



North Carolina Department of Health and Human Services
Division of Medical Assistance

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**NOTICE OF CASE MANAGEMENT REDUCTION FOR COMMUNITY
ALTERNATIVES PROGRAMS FOR DISABLED ADULTS (CAP/DA), CHOICE
(CAP/CHOICE), CHILDREN (CAP/C), MENTAL RETARDATION AND
DEVELOPMENTAL DISABILITIES (MR/DD), TARGETED CASE MANAGEMENT
FOR PERSONS WITH DEVELOPMENTAL DISABILITIES,
AND EARLY INTERVENTION (EI)**

January 29, 2010

Dear Recipient or Legal Guardian:

Pursuant to Session Law 2009-451, Sections 10.68A.(a)(2)a. and 10.68A.(a)(10), the Division of Medical Assistance (DMA) has been directed by the North Carolina General Assembly to consolidate and reduce Medicaid case management services. Additionally, in accordance with Session Law 2009-451, Section 10.68A.(c), DMA is required to notify recipients of any changes in policy at least thirty (30) days prior to the adoption of new or amended medical coverage policies.

Beginning **March 1, 2010**, DMA will change the policies as described below for the following programs: CAP/DA, CAP/Choice, CAP/C, CAP-MR/DD, Targeted Case Management for Persons with Developmental Disabilities, and Early Intervention.

- The maximum number of units for case management services will be limited to no more than three hours (12 units) per calendar month for each recipient.
- No more than six additional hours (24 units) may be available if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation. These additional hours/units are cumulative within a 365 day period. These six hours (24 units) are in addition to the three hours per calendar month.

Your case management agency has been notified of these changes.

If you receive case management services through Early Intervention and receive more than three hours (12 units) per calendar month, effective March 1, 2010, your hours of service will be reduced to three hours (12 units) per calendar month. This will not affect the entitlement that is applied under the Early Intervention Program for service coordination as listed in your Individualized Family Service Plan. See the section below regarding children and Early Periodic Screening, Diagnostics, and Treatment (EPSDT) or Medicaid for Children.



Case management services for all other affected programs will continue as currently approved until the next reauthorization or continued need review is submitted by your case manager. At that time, the reductions in case management will be applied as specified below.

Children (Under 21 Years of Age)

While the new limit on case management services has been reduced to no more than three hours (12 units) per calendar month and no more than six additional hours (24 units) if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation, these limits may not apply to children under 21 years of age. Federal law, 42 U.S.C. §1396d(r)(5), requires the state Medicaid agency to provide to Medicaid recipients under 21 years of age “necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the [Social Security] Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State [Medicaid] Plan.” Additionally, if the recipient is under 21 years of age, service limitations on scope, amount, duration, and/or frequency and other specific criteria described in clinical coverage policies/program manuals may be exceeded or may not apply, provided that documentation shows the requested service is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified by a licensed clinician. This special provision for recipients under 21 years of age is known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) or Medicaid for Children. In regard to case management services, this provision means your child may receive more than three hours (12 units) per calendar month of case management services if required to meet your child’s needs or more than six additional hours (24 units) if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation. It is **important** to remember that the conditions set forth in the CAP waiver concerning the recipient’s budget and continued participation in the waiver apply. That is, the cost of the recipient’s care, including case management services, must not exceed the waiver cost limits specified in the CAP waiver. For more information about EPSDT, please visit <http://www.ncdhhs.gov/dma/epsdt/>.

At the time of your child’s next reauthorization or annual review, the case manager should include a request for case management services that will meet your child’s needs. For Early Intervention services, providers may request additional units by following EPSDT guidelines as outlined on <http://www.ncdhhs.gov/dma/epsdt/> and in the February 2010 Medicaid Bulletin. If the request exceeds the policy limits described above, the request will be reviewed under the EPSDT criteria. If the request meets all of the EPSDT criteria and the requested amount is necessary to meet your child’s needs, the request will be approved. If the request does not meet all of the EPSDT criteria or the request exceeds what is necessary to meet your child’s needs, the request will not be approved at the level requested. You will receive a written notice explaining the decision. The notice will state the decision and effective date of the reduction, explain the reduction is based on Session Law 2009-451, Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10), Division policy promulgated pursuant to S.L. 2009-451, Section 10.68A.(c), as well as state the EPSDT criteria not met, and an explanation about how to appeal the decision should you so desire.

ADULTS (21 Years of Age and Older)

In keeping with the Division’s policy that case management hours/units may not exceed the above requirements, your case manager should submit a request at the time of your next reauthorization or annual review for no more than three hours per calendar month and/or no more than six additional hours if needed for completing an assessment, completing a

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reauthorization or continued need review, or for a crisis/emergency situation within 365 days. Should your case manager submit a request that exceeds these amounts, your case will be reviewed to determine how many hours/units are necessary to meet your needs (one, two, or three hours per calendar month and/or six or less additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days). You will receive written notification of the decision via trackable mail.

If the decision authorizes case management services to the policy limit (three hours per calendar month and/or six additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days), you will receive a written notice explaining the decision. The notice will state the decision and effective date of the reduction to the policy limit, explain the reduction is based on Session Law 2009-451, Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10) as well as Division policy promulgated pursuant to S.L. 2009-451, Section 10.68A.(c), and that pursuant to 42 CFR §431.210 and §431.220(b), you are not entitled to appeal this decision.

Should less than three hours (12 units) per calendar month and/or less than six additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days be authorized, you will receive a written notice explaining the decision, and that you are entitled to appeal the decision to authorize less than the policy limit. The notice will state the decision and effective date of the reduction, explain the reduction is based on Session Law 2009-451, Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10) as well as Division policy promulgated pursuant to S.L. 2009-451, Section 10.68A.(c), and an explanation about how to appeal the decision should you so desire.

Questions about the reductions in case management services may be directed to your case manager or to the Division of Medical Assistance at 919-855-4260. You may also call the **CARE-LINE Information and Referral Services** toll free between 7 a.m. and 11 p.m. 7 days a week, including State holidays, by calling 1-800-662-7030 (English/Spanish) or 1-877-452-2514 (TTY). For local calls, you may dial 855-4400 (English/Spanish) or 919-733-4851 (TTY). Please request that your call be transferred to DMA, Clinical Policy and Programs.