
SECTION 8

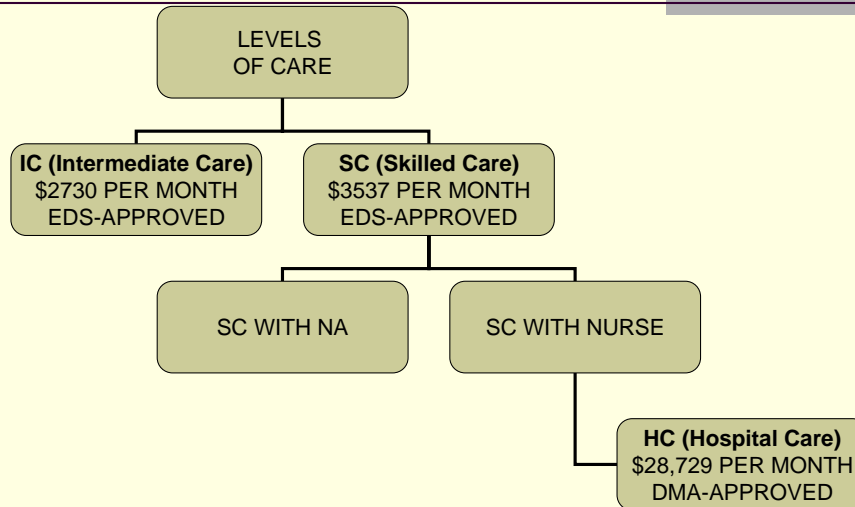
LEVELS OF CARE

Learning Objectives

1. Identify CAP/C's three levels of care and their respective budgets.
2. Estimate what level of care a child will be approved for base on nursing needs.
3. Follow the correct procedure for competing a FL-2 and obtaining prior approval.

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CAP/C LEVELS OF CARE



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IC (INTERMEDIATE CARE)

- CAP/C's lowest level of care
- Monthly budget of \$2730
- Always staffed with NA (or Home Health Aide)
- GENERALLY for children with only ADL needs; sometimes approved for children with long-standing and very stable technology interventions such as feeding tube, VNS; also approved for children that require a minimum of three therapy sessions per week (any combination)

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Remember that age-appropriate ADLs and personal care needs will not meet the criteria for Intermediate level of care.

Some examples of children who are likely to meet the Intermediate Level of Care criteria are as follows (these examples are provided for guidance and are not intended to be all inclusive):

Situation 1: Sara is a 7 year old with muscular dystrophy. She is non-ambulatory and requires extensive assistance with bathing, dressing, toileting, and transfers. She uses a wheelchair that is in the home. She takes a regular diet by mouth and requires limited assistance with feeding.

Situation 2: John is a 10 year old boy with cerebral palsy. He is semi-ambulatory with a walker for short distances and a wheelchair for long distances. He wears AFOs to both legs, and has slight contractures of his upper extremities. He therefore needs extensive assistance with bathing, dressing, and grooming. He is incontinent of bowel and bladder and is totally dependent for incontinence care. John receives PT, OT, and ST one time each per week.

Situation 3: Mary is a 5 year old with cerebral palsy, developmental delays, seizure disorder, and reflux. She receives weekly therapy sessions for PT, OT, and ST through the school system. Her seizures are well-controlled with medication; she has not had a seizure for over one year. She has a GT, but it is usually only used for medications and occasionally when she is sick and will not drink adequate fluids. She is incontinent. Her parents need help caring for her between the time she gets out of school and the time they get home from work.

Frequency of therapy services can affect the patient's level of care. Be alert for this when a client's therapy schedule changes between the school year and the summer vacation, If the change would affect the level of care, you would need to obtain a new FL-2 and submit it with a plan of care revision.

SC (SKILLED CARE)

- CAP/C's middle level of care
- Monthly budget of \$3537
- Choice of staffing: nurse aide or nurse
- GENERALLY for children with more nursing/nurse aide intervention than just ADLs/personal care needs; also approved for children who require a minimum of five therapy sessions per week (any combination)

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Some examples of children who are likely to meet the Skilled Level of Care criteria are as follows (these examples are provided for guidance and are not intended to be all inclusive):

Situation 1: Jane is a 13 year old with cerebral palsy. She is nonambulatory, nonverbal, and incontinent. She requires total care for all ADLs. She has a feeding tube through which she gets bolus feeds four times per day and a continuous infusion overnight. She takes nothing by mouth.

Situation 2: Christopher is a sixteen year old male who was involved in a motor vehicle accident. He is now quadriplegic. He is completely dependent for all ADLs, he is fed via gastrostomy tube boluses, and he is catheterized every 4 hours while awake.

Situation 3: Mark is a 12 year old with chronic lung disease. He requires pulse oximetry and oxygen, and the oxygen rate needs to be adjusted 1-2 times per day. He needs some help with ADLs because he is easily fatigued. He is otherwise age appropriate developmentally and physically.

Frequency of therapy services can affect the patient's level of care. Be alert for this when a client's therapy schedule changes between the school year and the summer vacation, If the change would affect the level of care, you would need to obtain a new FL-2 and submit it with a plan of care revision.

The decision of whether to provide a nurse aide or a nurse under the skilled level of care is determined by care needs of the child and the minimal scope of practice that can meet those needs. If a nurse aide can meet the child's needs, an nurse will not be approved because of family preference, staffing issues, etc. While it is at times appropriate to have a combination of nurse aide care with periodic RN/LPN visits, a patient cannot receive a combination of continuous nurse aide care and continuous nurse care.

HC (HOSPITAL CARE)

- CAP/C's highest level of care
- Monthly budget of \$28,729
- Always staffed with an RN or LPN

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HC (HOSPITAL CARE), continued

GENERALLY approved for children who

- Are dependent on mechanical ventilators
- Require substantial and complex nursing care due to AIDS or AIDS-related conditions, or
- Require a combination of two or more of the following services:
 - Device-based respiratory support requiring on-going intervention including: tracheostomy tube care along with frequent suctioning or tracheostomy care with continuous oxygen therapy for long term respiratory dysfunction;
 - Nutritional management requiring tube feeding;
 - Intravenous administration of drugs, nutritional substances, or fluids over extended periods (greater than four hours daily) secondary to a complex or terminal medical condition;
 - Intensive pain control management through intravenous or epidermal/intrathecal analgesic drug administration

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Some examples of children who are likely to meet the Hospital Level of Care criteria are as follows (these examples are provided for guidance and are not intended to be all inclusive):

Situation 1: Seth is a four-month-old infant who is 24 hour ventilator dependent.

Situation 2: Amanda is a three year old who has a tracheostomy and requires suctioning at least once every 30 minutes. She has a gastrostomy tube and requires continuous feeds. Because of her reflux tendencies, her feedings must be monitored and sometimes requires adjusting the rate of the feedings.

Situation 3: Kyle is a six year old who receives TPN around the clock and replacement fluids equal to the amount lost. He requires antiemetics for frequent vomiting. On going nursing assessments are necessary to monitor pain management both before and after the intravenous administration of pain medication - the medication often is given every two to three hours.

Remember that observation needs are not covered under CAP/C. Nursing services needed to be there just in case something happens, is not considered in determining hospital level of care.

DETERMINING THE LEVEL OF CARE

- EDS approves IC or SC level of care based on the information from the FL-2
- DMA, in conjunction with the case manager and the child's family, determines whether a SC level child is staffed with a NA or an RN/LPN.
- DMA, in conjunction with the case manager and the child's family, determines whether a SC level child staffed with a RN/LPN meets the criteria for HC.

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EDS makes the final determination regarding IC or SC, and DMA accepts that decision. There are children on the program, who, from a nursing point of view, have intermediate care needs, but EDS assigns them skilled care because of the frequency of therapies. When that happens, that child is SC, and does get the SC budget. However, DMA's approval of participation in CAP/C and of the child's CAP/C plan of care will be based on the nursing needs.

COMPLETING THE FL-2

- The FL-2 should be completed by the physician who best knows the child
- The FL-2 should be completed at the initial assessment and then annually. It need only be called in to EDS at the initial assessment and if there has been a change in the patient's condition that affects the level of care.

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The FL-2 should ideally be completed by the physician. The case manager's assessment is found on the assessment form and plan of care; the FL-2 is supposed to reflect the physician's assessment. It also helps to ensure our clients' health, safety, and well-being by noting any discrepancies between the physician's, case managers', and families' information, and resolving those discrepancies.

If, however, the physician will not complete the FL-2, the case manger may complete it and submit it to the physician for review and signature. Please explain to the physician the importance of a complete and accurate FL-2 form and the need for his/her thoughtful consideration of the information and recommendations contained in it.

COMPLETING THE FL-2

Boxes 1-9

NORTH CAROLINA MEDICAID PROGRAM LONG TERM CARE SERVICES					
PRIORITY APPROVAL		UTILIZATION REVIEW		ON-SITE REVIEW	
IDENTIFICATION					
1. PATIENT'S LAST NAME	2. FIRST NAME	3. MIDDLE INITIAL	4. BIRTHDATE (M/D/Y)	5. SEX	6. ADMISSION DATE (CURRENT LOCATION)
7. COUNTY AND MEDICAID NUMBER		8. FACILITY		9. ADDRESS	
10. ATTENDING PHYSICIAN NAME AND ADDRESS			11. RELATIVE NAME AND ADDRESS		
12. CURRENT LEVEL OF CARE		13. RECOMMENDED LEVEL OF CARE		14. PRIOR APPROVAL NUMBER	
<input type="checkbox"/> HOME <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> HOSPITAL	<input type="checkbox"/> DOMICILIARY <input type="checkbox"/> (REST HOME)	<input type="checkbox"/> HOME <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> OTHER	<input type="checkbox"/> DOMICILIARY <input type="checkbox"/> (REST HOME)	<input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> OTHER	<input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> OTHER
15. DATE APPROVED / DENIED			16. DISCHARGE PLAN		
			<input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> DOMICILIARY / REST HOME <input type="checkbox"/> OTHER		

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Box 1. Patient Name. Print last name, first name, and middle initial as the client's name is recorded for Medicaid. If no middle name, indicate NMN.

Box 2. Birthdate. Enter month, day, year.

Box 3. Sex. Enter F for female and M for male.

Box 4. Admission Date. If the client is in a facility when the FL-2 is completed, enter the admission date – month, day, year. If the client is at home, enter N/A.

Box 5. County and Medicaid number. Enter 2 digit county number and 9 digit and alpha suffix Medicaid number.

Box 6. Facility Name and Address. If currently institutionalized, enter 7 digit number of institution. Enter N/A if not institutionalized.

Box 7. Provider Number. If currently institutionalized, enter 7-digit number of institution. Enter N/A if not institutionalized.

Box 8. Attending Physician Address. Enter complete name and address. The physician's name that appears in this block must be the physician who signs the FL-2.

Box 9. Relative. Enter complete name and address of the person responsible for the client.

COMPLETING THE FL-2

Boxes 10-14

NORTH CAROLINA MEDICAID PROGRAM LONG TERM CARE SERVICES				
<input type="checkbox"/> PRIOR APPROVAL		<input type="checkbox"/> UTILIZATION REVIEW		<input type="checkbox"/> ON-SITE REVIEW
IDENTIFICATION				
1. PATIENT'S LAST NAME	2. FIRST NAME	3. BIRTHDATE (M/D/Y)	4. SEX	5. ADMISSION DATE (CURRENT LOCATION)
6. COUNTY AND MEDICAID NUMBER		7. FACILITY		8. ADDRESS
9. ATTENDING PHYSICIAN NAME AND ADDRESS			10. PROVIDER NUMBER	
11. CURRENT LEVEL OF CARE		12. RECOMMENDED LEVEL OF CARE		13. PRIOR APPROVAL NUMBER
<input type="checkbox"/> HOME	<input type="checkbox"/> DOMICILIARY	<input type="checkbox"/> HOME	<input type="checkbox"/> DOMICILIARY	<input type="checkbox"/> SNF
<input type="checkbox"/> SNF	<input type="checkbox"/> (REST HOME)	<input type="checkbox"/> SNF	<input type="checkbox"/> (REST HOME)	<input type="checkbox"/> ICF
<input type="checkbox"/> ICF	<input type="checkbox"/> OTHER	<input type="checkbox"/> ICF	<input type="checkbox"/> OTHER	<input type="checkbox"/> SNF
<input type="checkbox"/> HOSPITAL				<input type="checkbox"/> (REST HOME)
				<input type="checkbox"/> OTHER
14. DATE APPROVED/DENIED				
15. DISCHARGE PLAN				
<input type="checkbox"/> SNF				
<input type="checkbox"/> ICF				
<input type="checkbox"/> DOMICILIARY				
<input type="checkbox"/> REST HOME				
<input type="checkbox"/> OTHER				

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Box 10. Current Level of Care. Enter current level of care provided. If a new CAP/C applicant who lies at home, enter N/A. If the client is on CAP/C, check the current level of care.

Box 11. Recommended Level of Care. Check the block for the recommended level of care. For a child to be eligible for CAP, the recommended level must be ICF or SNF. If the child needs hospital level of care, check SNF. DMA will make the determination regarding hospital level of care after SNF level has been approved by the fiscal agent.

Box 12. Prior Approval Number. When you get telephone approval of the FL-2, enter the prior approval number given by the fiscal agent. The fiscal agent must receive the completed FL-2 within 10 workdays of telephone approval. The prior approval number is an 13 digit number which begins with the year in which the approval was given.

Box 13. Date Approved/Denied. When you get telephone approval, circle Approved, enter the date of phone approval, and enter the initials of the fiscal agent who granted the approval, and enter IC or SC to indicate which level of care was approved. The completed assessment and plan of care must be received by DMA within 60 days of this date.

Box 14. Discharge Plan. Check other and enter CAP/C.

COMPLETING THE FL-2

Box 15

15. ADMITTING DIAGNOSES - PRIMARY, SECONDARY, DATES OF ONSET	
1	5
2	6
3	7
4	8

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Box 15. Admitting Diagnoses – Primary, Secondary, Dates of Onset. Enter primary and secondary with dates of onset or surgery. It is expected that this list of diagnoses will match the list on the CAP/C assessment and on the CMS-485, if applicable.

COMPLETING THE FL-2 Boxes 16-17

16. PATIENT INFORMATION			
DISORIENTED	AMBULATORY STATUS	BLADDER	BOWEL
CONSTANTLY	AMBULATORY	CONTINENT	CONTINENT
INTERMITTENTLY	SEMI AMBULATORY	INCONTINENT	INCONTINENT
INAPPROPRIATE BEHAVIOR	NON AMBULATORY	INWELLING (CATHETER)	COLOSTOMY
WANDERER	FUNCTIONAL LIMITATIONS	COMMUNICATION OF NEEDS	RESPIRATION
OR PHYSICALLY ABUSIVE	UP	VERBALLY	NORMAL
OR PHYSICALLY TO HIMSELF	NEEDS	NON VERBALLY	TRACHEOSTOMY
OR ABUSIVE TO OTHERS	DOWN	DOES NOT COMMUNICATE	OTHER
OR ABUSIVE TO PROPERTY	CONTRACTURE		OPEN
OTHER	ACTIVITIES/SOCIAL	SKIN	NUTRITION STATUS
PERSONAL CARE ASSISTANCE	PASSIVE	NORMAL	ORAL
BATHING	ACTIVE	OTHER	ORAL/ENTERAL
FEEDING	GROUP PARTICIPATION	DESCRIBE	SPONGE
DISSING	RE SOCIALIZATION		PARCENTRAL
TOTAL CARE	FAMILY SUPPORTIVE		MANDRAGING
PHYSICAL VISITS	NEUROLOGICAL	DRESSINGS:	GASTROSTOMY
NO DAYS	CONVULSIONS SEIZURES		INTAKE AND WEIGHT
30 DAYS	GRAND MAL		FORCE FEEDING
60-90 DAYS	OTHER		WEIGHT
	FREQUENCY		HEIGHT
17. SPECIAL CARE FACTORS	FREQUENCY	SPECIAL CARE FACTORS	FREQUENCY
BLOOD PRESSURE		BOWEL AND BLADDER PROGRAM	
DIABETIC URINE TESTING		RESTORATIVE HEARING PROGRAM	
PT (BY LICENSED PT)		SKULLCH THERAPY	
RANGE OF MOTION EXERCISES		RESTRAINTS	

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Box 16. Patient Information. Check the blocks applicable to this patient under the designated heading. It may be necessary to check more than one block under a heading or write additional information in blanks. Make information as specific as possible to support recommended level of care. It is expected that the information in this section will match the information on the assessment and on the CMS-485, if applicable.

Box 17. Special Care Factors. Check those applicable and indicate the frequency for those factors. Note that Occupational Therapy is not listed, so please write this in if it applies.

COMPLETING THE FL-2 Boxes 18-22

18. MEDICATIONS / NAME & STRENGTHS, DOSAGE & ROUTE	
1	8
2	9
3	10
4	11
5	12
6	
19. X-RAY AND LABORATORY FINDINGS / DATE	
20. ADDITIONAL INFORMATION	
21. PHYSICIAN'S SIGNATURE	
DATE	

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Box 18. Medications/Name & Strengths, Dosage, and Route. List current medications, dosage, and route of administration. Include all prescription and over-the-counter meds. This list of medications is expected to match the list on the assessment and on the CMS-485 if applicable.

Box 19. X-Ray and Laboratory Findings/Date. Include if available.

Box 20. Additional Information. Use to provide any additional data or information pertinent to the care of the patient and which justifies the type of care requested.

Box 21. Physician's Signature. The physician must validate by signature the care needs presented by this patient. The signature must be that of the physician indicated in box 8. FL-2s that are signed by a Physician Assistant or Nurse Practitioner must be cosigned and dated by the attending physician, and both names should be in box 8. An FL-2 signed by a physician in the same practice as the physician in box 8 is acceptable as long as the physician writes 'in practice with' and his/her name in box 8 next to the first physician's name. An out-of-state physician may sign the FL-2.

Box 22. Date. The FL-2 must be dated by the physician who signs it. The fiscal agent must approve the FL-2 within 30 days of this date.

DEADLINES ASSOCIATED WITH THE FL-2

- The FL-2 must be approved by the fiscal agent, or if not called in to the fiscal agent, then signed by the physician, within 12 months of the prior year's date.
- The FL-2 should be obtained no earlier than the month before the CNR month.
- The FL-2 must be called in to the fiscal agent within 30 days of the date it was signed by the physician.
- The FL-2 must be received by the fiscal agent within 10 business days of the telephone approval.
- The assessment and plan of care must be received by DMA within 60 days of the FL-2 approval.

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No more than one year may elapse between level of care approvals. If EDS approved the FL-2 for your initial on October 12, then next year's FL-2 must be either approved by EDS or signed by the physician on or before October 12.

The CNR month is the month you are actively working on conducting your assessment and developing your plan of care. If your CNR is due to DMA on November 5, then your CNR month is October. The FL-2 may not be obtained any earlier than September.

If prior approval is delayed or voided due to a processing problem that is beyond the control of the case manager (i.e., the hard copy of the telephone-approved FL-2 gets lost in the mail), contact your DMA Consultant for guidance. You will need to obtain a new FL-2, but DMA may be able to get it approved retroactive to the original date.

DATES ASSOCIATED WITH THE FL-2

- The CNR due date is the 5th of the month following the month in which the original FL-2 was approved.
- The CAP effective date may be the same as the FL-2 approval date.

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If the original FL-2 is approved during the month of September, the CNRs will be due each October 5.

EDS PRIOR APPROVAL UNIT

Call 1-800-688-6696

- to call in an FL-2 for telephone approval
- to obtain blank FL-2 forms

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If EDS does not approve the FL-2, the client will be notified of their due process (appeal) rights. Determination of CAP/C eligibility will be put on hold until all DSS appeals are exhausted.

GETTING THE PINK COPY OF THE FL-2

- Once EDS receives the hard copy, they will send the processed FL-2 to DSS.
- DSS will send you the facility copy (pink copy) of the stamped form to you.
- You must keep this copy in your records.

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If you do not receive the pink copy within 30 days, please refer to section 8-5 of the CAP/C Manual. The manual will tell you how to obtain a copy of the stamped FL-2 or some other appropriate documentation of the prior approval. You **MUST** have a record of the prior approval in the client's record.

THE PURPOSE OF THE FL-2

- The FL-2 is the same form that nursing facilities use. Since CAP/C is an alternative to nursing facility placement, using the same form that nursing facilities use proves that the child meets that level of care and is at risk for institutionalization.
- It is the only input we have from the physician regarding the medically fragile child. Comparing that information to our own assessment and making sure they are the same helps ensure health safety and well-being by making sure that everyone involved with the child is 'on the same page'.

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SUMMARY

- IC – EDS approved – NA - \$2730
- SC – EDS approved – NA or RN/LPN - \$3537
- HC – DMA approved – RN/LPN - \$28,729
- The FL-2 must be approved within one year of the last FL-2, and no earlier than the month prior to the CNR month.
- Call in the FL-2 for telephone approval within 30 days of the physician's signature.
- Get the hard copy of the FL-2 to EDS within 10 days of telephone approval.
- Submit the assessment and plan of care within 60 days of the approval.
- The FL-2 needs to be completed annually, but needs to be called in only for the initial and if the level of care changes.
- **THE INFORMATION ON THE FL-2 MUST MATCH THE INFORMATION ON THE ASSESSMENT.**

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REVIEW QUESTIONS

Please make sure you can answer the following questions before proceeding to the next section.

Match the level of care with it's definition.

- | | |
|-------|---|
| 1. IC | A. high technology, continuous nursing needs, often a patient with a ventilator or a trach and feeding tube |
| 2. SC | B. some technology, or 5 therapies per week |
| 3. HC | C. no technology or very established and stable technology, often only ADLs |

Match the level of care with the appropriate level of in-home staff.

- | | |
|-------|------------------------|
| 4. IC | A. Nurse or Nurse Aide |
| 5. SC | B. Nurse Aide only |
| 6. HC | C. Nurse only |

Match the level of care with the monthly budget..

- | | |
|-------|-------------|
| 7. IC | A. \$3537 |
| 8. SC | B. \$28,729 |
| 9. HC | C \$2730 |

Match the level of care with the approving agent..

- | | |
|--------|--------|
| 10. IC | A. EDS |
| 11. SC | B. DMA |
| 12. HC | |

13. Which of the following may NOT sign the FL-2?

- A. A pediatrician
- B. A specialist
- C. A nurse practitioner without a co signature
- D. An out-of-state physician

14. True or false: The information on the FL-2 should match the information obtained from other sources, such as the assessment and the CMS-485.

REVIEW ANSWERS

1. C

2. B

3. A

4. B

5. A

6. C

7. C

8. A

9. B

10. A

11. A

12. B

13. C

14. True