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**Related Clinical Coverage Policies**

Refer to <http://www.ncdhhs.gov/dma/mp/> for the related coverage policies listed below:  
2B-1, Nursing Facilities

## **1.0 Description of the Procedure, Product, or Service**

### **1.1 Community Alternatives Program for Children**

The Community Alternatives Program for Children (CAP/C) seeks to allow beneficiaries who need long-term institutional care to return to or remain in the community. It is designed to serve a limited number of medically fragile children who would be institutionalized in a nursing facility or hospital if payment for home care services were not available through this NC Medicaid (Medicaid) CAP/C waiver. CAP/C exists to supplement rather than replace the formal and informal services and support already available to a child.

The CAP/C program is authorized by a Division of Medical Assistance (DMA) Home- and Community-Based Services Waiver (HCBS) granted by the Centers for Medicare and Medicaid Services (CMS) under Section 1915(c) of the Social Security Act. HCBS waivers are approved by CMS for a specified time period and can be renewed, amended, or terminated by CMS. The HCBS waiver establishes the requirements for program administration and funding. Federal regulations for HCBS waivers are found in 42 CFR 441.300 through 310.

CAP/C waiver services are specified below.

- a. Case Management
- b. CAP/C Nursing services
- c. CAP/C Pediatric Nurse Aide services
- d. CAP/C Personal Care services
- e. Respite care (institutional, in-home nursing, and in-home nurse aide)
- f. Waiver supplies
- g. Home modifications
- h. Motor vehicle modifications
- i. Community transition funding
- j. Palliative care
- k. Caregiver Training and Education

### **1.2 Definitions**

#### **1.2.1 Medically Fragile**

A Medically Fragile child is defined as an individual under the age of 21 who has all of the following:

- a. A primary medical (physical rather than psychological, behavioral, cognitive, or developmental) diagnosis(es);

- b. A serious, ongoing illness or chronic condition requiring prolonged hospitalization, ongoing medical treatments, nursing interventions, or any combination of these; and
- c. A need for life-sustaining devices or care to compensate for the loss of bodily function.

### **1.2.2 Risk of Institutionalization**

Risk of Institutionalization refers to children who

- a. meet nursing facility level of care (LOC) criteria; and
- b. do not have other available resources, formal or informal, including daycare, developmental daycare, or family support, that can meet their needs.

### **1.2.3 Parent or Legally Responsible Representative**

The Parent or Legally Responsible Representative is defined as a person acting for and legally authorized to execute a contract for the applicant or recipient, such as but not limited to a legal guardian, parent of a minor child, or holder of medical power of attorney. Except for parents of minor children, legal authorization requires a separate legal document.

**Note:** Throughout this policy, wherever the term “parent(s)” appears, “parent(s), legally responsible representative, or both” is implied.

### **1.2.4 Family**

Family is an informal support system and is defined as one or more of the following:

- a. The recipient’s parent, stepparent, foster parent, custodial parent, or adoptive parent;
- b. Anyone who has legal responsibility for the minor recipient;
- c. Grandparents of the recipient;
- d. Siblings of the recipient;
- e. The spouse of an adult (18 and over) recipient; or
- f. Anyone who has legal responsibility for an adult (18 and over) recipient.

The Case Manager is responsible for verifying legal guardianship when that person is not the parent of a minor or when an adult recipient has a legal guardian. The Case Manager is not expected to keep copies of this documentation or submit the documentation to DMA.

### **1.2.5 Activities of Daily Living**

Activities of daily living (ADL) consist of basic personal care tasks usually performed in the course of the day and include feeding (either orally or by gastrostomy), bathing, dressing, grooming, elimination, ambulating, transfers, and bed mobility. These activities are directly linked to the recipient’s medical condition or diagnosis and are not age-appropriate personal care needs. These activities are usually performed by unlicensed personnel (nurse aides) and do not constitute skilled medical or skilled nursing care. However, if a recipient requires

CAP/C nursing services, the nurse would be expected to perform or assist the recipient with his or her ADLs.

### 1.2.6 Significant Change in Condition

For purposes of submitting a new FL2, a significant change in condition is defined as one of the following:

- a. start or discontinuation of a ventilator;
- b. start or discontinuation of a tracheostomy tube;
- c. change in level of staff between nurse aide level and nurse level;
- d. start or discontinuation of tube feedings;
- e. increase or decrease in seizure activity such that a revision to the plan of care is needed;
- f. increase or decrease in need for ADL assistance such that a revision to the plan of care is needed; or
- g. as requested by the DMA CAP/C Nurse Consultant.

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

## 2.0 Eligibility Requirements

### 2.1 Provisions

#### 2.1.1 General

*(The term "General" found throughout this policy applies to all Medicaid and NCHC policies)*

- a. An eligible beneficiary shall be enrolled in either:
  1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
  2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

## 2.1.2 Specific

*(The term “Specific” found throughout this policy only applies to this policy)*

- a. **Medicaid**  
None Apply.
- b. **NCHC**  
NCHC beneficiaries are not eligible for Community Alternatives Program for Children (CAP/C).

## 2.2 Special Provisions

### 2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

#### a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary’s physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary’s right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider’s documentation shows that the requested service is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition” [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**b. EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

*NCTracks Provider Claims and Billing Assistance Guide:*

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

**2.2.2 EPSDT does not apply to NCHC beneficiaries**

**2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age**

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

**2.3 Benefit Aid Category**

Although there are a variety of Medicaid coverage categories, only Medicaid beneficiaries in the categories specified below are eligible for CAP/C.

- a. Medicaid Aid to the Blind (MAB)
- b. Medicaid Aid to the Disabled (MAD)  
**Note: MAB and MAD** beneficiaries need to be approved for disability by the Social Security Administration.
- c. Medicaid for Children Receiving Adoption Assistance (I-AS)
- d. Medicaid for Children Receiving Foster Care Assistance (H-SF)

**3.0 When the Procedure, Product, or Service Is Covered**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

**3.1 General Criteria Covered**

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

### 3.2 Specific Criteria Covered

#### 3.2.1 Specific criteria covered by both Medicaid and NCHC

None Apply.

#### 3.2.2 Medicaid Additional Criteria Covered

##### a. Beneficiary Criteria

The Medicaid beneficiary shall meet all of the criteria below.

1. Be medically fragile;
2. Reside in a primary residence used as a home (for the purposes of this policy, primary residence is defined as a residence other than a hospital or nursing facility (unless planning to transition to a primary residence once CAP/C is approved). Refer to **Subsection 4.2 item b**;
3. Require nursing facility LOC as determined by DMA's fiscal agent based upon the N.C. Medicaid Program Long term care services (FL-2) level of care, or by the CAP/C Nurse Consultant based upon the FL-2 and assessment data;
4. Be under the age of 21 years;
5. During each continuous 90 consecutive day time period of CAP/C participation, require and use case management and at least one other waiver service (excluding respite and waiver incontinence supplies), which is directly related to a documented medical diagnosis(es) and identified medical care needs;
6. Desire CAP/C services instead of institutional care, as evidenced by the written statement of the beneficiary's parent(s) on the Letter of Understanding and Freedom of Choice form (DMA-3162); and
7. Be able to have his or her health, safety, and well-being maintained at home.

##### b. Service Criteria

The provision of service shall contain all of the following components:

1. Care is maintained at home within the cost limitations of the waiver; the cost limit for each service as established by DMA may not be exceeded.
2. Amount, duration, frequency, and provider type of each service is indicated in the beneficiary's CAP/C plan of care (POC). Approval for non-waiver services remains with the approval authority for the specific service. The DMA CAP/C Nurse Consultant approves waiver services and the overall POC.
3. Services are provided in accordance with all requirements specified in this policy; all applicable federal and state laws, rules, and regulations; the current standards of practice; and provider agency policies and procedures.

### c. Level of Care Determination

There are two LOCs within the CAP/C program: Nursing Facility LOC and Hospital LOC. Both require that the beneficiary meet the minimum nursing facility LOC criteria. Hospital level of care requires that the beneficiary meet at least one of the following additional criteria:

1. ventilator dependency, for all or part of the day;
2. a tracheostomy requiring suctioning more often than every four hours;
3. oxygen dependency when the flow rate requires adjustment based on oxygen saturation levels;
4. PRN medications, excluding routine topical medications such as those for diaper rash, administered more often than every four hours and requiring the assessment, judgment, and intervention of a nurse;
5. more than two unplanned hospitalizations within the last year, or more than three total hospitalizations within the last year; or
6. interventions that occur at least every two hours AND require the scope of practice of an RN or LPN.

**Note:** DMA Nursing Facility LOC criteria can be found in clinical coverage policy 2B-1, *Nursing Facilities*, which can be found on DMA's website at <http://www.ncdhhs.gov/dma/mp>.

A LOC determination shall be completed at initial assessment and also with each annual review and as needed for significant changes in condition. The Nursing Facility LOC will be approved by the fiscal agent at the initial assessment and with significant changes in condition that may cause the child to no longer meet NF level of care. The fiscal agent's determination will be reviewed and approved by the DMA Nurse Consultant. The DMA Consultant will make the determination regarding Hospital LOC. The DMA Nurse Consultant will also review and approve LOC annually during the Continued Needs Review and with each significant change in condition. Refer to **Appendix A, Level of Care Determination**.

## 4.0 When the Procedure, Product, or Service Is Not Covered

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### 4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

## 4.2 Specific Criteria Not Covered

### 4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

None Apply.

### 4.2.2 Medicaid Additional Criteria Not Covered

CAP/C participation and services are not covered for any of the following:

- a. The CAP/C code is deleted by the local department of social services (DSS) (for example, secondary to institutionalization for more than 30 consecutive days). Refer to **Subsection 7.3, Absence from CAP/C Participation**, and **Subsection 7.6, Terminations**.
- b. The beneficiary is admitted to, resides in, or is receiving medical care in a hospital, nursing facility, or other institutional setting where licensed personnel are employed (except when receiving CAP/C institutional respite services).

**Note:** Transitional case management provided under specific circumstances, such as planning for discharge, is covered. Case management activities must not duplicate the facility's discharge planning.

- c. The beneficiary is receiving other Medicaid services or other third-party reimbursed services that duplicate care being provided [such as In Home Care, home health nursing services, or respiratory therapy that duplicates the nurse aide or nurse care provided through the waiver.].
  - d. The beneficiary lives alone, unless there is a caregiver who accepts responsibility and provides direct care to the beneficiary, including during the planned and unplanned absences of the paid provider if applicable.
- Note:** For the purposes of this policy, 'caregiver' refers to an individual who provides direct services to the beneficiary when a paid provider is not available.
- e. The beneficiary does not require at least one waiver service (excluding respite and waiver incontinence supplies) in addition to case management during any given 90 consecutive days.
  - f. The beneficiary resides in or is cared for in the home of the paid nurse or nurse aide.
  - g. Services are furnished by a member of the beneficiary's family as defined in **Subsection 1.2.4**, even if that family is a qualified nurse, nurse aide, or other provider.
  - h. When the beneficiary resides in an unsafe home environment and the family is not compliant with the established plan of care, placing the child at risk.
  - i. When services are included in a child's Individualized Education Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA), the funding of such services is the responsibility of state and local education agencies. Services may be provided under the State Plan in accordance with §1903(c)(3) of the Act and in accordance with the specific criteria of each service.

- j. CAP/C does not permit the use of restraints or seclusion, including personal restraints, drugs used as restraints, mechanical restraints, or seclusion. CAP/C complies with the definition of restraint as stated in the June 22, 2007 memo to State Survey Agency Directors, Ref S&C-07-22, re:

Clarification of Terms Used in the Definition of Physical Restraints as Applied to the Requirements for Long Term Care Facilities. Refer to: <http://www.cms.gov/surveycertificationgeninfo/downloads/SCletter07-22.pdf>

- k. CAP/C does not permit the use of restrictive interventions that restrict participant movement; participant access to other individuals, locations, or activities; restrict participant rights; or that employ aversive methods to modify behavior.

#### **4.2.3 NCHC Additional Criteria Not Covered**

- a. NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
  - 1. No services for long-term care.
  - 2. No nonemergency medical transportation.
  - 3. No EPSDT.
  - 4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

**Note: Subsection 4.2.3(b)** applies to NCHC only.

## **5.0 Requirements for and Limitations on Coverage**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

### **5.1 Prior Approval**

Medicaid shall require prior approval for CAP/C beneficiaries.

#### **5.1.1 Lead Agency Responsibilities**

DMA is the lead agency and shall:

- a. Manage the CAP/C program and authorize the case management providers who can provide case management and arrange for CAP/C services.
- b. Select and monitor the local case management providers to ensure that they are operating according to all applicable state and federal laws, state and federal rules and regulations, and agency policy.
- c. Publish a CAP/C Training Manual for case managers that describes the provision of CAP/C services.
- d. Provide training and technical assistance to case managers including the following:
  - 1. Completing CAP/C assessments and POCs;
  - 2. Developing and implementing CAP/C services and;
  - 3. Coordinating CAP/C services with other resources and services in the community.
- e. Prescreen referrals and provide written authorization for an assessment to be conducted by the case management provider.

- f. Review and approve CAP/C assessments and POCs for all CAP/C participants in accordance with due process
- g. Monitor the CAP/C program through various audits and reports to CMS including on-site visits to case management agencies and beneficiaries, if applicable, and beneficiary record reviews—to ensure that the provision of CAP/C services complies with the intent of the waiver and with state policies and procedures.
- h. Establish ongoing communication mechanisms with CAP/C providers to include:
  - 1. Posting Frequently Asked Questions (FAQs) to the DMA website (<http://www.dhhs.state.nc.us/dma>).
  - 2. Providing instructional memos to CAP/C providers when changes occur to the program.

### 5.1.2 Case Management Agency Responsibilities

The CAP/C case management agency shall:

- a. Serve a regional geographical area.
- b. Accept referrals and submit them to DMA for prescreening.
- c. Educate the caregivers and community about the benefits and limitations of the CAP/C program.
- d. Ensure that the parent(s) understand free choice as it relates to institutionalization versus the CAP/C program and to choice of providers.
- e. Manage a wait list in accordance with the following criteria:

Applicants who have been approved for assessment who the case management agency cannot serve within two weeks of receiving the referral approved notification are considered on a wait list. Applicants who the case management agency is able to serve, but cannot because of hospitalization, being unable to reach the family, etc., are not considered wait list applicants. All efforts should be made to avoid a wait list. If an agency with no wait list finds they need to start one, they contact DMA and joint efforts are made to find a solution.

If a wait list does occur, the agency notifies DMA by the 5<sup>th</sup> day of each month for each month a wait list exists regarding the status of the wait list, including, at a minimum, the number of applicants on the list, and the length of time of the wait.

Priority must be given to CAP/C beneficiaries transferring from another county or from another Medicaid program, and to new applicants requiring home care in order to be discharged from current institutionalization. Other criteria such as first come, first serve or acuity may be established by the case management provider's policy after the above criteria are met.

Applicants must be referred to other programs or resources for which they are eligible and could receive while waiting for CAP/C.

Applicants must be contacted at least every 60 days as long as they are waiting to determine their continued interest in the program, inform them of their wait list status, and assess for any changes in condition or caregiver availability that could impact their priority on the wait list or their referral to other programs or resources.

- f. Initiate and oversee the process of assessment and reassessment of LOC and review of POCs annually or more often as needed.
- g. Arrange for a complete assessment of beneficiaries who are authorized by DMA for a CAP/C assessment. The assessment must be performed by a registered nurse (RN) or a team comprised of an RN and a non-nurse case manager experienced in home and community long-term-care assessment and case management. A Registered Nurse performing a CAP/C assessment shall not be employed by the agency providing that beneficiary's direct care.
- h. Plan and communicate authorization of care to meet the unmet needs of the beneficiary.
- i. Collaborate with local providers to coordinate and oversee the implementation of the POC.
- j. Coordinate with local providers to ensure that beneficiaries receive approved services and supplies to enhance their safety and functioning in their homes.
- k. Coordinate closely with other agencies that work with CAP/C beneficiaries, such as health departments, local departments of social services, child development services agencies (CDSA), and home care agencies to meet the health, safety, and well-being needs of the beneficiary; prevent duplication of services; and ensure cost-effectiveness of services provided.

The case manager also collaborates with the school system to ensure that the beneficiary's Individualized Health Plan (IHP) or Individualized Education Plan (IEP) addresses his or her medical needs.

- l. Monitor services to ensure that the beneficiary's needs are met and that services are provided as authorized. **Refer to Subsection 5.8.8.**
- m. Determine case management capacity based on staffing and acuity of caseload.
- n. Develop agency-specific policies for the following:
  - 1. Wait list management, in accordance with **Subsection 5.1.2 e**, above;
  - 2. Charging for assessment-only visits;
  - 3. Documentation requirements (referrals, assessments, POCs, changes in condition, contact notes);
  - 4. Monitoring visits;
  - 5. Quality management program (to include management of critical incident reports and clinical and financial oversight);
  - 6. Billing practices;
  - 7. Admission, transfer, and discharge policies;
  - 8. Communicable disease reporting and prevention;
  - 9. Beneficiary confidentiality;
  - 10. Provider choice;
  - 11. Record retention and safekeeping;
  - 12. Personnel policies (hiring, dismissal, validation of credentials, and continuing education, if applicable); and
  - 13. Language Access Plan.All agency policies should be consistent with DMA and CAP/C policies.
- o. Locate qualified providers and oversee the provision of CAP/C services, which may include providing and billing for some supplies or services

- p. Ensure that CAP/C beneficiaries are aware of their right to select from among enrolled Medicaid providers.
- q. Employ a Case Manager Supervisor to oversee case management activities, including ensuring qualifications and training of case management staff, determining/distributing caseloads, ensuring case manager coverage of beneficiaries in the event of a case manager's absence, overseeing agency quality assurances and addressing results of state quality assurance activities that were impacted by the case management agency, ensuring timely and accurate submission of paperwork to DMA, and working with the Case Manager, the DMA Nurse Consultant, and/or the DMA CAP/C Supervisor to address individual issues.

## 5.2 CAP/C Waiver Services—Nursing

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

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

- a. The beneficiary qualifies for nursing facility (NF) level of care or Hospital LOC.
- b. All of the criteria in **Sections 2.0 and 3.0** are met.
- c. The beneficiary requires interventions that can be performed only by a licensed nurse in accordance with the North Carolina Nurse Practice Act (NCGS 90-171; 21 NCAC 36).
- d. There are actual assessments and nursing interventions to be performed. Nursing care that does not require intervention and is only for observation in case an intervention is required will not be covered by Medicaid as medically necessary CAP/C skilled nursing services.
- e. Skilled nursing assessment, interventions, or both are performed by a licensed nurse usually at least every 2–4 hours during the hours that Medicaid-covered CAP/C nursing services are provided. The care cannot be provided as an intermittent home health nursing visit.

One example of such a nursing intervention is the administration of “as needed” (PRN) oxygen or medications.

**Note: Required interventions exclude routine orders for medications.**

- f. CAP/C nursing is not covered if the beneficiary has third-party insurance coverage for nursing services for equal to or greater than the total number of Medicaid-approvable hours for the approval period. The approval period is the dates on the service authorization. Refer to **Subsection 5.8.8** for dates of service authorizations. Only hours approved by third party insurance will be considered; neither the presence of deductibles or co-pays, nor the insurance provider's reimbursement rate will factor into a decision for approval of CAP/C services.
- g. If an individual or an individual's legally responsible party voluntarily cancels any insurance plan which would have provided coverage for in home nursing services in

- order to become eligible for waiver nursing services within one year prior to the date the waiver services are requested, the waiver services shall be denied
- h. CAP/C Nursing Services may not be provided at the same day and time as CAP/C Pediatric Nurse Aide Services or CAP/C Personal Care Services. CAP/C Nursing Services may not be provided if it duplicates other Medicaid or non-Medicaid nursing services.
  - i. Respiratory therapy services may not be billed at the same time as CAP/C Nursing. In the case of medically fragile children who are on life sustaining devices such as oxygen, mechanical ventilation, CPAP, etc an initial training of 1 – 2 hours with each nurse caring for the beneficiary with a follow-up each quarter may be provided if needed. The purpose of the respiratory therapy visit is to teach and train caregivers and licensed nursing staff, as needed, regarding the beneficiary’s care. Ongoing respiratory therapy visits during nursing services is considered duplication of care. The nursing agency is responsible for ensuring the competency of nursing staff per Home Care Licensure Rules.
  - j. Home Infusion therapy services may not be billed at the same time as CAP/C Nursing. When an agency accepts a client for nursing care, they must be able to meet all of the beneficiary’s care needs. If the agency does not have personnel qualified to perform venipunctures, IV medications, etc, that agency must either subcontract with another agency or transfer the beneficiary to a different agency.
  - k. There is a signed Physician’s Request Form (DMA 3063) documenting physician’s order of, and medical necessity for, nursing services. Authorized services are documented on an established plan of care (for example, the CMS-485) signed by the physician.
  - l. The beneficiary has a caregiver available to provide needed services during the planned and unplanned absences of the nurse. There is a back-up plan for when the usual caregiver is unavailable. This plan includes a person able to physically be with the beneficiary and make judgments on behalf of the beneficiary or as designated by the parent.
  - m. A nurse may accompany a patient and his/her caregiver to a medical appointment (or to/from school or other activities) so that the nurse can provide medical care (i.e., tracheal suctioning) for the beneficiary while the caregiver drives. Under no circumstances may the nurse drive, even if allowed by the nursing agency policy. Once they reach the medical office, Medicaid will not reimburse for the nurse time spent in the physician’s office. The nurse should defer to her agency policies and Standards of Practice regarding the provision or lack of provision of care while the nurse is “off the Medicaid clock”. If transportation is arranged through the county DSS, DSS may allow the nurse to be considered the paid attendant. The agency should coordinate this with the local DSS.

The decision for initial admission to CAP/C nursing services and continuation at this level of service is made following a review of the plan of care (POC) records that have similar requirements as Form CMS-485, Home Health Certification and Plan of Care (as applicable); physician’s orders; FL-2; CAP/C assessment and POC; Physician’s Request Form (DMA 3063); nursing documentation; medication administration records; and treatment records, as applicable. This decision is made by a CAP/C Nurse Consultant who evaluates the information to determine if the beneficiary meets the criteria specified

above. The DMA Nurse Consultant sends a written notice in accordance with DMA's beneficiary notices to the parent if a service is denied, reduced, or terminated.

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

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

**Nursing Services in the School:**

Waiver funding may NOT be used to pay for any services, including nursing, that are part of the beneficiary's Individualized Education Plan (IEP). The funding of such services is the responsibility of state and local education agencies.

Waiver funding may be used to pay for nursing services in the school only under the following specific circumstances:

- a. 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.
- b. The school is developing a plan to meet the identified IEP service needs, but the plan is not yet in place.
- c. 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.
- d. The child is attending a private school, per parental preference, and the child needs a medically necessary service during school hours.

A "Documentation of Payer Source for CAP/C Children Receiving Nurse or Nurse Aide Services in the School and Justification for CAP/C Payment of Those Services if Applicable; form number DMA -3019" is completed to document the reason for the use of waiver funding. Refer to **Attachment C**.

Nursing services furnished by a member of the beneficiary's family, as defined in **Subsection 1.2.4**, are not covered, even if the family member meets the qualifications of RN or licensed practical nurse (LPN).

In addition, nursing services performed in the home of any caregiver paid to be the nurse or nurse aide for that beneficiary are not covered.

CAP/C Nursing services are not approved exclusively for services in the school or home school.

CAP/C nursing services (RN or LPN) are not covered if any of the following apply:

- a. A task can be delegated to a Nurse Aide (21 NCAC 36 .0221).
- b. A provider agency does not have a Nurse Aide available to provide services.
- c. A provider agency will not allow unlicensed personnel to perform a Nurse Aide task that meets the delegation criteria.

The number of hours of nursing care authorized for a beneficiary is based on medical necessity, caregiver availability, and other available resources. The case manager assesses the child's care needs and caregiver availability. Refer to **Appendix B, Determination of Nursing and Nurse Aide Hours**, for more information.

Congregate services are allowed when more than one Medicaid hourly nursing beneficiary resides in the same home.

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

CAP/C nursing is limited to a maximum of \$265,000 per waiver year. There is no entitlement of services up to this limit.

### 5.3 CAP/C Waiver Service – Pediatric Nurse Aide Services

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

The need for assistance with ADLs relates directly to the beneficiary's physical medical condition, and not only to another psychosocial, cognitive, behavioral, or developmental diagnosis that, in and of itself, would not qualify a participant for the CAP/C program. Pediatric Nurse Aide services are not provided to meet only age-appropriate needs; this is considered parental responsibility. If specified in the POC, Pediatric Nurse Aide services may also include home management tasks that are essential, although secondary, to the personal care tasks furnished, and that are essential to the health and safety of the beneficiary (rather than the beneficiary's family).

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

To qualify for initial and ongoing Pediatric Nurse Aide services, all of the following components are present:

- a. The beneficiary qualifies for Nursing Facility LOC.
- b. All criteria specified in **Sections 2.0 and 3.0** are met.
- c. There are actual interventions to be performed. Nurse aide care that is only for observation in case an intervention is required will not be covered by Medicaid as medically necessary Pediatric Nurse Aide services.
- d. The beneficiary shall require interventions throughout the nurse aide's shift, or lasting the duration of the nurse aide's shift. The care could not be provided as an intermittent home health aide visit.
- e. There is a signed physician order for Pediatric Nurse Aide services (NA I+ or NA II) as under 10A NCAC 13J .1302. Authorized services are documented on an established POC (for example, a CMS-485) signed by the physician.
- f. The beneficiary's needs can be met by unlicensed personnel at the Nurse Aide I+ or Nurse Aide II level. Nurse Aide services shall not be provided by personal care

aides/home health aides not registered with DHSR, or by Nurse Aide I personnel without the additional training in up to four NA II tasks.

- g. If the needed ADL assistance includes personal care needs, the care is not for normal age-appropriate functioning, which is considered a parental responsibility.
- h. The beneficiary has a caregiver available to provide needed services during the planned and unplanned absences of the nurse aide. If the regular informal caregiver (parent) is not available, there must be a back-up informal caregiver designated by the parent who can be physically present with the beneficiary and make judgments on the parent's behalf regarding the care of the beneficiary.

The decision for initial admission to CAP/C Pediatric Nurse Aide services and continuation at this level of service is made following a review of the current LOC determination, CAP/C assessment and POC, and nurse aide's flow sheets if available. This decision is made by a DMA Nurse Consultant who evaluates the information to determine if the beneficiary meets the criteria specified above. The DMA Nurse Consultant sends a written notice in accordance with DMA's due process procedures to the parent if a service is denied, reduced, suspended, or terminated.

The licensed nurse maintains accountability and responsibility for the delivery of safe and competent care (N.C. Board of Nursing). Decisions regarding the delegation of any nurse aide tasks are made by the licensed nurse on a beneficiary-by-beneficiary basis. The criteria stated below shall be met in order for a task to be delegated to unlicensed personnel (Nurse Aide I or II).

- a. The task is performed frequently in the daily care of a beneficiary or group of beneficiaries.
- b. The task is performed according to an established sequence of steps.
- c. The task may be performed with a predictable outcome.
- d. The task does not involve ongoing assessment, interpretation, or decision-making that cannot be logically separated from the task itself.

The number of hours of CAP/C Pediatric Nurse Aide Care authorized for a beneficiary is based on medical necessity, caregiver availability, and other available resources. The Case Manager assesses the child's care needs and caregiver availability. Refer to **Appendix B, Determination of Approving Nursing and Nurse Aide Hours**, for more information.

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

Waiver funding may NOT be used to pay for any services, including nurse aides, that are part of the beneficiary's IEP (Individualized Education Plan). The funding of such services is the responsibility of state and local education agencies.

Waiver funding may be used to pay for nurse aide services in the school only under the following specific circumstances:

- a. 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.

- b. The school is developing a plan to meet the identified IEP service needs, but the plan is not yet in place.
- c. 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.
- d. The child is attending a private school, per parental preference, and the child needs a medically necessary service during school hours.

The “Documentation of Payer Source for CAP/C Children Receiving Nurse or Nurse Aide Services in the School and Justification for CAP/C Payment of Those Services if Applicable; form number DMA -3019” is completed to document the reason for the use of waiver funding. **Refer to Attachment D.**

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

A Pediatric Nurse Aide may accompany a patient and his/her caregiver to a medical appointment (or to/from school or other activities) so that the aide can provide medical care (i.e., oral suctioning, positioning) for the patient while the caregiver drives. Under no circumstances may the aide drive, even if allowed by agency policy. Once they reach the medical office, Medicaid will not pay that aide for the time spent in the physician’s office. The aide should defer to her agency policies and Standards of Practice regarding the provision or lack of provision of care while she is “off the Medicaid clock”. If transportation is arranged through the county DSS, DSS may allow the aide to be considered the paid attendant. The agency should coordinate this with the local DSS.

Services are limited to a maximum of \$75,000 per waiver year for Pediatric Nurse Aide services alone or in combination with CAP/C Personal Care Services.. There is no entitlement of services up to this limit.

Pediatric Nurse Aide services furnished by a member of the beneficiary’s family (as defined in **Subsection 1.2.4**) are not covered, even if the family member meets the qualifications of NA1+ or NA II.

In addition, Pediatric Nurse Aide Care services performed in the home of any caregiver paid to be the nurse or nurse aide for that client are not covered.

Pediatric Nurse Aide services are not approved exclusively for services in the school or home school. Pediatric Nurse Aide services are not approved for assistance with school homework.

Congregate services are allowed when more than one Medicaid hourly nursing beneficiary resides in the same home.

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

#### 5.4 CAP/C Waiver Services - Personal Care Services

Personal Care is a level of service that, during the hours of service provision, provides hands-on (not merely set-up or cuing) assistance with a minimum of two ADLs for beneficiaries who are unable to perform these tasks independently due to a medical condition named and documented on a validated assessment. The need for assistance with ADLs relates directly to the beneficiary's physical medical condition, and not only to another psychosocial, cognitive, behavioral, or developmental diagnosis that, in and of itself, would not qualify a participant for the CAP/C program. Personal Care services are not provided to meet only age-appropriate needs; this is considered parental responsibility. If specified in the POC, personal care services may also include home management tasks that are essential, although secondary, to the personal care tasks furnished, and that are essential to the health and safety of the beneficiary (rather than the beneficiary's family).

Personal Care services are provided as defined by the N.C. Board of Nursing (<http://www.ncbon.com/>) and DHSR.

To qualify for initial and ongoing personal care services, all of the following components are present:

- a. The beneficiary qualifies for Nursing Facility LOC;
- b. All criteria specified in **Sections 2.0 and 3.0** are met;
- c. There are actual interventions to be performed. Nurse Aide care that is only for observation in case an intervention is required will not be covered by Medicaid as medically necessary personal care services;
- d. The beneficiary shall require interventions throughout the nurse aide's shift, or lasting the duration of the nurse aide's shift. The care could not be provided as an intermittent home health aide visit;
- e. There is a signed physician order for personal care services as under 10A NCAC 13J .1302. Authorized services are documented on an established POC (for example, the CMS-485) signed by the physician;
- f. The beneficiary's needs can be met by unlicensed personnel at the Nurse Aide I; nurse aide services shall not be provided by personal care aides/home health aides not registered with DHSR;
- g. If the needed ADL assistance includes personal care needs, the care is not for normal age-appropriate functioning, which is considered a parental responsibility; and
- h. The beneficiary has a caregiver available to provide needed services during the planned and unplanned absences of the nurse aide. If the regular informal caregiver (parent) is not available, there must be a back-up informal caregiver designated by the parent who can be physically present with the beneficiary and make judgments on the parent's behalf regarding the care of the beneficiary.

The decision for initial admission to CAP/C personal care services and continuation at this level of service is made following a review of the current LOC determination, CAP/C assessment and POC, and nurse aide's flow sheets if available. This decision is made by a DMA Nurse Consultant who evaluates the information to determine if the beneficiary meets the criteria specified above. The DMA Nurse Consultant sends a

written notice in accordance with DMA's due process procedures to the parent if a service is denied, reduced, suspended, or terminated

The licensed nurse maintains accountability and responsibility for the delivery of safe and competent care (N.C. Board of Nursing). Decisions regarding the delegation of any nurse aide tasks are made by the licensed nurse on a beneficiary-by-beneficiary basis. All the criteria stated below shall be met in order for a task to be delegated to unlicensed personnel:

- a. The task is performed frequently in the daily care of a beneficiary or group of beneficiaries;
- b. The task is performed according to an established sequence of steps;
- c. The task may be performed with a predictable outcome; and
- d. The task does not involve ongoing assessment, interpretation, or decision-making that cannot be logically separated from the task itself.

The number of hours of nurse aide care authorized for a beneficiary is based on medical necessity, caregiver availability, and other available resources. The Case Manager assesses the child's care needs and caregiver availability. Refer to **Appendix B, Determination of Nursing and Nurse Aide Hours**, for more information.

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

Waiver funding may NOT be used to pay for any services, including nurse aides, that are part of the beneficiary's IEP (Individualized Education Plan). The funding of such services is the responsibility of state and local education agencies.

Waiver funding may be used to pay for nurse aide services in the school only under the following specific circumstances:

- a. 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;
- b. The school is developing a plan to meet the identified IEP service needs, but the plan is not yet in place;
- c. 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; and
- d. The child is attending a private school, per parental preference, and the child needs a medically necessary service during school hours.

The "Documentation of Payer Source for CAP/C Children Receiving Nurse or Nurse Aide Services in the School and Justification for CAP/C Payment of Those Services if Applicable; form number DMA -3019" is completed to document the reason for the use of waiver funding. Refer to **Attachment D**.

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

Services are limited to a maximum of \$60,000 per waiver year for CAP/C Personal Care Services or \$75,000 per waiver year for Pediatric Nurse Aide Services and CAP/C Personal Care Services combined. There is no entitlement of services up to this limit.

Personal care services furnished by a member of the beneficiary's family (as defined in **Subsection 1.2.4**) are not covered, even if the family member meets the qualifications of NAI.

In addition, personal care services performed in the home of any caregiver paid to be the nurse, nurse aide, or attendant for that client are not covered.

Personal care services are not approved exclusively for services in the school or home school. Personal Care Services are not provided for assistance with school homework.

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

## **5.5 CAP/C Waiver Services—Supplies**

Waiver supplies and equipment include the following:

- a. Devices, controls, or appliances specified in the POC that increase the beneficiaries' ability to perform ADLs;
- b. Items necessary for life support or to address physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items;
- c. Other durable and non-durable medical equipment (DME) not available under the State Medicaid Plan that is necessary to address beneficiaries' functional limitations and; and
- d. Necessary medical supplies not available under the State Medicaid Plan or approved under EPSDT.

Items provided through the CAP/C waiver are in addition to any medical equipment or supplies furnished under the State Medicaid Plan and exclude those items that are not of direct medical or remedial benefit to the beneficiary. All items should meet applicable standards of manufacture, design, and installation.

The following items are included in this service:

- a. reusable incontinence undergarments;
- b. disposable liners for the reusable incontinence undergarments; and
- c. adaptive tricycles when prescribed by a physical or occupational therapist and used for the development of gross motor skills, range of motion, improved endurance, improved circulation, trunk stabilization and balance, or as an adjunct to gait training.

This service will also include:

- a. the performance of assessments by an appropriate professional to identify the type of equipment needed by the participant;
- b. training the participant or caregiver in the operation or maintenance of the equipment or use of the supply; and
- c. repair of equipment as long as the cost of the repair does not exceed the cost of purchasing a new piece of equipment.

**Limitations** of this service include the following:

- a. A physician's signature certifying medical necessity for the supply is required. The case manager is responsible for obtaining the physician's order that details type and quantity of supplies. The case manager is responsible for issuing the Service Authorization for waiver incontinence supplies as appropriate.
- b. Physician orders for reusable incontinence undergarments and disposable liners are renewed at least annually.
- c. In addition to the physician's order, adaptive tricycles are justified by an assessment by a Physical or Occupational Therapist. The assessment contains information regarding the rationale for the supply.
- d. Equipment or supplies purchased for exclusive use at school or home school are not covered.
- e. Items that are covered through Durable Medical Equipment and Supplies (DMES), orthotics and prosthetics, home health supplies, and EPSDT are obtained through the respective programs prior to requesting from the waiver. The waiver does not cover items that are covered by one of these programs but were denied for the particular beneficiary for lack of medical necessity. Medicaid is the payer of last resort; if the beneficiary has private insurance that covers the item, this insurance is billed first.
- f. Replacement of equipment that has not been properly used, has been lost, or has been purposely damaged is not covered. Items that have been stolen may be replaced when a copy of the police report is submitted.
- g. Service agreements, maintenance contracts, and extended warranties are not covered.
- h. The following waiver limitations apply;
  1. Reusable incontinence undergarments: \$500 per waiver year
  2. Disposable liners: \$1000 per waiver year
  3. Adaptive tricycle: \$600 per waiver year

Medicaid is the payer of last resort. Medicaid will allow payment up to these maximums, inclusive of third-party and Medicaid funds. It is the responsibility of the case manager to track the cost of the supplies to avoid exceeding the limit. **Note:** Waiver year is defined as July 1 through June 30 each year.

- i. Approval of waiver supplies is based upon medical need; there is no entitlement of services up to the program limit.
- j. Incontinence products of any type (reusable or disposable) are not approved for children under the age of three years.
- k. Waiver incontinence products may not be the only waiver service used besides case management.
- l. Waiver supplies are provided and billed only at a frequency and in amounts consistent with documented beneficiary's medical needs and physician orders.
- m. It is the case manager's responsibility to bill Medicaid for the adaptive tricycles, DME providers enrolled as CAP providers may bill other waiver supplies.
- n. Waiver supplies are provided by an appropriate professional who identifies the beneficiary's needs with regard to the supply(ies) being requested.
- o. For adaptive tricycles, documentation of medical necessity and a price quote shall be submitted in writing with the Plan of Care in order to obtain approval of the requested supply.
- p. Waiver supplies can only be provided when they are documented in the Plan of Care as necessary to meet the needs of the beneficiary. Outcomes and goals related to the use of the supplies shall be included in the Plan of Care. Outcomes and goals related

to training needs associated with the participant's/family's use of the requested supply(ies) are included in the Plan of Care as appropriate.

- q. Provision of incontinence products will be discontinued if not required and used within a 90 consecutive day time period.

## **5.6 CAP/C Waiver Services—Home Modifications**

Home modifications include equipment and physical adaptations to the beneficiary's home that are required by his or her needs for health, safety, and well-being and are contained in the approved POC. They are intended to give the beneficiary mobility, safety, and independence in the home, thus avoiding institutionalization. These services are not part of the State Medicaid Plan and are not available under EPSDT. Those items that are not of direct medical or remedial benefit to the beneficiary are excluded. All items should meet applicable standards of manufacture, design, and installation. It is recommended that several quotes be obtained on all home modifications to ensure the most efficient use of Medicaid funds. It is the case management agency's responsibility to bill Medicaid for this service and retain the original invoice within the beneficiary's file.

The following modifications are included in this service:

- a. Wheelchair ramps, stationary or portable;
- b. Threshold ramps, used to allow wheelchairs to move over small rises such as doorways or raised landings;
- c. Grab bars or safety rails mounted to wall;
- d. Modification of bathroom facilities to improve accessibility for a disabled individual, including: roll in shower, sink modifications, water faucet controls, tub modifications (excluding handheld showers which are covered by EPSDT), toilet modifications, floor urinal adaptations, and plumbing modifications;
- e. Widening of doorways for wheelchair access, turnaround space modifications for wheelchair access;
- f. Bedroom modifications other than doorway widening to accommodate hospital beds and wheelchairs;
- g. Lifts, elevators, manual, hydraulic, or other electronic lifts, including portable lifts or lift systems that are used inside a participants home;
- h. Porch stair lifts;
- i. Floor coverings for ease of ambulation when existing floor coverings are in disrepair and pose increased risk to a beneficiary with documented fall risk, or when those floor coverings are contributing to asthma exacerbations requiring repeated emergency room or hospital treatment;
- j. Portable or whole house air filtration system and filters under the following circumstances:
  1. For beneficiaries with severe allergies or asthma, when all other preventive measures such as removal of the allergen or irritant, removal of carpeting and drapes have been attempted, and the beneficiary's asthma remains classified as moderate persistent or severe persistent, and a physician has certified that air filtration will be of benefit. Ozone generators and electronic or electrostatic or

- other air filters which produce ozone or  $\leq 50$  parts per billion ozone byproduct will not be covered.
2. For beneficiaries susceptible to infection, when adequate infection control measures are already in place yet the beneficiary continues to acquire airborne infections, and when a physician has certified that air filtration will be of benefit in preventing infection, a germicidal air filter (with UV light) may be provided.
  3. The smallest unit that will meet the beneficiary's needs is covered; i.e., if a beneficiary spends most of his or her time confined to a specific area of the house, then a whole-house system will not be approved.
- k. Back-up generator for a ventilators, when the beneficiary uses the ventilator more than eight hours per day and when in the event of a power outage the beneficiary would require hospitalization if not for the presence of the generator.

This service also includes:

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

Limitations of this service include the following;

- a. Service agreements, maintenance contracts, and extended warranties are not covered;
- b. Equipment or supplies purchased for exclusive use in the school or home school are not covered;
- c. Roof repair, central air conditioning, swimming pools, hot tubs, and locks are not covered;
- d. The service is limited to those modifications needed to adapt the individual's home environment to his or her specific disabilities; items that have general utility to non-disabled individuals are not covered;
- e. This service is limited to modifications of an existing home. It is not available for new construction;
- f. Home modifications that add to the total square footage of the home are excluded;
- g. Modifications for exclusive use in the school or home school are not covered;
- h. Home modifications may be provided only in the following settings:
  1. A dwelling where the beneficiary resides and that is owned by the beneficiary's family (biological, adoptive, or foster);
  2. A rented residence, when the modifications are allowed by the owner. Medicaid assumes no liability related to use or maintenance of the equipment and assumes no responsibility for returning the home to its pre-modified condition;
  3. The total cost of home modifications can not exceed \$10,000 over the life (CMS approved 5 year waiver cycle) of the waiver. As always, Medicaid is the payer of

last resort. It is the responsibility of the Case Manager to track the cost of home modifications billed and paid in order to avoid exceeding the limit. Participants not in the waiver for the full five years will receive the benefit prorated to \$2000 for each year of participation, the total amount to be used over the duration of participation.

- i. This service will not to be used for major home renovations and repairs;
- j. Replacement of equipment that has not been properly used, has been lost, or has been purposely damaged is not covered;
- k. Home modifications can be provided as a waiver service only when they are documented in the POC as medically necessary to meet the needs of the beneficiary, and there is a signed physician order. Outcomes and goals related to training needs associated with the beneficiary's or family's use of the requested adaptation are included in the POC as appropriate;
- l. The items are provided by an appropriate professional and shall identify the beneficiary's needs with regard to the home modifications being requested;
- m. Construction and installation are completed by contractors in accordance with state and local licensure regulations and building codes as applicable. All items meet applicable standards of manufacture, design, and installation;
- n. A copy of the assessment by a Physical Therapist (PT), Occupational Therapist (OT), or Rehabilitation Engineer certifying medical necessity is included with the request for Home Modifications (with the exception of floor coverings, air filters, and generators). A physician's order certifying that the requested adaptation is medically necessary must be obtained and on file with the case manager's records. The case manager should submit this documentation as well as a price quote in writing with the plan of care in order to obtain approval;
- o. Items that are covered through DMES, orthotics and prosthetics, home health supplies, and EPSDT are obtained through the respective programs prior to requesting from the waiver. The waiver does not cover items that are covered by one of these programs but were denied for the particular beneficiary for lack of medical necessity. Medicaid is the payer of last resort; if the beneficiary has private insurance that covers the item, this insurance is billed first;
- p. Home modifications are not be furnished to adapt living arrangements that are owned or leased by providers of waiver services, unless the modification is to the provider's own home and for the exclusive use of that provider's own CAP/C beneficiary;
- q. Approval for home modifications is based upon medical need; there is no entitlement of services up to the limit;
- r. Funding for home modifications is assigned on a per-home and per client basis. In other words, if there are two CAP/C children residing in the home, that family does not receive \$20,000 – there is one home to be modified, so there is one allotment of funds. If one child resides in two homes, the \$10,000 limit still applies, although the funds may be used for either home;
- s. A beneficiary who leaves and then re-enters CAP/C within the same waiver period will not receive additional funds upon re-entering. For example, a beneficiary was receiving CAP/C prior to June 30, 2011, and so was eligible to receive \$10000 in home modifications. The beneficiary spent all of this money and then withdrew from the CAP/C program. In August 2012 he reapplied and was approved for CAP/C. This beneficiary would not get \$6000 at this time; he would get no money until the

next waiver period because he had already spent his allotment for this waiver period;  
 and

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

### 5.7 CAP/C Waiver Services—Respite Care

Respite care provides short-term support (as according to the chart below) to a family caring for a CAP/C beneficiary. It can be used as day, evening, or overnight care to meet a range of beneficiary needs such as caregiver relief. Respite care may be provided either in the beneficiary’s residence or in a facility licensed to provide the LOC required by the beneficiary (such as a nursing facility or hospital). Respite hours are determined and approved according to the number of regularly scheduled weekly hours of formal support a beneficiary receives. The chart below shows the maximum number of hours that can be provided (actual hours provided may be fewer).

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

Respite hours are assigned per household. Families with more than one CAP/C beneficiary in the home will be given respite hours according to the child with the least amount of in home care support per week. Those services will be provided as simultaneous care.

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

Respite care is not available as the only waiver service besides case management. It is only available to beneficiaries who require case management plus one other additional waiver service in addition to respite each quarter.

There are three types of respite. The allotted respite hours may be used as any combination of the following;

- a. In-home aide respite (Personal Care or Pediatric Nurse Aide)
- b. In-home nursing respite
- c. Institutional respite

Each day of institutional respite counts as 24 hours towards the annual limit. (The “day” is defined by the institution.) In-home respite is counted as the hours provided that are in addition to the regularly scheduled hours.

It is the joint responsibility of the case manager, provider agency, and family to track the use of respite hours to ensure that the beneficiary remains within the approved limit.

Respite hours are indicated on the cost summary and service authorization as a “per year” allotment. Families may use as much or as little of their respite time as they wish within a given month, as long as they do not exceed their approved allotment by the end of the waiver year. Hours may be used on a regularly scheduled or on an as needed basis.

Respite hours should not be used for situations in which short-term-intensive hours could be approved.

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

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

Respite services will not be approved to provide oversight of additional minor children or to relieve other paid providers.

Federal financial participation is not claimed for the cost of room and board except when provided as part of respite furnished in a facility approved by the State that is not a private residence.

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

## **5.8 CAP/C Waiver Services—Case Management**

Targeted case management services are defined as services furnished to assist individuals in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- a. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  1. taking client history;
  2. identifying the individual’s needs and completing related documentation; and
  3. gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

The case managers shall conduct a comprehensive assessment. The case management assessment should address all aspects of the beneficiary, including medical, physical/functional, psychosocial, behavioral, financial, social, cultural, environmental, legal, vocational/educational, and other areas. The case management assessment should include early identification of conditions and needs for prevention and amelioration. The case management assessment involves consultation with other natural and paid supports such as family members, medical and behavioral health

providers, and educators to form a complete assessment. The case management assessment would integrate all other current assessments including the comprehensive clinical assessment, medical assessments, and any other appropriate assessments. The case management assessment includes periodic reassessment to determine whether a beneficiary's needs or preferences have changed.

- b. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
  1. specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  2. includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  3. identifies a course of action to respond to the assessed needs of the eligible individual.
- c. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
  1. activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- d. Monitoring and follow-up activities:
  1. activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, to determine whether the following conditions are met:
    - A. services are being furnished in accordance with the individual's care plan;
    - B. services in the care plan are adequate; and
    - C. changes in the needs or status of the individual are reflected in the care plan.Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring includes contacts with non-eligible beneficiaries that are directly related to identifying the eligible beneficiary's needs and care, for the purposes of helping the eligible beneficiary access services; identifying needs and supports to assist the eligible beneficiary in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible beneficiary's needs.

(42 CFR 440.169(e))

CAP/C Case Management activities include those stated below and are documented in the beneficiary's record.

### **5.8.1 Receive and Process Inquiries and Referrals**

When a parent, discharge planner, or other person inquires about CAP/C services, the case manager shall provide information about the eligibility for, requirements of, and services of the waiver program. This is an opportunity to discuss the benefits and limitations of the waiver program in relation to the

child's needs. The case manager then completes the referral form and submits it to DMA's Home Care Initiatives (HCI) unit for prescreening. If the inquiry does not result in a referral, the case manager documents the inquiry and results, and submits those to DMA upon request.

#### **5.8.2 Obtain Approval for Assessment**

The DMA Nurse Consultant shall generate a letter providing an authorization for assessment and send it to the beneficiary in care of the parent(s).

A copy is sent to the case manager, who contacts the parent(s) within 2 weeks to schedule the assessment and coordinate other necessary arrangements.

#### **5.8.3 Coordinate with Medicaid Eligibility Staff**

The case manager advises the parent(s) to alert the county DSS case worker that the CAP/C referral is pending. The case manager also follows up with DSS to ensure that the application is being processed.

#### **5.8.4 Obtain the Level of Care Approval**

The case manager obtains a LOC determination. Refer to **Appendix A, Level of Care Determination**.

#### **5.8.5 Coordinate with Community Care of North Carolina (CCNC)**

The case manager contacts the local CCNC network to obtain data available in their Provider Portal. The case manager follows all the requirements for consents in order to do this. This information helps guide the assessment and the Plan of Care Development.

#### **5.8.6 Conduct the Assessment**

Case managers are responsible for conducting assessments authorized by DMA Nurse Consultants in a timely and cost-effective manner. The parent(s) are responsible for cooperating in gathering the information required to complete the assessment.

The assessment is generally conducted at the home of the beneficiary.

The assessment is documented on the CAP/C Assessment Form (DMA-3045), or an agency-derived form with the same content.

#### **5.8.7 Develop the Plan of Care**

The services documented on the POC effectively meet the needs identified in the assessment. Case managers use the POC to achieve the following:

- a. Summarize the evaluation and assessment information to highlight the beneficiary's strengths and needs;
- b. Outline goals and objectives based on the assessment and identified needs;
- c. Ensure the beneficiary's rights to choose between CAP/C and institutionalization and from among Medicaid-enrolled providers. Obtain the signature of the parent(s) on the Letter of Understanding and Freedom of Choice, DMA-3162;
- d. Provide a plan for the provision of services;

- e. Develop a comprehensive list of all services, medical supplies, and DME, including provider, amount, and frequency to be provided and calculate the cost of the waiver services; and
- f. Ensure that the beneficiary understands and is in agreement with the Plan of Care, and obtain the beneficiary's signature certifying this.

## **5.8.8 Obtaining Approval for Participation/Approval of the Plan of Care**

### **5.8.8.1 Regular Initial Application**

The case manager submits the FL-2, assessment, POC, and other required documentation such as the Physician's Request Form for Nursing Services, DMA- 3063 to the DMA Nurse Consultant for approval. This is done no later than 60 calendar days after FL-2 approval by the fiscal agent. If the assessment, POC, and FL-2 are not received by DMA within the time limit, a new FL-2 is obtained and the assessment process reinitiated.

### **5.8.8.2 Expedited Initial Application**

An expedited application process is available for beneficiaries waiting to be discharged from a hospital or institutional setting, and for beneficiaries moving into the county, only when services will need to be immediately available upon arrival to the home. The expedited initial application process includes the following:

- a. The Case Manager shall submit all pertinent information, including the following minimum requirements:
  - 1. The CAP/C referral form
  - 2. The telephone-approved FL-2
  - 3. The anticipated discharge/start of service date
  - 4. The family's demographic information
  - 5. The home environment assessment which may be completed by interviewing the family
  - 6. A list of services the child currently receives and those services he/she is currently being referred to
  - 7. A preliminary cost summary
  - 8. A preliminary 24 hour coverage schedule
- b. The Case Manager shall verify the beneficiary's Medicaid eligibility.
- c. The Consultant will prioritize these reviews. If approved, approval will be granted for a maximum of six weeks of service. There is no guarantee that services will continue beyond the six weeks.
- d. The Case Manager may issue service authorizations and participation notices as needed for the six weeks.
- e. The nurse case manager or social worker and nurse case management team should plan to be at the patient's home upon arrival to ensure that all equipment, caregivers, etc are in place and that caregivers are adequately trained regarding care and equipment, so that the child can be safely case for in the home. Any issues regarding health, safety, or well-being should be addressed.

- f. The case manager shall follow up by phone or visit approximately one week after start of services. The purpose of this follow-up is to assess the provision of services and address any needs or issues that have arisen related to caring for the beneficiary at home.
- g. No later than 30 days after start of services, the entire assessment and plan of care, including review and changes to the previously submitted information, shall be received at DMA.
- h. The consultant will prioritize these reviews. If approved, the approval will be for the remainder of the CNR year. If denied, services will end at the end of the six weeks.

#### **5.8.8.3 CAP Effective Date**

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

- a. the date of the Medicaid application;
- b. the date of the FL-2 approval; or
- c. the date of deinstitutionalization.

#### **5.8.9 Communicate Authorization of Services**

Upon DMA's review and approval of CAP/C participation, the case manager sends the service authorizations and participation notices to provider agencies according to the approved POC. The service authorization details the tasks to be provided. The dates of the initial authorization are from approval through the end of the next birth month. For Continued Need reviews, the authorization begins at the beginning of the month following the beneficiary's birth month and expires in one year. The Case Manager should also forward a copy of Service Authorizations for CAP/C Nursing, CAP/C Pediatric Nurse Aide, CAP/C Personal Care, and all In-Home Respite services to the Carolinas Center for Medical Excellence (CCME) for the purpose of CCME's claims reviews.

#### **5.8.10 Monitor and Coordinate Care**

The case manager shall:

- a. Complete a home visit at least quarterly (quarterly means at least every 90 calendar days) with the CAP/C beneficiary and the parent or caregiver in their primary residence to assess the beneficiary, update the child's needs, resources, reception of, continued appropriateness of, and satisfaction with services and supplies, and observe the home environment. Annually, this visit should be conducted during the hours of CAP/C service provision to observe the services being rendered. Home visits are conducted with the goal of ensuring developing and ensuring a safe and effective treatment plan including a teaching plan for the parents-or caregivers.
- b. Make a monthly contact (monthly means at least every 30 calendar days) with the beneficiary's family to review the child's health and care needs, satisfaction with services, and assess the provision of all services and supplies to confirm their continued appropriateness
- c. Make monthly contact with all provider(s) of waiver services including home care, regarding the provision of CAP/C services and the beneficiary's status.

- d. Make quarterly contact with providers of non-waiver services regarding the provision of services and the beneficiary's status.
- e. Review the monthly claims review report from CCME and address any identified issues.
- f. Contact the beneficiary's caregiver following the construction of or installation of home modifications to confirm that the modifications safely meet the beneficiary's needs.
- g. Contact the beneficiary's caregiver within 72 hours of discharge from a hospital or rehabilitation facility to assess the beneficiary's health status and changes in his or her needs.
- h. Review a quarterly, random sample review of service notes for each beneficiary regarding CAP/C nursing services, nurse aide services, attendant care, and respite care, as applicable, to review the provision of and continued appropriateness of these services.
- i. Ensure that services offered to a CAP/C beneficiary do not duplicate other services (such as hospice, respiratory therapy, or Early Intervention).
- j. Coordinate services with third-party insurance case managers.
- k. Locate and coordinate sources of assistance from natural and informal sources, such as the family and community, so that the burden of care is not exclusively the responsibility of formal health and social agencies.
- l. Ensure that the policies and procedures of the CAP/C program are upheld to maintain the health, safety, and well-being of the beneficiary.
- m. Review and approve claims for waiver services to ensure that services are provided in accordance with the POC. For claims reviewed by CCME, review CCME's reports.
- n. Ensure that CAP/C beneficiaries are aware of their right to select from among enrolled Medicaid providers.

**Note:** Contacts may be made by telephone or by visit, unless otherwise specified.

#### **5.8.11 Document Changes and Revise the Plan of Care When Needed**

The CAP/C case manager determines whether to revise the POC when there is a change in the beneficiary's needs.

- a. *Documenting a change in services:* The CAP/C case manager shall revise the POC as the beneficiary's needs change. Changes to the POC are submitted to the DMA Nurse Consultant for approval. If the POC contains more than the maximum hourly or monetary allowance for that service, then the POC is revised.

A POC revision is required when a waiver service is added, reduced, increased, or deleted or when there are changes in duration or frequency of a waiver service.

**Note:** The revision does not need to be submitted to DMA for approval if it is only a change in a non-waiver service. The POC needs to reflect this change at the next revision submission.

- b. *Documenting a change of provider agency:* A POC revision is not required for a change in provider agency, but the change is documented and

maintained within the beneficiary's record. The document includes a signed agreement from the parent(s) consenting to the change in providers.

**Note:** The POC needs to reflect this change at the next revision submission.

- c. *Approval of changes:* POC revisions are approved by the DMA Nurse Consultant. Revisions may be approved retroactively for up to 30 calendar days prior to the date that the revised plan is received by DMA's HCI unit. The parent(s) shall agree to and sign POC changes. (In the event that the parent is hospitalized, incarcerated, or incapacitated, the back-up caregiver or legally responsible party may sign.) The DMA Nurse Consultant sends a written notice in accordance with DMA's beneficiary notices to the parent if a service is denied, reduced, or terminated.

#### **5.8.12 Conduct the Annual Continued Needs Review**

A CNR is completed every 12 months to determine if the beneficiary continues to meet the CAP/C eligibility and medical necessity criteria specified in **Sections 2.0** and **3.0**. The CNR is due to DMA on the 5th day of the beneficiary's birth month. It is completed during the month prior to that date. The CNR POC is prepared with the caregivers involved in the beneficiary's care, including family and other appropriate parties, and signed by the beneficiary's parent(s). (In the event that the parent is hospitalized, incarcerated, or incapacitated, the back-up caregiver may sign.) The Plan of Care submitted with the CNR is effective the first day of the month after the submission month and expires one year later.

The CNR includes the following information:

- a. New FL-2 with the physician's recommendation for nursing facility LOC.
- b. Reassessment of the beneficiary's strengths, needs, and appropriateness for CAP/C.
- c. New POC based on beneficiary's current situation and medical needs.

**Note:** For Nurse LOC, the medication administration records, nurse documentation, treatment records, and plan of care (POC) records with similar requirements as on Form CMS 485 Home Health Certification and Plan of Care are submitted. Employment Verification and Request for Nursing Services in the School should be submitted if applicable. Other documentation may be requested on an individual basis.

#### **5.8.13 Coordinate Transfers and Withdrawals**

The case manager shall discharge the beneficiary when CAP/C is no longer appropriate, as directed by DMA and in accordance with CAP/C policies and procedures. Voluntary transfers and withdrawals are documented, signed by the parent(s), and forwarded to the DMA Nurse Consultant as applicable.

**Note:** The case manager shall use DMA-approved forms or agency forms containing the same information for service authorizations and participation agreements. They are located on DMA's web site at <http://www.dhhs.state.nc.us/dma/services/capc.htm>.

#### **5.8.14 Validate the Ongoing Need for Services**

To determine the continued need for CAP/C nursing, pediatric nurse aide, or personal care and to ensure that the delivery of services complies with all applicable laws, rules, regulations, and professional practice, the CAP/C case manager submits the POC to DMA Nurse Consultant when there is a significant change in condition or, at a minimum, annually. Other documentation may be requested as needed, such as nurses' notes; nurse aide flow sheets; medication administration and treatment records; the Plan of care (POC) records that have similar requirements as Form CMS-485, Home Health Certification and Plan of Care; and the Form CMS-486, Medical Update Form.

#### **5.8.15 Billing**

The Case Manager, or designated person within the case management agency, shall bill for case management services, home and vehicle modifications, adaptive tricycles, and other waiver services and supplies in accordance with this CAP/C policy, their own agency policy, and the Basic Medicaid Billing Guide.

A case management agency acting as a provider (for example, for incontinence waiver supplies) may bill the cost for the item including delivery charges and taxes plus 10% for overhead, up to the Medicaid maximum allowed rate for that item.

The following case management activities, performed for a specific beneficiary, are billable:

- a. Assessing the client for CAP/C participation. This includes the time for both members of the assessment team (if applicable) to arrange, coordinate, and complete assessment activities.
- b. Planning CAP/C services, including completing the plan of care and revising the plan as needed.
- c. Locating service providers for approved CAP/C services and ordering the services from those providers. Locating and arranging informal support to meet the beneficiary's needs.
- d. Coordinating the provision of other Medicaid home care services, such as Home Health and DME.
- e. Monitoring CAP/C services, including the delivery of the services and reviewing claims and related documentation.
- f. Monitoring the beneficiary's situation, including the continuing need for CAP/C participation, the level of care and the appropriate services, as well as taking appropriate action on your findings.
- g. Working with the client, family, and others involved in the beneficiary's care to assure the beneficiary's health, safety, and well-being. This includes emergency planning and backup planning activities.
- h. Coordinating Medicaid eligibility issues with DSS, including those related to helping the beneficiary get information to DSS.
- i. Arranging and coordinating activities related to the termination of CAP/C that occurs prior to the termination date.
- j. Time spent talking with those involved in the beneficiary's care.
- k. Time completing service authorizations.

- l. Time spent completing other correspondence directly related to the beneficiary's care.

The following case management activities are considered administrative costs are not allowed to be billed separately:

- a. Outreach.
- b. travel time.
- c. activities after the beneficiary's discharge, termination, or death.
- d. activities such as taking the referral and obtaining the FL-2, that occur prior to the CAP effective date.
- e. attending training.
- f. completing time sheets.
- g. recruiting, training, scheduling, and supervising staff.
- h. billing Medicaid.
- i. documenting case management activities.
- j. gathering information to respond to quality assurance requests.

#### **5.8.16 Limitations**

CAP/C case management services are not allowed when other Medicaid-reimbursed case management services are also in place.

Case management is limited to 72 hours (288 units) per CNR year. Exceptions to these limits may be made in situations that meet EPSDT criteria for approval.

### **5.9 Motor Vehicle Modifications**

Adaptations or alterations to a motor vehicle such as an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, safety, and well-being of the beneficiary. The installation, repair, maintenance, and training in the care and use of these items are included. Repair of equipment (both of equipment obtained through the waiver and equipment that would be included under the definition if purchased new) is covered as long as the cost of the repair does not exceed the cost of purchasing a new piece of equipment. The waiver participant or his or her family shall own any equipment that is repaired. Professional consultation shall be accessed to ensure that the adaptation will meet the needs of the participant. All items shall meet applicable standards of manufacture, design, and installation. It is recommended that several quotes be obtained on all motor vehicle modifications obtained through the CAP/C waiver in order to ensure the most efficient use of Medicaid funds. It is the case management agency's responsibility to bill Medicaid for this service. The Case Manager bills the cost of the item including applicable installation and delivery charges, taxes, and permit fees, up to the beneficiary's limit. The Case Manager retains the original invoice within the beneficiary's file.

Adaptations include the following:

- a. Door handle modifications.
- b. Door modifications.
- c. Electric door openers.
- d. Installation of raised roof or related alterations to existing raised roof system to improve head clearance.
- e. Lifting devices.
- f. Devices for securing wheelchairs or scooters inside the vehicle.
- g. Devices for securing oxygen tanks.
- h. Devices for transporting mobility devices such as Rooftop Wheelchair Carriers, Trailers, and Trunk Lifts.
- i. Adapted steering, acceleration, signaling, and breaking devices only when recommended by a physician and a certified driving evaluator for people with disabilities, and when training in the installed device is provided by certified personnel.
- j. Handrails and grab bars.
- k. Seating modifications.
- l. Lowering of the floor of the vehicle.
- m. Safety and security modifications including additional mirrors and pedal guards
- n. Adaptive car seats or vehicular transport vests for children weighing over 30 pounds or with a seat to crown height that is longer than the back height of the largest safety car seat if the child weighs less than the upper weight limit of the current car seat, who are unable to be transported safely with a seat belt or standard child car safety seat.

Limitations of this service include:

- a. Items that are not of direct or remedial benefit to the participant are excluded from this service. Recommended equipment or modification shall be justified by an assessment by a PT or OT specializing in vehicle modifications, or a Rehabilitation Engineer or Vehicle Adaptation Specialist, or Certified Driving Rehabilitation Specialist., and accompanied by a physician's signature certifying medical necessity for the person. All vehicles are evaluated by an adapted vehicle supplier with an emphasis on the safety and "life expectancy" of the vehicle in relationship to the modifications. These assessments contain information regarding the rationale for selected modification, condition of the vehicle to be modified, insurance on the vehicle to be modified, and training plan for the use of the prescribed modification.
- b. Documentation regarding medical necessity and a price quote should be submitted in writing with the Plan of Care in order to obtain approval of the requested Vehicle Adaptations.
- c. The waiver does not cover items that are covered by state plan programs, but were denied for a particular beneficiary because of lack of medical necessity.
- d. The vehicle that is adapted belongs to the individual, to a family member with whom the individual lives or has consistent and on-going contact, or non-relative who provides primary long-term support to the individual and is not a paid provider of such services.

- e. Payment may not be made to adapt the vehicles that are owned or lease by paid providers of waived services.
- f. This service does not include the purchase or lease of the vehicle itself. Vehicle Modifications may in some cases be used to pay for a lift that is existing on a van. All the following information shall be submitted to DMA when approval for an existing lift is being requested:
  - 1. the age of the lift;
  - 2. the original price of the lift and the assessed condition;
  - 3. the current value of the lift;
  - 4. the age of the vehicle; and
  - 5. the current appraised condition and value of the vehicle.
- g. Items not covered include: the cost of renting a vehicle with adaptations; service and maintenance contracts and extended warranties; and adaptations purchased for exclusive use at the school or home school. Adaptations or improvements to the vehicle that are of general utility to non-disabled persons, and are not of direct medical or remedial benefit to the child are excluded.
- h. Regularly scheduled upkeep and maintenance of a vehicle is excluded.
- i. Replacement of a vehicle adaptation is not covered if the participant or family fails to keep their automobile insurance policy current when the repair would have been covered by the insurance.
- j. The total cost of vehicle modifications may not exceed \$15,000 over the life of the waiver. It is the responsibility of the Case Manager to track the cost of vehicle modifications billed and paid in order to avoid exceeding the limit. Participants not in the waiver for the full five years will receive this benefit prorated to \$3000 for each year of participation, the total amount to be used over the duration of participation. Approval for vehicle modifications is based upon medical need; there is no entitlement of services up to the program limit.
- k. Vehicle modifications are provided and installed in accordance with the manufacturer's installation instructions, and national Mobility Equipment Dealer's Association, Society of Automotive Engineers, and National Highway and Traffic Safety Administration guidelines.

## **5.10 Community Transition Funding**

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

The costs of these services are considered to be incurred and billable when the person leaves the institutional setting and enters the waiver. Funds for this service are limited to the difference between the maximum allowed amount for that service and the prorated amount already available to the beneficiary, such that the total amount available to the beneficiary is never more than \$10,000 for home modifications and \$15,000 for vehicle modifications.

For home modifications,

A beneficiary entering the waiver in year	may receive a maximum of
1	\$0
2	\$2,000
3	\$4,000
4	\$6,000
5	\$8,000

For motor vehicle modifications,

A beneficiary entering the waiver in year	may receive a maximum of
1	\$0
2	\$3,000
3	\$6,000
4	\$9,000
5	\$12,000

The limits for home and vehicle modifications apply. For example, if a beneficiary is entitled under Community Transition Funding to have \$2,000 for home modifications and \$3,000 for vehicle modification, that beneficiary may not use the entire \$5,000 for home modifications.

This service is available only as a one-time expense per beneficiary (waiver lifetime maximum) to facilitate transition from an institutional setting to a private residence. This service is not available to beneficiaries who change their place of residence.

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

All other definitions, requirements, limitations, and provider qualifications for home modifications and for vehicle modifications apply.

## 5.11 Caregiver Training and Education

Caregiver Training and Education includes training for the individuals (including family members, neighbors, friends, or companions) who provide unpaid care, support, training, companionship, or supervision to a waiver participant. The purpose of training is to enhance the decision making capacity of the beneficiary's support system. Training will provide orientation regarding the nature of the illness or disability and its impact on the child and family, treatment regimens, and equipment. Caregiver Training and Education will also include updates as necessary to maintain the child safely at home. All caregiver training and outcomes will be included in the beneficiary's Plan of Care. Training shall be directly related to the individual's role in supporting the beneficiary in areas specified in the service plan.

The service includes:

- a. Registration and enrollment fees associated with formal instruction in areas relevant to participant needs identified in the service plan.

Note that the service is billed in 15 minute units, but is not paid according to the length of time of the training. The amount billed is the amount of 15 minute units that add up to the cost of registration or enrollment.

Service Limitations include:

- a. The service is limited to a maximum expenditure of \$500 per waiver year.
- b. This service does not include the cost of travel, meals, or overnight lodging to attend a training event or conference.
- c. Individuals who are paid service providers are excluded from this service.
- d. A documentation of paid registration or invoice, and a certificate of attendance is required.

## 5.12 Palliative Care Services

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

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

This service is provided by a certified Hospice agency and includes the following:

- a. Counseling by a Clinical Social Worker, Licensed Professional Counselor (LPC), or Licensed Psychologist, with experience working with clients with life-limiting illnesses and their families, provided to the participant and family members in order to guide and help them cope with the participant's illness and the related stress that accompanies the continuous, daily care required by caring for a chronically disabled child.
- b. Expressive Therapy. Expressive Therapy is defined as provision of creative art, music or play therapy i.e., book writing, painting, music therapy, scrap-book making, which gives children the ability to creatively and kinesthetically express their medical situation. Use of these therapies can decrease a beneficiary's feelings of isolation, improve communications skills, decrease emotional suffering due to health status, and develop coping skills. Expressive therapy is activity which is not for recreation but related to the care and treatment of the patient's disabling health problems.
- c. Bereavement activities and opportunities for dialogue offer the family a mechanism for expressing emotion and asking questions about death and grieving in a safe environment thereby potentially decreasing complications for the family after the child dies.

The services may be provided as in-home or as outpatient care.

Limitations of this service:

- a. There must be a signed physician's order for the service.
- b. This service is not available to beneficiaries of Medicaid or Medicare Hospice services.
- c. Counseling services are limited to 98 visits per year.
- d. Beneficiary, Family, or Caregiver Counseling will be provided according to the assessment of the beneficiary in the continuum of care after a diagnosis of a life-limiting illness or condition. When a child is first diagnosed with the illness, the child and family might need a significant amount of anticipatory grief and loss counseling that may taper off during the treatment phase when the child has some improvement or remission of symptoms. As the child's health deteriorates counseling services may be required at an intensive level.
- e. Expressive therapy is limited to 39 hours (156 units) per year.
- f. Bereavement is limited to a one time visit, which must be billed on or before the beneficiary's last date of service.
- g. Approval for this service is based upon need; there is no entitlement of services up to the program limit. As always, Medicaid is the payer of last resort. Medicaid will allow payment up to this maximum, that payment inclusive of third party and Medicaid payments.
- h. Palliative Care Services will be discontinued if not required and used within a 90 consecutive day time period.

### **5.13 Service Delivery Location**

With the exception of a school setting, if services are provided in an alternate primary residence, the setting is assessed and approved by the case manager prior to delivery of the service. Case managers do not need to assess a family child care, child care center, or religious-based center, as long as the facility has at least a one-star rating or a DCD notice of compliance (10A NCAC 09 .0305 and NCGS § 110, Article 7).

### **5.14 Limitations**

- a. Services are provided in an amount, duration, and scope consistent with the beneficiary's medical needs.
- b. The amount of service provided does not exceed what is contained in the approved CAP/C POC. While EPSDT applies to all beneficiaries under the age of 21, cost limitations guidelines shall be maintained.
- c. A provider shall not bill for a service if the procedure is not valid for the CAP/C benefit program.
- d. CAP/C providers cannot file a claim for a beneficiary who is ineligible for CAP/C services, except for some 'assessment only' claims billed by case managers.
- e. Assessment-only claims are limited to those approved by the DMA HCI Unit.

## 6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet Medicaid or NCHC qualifications for participation;
- b. be currently Medicaid - enrolled; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

For beneficiaries of CAP/C where school is a place of service, DMA has no authority to require the school system to employ a particular provider. If the family disagrees with the school's choice of providers, the family must address that concern through the school system's appeals process.

### 6.1 Case Management Provider Agencies

#### Provider Enrollment

Providers must meet conditions defined in the NC DHHS Provider Administrative Participation Agreement. A list of all CAP/C case management providers may be found at <http://www.ncdhhs.gov/dma/capc/capcagency.htm>.

#### Provider Certification

Provider agencies must be certified in accordance with standards established by the NC DHHS as meeting both business and service quality criteria.

Provider agencies are authorized by the DMA HCI Unit and enroll with DMA as CAP/C case management providers. The DMA HCI nurse supervisor authorizes agencies for CAP/C case management services once all criteria are met.

The case management agency should demonstrate the following:

- a. The agency is capable of providing case management by both nursing and social work staff as defined in **Subsection 6.1.1**
- b. The agency complies with policy development as defined in **Subsection 5.1.2**.
- c. The agency completes all required application and enrollment documentation and provides required certifications and tax information as defined in the DMA Provider Enrollment guidelines. Eligible providers may include health departments, departments of social services, home care agencies licensed by DHSR under 10A NCAC 13J, aging agencies, and private providers.
- d. Providers demonstrate experience with pediatric case management.
- e. Providers conduct criminal background checks on all case managers in accordance with GS131E-265.
- f. The agency has capability of web-based automation.
- g. 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 beneficiary. Exceptions to this criterion may be approved on a case-by-case basis when:

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

#### **6.1.1 Individual Provider Qualifications**

The individual case manager must meet the following qualifications:

- a. Bachelor's degree in social work from an accredited school of social work, and one year of directly related experience or
- b. Bachelor's degree in a human services or equivalent field (as set forth in "Guidelines for Evaluating Human Services Degrees, Prepared by Office of State Personnel Local Government Services, October 2003" located at [http://www.osp.state.nc.us/ExternalHome/Group5/LocalGovmt/HRManual/vi\\_humansrvcddegrees.pdf](http://www.osp.state.nc.us/ExternalHome/Group5/LocalGovmt/HRManual/vi_humansrvcddegrees.pdf)) from an accredited college or university and one year directly related experience. or
- c. Bachelor's degree from an accredited college or university and two years directly related experience, or
- d. Registered nurses who hold a current North Carolina license, regardless of whether they have completed a two or four year educational program, must have one year of directly related experience.

#### **6.1.2 Individual Case Manager Supervisor Qualifications**

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

All of the qualifications of the individual case manager, and

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

OR

- b. the following *additional* experience (above what is required for the individual case manager)
  - 1. Bachelor of Social Work (BSW), Bachelor degree in a human services field, or RN with two years of directly related experience, one of those years to have been case management experience.
  - 2. Bachelor degree in a non-human services field and three years directly related experience, one of those years to have been case management experience.

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

#### **Transition Period**

For Case Manger Supervisors, a one year sunset clause (ending December 31, 2012) is allowed to meet the minimum standards of Case Manager Supervisor.

#### **Case Manager Training Requirements**

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

- a. Bloodborne pathogen/infection control training
- b. HIPAA training
- c. Completion of the DMA-sponsored CAP/C training within 90 calendar days of employment.
- d. Completion of the “Training for Case Managers – Improving the Quality of Home and Community Based Waiver Services”, within 90 calendar days of employment, located at <http://www.hcbsassurances.org>.
- e. One year of experience in pediatrics or completion of DMA-approved pediatric training curriculum.

Until these trainings are completed, the case manager supervisor shall sign off on the case manger’s work prior to billing for those case management services.

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

#### **Competencies**

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

##### **1. Assessment**

###### Knowledge of:

- a. Formal and informal assessment practices.
- b. The population/disability/culture of the beneficiary being served.

###### Skills and Abilities to:

- a. Apply interviewing skills such as active listening, supportive responses, open-and closed-ended questions, summarizing, and giving options.

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

## 2. Care Planning

### Knowledge of:

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

### Skills and Abilities to:

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

## 3. Linkage/Referral

### Knowledge of:

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

### Skills and Abilities to:

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

- d. Assist the beneficiary in accessing a variety of community resources.

#### **4. Monitoring & Follow-Up**

Knowledge of:

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

Skills and Abilities to:

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

#### **5. Professional Responsibility**

Knowledge of:

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

Skills and Abilities to:

- a. Use critical thinking skills and consultation with other professionals to make ethical decisions and conduct ethical case management.
- b. Use initiative and creative problem solving to support people in accessing the community and developing socially valued roles.
- c. Form constructive, collaborative relationships with beneficiaries of various cultures and use effective strategies for conducting culturally-competent case management.
- d. Form constructive, collaborative relationships with medical and other service providers.
- e. Discern with whom protected health information can be shared.
- f. Communicate clearly, both verbally and in writing.
- g. Discern when the severities of family problems are beyond the case manager's skill or responsibility, and when referrals to other professionals are necessary.
- h. Identify areas for self improvement, pursue necessary education and training, and seeks appropriate supervision.

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

- a. initial and annual assessments .
- b. a joint home visit with the social work case manager every 6 months, to coincide with the midyear review as applicable.
- c. review of all incident reports regarding emergency room use, hospitalization, injury, or other medical issues.
- d. a quarterly review of the beneficiary's file and consultation with the social work case manager.

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

An RN Case Manager or a person contracted to perform nursing functions of case management (for example, the annual assessment), may not do so for any CAP/C beneficiary for whom she or her employing agency provides direct care.

Providers licensed by the DHSR under 10A NCAC 13J as a home care agency and enrolled with N.C. Medicaid to provide in-home aide and nursing services may provide CAP/C Nursing, CAP/C Pediatric Nurse Aide Services, CAP/C Personal Care Services, and medical supplies as authorized by the Case Manager on the Service Authorization notice.

### **6.1.3 Nurse Qualifications**

Nurses are qualified and supervised according to the N.C. Home Care Licensure Rules (10A NCAC 13J), the N.C. Nurse Practice Act (NCGS 90-171), and N.C. Board of Nursing rules and regulations (21 NCAC 36).

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

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

#### 6.1.4 Nurse Aide Qualifications

Services are provided by a home care agency licensed by the DHSR under 10A NCAC 13J to provide nurse aide services. The aide providing direct care is trained, listed, and supervised as a Nurse Aide I with the Healthcare Personnel Registry at DHSR or listed as a Nurse Aide II in accordance with the Nurse Practice Act (NCGS 90-171) and N.C. Home Care Licensure Rules (10A NCAC 13J). The Nurse Aide providing Pediatric Nurse Aide services completes DMA-approved training regarding pediatric growth and development, pediatric client interactions, and home care of pediatric clients. This training is completed prior to billing for Pediatric Nurse Aide services. The provider agency is responsible for verifying the aide's qualifications as follows:

- a. Check of Health Care Personnel Registry (10NCAC27G.0202) at hire and with each renewal date (every two years).
- b. Criminal background check in accordance with GS 131E-265. It is recommended that the nurse aide not begin providing services until the check has come back satisfactorily. It is further recommended that state criminal background checks be repeated every two years at time of registry renewal.
- c. Verification of CPR certification at hire and every two years coinciding with expiration dates. It is recommended that First Aid certification also be maintained and verified.
- d. Review of trainings and beneficiary-specific competencies upon hire at each job performance review as per agency policy.
- e. The RN supervises the nurse aide in the beneficiary's home at least every three months, as specified in 10A NCAC 13J .1110.

#### 6.2 Waiver Supplies

Reusable incontinence undergarments and disposable liners are of sufficient quality and appropriate to the needs of the beneficiary as determined by the case manager based on an RN's assessment and ordered by the physician annually.

The incontinence supplies may be provided by the following:

- a. a DME company enrolled as a CAP provider
- b. a CAP/C case management agency

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

The providing agency must be located within the boundaries of North Carolina or in an adjoining state from which North Carolina beneficiaries living on the border can use the agency as a general practice. Out-of-state providers will be enrolled when the product they supply or manufacture is not available through an enrolled provider located within the state or border area.

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

Adaptive Tricycles are requested by a licensed physical or occupational therapist and ordered by the physician. They are provided by a specialized vendor with the appropriate state/local business license. The Case Manager is responsible for billing for adaptive tricycles.

### **6.3 Home Modifications**

Approval for home modifications is based on an assessment by a PT, OT, or rehabilitation engineer and accompanying MD certification of medical necessity, with the exception of floor coverings, air filters, and back-up generators which are based on RN assessment and MD certification.

The commercial/retail business that obtains and/or installs the equipment or modification must hold an applicable state/local business license and be capable of making modifications and installing equipment according to applicable State and local building codes and other regulations with items that meet applicable standards of manufacture, design, and installation.

The Case Manager is responsible for billing for Home Modifications.

### **6.4 Respite Services**

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

In-home respite is subject to the same provider qualifications listed in **Subsections 6.2.1, 6.2.2, and 6.8.**

### **6.5 Motor Vehicle Modifications**

Recommended equipment or modification shall be justified by an assessment by a PT or occupational therapist specializing in vehicle modifications, or a rehabilitation engineer or vehicle adaptation specialist, and accompanied by a physician's signature certifying medical necessity for the person.

The commercial or retail business that obtains or installs the equipment or modification must hold an applicable state-or local business license and be capable of installing in accordance with applicable standards and safety codes including manufacturer's installation instructions, National Mobility Equipment Dealer's Association guidelines, Society of Automotive Engineers guidelines, and National Highway and Traffic Safety Administration guidelines, based on evaluation by an adapted vehicle supplier. The Case Manager is responsible for billing for Motor Vehicle Modifications.

### **6.6 Community Transition Funding**

All other definitions, requirements, limitations, and provider qualifications for home modifications and for vehicle modifications apply. The Case Manager is responsible for billing for Community Transition Funding.

## 6.7 Caregiver Training and Education

This service is provided by colleges, universities, AHECs, and other organizations that have expertise as appropriate in the field in which the training is being provided, and/or have been awarded CEUs for the training by an authorized entity. The training/curriculum must be approved by the CAP/C Consultant.

The Case Manager is responsible for billing for Caregiver Training and Education based upon documented paid registration and invoice and certificate of attendance.

## 6.8 Palliative Care

Services are provided by a certified Hospice agency as according to 10A NCAC 13J .1005.

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

Expressive therapies are provided by one of the following:

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

## 6.9 Non-eligible Providers

A CAP/C provider shall not employ a family member of a CAP/C beneficiary (as defined in **Subsection 1.2.4**) to care for that beneficiary.

Services are not covered if provided in the home of a caregiver paid to care for that beneficiary.

## 7.0 Additional Requirements

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### 7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

## **7.2 Coordination of Care**

Beneficiaries are eligible to receive all Medicaid services according to Medicaid policies and procedures, except when those policies or procedures restrict participation. For example, a CAP/C beneficiary may not receive another Medicaid-reimbursed case management service in addition to CAP/C case management.

## **7.3 Absence from CAP/C Participation**

### **7.3.1 Hospital Stays of 30 Calendar Days or Less**

When a CAP/C beneficiary is admitted to a hospital, the case manager determines the reason for the admission, the prognosis, and anticipated length of the absence from home. If a hospital stay of 30 calendar days or less is anticipated, the case manager does the following:

- a. Suspends all CAP/C services except for case management
- b. Notifies the discharge planner that the beneficiary is a CAP/C participant
- c. Notifies the county DSS that the beneficiary has been hospitalized
- d. Monitors the beneficiary's progress through contact with the discharge planner and other appropriate parties
- e. Monitors any changes that can extend the hospitalization beyond 30 days or result in a transfer to a nursing facility or rehabilitation center
- f. Determines, as necessary, the medical and related home care needs with the physician, discharge planner, and other appropriate parties when the beneficiary is released
- g. Alerts CAP/C providers when to resume care
- h. Informs the DSS Medicaid staff that the beneficiary continues on CAP/C
- i. Revises the POC, if needed, and sends it to the DMA Nurse Consultant for approval

### **7.3.2 Hospital Stays Longer than 30 Calendar Days**

Hospital stays of more than 30 calendar days affect Medicaid eligibility and CAP/C participation. If the beneficiary is hospitalized for more than 30 days, the CAP/C case manager contacts the local DSS staff to learn when the beneficiary's Medicaid status will change to long-term-care budgeting. The case manager then conveys that information to the DMA Nurse Consultant so that CAP/C services can be terminated.

### **7.3.3 Nursing Facility Admissions**

Beneficiary admission to a nursing facility or a rehabilitation center that is billed to Medicaid as nursing facility care affects Medicaid eligibility and CAP/C participation. If the beneficiary is admitted to a nursing facility or rehabilitation center, the case manager contacts the DMA Nurse Consultant so termination of CAP/C participation can be initiated.

### **7.3.4 Temporary Residence Changes**

If a beneficiary temporarily (for 30 calendar days or less) leaves the county, the case manager suspends the delivery of CAP/C services by contacting the provider agencies. The case manager tracks the absence, since an extended absence (greater than 30 calendar days) can affect Medicaid eligibility and

continued CAP/C participation. The local DSS Medicaid eligibility staff is notified when an extended absence occurs.

#### **7.4 Case Management Agency Transfers**

A transfer occurs when a beneficiary moves from one CAP/C case management agency to another CAP/C case management agency without a break in participation in CAP/C service provision. The transferring beneficiary is prioritized to ensure timely admission to the program.

#### **7.5 Withdrawals**

A beneficiary's or parent's decision to withdraw from CAP/C participation is submitted in writing to the local case manager, who forwards the document to the DMA Nurse Consultant. This notification is forwarded to DMA within 15 business days of the signature date.

**Note:** When the beneficiary withdraws for purposes of a closed or confidential adoption, the case manager forwards the written withdrawal to the DMA Nurse Consultant for termination of CAP/C services under the previous name. The case manager and DMA open a new record that contains a new referral, initial assessment and POC using the child's adopted name.

#### **7.6 Terminations**

Only the DMA Nurse Consultant can initiate termination. The proposed effective date depends on the cause of the termination. When a beneficiary's participation is terminated, the beneficiary and the parent(s) are notified in writing and notices of due process rights are issued in accordance with the DMA beneficiary rights and appeals procedures. Refer to **Subsection 7.8. Hearings and Appeals Process**, for additional information.

Reasons for termination include any one of the following.

- a. The beneficiary's Medicaid eligibility is terminated.
- b. The beneficiary's physician does not recommend CAP/C participation.
- c. The beneficiary's physician does not recommend nursing facility or hospital LOC.
- d. The fiscal agent does not approve nursing facility LOC.
- e. The beneficiary is admitted to an institutional setting for 30 or more calendar days and the DSS removes the CAP Indicator code secondary to institutionalization.
- f. The CAP/C case manager has been unable to establish contact with the beneficiary or his or her parent(s) for more than 60 calendar days.
- g. The beneficiary fails to qualify for program participation based on medical needs; that is, the beneficiary does not require case management plus one (excluding respite) other waiver service on a quarterly basis in order to remain safely at home.
- h. The beneficiary's health, safety, and well-being cannot be reasonably assured.
- i. The beneficiary has reached the age of 21 years (Refer to **Subsection 2.3**).
- j. The beneficiary or parent(s) do not participate in development of or sign the beneficiary's POC.

- k. The beneficiary or parent(s) fail to comply with all program requirements. This includes the parent's failure to arrive home at the end of the approved hours of service (CAP/C nurse's or nurse aide's shift) or their manipulation of the coverage schedule without contacting the case manager for approval. Discharge from CAP/C may ensue if there are three such occurrences and the beneficiary or the parent(s) have been counseled regarding this issue; or after one occurrence should the beneficiary's health, safety, and well-being at risk.

## **7.7 Documentation Requirements**

The following information is documented in the beneficiary's record as specified below.

- a. The agency providing CAP/C personal care services, CAP/C nursing services, or both documents the physician's orders on the plan of care (POC) records with similar requirements as the Form CMS -485 Home Health Certification and Plan of Care, or other equivalent form.
- b. The direct service provider documents care rendered on agency forms with date, time, legal signature and credentials. Case Managers' service notes are incorporated into the record within 5 business days.
- c. The case manager documents all case management activities on agency forms.
- d. All records contain the beneficiary's name and Medicaid identification number.
- e. The case management agency retains the referral, all assessments, POCs, case management notes, service authorizations, copies of claims generated by the case management agency and those generated by other providers and reviewed by the case management agency, and related correspondence in compliance with all applicable federal and state laws, rules and regulations, and agency policy for at least six years from date of services or six years after the age of majority (which would be the child's 24th birthday), whichever is later.
- f. Service (nursing, nurse aide, respite, etc.) documentation must fully document services provided, with time, activity according to physician's orders, and service authorizations. The beneficiary or parent(s) signs the time log (after service delivery) to certify that the tasks were performed satisfactorily and the time is correct.
- g. Electronic records and signatures and facsimile signatures may be used if the provider's process is consistent with all applicable laws, rules and regulations (including the N.C. Boards of Medicine and Nursing and the N.C. Rules Governing Licensure of Home Care Agencies), and agency policy.

## **7.8 Hearings and Appeals Process**

In accordance with the beneficiary notices procedure, DMA provides written notice to the beneficiary, parent(s), or both of all adverse decisions. A beneficiary whose LOC request is denied, or whose services are denied, suspended, terminated, or reduced, has the right to appeal. Examples of such decisions are:

- a. denial of initial or continued participation in the CAP/C program;
- b. denial of increase, or reduction, of waiver services included in the POC; and
- c. termination from the CAP/C program.

Only actions initiated by DMA may be appealed. Therefore the following decisions may not be appealed:

- a. A provider's refusal to serve a CAP/C beneficiary
- b. A physician's LOC recommendation
- c. A physician's order

## **7.9 Quality Assurance**

### **7.9.1 Objectives**

Quality assurance activities are conducted to monitor the following:

- a. The health, safety, and well-being of CAP/C beneficiaries
- b. The quality, appropriateness, and outcomes of services provided to CAP/C beneficiaries
- c. CAP/C beneficiaries' appropriate (nursing facility) LOC
- d. The cost efficiency of the CAP/C beneficiary's care

### **7.9.2 Framework**

The CAP/C Quality Improvement program is based on the Home and Community Based Services Quality Framework, which focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services. They are as follows:

- a. **Participant Access:** Individuals have access to home- and community-based services and supports in their communities.
- b. **Participant-Centered Service Planning and Delivery:** Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences, and decisions concerning his or her life in the community.
- c. **Provider Capacity and Capabilities:** There are sufficient HCBS providers, and they possess and demonstrate the capability to effectively serve participants.
- d. **Participant Safeguards:** Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
- e. **Participant Rights and Responsibilities:** Participants receive support to exercise their rights and accept personal responsibilities.
- f. **Participant Outcomes and Satisfaction:** Participants are satisfied with their services and achieve desired outcomes.
- g. **System Performance:** The system supports participants efficiently and effectively and constantly strives to improve quality.

### **7.9.3 Components**

Quality improvement activities are a joint responsibility of DMA and the local case management agencies. Local case management agencies and providers cooperate with all quality improvement activities by submitting all requested documents, including self audits, within defined timeframes and by providing evidence of follow-up and corrective action when review activities reveal their necessity.

The major components of the quality improvement activities include the following:

- a. Review of initial applications and Continued Need Reviews for appropriateness, accuracy, and outcomes.
- b. Review of Medicaid claims billed.
- c. Annual Participant experience survey sent by DMA to a random sample of CAP/C caregivers.
- d. Critical incident reporting.
- e. Site audits of case management provider agencies.

#### **7.10 Program Integrity**

CAP/C case management agencies that arrange for services that are not documented on the POC and authorized by DMA and are not medically necessary will be referred to Medicaid's Program Integrity unit for evaluation and potential recoupment of reimbursement.

Home care agencies that provide nursing or nurse aide services that are not medically necessary and/or not performed according to the Service Authorization will be referred to Medicaid's Program Integrity unit for evaluation and possible recoupment of reimbursement.

Licensed nurses and nurse aides who falsify medical records in an effort to qualify a beneficiary for CAP/C will be referred to the N.C. Board of Nursing or the appropriate North Carolina Health Care Personnel Registry (DHSR, the N.C. Board of Nursing, or both).

## 8.0 Policy Implementation/Revision Update Information

**Original Effective Date:** November 1, 1992

### Revision Information:

Date	Section Revised	Change
7/1/2010	Sections detailed below	CMS approval of July 2010 waiver renewal
7/1/2010	2.3	Ages eligible for participation changed from birth through 18 years to birth through 20 years
7/1/2010	3.2	Criteria for participation changed to: During each quarter of CAP/C participation, recipient must require case management and at least one other waiver service (excluding respite).
7/1/2010	3.3	Cost Neutrality mechanism changed from individual recipient monthly budget limits to aggregate model with limits on individual services
7/1/2010	3.4	Levels of care changed from Intermediate, Skilled, and Hospital to Nursing Facility and Hospital
10/1/2010	Sections detailed below	Initial promulgation of existing coverage with revisions based on the CMS approval of July 2010 waiver renewal
10/1/2010	5.1.2	Wait list policy changed to prioritize beneficiaries becoming de-institutionalized or transferring from another county or another Medicaid program
10/1/2010	5.2	Addition of congregate nursing care
10/1/2010	5.3	Addition of new service: Pediatric Nurse Aide
10/1/2010	5.4	Change in CAP/C Personal Care services staff level and qualifications
10/1/2010	5.5	Waiver supplies changed to delete items now offered by state plan and add adaptive tricycles
10/1/2010	5.6	Expanded allowable home modifications and budget limit for home modifications
10/1/2010	5.8.11	Addition of mid-year review for high-cost recipients
10/1/2010	5.9	Addition of new service: Motor Vehicle Modifications
10/1/2010	5.10	Addition of new service: Community Transition Funding
10/1/2010	5.11	Addition of new service: Attendant Care
10/1/2010	5.12	Addition of new service: Caregiver Training and Education
10/1/2010	5.13	Addition of new service: Palliative care
10/1/2010	6.1.1	Provider qualifications for case managers changed
10/1/2010	6.2.1	Provider qualifications for direct care nursing staff changed

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
10/1/2010	6.2.2	Provider qualifications for direct care nurse aides changed
11/1/2010	Attachment A: Claims-Related Information	Addition of TD and TE modifiers for T1000, T1005 and addition of Congregate Nursing Code, G1054 TD and G0154 TE
1/1/2012	Section 1.1, 5.2, 5.3, 5.4, 5.7, 5.11	Attendant care service deleted
1/1/2012	Section 3.2.c	Clarification that level of care is determined by both HP and the DMA Nurse Consultant
1/1/2012	Section 3.2.e, 4.2 c	Wording added to clarify that “quarter” is defined as a rolling 90 calendar days
1/1/2012	Section 4.2 j	Clarification of use of restraints.
1/1/2012	Section 5.1.2 g	Changed “social worker” to “non-RN” to more accurately reflect case manager qualifications
1/1/2012	Section 5.2, 5.3, 5.4, 5.5, 5.13	Clarification that the service will be discontinued if not required and used for one quarter.
1/1/2012	Section 5.2.f	Clarification of criteria for approval of CAP/C nursing services when private insurance is paying for nursing services
1/1/2012	Section 5.2.k	Wording changed to include adult (18-20 year old) recipients
1/1/2012	Section 5.3	Annual limit on service raised due to higher rate
1/1/2012	Section 5.5	Clarification that service authorization for waiver supplies is given only for waiver incontinence products
1/1/2012	Section 5.6	Criteria for approval of generator changed
1/1/2012	Section 5.6.h.2	Clarification of criteria for approval of home modifications to rental property
1/1/2012	Section 5.6.m	Deleted requirement for contractor to be licensed
1/1/2012	Section 5.6.n	Clarification of what must be submitted with a request for home modifications
1/1/2012	Section 5.7	Clarification that respite hours are based on total formal support hours
1/1/2012	Section 5.8.5	Information added regarding data sharing with CCNC.
1/1/2012	Section 5.8.11	Criteria for submission of mid year reviews changed
1/1/2012	Section 6.1.1	Added qualifications for Case Manager supervisors
1/1/2012	Section 7.7.e	Period of time for record retention increased
1/1/2012	Appendix A	Clarified that “calendar” days are used.
1/1/2012	Appendix B	Clarified method for obtaining employment verification
1/1/2012	Attachment A(C)	Added code T1004 for Pediatric Nurse Aide Respite; deleted codes and references to T2027 Attendant Care Services and G0154 TD and TE Congregate Care.
1/1/2012	Attachment B	Updated Letter of Understanding

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
1/1/2012	3.2 e, 4.2.e	States that waiver incontinence supplies may not be the only waiver service besides case management.
1/1/2012	5.1.2 e	Criteria for monitoring of wait list recipients added
1/1/2012	5.1.2.r	Responsibilities of Case Manager Supervisor added
1/1/2012	5.2, Attachment A	Congregate nursing services added back in.
1/1/2012	5.2.g	Criteria added that nursing services will be denied if private insurance covering nursing services was voluntarily dropped within preceding year.
1/1/2012	5.3, Attachment A	Congregate services added.
1/1/2012	5.6	Clarification of assessor requirements for home modifications
1/1/2012	5.8.9, 5.8.10	Modified to include new procedure of CCME doing claims reviews.
1/1/2012	5.10	Clarification of limits on Community Transition Funding
1/1/2012	6.1.2	Criteria added for case manger supervisor to co-sign work before billing case management activities provided before training completed.
1/1/2012	6.8	Provider qualifications for palliative care services changed
3/1/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

## Appendix A: Level of Care Determination

There are two LOCs within the CAP/C program: Nursing Facility LOC and Hospital LOC. Both require that the beneficiary meet the minimum nursing facility LOC criteria and be prior approved by DMA's fiscal agent. Hospital level of care requires that the beneficiary meet at least one of the following additional criteria:

1. ventilator dependency, for all or part of the day.
2. a tracheostomy requiring suctioning more often than every four hours.
3. oxygen dependency when the flow rate/concentration of oxygen needs to be adjusted at least twice per day.
4. PRN medications, excluding routine topical meds such as those for diaper rash, administered at least every two-four hours and requiring the assessment, judgment, and intervention of a nurse.
5. more than two unplanned hospitalizations within the last year, or more than three total hospitalizations within the last year.
6. interventions that occur at least every two hours AND require the scope of practice of an RN or LPN.
- 7.

**Note:** DMA Nursing Facility LOC criteria may be found in Clinical Coverage Policy 2B-1, *Nursing Facilities*, at <http://www.dhhs.state.nc.us/dma/mp>.

The beneficiary's physician initiates the initial LOC process by completing and signing a FL-2. The FL-2 is submitted to the fiscal agent by the case manager within 30 calendar days of the physician's signature. A new FL-2 is required when this date requirement is not fulfilled.

The fiscal agent reviews the FL-2 to determine whether the beneficiary meets nursing facility level of care.

If nursing facility level of care is approved, the case manager proceeds with assessment and plan of care development. The entire initial application for CAP/C services is submitted to DMA within 60 calendar days of the level of care approval. If it is not received at DMA within 60 calendar days, a new FL-2 will need to be obtained.

The CAP/C Nurse Consultant also reviews the FL-2 form, as well as the assessment and other documentation, to verify that level of care was determined correctly.

A new FL-2 is obtained any time there is a significant change in condition, defined as:

- a. start or discontinuation of a ventilator.
- b. start or discontinuation of a tracheostomy tube.
- c. change in level of staff between nurse aide level and nurse level.
- d. start or discontinuation of tube feedings.
- e. increase or decrease in seizure activity such that a revision to the plan of care is needed.
- f. increase or decrease in need for ALD assistance such that a revision to the plan of care is needed.
- g. as requested by the DMA CAP/C Nurse Consultant.

If the change of condition is for the worse, or if there is improvement in one area but care needs are such that the beneficiary remains at nursing facility level of care, the FL-2 does not need to be approved by the fiscal agent. If the change is a significant improvement, such that the beneficiary may no longer meet nursing facility level of care, the FL-2 must be approved by the fiscal agent. In all cases, the FL-2 is submitted to the DMA CAP/C Nurse Consultant who verifies the beneficiary's level of care.

A new FL-2 is obtained annually during the CNR process, An FL-2 must always be obtained within 60 calendar days prior to the CNR, even if it has not been 12 months since the last determination. As with all FL-2s, it is reviewed by the DMA CAP/C Nurse Consultant to verify that the beneficiary's level of care was determined correctly.

Any time that an FL-2 goes through the fiscal agent approval process, the pink copy will be sent back to the Case Manager. The Case Manager keeps this in the beneficiary's record.

If the physician requests nursing facility LOC and it is denied by DMA's fiscal agent or DMA, the beneficiary or parent(s) will be notified in writing in accordance with DMA's beneficiary notices procedures and due process rights will be issued.

The DMA Nurse Consultant makes a determination regarding Hospital Level of Care based upon the FL-2, assessment, plan of care, and other submitted documentation.

## Appendix B: Determination of Nursing and Nurse Aide Hours

### A. Basic Formula

The number of hours of nursing care authorized for a beneficiary is based on medical necessity, caregiver availability, and other available resources. The case manager assesses the child's care needs and the caregivers' availability and determines the number of hours a family is eligible to receive using the following formula:

*Parent's Work Time*

actual hours worked

+ ½ to 1 hour lunch per day

+ ½ to 2 hours commute per day (parent's actual commute time)

- # hours other support available

= 50 hours max per week

The Case Manager verifies the caregiver's employment schedule. Verification consists of a written statement on employer letterhead. The statement verifies that the caregiver is employed, and details the hours and schedule of employment. Hours for work are not approved unless employment verification is provided. If a caregiver is self-employed or if obtaining a written statement from the employer could jeopardize the caregiver's employment, the substitute work verification form prepared by DMA may be used instead. If this form is used, the case manager or another independent party shall be reasonably sure that the information in it is accurate. If a caregiver does not meet the criteria for use of the form, the form is not permitted to be used as work verification and hours for work are not approved.

*Sleep Time* (Nurse level only)

56 hours maximum per week

*Personal Time*

Time for caregiver ADLs and IADLs = 20 hours max per week

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

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

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

Total formal support does not exceed 126 hours per week for any CAP/C beneficiary. For nurse aide level beneficiaries, a maximum of 70 of those hours per week may be provided by CAP/Cs. Formal support hours include those hours during which the beneficiary attends school or daycare (even if not paid by Medicaid) and those hours paid by private insurance or another payer source.

Short-term-intensive care is used to approve extra hours that are needed due to a change in the beneficiary's condition resulting in additional or increased medical needs, caregiver crisis (illness or death in the family), coverage for school holidays if the caregiver works outside the home and there is no other caregiver available, and occasional, intermittent work obligations of the caregiver when no other caregiver is available. The cost of this care is managed within the annual monetary allocation for the service.

For beneficiaries eligible for short-term-intensive services for school days off, the plan of care may include up to sixty hours per school year for sick days or adverse weather days. Any hours above the sixty hour limit are submitted on a plan of care revision as short-term-intensive services and approved by a DMA Nurse Consultant. Short-term-intensive hours for any other reason must be prior-approved by the DMA Nurse Consultant. The cost of this care is managed within the annual monetary allocation for the service.

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

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

CAP/C services are provided to meet the unmet needs of the beneficiary, not the needs or preferences of caregivers, provider agencies, or others involved in the child's care. For example, a request for a nurse will not be authorized when unlicensed personnel can provide the needed services.

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

## **B. Working at Home**

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

**C. Caregiver's Overtime and On-call**

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

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

**D. Work and School or Multiple Jobs**

The number of hours approved is subject to program and budget limitations. Exceptions to the maximum hours allowed will not be made based on co-occurrence of work and school. If both are part-time, the total up to 50 hours per week, will be allowed if otherwise eligible. If more than 50 hours per week are used, the parent will need to make other arrangements for the remaining time.

**E. Multiple Siblings**

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

## Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

### A. Claim Type

Professional (CMS-1500/837P transaction)

### B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

### C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

CAP/C services are billed with HCPCS codes assigned for each waiver service. The HCPCS codes are listed in the table below.

Procedure Code	Description	Program Description
99510	Home visit for individual, family, or marriage counseling; per visit	Palliative Care - Counseling
H0045	Respite care services, not in the home, per diem	Respite care institutional
S5108	Home care training to home care client, per 15 minutes	Palliative Care – Expressive Therapy
S5110	Home care training, family; per 15 minutes	Caregiver Training and Education
S5111	Home care training, family; per session; per visit, one time only	Palliative Care – Bereavement Counseling
S5125	Attendant care services; per 15 minutes	CAP/C personal care services
S5150	Unskilled respite care, not hospice; per 15 minutes	Respite care, in-home aide level
S5165	Home modifications; per service	Home modifications
T1000 TD	Private duty/independent nursing service(s), licensed, up to 15 minutes	CAP/C nursing services, RN

Procedure Code	Description	Program Description
T1000 TE	Private duty/independent nursing service(s) , licensed, up to 15 minutes	CAP/C nursing services, LPN
T1005 TD	Respite care services, up to 15 minutes	Respite care, in-home RN level
T1005 TE	Respite care services, up to 15 minutes	Respite care, in-home LPN level
G0154 TD	Services of skilled nurse in home health, or nurse in hospice settings, each 15 minutes	Congregate CAP/C Nursing, RN
G0154 TE Effective	Services of skilled nurse in home health, or nurse in hospice settings, each 15 minutes	Congregate CAP/C Nursing, LPN
G0156 TG	Services of home health/hospice aide in home health or hospice settings, each 15 minutes	Congregate CAP/C Pediatric Nurse Aide Services
G0156 TF	Services of home health/hospice aide in home health or hospice settings, each 15 minutes	Congregate CAP/C Personal care Services
T1004	Services of a qualified nursing aide, up to 15 minutes	Pediatric Nurse Aide respite
T1016	Case management, each 15 minutes	CAP/C case management
T1019	Personal care services, per 15 minutes. Not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment	CAP/C Pediatric Nurse Aide
T2029	Specialized supply, not otherwise specified, waiver	Adaptive tricycles
T2038	Community transition, waiver; per service	Community Transition Funding
T2039	Vehicle Modifications, waiver; per service	Motor Vehicle modifications
T4535	Disposable liner/shield/guard/pad/undergarment, for incontinence, each	Disposable liner/shield for incontinence
T4539	Incontinence product, diaper/brief, reusable, any size, each	Incontinence product, diaper/brief, reusable, any size

**Unlisted Procedure or Service**

**CPT:** The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

**HCPCS:** The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

#### **D. Modifiers**

Provider(s) shall follow applicable modifier guidelines.

#### **E. Billing Units**

Units of service depend on the type of service that is provided. For the following services, one unit equals 15 minutes, and billing is limited to 96 units per day.

1. CAP/C Nursing
2. CAPC Pediatric Nurse Aide
3. CAP/C PCS
4. Respite care, in-home, Nurse or Nurse Aide level
5. Case management services
6. Caregiver training and education
7. Palliative Care: Expressive Therapy

For the following services, one unit equals 'per service':

1. Home Modifications
2. Motor Vehicle Modifications
3. Community Transition Funding
4. Waiver Supplies – Adaptive Tricycle

For the following services, one unit equals 'each'

1. Waiver Supplies – reusable incontinence undergarments
2. Waiver Supplies – disposable liners for reusable incontinence undergarments

For the following services, one unit equals one visit:

1. Palliative Care – Counseling
2. Bereavement Counseling – limited to one visit

For the following services, one unit equals 'per diem'

1. Institutional Respite.

#### **F. Place of Service**

Acceptable places of service include the following:

Office (case management only), Beneficiary's primary residence, Inpatient hospital (case management only), Nursing facility (case management or institutional respite only)

#### **F. Co-payments**

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at <http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at

[http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter\\_108A/GS\\_108A-70.21.html](http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html)

## **G. Reimbursement**

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <http://www.ncdhhs.gov/dma/fee/>

1. For home and vehicle modifications and adaptive tricycles, CAP/C case management providers bill their cost for the item, including applicable installation and delivery charges.
2. A provider is not reimbursed for a service if the billed procedure is not valid for the CAP/C benefit program.

## Attachment B: Letter of Understanding and Freedom of Choice

### NC DMA - Community Alternatives Program for Children (CAP/C) Letter of Understanding and Freedom of Choice

By signing this form, I, as the primary caregiver (parent or legally responsible party) for \_\_\_\_\_,

MID # \_\_\_\_\_ acknowledge my understanding of the CAP/C policies stated below.

1. I have a choice between A) placing my child in a nursing home or hospital and B) receiving in-home care for my child through CAP/C services. I have chosen for my child to receive CAP/C services.
2. I understand that I have the freedom to choose from among any enrolled Medicaid provider(s) to provide care or services for my child.
3. I understand that the following people may not be the paid CAP/C providers for the recipient: the recipient's parent, stepparent, foster parent, custodial parent, or adoptive parent; the recipient's grandparents; the recipient's siblings; the recipient's spouse; anyone who has legal responsibility for the recipient; and anyone who lives in the same household as the recipient.
4. I understand that the recipient may not receive CAP/C services in the home of any caregiver paid to provide those services.
5. My child, the recipient, must require skilled nursing care equivalent to care received in an institutional setting to be eligible for this program.
6. CAP/C is designed to supplement, not replace, the formal and informal services already available to my child.
7. As the primary caregiver, I will actively participate in planning for my child's care, and will comply with the mutually agreed upon Plan of Care and will provide or make arrangements for needed care to be provided to my child during the planned and unplanned absences of the CAP/C provided nurses or nurse aides.
8. The amount, frequency, or type of services my child receives may change over time based on changes in the care needs of my child or in the availability of his or her supports.
9. CAP/C services will be terminated when my child meets any of the following criteria:
  - The recipient's Medicaid is terminated.
  - The recipient's physician does not recommend CAP/C participation.
  - The recipient's physician does not recommend nursing facility level of care.
  - Nursing facility level of care is not approved.
  - The recipient is admitted to a facility for 30 or more calendar days (including admission to inpatient facilities, including but not limited to a hospital, nursing facility, or rehabilitation facility).
  - The recipient moves out of his/her primary residence to a hospital, nursing facility, or adult care home for long-term care.
  - The CAP/C case manager has been unable to establish contact with the recipient and/or his/her parent or legally responsible party for more than 60 days.
  - The recipient fails to qualify for program participation based on medical needs; that is, the recipient does not require CAP/C services to remain safely at home.
  - The recipient does not need and use at least one waiver service besides case management and respite each quarter.
  - The recipient's health, safety, and well-being cannot be reasonably assured with services provided within program limits.
  - The recipient's 21<sup>st</sup> birthday. The last day of CAP/C services must be on or before the last day the recipient is 20 years old.
  - The recipient, recipient's parent, or legally responsible party does not participate in development of or sign the recipient's plan of care.
  - Case management services are not available.
10. If a waiver service is denied, reduced, or terminated, I will be notified in writing and be told how to appeal the denial if applicable.
11. Decisions made by my child's physician or home care provider agency cannot be appealed to DMA.
12. The providers may have certain requirements regarding my participation in my child's treatment and enrollments with their agency.
13. The Case Manager is responsible for coordinating the assessment, plan of care, and monitoring CAP/C services to ensure that my child's needs are met within program guidelines. I understand that I must maintain communication with my Case Manager by returning telephone calls, being available for home visits, and informing him/her of
  - Changes in my child's condition
  - Change in availability of caregivers
  - Hospitalizations, emergency room visits, and physician appointments
  - Absences from the county
  - New equipment or supplies
14. The Division of Medical Assistance has sole approval authority over the plan of care. My Case Manager is unable to approve or deny any services or supplies.

I have been given a copy of or provided access to the CAP/C Parent Handbook (<http://www.ncdhs.gov/dma/capc/capcparenthandbook.pdf>.)

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

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

\_\_\_\_\_  
Date

## Attachment C: Physician's Request Form for Nursing Services

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

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

Address \_\_\_\_\_

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

Diagnoses \_\_\_\_\_

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

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

### TECHNOLOGY REQUIREMENTS AND CARE NEEDS

**1. Ventilator**

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

**2. Tracheostomy**

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

**3. Oxygen**

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

**4. Other Needs for a Nurse**

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

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

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

**5B. Caregiver availability**

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

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

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

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

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

MD Name \_\_\_\_\_ Name of Practice \_\_\_\_\_

MD Signature \_\_\_\_\_ Date \_\_\_\_\_

### Attachment D: Documentation of Payer Source for CAP/C Children Receiving Nurse or Nurse Aide Services in the School and Justification for CAP/C Payment of Those Services if Applicable

Completed by the Case Manager Name/Agency: \_\_\_\_\_  
and/or the  
Exceptional Children's Director Name/School System \_\_\_\_\_  
Date: \_\_\_\_\_  
Student/CAP-C Beneficiary Name \_\_\_\_\_  
Medicaid ID # \_\_\_\_\_ Student ID # \_\_\_\_\_

The above named child is a beneficiary of CAP/C, and has requested that  nurse  nurse aide services be provided in the school.

In an effort to coordinate care, DMA requires the following information:

**Y N** Nursing or Nurse Aide services are designated in the student's IEP/IHP.

If not, please indicate specific reason

- 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.
- Other:

**Y N** The nurse or nurse aide services are being funded by the school.

**Y N N/A** Nursing services ordered by an MD and being provided as an IEP service are being billed to Medicaid by the LEA as outlined in the DMA LEA policy 10C. RN, LPN and delegated services are billed in 15 minute increments.

If not, please indicate specific reason.

**T F** Funds for this service are not otherwise available under Section 110 of the Rehabilitation Act of 1973 or the IDEA, and all other avenues for funding have been exhausted.

**Y N N/A** The care that the Nurse Aide is to provide can be delegated to school personnel.

If not, please indicate the specific reason.

**T F** The IEP/services for educational need does not provide all the medically necessary services the child's waiver team deems necessary for assuring the child's health and welfare.

**Y N** The child is attending a private school, per parental preference, and the child needs medically necessary service during school hours.

I have read and agree with the statements above and give my consent for my student's school to release information to Medicaid.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
CAP/C Case Manager Signature

\_\_\_\_\_  
LEA Representative Signature

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