



North Carolina
Department of Health and Human Services
Division of Medical Assistance
Facility and Community Care

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CAP/C CASE MANAGER TRAINING

JUNE 16, 2008

QUESTION AND ANSWER SESSION

as recorded by Jennifer Brest, RN, Lead CAP/C Nurse Consultant

EPSDT (Early and Periodic Screening, Diagnosis, and Treatment)

Jane Plaskie, RN,MS

Background Information

Early Periodic Screening, Diagnosis, and Treatment

- Screening = HealthCheck – vision, dental, hearing.
- Diagnosis = based on results of screening.
- Treatment = includes the in-home care services provided by CAP/C and all Medicaid services listed in the Social Security Act (SSA) at 1905(a). The cost of all CAP/C and EPSDT or Medicaid services must fit into the child's CAP/C budget.
- **EPSDT policy instructions on DMA web under the provider link** – contains listing of SSA 1905(a) services, both required and optional.
- **NC State Medicaid Plan**--NC Medicaid (DMA) must agree to provide all the required services and must determine which optional services will be provided as well as how they will be provided. The NC State Medicaid plan is comprised of a combination of required and optional services.
- First component of EPSDT - optional services that NC opted not to provide must still be available to recipients under 21 as long as the child meets all EPSDT criteria. Services cannot be experimental or investigational.
- Second component of EPSDT – if a service has hard limits, the service cannot be denied based only on those hard limits. For example, the PCS 60 or 80 hour limit does not apply to recipients under 21 as long as the child meets all the EPSDT criteria.

CSHS – Children’s Special Health Services

Most services covered by CSHS could be covered under EPSDT.

- Car seats are not coverable under 1905a, so continue to request those through CSHS.
- Oral formula will be covered under the State Plan effective July 1.
*** Please note that this did not happen as scheduled. Refer to your Medicaid Bulletins to find out when this change will take effect. ***
- Augmentive communication devices are covered under EPSDT as a non-covered service until August 1. Beginning August 1, augmentive communication devices will be covered under the State Plan.
*** Please note that this did not happen as scheduled. Refer to your Medicaid Bulletins to find out when this change will take effect. ***
- Over-The-Counter medications – if the medication has an NDC number it can sometimes be covered by Medicaid – the company would have to be approved by CMS. If there is not a NDC number, you may still get the medication through CSHS if it meets the CSHS criteria.

Questions and Answers

Q. What would make a child qualify for PCS through EPSDT?

A. The child would need to be Medicaid eligible, with age-inappropriate personal care needs. For example, a child with cerebral palsy, who is wheelchair-dependent, attends school where he needs assistance with eating, and also needs help at home with bathing and grooming. If the school plus home hours could not fit into the CAP/C budget, the child could receive PCS instead of CAP/C services because the limitation of 60 or 80 hours does not apply to a child under 21 years of age. Additionally, the child must meet all EPSDT criteria.

Q. If a child is going to be over-budget on CAP/C, can the Case Manager refer the child to PDN and get the Case Management through EPSDT?

A. DMA is looking for ways to make Case Management more available. There is no way for the system to reimburse a CAP/C Case Manager for providing non-CAP/C Case Management.

Q. Where does an EPSDT request get sent?

A. Send it to the address on the non-covered services form – that person who receives the form notifies the CAP Consultants of the request. This form can be used to request covered services over policy limits or non-covered state Medicaid plan services.

Q. Whose responsibility is it to determine eligibility for EPSDT?

A. The department which will approve or deny the request. For example, if it is a pharmacy item, the pharmacy department will determine eligibility. If the request is denied, they will issue appeal rights to the recipient.

Q. Which EPSDT services count against the CAP/C budget?

A. The same services which normally count, such as equipment, supplies, and in-home services. Dental benefits, for example, would not count, as they are not counted now.

Q. What is the length of time between request and approval?

A. Five to ten days for contractors (ValueOptions, EDS); 15 days for Medicaid staff. This is the time frame in which there must be some response. If more information is requested, it can be another 15-30 days. The entire process could take 30-45 days to complete if the request is incomplete. Should the request be denied, reduced, or terminated, a written notice will be sent to the recipient/guardian and provider who requested the service. The notice will contain appeal rights.

Q. If a child is identified as eligible for PCS and is not on CAP, how can the child receive PCS?

A. Call an agency that provides PCS. They will complete the appropriate assessments and paperwork.

Q. Is there a person whom we can contact to check on the status of a request?

A. Laura Brown 919-855-4260.

Q. If a child is over-budget on CAP/C, PCS only gives 3.5 hours, and mom works, how does the child get enough hours to cover mom's work schedule?

A. Those hours can be provided under EPSDT provided that they are medically necessary and not just for babysitting.

Q. Respite is not a covered service except within the waivers?

A. Correct.

Q. Is it up to the PCS provider to request additional hours?

A. Yes.

Q. Where should a referral be sent for EPSDT consideration?

A. All referrals are automatically reviewed under EPSDT. There is no EPSDT "program" or "funds" to be requested.

Q. How can I obtain therapy balls for a recipient?

A. As a non-covered DME request.

Private Duty Nursing (PDN)

Pat Minish, RN, PDN Nurse Consultant, CAP/C Nurse Consultant

Background Information

Handout – comparison between PDN and CAP/C – see attached

Questions and Answers

Q. Who makes the referral from PDN to CAP/C?

A. The Discharge Planner many times refers to both programs simultaneously. Anyone can make a referral; the forms are on the web site.

PDN Referral - <http://www.dhhs.state.nc.us/dma/formsprov.html#pdn>

Complete the 'PDN Prior Approval Referral Form (DMA-3061)' AND the 'Physician's Request Form for Private Duty Nursing' OR a letter of medical necessity from the physician

CAP/C Referral - <http://www.dhhs.state.nc.us/dma/formsprov.html#capc>

Complete the 'CAP/C Referral Form'.

Q. Why does PDN require hospital level of care for CAP/C children? I have a child who is Skilled Level with a Nurse on CAP/C, and PDN would not accept the child.

A. The PDN criteria are such that most recipients require intense respiratory support such as a ventilator or tracheostomy. If a child was referred to PDN and did not meet the PDN guidelines, that referral would then be evaluated under EPSDT guidelines. If the child was still not approved for PDN services, that would indicate that the child's needs were being sufficiently met on CAP/C and that an exception to the PDN guidelines was not medically necessary to correct or ameliorate the child's condition.

Q. What is the requirement for supervisory visits under PDN?

A. At least every 60 days; this is a requirement of the Center for Medicare and Medicaid Services (CMS).

Q. Is there a requirement for staffing agencies, under either CAP/C or PDN, to let the Case Manager or Consultant know when the recipient's services need to be changed?

A. Yes. In CAP/C, this is stated on the Service Authorization. In PDN, the agency must send a patient update every 60 days in order for the recipient to continue receiving PDN services. The update should indicate the need for change, if any. If the provider agency, physician, or recipient/guardian initiates a reduction or termination of service, Medicaid is not required to send a written notice with appeal rights.

Q. How are the number of hours determined that a PDN recipient may receive?

A. It is the decision of the two PDN Nurse Consultants. It is dependent upon the diagnosis, and the need for teaching and/or adjustment to care.

(Community Alternatives Program for Persons with Mental Retardation or Developmental Disabilities)
Patti Kirk, CAP-MR/DD Nurse Consultant

Background Information

A waiver change will become effective in November 2008

- There will be two ‘tiers’: a support level and a comprehensive level. Two additional tiers will be added at a later date.
- The waiver will be self- directed within the year.

The CAP-MR/DD program is administered jointly between the Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

CAP-MR/DD Case Managers bill ‘fee for service’ – Their Case Management claims do not pay until the CAP indicator code is in the system. Case management is not currently under the waiver, but will be added back in.

There is a new prioritization tool for statewide use.

Questions and Answers

Q. How often will the assessment tool be re-done?

A. Everyone will have one done when the new tool comes out.

Q. How can you find out if someone is on the wait list?

A. Call the LME. A list is on the web at <http://www.dhhs.state.nc.us/mhddsas/lmedirectory.htm>.

Q Under the new tool, will a child get lower priority if they are already on CAP/C?

A. No. Some slots will be reserved for CAP/C and CAP/DA transfers.

Q. A LME told a parent that the patient needed to be re-prioritized and that the CAP/C Case Manager should do it. Is this correct?

A. The CAP/C Case Manager is not prohibited from doing it if (s)he is comfortable doing so, but it is the LME’s responsibility. This responsibility will be spelled out in the new waiver.

Q. Why are parents not being told where they are on the priority list?

A. The LME knows what number a recipient is, but emergency situations and higher-priority needs may come up, so it is difficult to tell where a child may be placed on the list in terms of priority.

Q. If a client is aging out of CAP/C and is medically stable, how do I determine whether to refer them to CAP-DA or to CAP-MR/DD?

A. If the client needs aggressive habilitative services (acquiring skills (s)he never had), refer to CAP-MR/DD. Recipients that just need assistance, such as a personal care services and other CAP-DA waiver services should be referred to CAP-DA.

PCS, PCS Plus (Personal Care Services/Personal Care Services Plus)
Phyllis Stevens, RN, PCS/PCS+ Nurse Consultant

Background Information

Lowest cost program.

Children average 120 hours per month of PCS. These hours are based on medical necessity, not on what the caregiver wants.

Last year, the legislature mandated prior approval for all PCS. This has not happened yet, because it did not get funded. PCS is back at the legislature now asking for either funding or removal of the mandate.

DMA is in the process of clarifying Level 2 and Level 3 personal care tasks.

Questions and Answers

Q. Can a recipient get more hours from PCS than from CAP/C or CAP/DA?

A. Possibly, because there is no budget restriction. However, the hours must be medically necessary. Specifically, the child must meet all EPSDT criteria.

Q. Is there a particular form that is needed to request the additional hours?

A. Yes, it is on the web site.

<http://www.dhhs.state.nc.us/dma/formsprov.html#pcs>

Q. Can PCS be provided in a school?

A. Yes, if it is medically necessary and the school will allow it.

Q. How are the number of hours a recipient is approved for determined?

A. There is no hard limit, but if 18 or 24 hours was requested, the child would likely be considered too medically unstable for PCS. If that were the case, PCS services would most likely be denied. A written notice would be issued with appeal rights. However, remember, all decisions are individual, case-by-case decisions.

Q. What kind of behavior issues would PCS be able to assist with?

A. PCS could not accept a child with only behavioral needs; there would have to be medical needs as well. The Nurse would have to compare the child's needs to

the scope of practice of a certified or non-certified aide to determine what the aide could or could not do.

Q. Can a PCS aide do dressing changes?

A. Yes, if it is a certified NA and within their scope of practice.

Q. Is there thought of limiting the number of PCS providers per service area?

A. That is the decision of DHSR (Division of Health Services Regulation). It is possible that they will go to a Certificate of Need system.

There is currently a proposal to have administrators take training before becoming PCS administrators.

HIV Case Management

Victoria Landes, HIV Case Management Consultant

Background Information

See handout - attached

Targeted case management only, no other services

Partnered with the AIDS Care Unit at the Division of Public Health - DMA has administrative and funding responsibilities; DPH is responsible for daily operations

Questions and Answers

None

	Private Duty Nursing (PDN)	Community Alternatives Program for Children (CAP/C)
Type of Program	Optional State Plan program	1915c Waiver
Financial Eligibility	Requires Medicaid (Blue Card)	Must be eligible for MAB, MAD, I-AS, H-SF; however parents' income is not considered
Client Type	All ages Require high-acuity RN/LPN care	Ages 0 through 18 Require RN/LPN care or NA care
Prior Approval	No FL2 requirement Referral form Letter of medical necessity from Physician Hourly Review Tool (test) DMA Nurse Consultant reviews information and approves/denies as indicated Relatively quick process –can get services in place faster	Must be a risk of institutionalization (FL-2 required) Must be medically fragile Requires Referral Form to be approved by DMA, then EDS-approved FL-2, local Case Mgr makes in-home initial assessment and develops plan of care approved by DMA DMA Nurse Consultant reviews assessment and plan of care and approves/denies as indicated Slower process – takes at least 4 weeks to get services started
Services Offered	Receives only regular Medicaid services	Receives regular Medicaid services in addition to the following Waiver Services <ul style="list-style-type: none"> ➤ Case Management (required) ➤ CAP/C Nursing } (one of these is required) ➤ CAP/C Aide } ➤ In Home Respite Care (nurse or aide) ➤ Institutional Respite Care ➤ Waiver Supplies (oral nutrition and reusable diapers) ➤ Home Modifications (such as mobility aids, widening doorways)
Recertification	Every 60 days provider agency submits 485 and 486 to DMA; nurses notes reviewed upon request	Annual Continued Needs Review (CNR) including FL-2, assessment, plan of care, as well as 485, nurses notes, and MAR as applicable
Provider Type	Must use only one agency to provide the nursing staff	Nurse or CNA staff can be provided by multiple agencies if needed
Care coordination/case management	Provider nursing agency coordinates services	Case manager (which is required component of program) provides comprehensive coordination of care including assessment, planning, and coordinating services, and including linkage to non-Medicaid resources.
Cost	No cost neutrality requirement	Cost neutrality requirement to waiver; care needs must be met within child's monthly budget: Intermediate Level of Care \$2730 Skilled Level of Care \$3537 Hospital Level of Care \$28729

SUMMARY OF HIV/CASE MANAGEMENT

HIV/Case Management is a targeted case management program which is funded by Medicaid. The program is owned jointly by Division of Medical Assistance and Division of Public Health. While DMA has administrative oversight for the program, the day to day operations are managed by the AIDS Care Unit within the Division of Public Health.

- The clients are served at the county level by agencies certified by the AIDS Care Unit and enrolled by Medicaid as HIV/Case Management agencies.
- The procedure code is T1017 and the current reimbursement rate is \$13.82/unit which represents \$55.28/Hour.
- Eligible recipients are those individuals who are Medicaid eligible and meet the medical criteria set forth in the HIV /Case Management manual.
- A client seeking HIV/Case Management services makes contact with a certified Case Management agency and goes through the Intake process.

Monitoring Activities

The AIDS Care Unit within the Division of Public Health is charged with the responsibility not only of certifying the agencies but also providing Quality Assurance and Technical Assistance. According to the current MOU with DPH, once an agency is certified they are to be recertified every three years. This involves an onsite visit to review client's records. They presently review 10% of the existing caseload and staff qualifications. If deficiencies are found that warrant a referral to Program Integrity, then such a referral is made. Newly certified agencies are required to receive four TA visits during their first year of operation. This is based on internal policy within the ACU. Likewise, if problems are found that justify a referral to PI then one is made. Findings of a serious nature could additionally result in a decision to decertify the agency.

The ACU provides DMA with a written report of their findings.

Our section's administrative officer provides us with a monthly report that identifies the amount of money billed to Medicaid by each provider and further has it broken down by the "average cost per client". We are currently looking at ways to enable the AIDS Care Unit to prioritize their schedule in order to target those agencies that are consistently billing seemingly excessive amounts.