services, reduce the amount of services they receive, or stop their participation in CAP/C.
2. The Case Manager must ensure that the decision is truly voluntary, and that the family was fully informed before they made their decision.
3. There are no appeal rights with a voluntary withdrawal or termination.
4. A family can reapply for CAP/C at any time they wish.

Test Your Knowledge

1. True or False: A voluntary termination is when DMA decides to stop a child's CAP/C services, but the family does not object.

2. When a recipient turns 21 years of age, CAP/C services must stop
   a. the day before the 21st birthday
   b. the end of the month before their 21st birthday
   c. the end of the month after their 21st birthday

3. A child who once had CAP/C:
   a. can never receive CAP/C services again
   b. must wait at least one year before restarting services
   c. may receive services again at any time but will have to reapply

4. When a family wishes to discontinue receiving one waiver service, but will still be receiving other services, you would:
   a. have the family complete a voluntary withdrawal form for the service they want to discontinue
   b. submit a plan of care revision

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

SECTION 6
STOPPING OR REDUCING SERVICES

CHAPTER 53
Involuntary Adverse Decisions

WHAT IS AN INVOLUNTARY ADVERSE DECISION?

An involuntary adverse decision is one in which a decision is made *by DMA or one of its representatives, not by the family,* to

- deny a service; that is, the service is not yet in place and DMA has decided not to put it in place,
- reduce a service; that is, DMA approves less than what was requested,
- suspend a service; that is, DMA puts services "on hold", or
- terminate a service; that is, DMA ends approval for a service that is currently being provided.

The word 'service' may refer to the overall CAP/C program, or to any individual service within that program.

WHO MAY MAKE AN INVOLUNTARY ADVERSE DECISION?

- The CAP/C Nurse Consultant, usually with the input of other consultants, her supervisor, and the DMA Medical Director
- HP (for level of care or for prior approval of a non-waiver service or supply)
- DSS (for Medicaid eligibility)
- Other DMA vendors such as Value Options and ACS

FH
Fair Hearing

Please note that a Case Manager does not have the authority to make an involuntary adverse decision. According to the recipient's due process rights, those decisions must come from DMA with appeal rights. Be careful to advise recipients and families of the limitations of the CAP/C program without giving

them the impression that you are telling them they can't have their request. If despite what you have told them they still wish to make their request, you must submit it.

WHAT ARE SOME REASONS FOR AN INVOLUNTARY ADVERSE DECISION?

- Medicaid is not approved or is terminated
  Medicaid eligibility may be affected, for instance, by prolonged hospitalization or absence from the county, admission to a nursing facility, the recipient moving out of a private residence, or a change in the child's income.
  If you know that a child is going to be absent from the county for more than 30 days (for example, due to custody arrangements), notify the DSS and your Nurse Consultant. It is possible that CAP/C will not need to be terminated.

LOC
Level of Care

- The client does not meet nursing facility level of care (the FL-2 is signed by the physician, but not approved by HP).
- Adequate care cannot be provided for the client to meet the health and welfare criteria. The usual reasons include:

HW
Health and Welfare

  - The client's living situation presents needs that cannot be met. This would include things such as substandard housing or parents that are unwilling to be trained in the child's care. However, the health and welfare of the child will always be considered. Prior to termination, the Case Manager and possibly Child Protective Services should intervene to try to get the needs met. CAP/C services would not be terminated if doing so would further risk the child's health and welfare.
  - The client or responsible party refuses to accept needed services. This usually happens with families who seek CAP/C participation as a means of obtaining Medicaid. They misrepresent their level of

need in order to obtain CAP/C, and then once on the program cancel or refuse services. If you identify a significant and repetitive pattern (three or more times in 12 months) of this behavior, notify your Nurse Consultant.

- The client or responsible party fails to comply with care requirements.

  It is rare for a child to be terminated from CAP/C for non-compliance with medical care and services. This type of situation would warrant case management intervention and possibly a referral to Child Protective Services, but withdrawal of CAP/C would likely exacerbate the situation and place the child at further risk.

  Usually this reason takes the form of parents not complying with case management services; for example, not returning your phone calls or being there for their home visits. Follow this procedure:

  1. Document each phone call you make and the results (left message, no answer…)
  2. After at least three phone calls, go to the home. If the recipient is not home, leave a note stating that you were there and that they need to contact you.
  3. If there is still no response, send a certified letter. State that you have been trying to reach them, and give them a date by which they need to contact you. Inform them that they are at risk for losing their services if you do not hear from them.
  4. After 60 days has elapsed with no contact, and all of the above has been done, notify your Nurse Consultant.

- Enrolled providers are not available to render needed services. This may be due to insufficient resources in the county or agencies refusing to provide care.
  Remember that the recipient must have case management and one other waiver service (excluding respite and waiver incontinence supplies) provided at least quarterly, to remain on the CAP/C program. It is important that you notify your Nurse Consultant if a waiver service is not provided at all within a quarter (for example, the child is supposed to receive in-home Nursing, but staff can not be found to provide the care).

MN
Medical Necessity

- The client does not require CAP/C waiver services of the type or amount requested in order to remain safely at home
  This may be due to the child not meeting the eligibility criteria for CAP/C, or may be due to the child's health improving (for example, the tracheostomy has been removed). Discontinuation of services because the child's health has improved is often a large and anxiety-filled adjustment for families. It is best for the Case Manager to begin early in preparing families for these transitions.

WHAT IS THE PROCEDURE FOR AN INVOLUNTARY TERMINATION?

If the reason for the denial or termination is Medicaid eligibility or denial of level of care, notice and information regarding appeal rights will be sent from those offices. Those notices will not mention CAP/C; they will deal only with the eligibility or level of care issue. The CAP/C Nurse Consultant will send a separate notice stating that CAP/C has been denied/terminated because of the issue with Medicaid eligibility or level of care. Both notices will contain information regarding appeal rights. The recipient would need to appeal both decisions. When the matter goes to mediation or to court, the two issues and processes will be coordinated.

FH
Fair Hearing

If the reason for the denial, reduction, or termination is because of lack of need, health and welfare, or some other reason, the request is automatically considered under EPSDT. If the Consultant feels that the request does not meet the CAP/C criteria and the EPSDT criteria:

- Your Nurse Consultant will contact you. She will tell you: "We have received a prior authorization request for [NAME OF RECIPIENT] and would like to discuss it with you. Nothing in this conversation is intended to discourage you from continuing with the request you have submitted. Your patient has the right to a written notice and a hearing if we deny the request, and to authorization for payment for services during the appeal process if this request involves a service your patient is currently receiving. I cannot ask you to withdraw the request you have submitted or to modify the request to accept a lower amount, level, or type of service. I am calling because at this time, we do not have enough information to approve this request. If you have additional information that you have not submitted that you think would support your request, please tell me about it now." Your Consultant will explain why the request may be denied and inform you of any alternative services for which the recipient may qualify.
- You will provide any additional information that you think would support the recipient's request (i.e., physician letters, parents' logs). Remember that you have a maximum of ~~15~~ 10 business days to provide this information. If you think you will be unable to provide the information within ~~15~~ 10 business days, notify your Nurse Consultant.
- You will discuss the alternative services, if available, with the recipient, to enable the recipient to make an informed decision.
- The Nurse Consultant will review the additional information. If she feels that the request still cannot be approved, she will forward the file to the

Lead Nurse Consultant and/or the CAP/C Supervisor for second review. It may also be forwarded to DMA's Medical Director for review.

- The Case Manager will immediately notify the Nurse Consultant if the recipient's situation changes so that a proposed reduction or termination may no longer be appropriate.
- A final decision will be made based upon the recommendations of all the reviewers. This decision will be made within 15 days of receipt of all the information.
- If the final decision is to deny, reduce, suspend, or terminate services, the DMA Nurse Consultant will send the recipient a written notice copied to you. The notice will explain the reason for the decision, the date the decision becomes effective, alternative services the recipient may wish to apply for, and instructions for how to appeal the decision.
- The Case Manager will notify service providers to discontinue services, notify CCME of the discontinuation of nurse, nurse aide, ore respite services, and assist the recipient with the transition to any new services. (If the recipient files an appeal and elects maintenance of services (see below), the case manager will continue or resume services until notified of the final appeal decision).

WHEN DO THE SERVICES STOP?

The date the services will stop or be reduced will be indicated on the notice. Normally, it is ten days after the date the adverse decision letter was written. If the recipient chooses to appeal, they may be entitled to 'maintenance of services'. Maintenance of services means that the recipient can choose to keep the services already in place at the current level (or a lower level) until the appeal process is exhausted and a final decision has been made. If the final decision upholds DMA's decision, the recipient may be required to reimburse Medicaid for the services that continued during the appeal.

FH
Fair Hearing

If Medicaid eligibility is changed or terminated, the last date of the current services is normally the last date of the month.

FH
Fair Hearing

IF A RECIPIENT IS INVOLUNTARILY TERMINATED, DO THEY GET APPEAL RIGHTS?

Yes. A recipient will receive appeal rights for any denial, reduction, suspension, or termination that is initiated by DMA or one of its representatives.

IF A RECIPIENT IS INVOLUTNARILY TERMINATED, CAN THEY EVER GET CAP/C AGAIN?

Absolutely. There is nothing that prohibits a family from reapplying any time they wish. Nor is there any period of time they must wait before they reapply. Each application will be reviewed on its own merit. In other words, having received CAP/C in the past is not a guarantee of receiving it in the future. Having been terminated from CAP/C in the past is not a guarantee of denial. The child must meet all of the usual CAP/C and Medicaid eligibility requirements.

CHAPTER REVIEW

🗝Key Points

1. An involuntary adverse decision is when someone from Medicaid or one of its representatives decides to deny, reduce, or stop a recipient's CAP/C service or participation in the CAP/C program.
2. Case Managers may not make involuntary adverse decisions.
3. You should notify your Consultant whenever the child is going to be absent from the county for 30 or more days, when there is a waiver service that has not been used in a calendar ~~month~~ quarter, and when you have been unable to contact the family to perform case management activities.
4. Involuntary adverse decisions may be made because of issues with Medicaid eligibility or level of care determination, because health and welfare can not be assured, or because the service or program is not medically necessary.
5. Involuntary adverse decisions made by your Nurse Consultant are always reviewed by other people, including other consultants, the supervisor, or the Medical Director.
6. You may not withdraw or modify a request for a service once it is submitted. However, you may make a new request.
7. A recipient may appeal any involuntary adverse decision.

Test Your Knowledge

1. For an absence of 30 days or more, you should:
   a. Notify your Nurse Consultant
   b. Notify your Medicaid eligibility worker
   c. Both
   d. Neither

2. A recipient's parent makes a request that will probably not be approved. Your best course of action is to:
   a. Submit the request
   b. Explain why the request may not be approved, and then submit the request if the family still wants you to
   c. Tell the family that the request will not be approved

3. True or False: You may change a request once it has been submitted.

4. You have _____ business days in which to provide additional information if needed to your Consultant. Your Consultant has _____ business days to respond to that information.

5. True or False: A recipient may appeal an involuntary adverse decision.

1. c, 2. bB, 3. False, 4. ~~15~~10, 15, 5. True

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SECTION 6
STOPPING OR REDUCING SERVICES

CHAPTER 54
Special Circumstances

CLOSED ADOPTION

When an adoption is a "closed" adoption, there must be no link from records pre-adoption to records post-adoption. Close out your old record, indicating that the child has been adopted. Do not indicate the child's new name, new MID, or other identifying information. Begin a new record, with the client's new identifying information, including a referral, assessment, and plan of care. Notify your Nurse Consultant; she will do the same with the DMA file.

This action is not necessary in an 'open' adoption when the name or the MID remain unchanged.

NO PHYSICIAN ORDER

If a physician refuses to sign the FL-2, CAP/C services must be denied or terminated. If a physician refuses to provide an order for a particular service or supply, that service or supply may not be provided. A decision made by the physician is not appealable, because it was not DMA's decision. The recipient must discuss the matter with the physician.

TRANSFER TO ANOTHER PROGRAM

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.

If the recipient is transferring voluntarily, follow the procedure outlined in Chapter 52 for voluntary reductions and withdrawals. 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.

DEATH

Notify your Nurse Consultant when a recipient dies. The Nurse Consultant will generate a letter to you, copied to the local Medicaid Eligibility Supervisor, confirming that the file has been closed effective the date of the patient's death. No notification will be sent to the family.

Complete and submit the Critical Incident Report form regardless of the cause of death.

CHAPTER REVIEW

Key Points

1. Your records must maintain the confidentiality of a closed adoption. Begin a new chart, and do not reference the new information in the old chart or the old information in the new chart.
2. CAP/C cannot provide anything a physician will not order. Decisions made by a physician must be settled with the physician; they cannot be appealed to DMA.
3. Transfers between Medicaid programs should ideally take place at the end/beginning of the month. They may be voluntary or involuntary.
4. When a recipient dies, notify your Nurse Consultant, and submit a Critical Incident Report.

Test Your Knowledge

1. True or False: When a recipient has gone through a closed adoption, you should include her old MID number in her new record.
2. True or False: A recipient can appeal a CAP/C denial when the denial reason was that the physician wouldn't sign the FL-2.
3. True or False: When a recipient is transferring to a different Medicaid program, there is a period of time in which he or she can be on both programs.
4. True or False: You do not need to submit a Critical Incident Report for a recipient's death that was expected and of natural causes.

1. False, 2. False, 3. False, 4. False

SECTION 6
STOPPING OR REDUCING SERVICES

SECTION REVIEW

1. Jane is a ten-year-old with cerebral palsy. Her seizures are well controlled with standing medications. She receives bolus GT feedings. She is totally dependent for ADLs. She has moderate mental retardation. Her family is applying for CAP/C. They want to have some in-home care to help with Jane's ADLs.

   You are developing the plan of care, and Jane's parents want a nurse to provide the in-home care. Your best course of action is to:

   a. put the nursing services on the plan of care
   b. tell them they can't have nursing services because Jane's needs can be met by a NA I+.
   c. explain to them that Jane's needs can be met by a NA I+, and what the differences are between a Nurse Aide and a Nurse, then let them make the decision

2. Jane's parents tell you that they would be ok having a Nurse Aide, but they would still like to request the nurse because that is really what they prefer. Your Nurse Consultant calls you after reviewing the plan of care and tells you she does not have enough information to support the request for a nurse. The correct course of action is to:

   a. submit a new request for a Nurse Aide, and the original request for the nurse will be denied with appeal rights
   b. mark through the old request to change the nurse services to nurse aide services

c. submit a 'corrected' plan of care with the nurse aide services on it, signed by the parent, and the original request for the nurse will be disregarded

3. Jane's parents had also applied for CAP-~~MR/DD~~ IDD and been on the waiting list. She has been receiving her CAP/C services, but now she has come up to the top of the ~~MR/DD~~ IDD wait list, and will be transferring to that program. Her parents are very happy about it. You:
   a. Notify your Nurse Consultant to write an involuntary adverse decision letter
   b. Have the parents sign the Notice of Voluntary Termination of Participation
4. The transfer should occur
   a. at any time
   b. with the next CNR
   c. at the end of the month
5. Within a couple weeks of transferring to CAP-~~MR/DD~~ IDD, Jane's condition takes a turn for the worse. She now requires some respiratory support, and everyone is in agreement that CAP/C is the more appropriate program for her. The correct course of action is to:
   a. reapply for CAP/C
   b. appeal the termination of CAP/C
   c. notify your Nurse Consultant and simply resume CAP/C services
   d. try to find some other resource to meet Jane's needs, she can not receive CAP/C again once it has been stopped

6. John's parents are divorced. He lives with his mother and receives CAP/C services. However, per the custody arrangements, John spends his summer vacations with his father who lives in Virginia. School is about to get out for the summer. Your first course of action would be to:
   a. terminate CAP/C services
   b. notify your Nurse Consultant and the DSS of the situation

c. there is no need to take any action except notify John's providers that services and supplies will stop for the summer

7. Mary's parents have been cancelling most of their nurse aide's shifts. Last time you went to do your home visit, no one was home, and the parents have not been returning your calls since then. Your next step is to:
   a. terminate CAP/C
   b. send a certified letter requesting response by a certain date and notifying family that if they do not respond we will proceed to termination.

8. Joe has been in foster care, and his foster parents have now adopted him. Joe's biological parents continue to have some involvement in his life. The adoptive parents have changed Joe's last name to match their own, but nothing else has been changed.
   a. You need to start a new file for Joe, with no link between the previous file and the new one.
   b. There is no need to start a new file for Joe.

9. Julie's physician does not feel she needs CAP/C, and would not sign the FL-2. The parents disagree, and would still like to get CAP/C. You advise them:
   a. They should discuss it with their physician
   b. They should appeal the decision
   c. It is not a problem; they can still get CAP/C without the physician's signature.

1. c, 2. a, 3. b, 4. c, 5. a, 6. b, 7. b, 8. b, 9. a

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