
SECTION 10
**DEVELOPING THE
PLAN OF CARE**

Learning Objectives

1. Know how to obtain updated fee schedules.
2. Place the correct codes, quantities, and prices on the cost summary.
3. Plan a nurse/nurse aide schedule that meets the needs of the family and the requirements of CAP/C.

ACCESSING FEE SCHEDULES

To access the fee schedule for CAP/C (as well as other programs), go to:

<http://www.ncdhhs.gov/dma/fee/fee.htm>

Click on the desired fee schedule.

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To access the mental health fee schedule, which includes the codes for Community Support Services and Developmental Therapy Services, go to <http://www.ncdhhs.gov/dma/fee/mhfee1.pdf>.

A copy of the fee schedule for Children's Developmental Services Agencies (CDSA) may be obtained from the Division of Medical Assistance Financial Operations Section using the Fee Schedule Request Form. The form is available on DMA's website at <http://www.ncdhhs.gov/dma/forms.html>.

To access the "Enteral Nutrition Product Classification List" (to be used in conjunction with the DME fee schedule) go to <http://www.palmettogba.com/classifications/enteral%20nutrition.pdf>

ACCESSING FEE SCHEDULES, CONT'D.

Fee schedules and quantity limitations change often and unpredictably.

- Read your monthly Medicaid Bulletin. It will contain information about changes.
- Access the web site at the beginning of each month. Look at the '*updated 00/00/00*'. View or print any that have been updated.

DURABLE MEDICAL EQUIPMENT (DME)

DME can be provided as a

- Rental

This is an item that is rented for as long as the client requires its use.

- Capped Rental

This is an item that is rented until the equivalent of the purchase price has been paid. Then it is considered purchased and owned.

- Purchase

This is an item that is purchased outright and is then owned by the recipient.

DURABLE MEDICAL EQUIPMENT (DME), CONT'D.

Capped rental vs. purchase

Capped rental if expected duration of use < 6 months

Purchase if expected duration of use \geq 6 months

DURABLE MEDICAL EQUIPMENT (DME), CONT'D.

- DME is approved for use in the home
- DME may be taken out of the home
- DME will not be approved for primary use in schools
- Duplicate DME will not be provided so that a child may have equipment at each parent's home, or at school and at home
- Once equipment is purchased or capped off, it is the client's to do with as he/she wishes.

DURABLE MEDICAL EQUIPMENT (DME) QUANTITY LIMITS

Most DME is subject to limitations on the amount provided or on how frequently the item is provided.

This information is found at <http://www.ncdhhs.gov/dma>. Click on "Provider Links", then click on "Clinical Coverage Policies and Provider Manuals". Scroll down to Number 5A, "Durable Medical Equipment", then scroll down to "Attachment D" (towards the end of the manual).

DURABLE MEDICAL EQUIPMENT (DME) QUANTITY LIMITS, CONT'D.

To request more than the quantity limitation allows:

The DME provider must send a written request to DMA, along with a letter of medical necessity from the prescribing physician, physician's assistant or nurse practitioner. Consideration will be given to the request and a written decision will be returned to the provider. Recipients will be notified in writing if the request is denied.

DURABLE MEDICAL EQUIPMENT (DME), CONT'D.

To request something that is not normally covered at all by North Carolina Medicaid:

Submit a Non-covered Services Request Form

(found at:

<http://www.ncdhhs.gov/dma/forms/noncoveredservicesrequest.pdf>)

DURABLE MEDICAL EQUIPMENT (DME), CONT'D.

Routine maintenance of DME is not paid by Medicaid. Items requiring such maintenance are among those items that are always rented with no option to purchase.

Providers may only bill labor when something needs actual repairs. Activities such as assembling a wheelchair are not billable.

DURABLE MEDICAL EQUIPMENT (DME), CONT'D.

- It is a good idea as you prepare your plan of care to contact the client's DME provider to obtain a list of equipment/quantities. Reconcile that list with your assessment and the parent's stated needs, and make changes as necessary.
- Make sure that the equipment needs 'make sense'. For example, in a client that gets suctioned, DMA would expect to see a suction pump, suction canister, suction tubing, and suction catheters on the cost summary. If any of these items are missing from your plan of care, explain why.

HOME HEALTH SUPPLIES

- 'use them once and throw them away' type supplies, as opposed to durable medical equipment – for instance, bandages, diapers, catheters
- Some items overlap and are available through DME and through Home Health
- Home health supplies have no quantity limitations, but require a nurse assessment every 60 days

HOME HEALTH SUPPLIES, CONT'D.

- Items routinely furnished as part of recipient care, i.e., alcohol wipes, thermometer probe covers, lubricants, applicators, non-sterile gloves, are considered part of an agency's overhead and cannot be reimbursed as a separate item.
- Items used by the family may be reimbursed separately, i.e., the agency cannot bill for the gloves that their staff use, but they can bill for the gloves used by the family.

HOME HEALTH SERVICES

- Nurse and Nurse Aide Visits
- Physical Therapy, Occupational Therapy, and Speech Therapy

All of above paid on a per visit basis. Note that a visit is a duration of 2 hours or less. It is designed so that the nurse/aide performs a specific task and then leaves. It is not continuous care, as with CAP/C.

Independent Practitioners program (IP)

Therapies (PT, OT, ST, and RT) that are NOT provided by a home health agency.

Reimbursed according to the IP fee schedule

HOURS

Personal Time: up to 20 hours per week
plus

Work Time: up to 50 hours per week
plus

Sleep Time: up to 56 hours per week
minus

Hours that other support is available
equals

Number of hours approved per week

HOURS

Personal Time

This is time that all CAP/C children are eligible for. It is enough time to provide ADL services to the patient, and to allow caregivers time to attend to their own ADLs and IADLs.

The MAXIMUM personal time that is allowed is 20 hours per week; if fewer hours meet the family's needs, then fewer hours will be approved.

HOURS

Work Time

Hours added to personal time to accommodate the caregiver's time away from home due to work or school.

Calculated as work time plus lunch time plus commute time

The MAXIMUM work time that will be approved is 50 hours per week; if the above calculation adds up to less than 50 hours, then hours will be approved according to the calculation.

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If work time adds up to more than 50 hours per week, only 50 hours per week may be covered by CAP/C. The family will need to find an alternate source of support to cover the remainder of the hours. This is true even when a caregiver has more than one job or works and attends school.

HOURS

Sleep Time

Generally only available to children staffed with a nurse.

A MAXIMUM of 56 hours per week will be approved; if fewer hours meet the family's needs, then fewer hours will be approved.

HOURS

- All approved hours must fit within the recipient's monthly budget limit.
- All hours are contingent upon continuous nurse or nurse aide interventions being required during that time.

HOURS

Hours are assigned on a weekly basis.

The family may use their hours however they choose, as long as there are continuous nurse/nurse aide interventions during the times that they choose.

Once they have used their weekly hours, there are no more available until the next week. If hours are needed, the family may choose to use their respite time. Short-term-intensive services will not be approved because of poor planning/unwise use of hours.

HOURS GENERAL

- Hours approved are inclusive of private insurance.
- Hours approved may be inclusive of other formal support systems, such as school. No child may receive more than 126 hours per week of formal support, regardless of whether or not CAP/C is paying for that support.

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Example 1: A patient is approved by CAP/C for 70 hours per week and private insurance pays for for 4 hours per day. The patient does not receive 70 hours per week from Medicaid and 28 hours per week form insurance. The patient receives 70 hours per week, with Medicaid paying for 42 hours and private insurance paying for 28 hours.

Example 2: A patient is approved by CAP/C for 70 hours per week and by the insurance company for 10 hours per day. The family is not requesting any other waiver services. Since there is no need for CAP/C services, CAP/C could not be approved for this child.

Example 3: A patient currently receives 126 hours per week. Her parents have now enrolled her in kindergarten for six hours per day on weekdays. The child can not receive 126 hours from CAP/C in addition to 30 hours in school. This client may still receive her TOTAL of 126 hours: 30 hours in school, and 96 hours of in home nursing through CAP/C.

HOURS

24-HOUR CARE

- 24-hour care will be approved for two weeks, in the event of acute increased medical needs, family emergency, or respite.
- If the needs continue, an additional two weeks may be approved.
- After four weeks, 24 hour care will not be approved. At that point, CAP/C is replacing, not supplementing. You will need to assist the caregivers in finding other resources to meet their needs.

HOURS MINIMUM

There is no minimum number of hours that a client must use to be eligible for CAP/C. However, use of very few hours raises questions of: Is the child really at risk for institutionalization? Is the child really medically fragile? Would home health visits be more appropriate? Does the child really need in-home care at all?

Carefully consider the answers to these questions as you develop the plan of care.

BUDGET LIMITS

- IC \$2730 per month
- SC \$3537 per month
- HC \$28, 729 per month

THERE IS NO 'ENTITLEMENT' OF SERVICES UP TO THE BUDGET LIMIT. THE PLAN OF CARE IS DRIVEN BY MEDICAL NECESSITY, NOT BY HOW MUCH MONEY THE CLIENT IS ALLOWED TO SPEND.

REMEMBER

Medicaid is always the payer of last resort. Look to other funding sources, and remember that if there is another funding source, they pay first and Medicaid pays the balance, if any, up to the Medicaid allowable cost.

REMEMBER, CONT'D.

- Be alert to potential duplications of services and various restrictions on services
- Your cost summary should correlate with your assessment, particularly for hours, formula, and diapers.
- If your last budget was amended by DMA, make sure those changes are reflected on your new budget!!!!

SUMMARY

- Stay alert for updates to fee schedules.
- Durable Medical Equipment may be obtained as a rental, a capped rental, or a purchase. There are quantity limitations to DME items.
- Home Health provides non-durable supplies, therapies, and nurse or nurse aide visits. There are no quantity limitations on supplies, but a nurse is required to assess the need for the supply every 60 days.
- Hours of in-home nurse or nurse aide care are determined according to criteria for personal time, work time, and sleep time in combination with the presence of continuous interventions and the monthly budget limit.
- Medicaid is the payer of last resort.
- Your plan of care should correlate with your assessment.

REVIEW QUESTIONS

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

1. The maximum number of hours per week that any child/family with the highest level need would be eligible for is:
 - 20
 - 70
 - 76
 - 126

2. Medicaid is the payer of _____ resort.

3. True or False: Medicaid pays for routine maintenance and upkeep of DME.

4. True or False: DME supplies have quantity and frequency limitation, whereas home health supplies do not.

5. True or False: There is no way to obtain equipment from Medicaid that is not on the fee schedule or that exceeds the quantity limitation.

REVIEW ANSWERS

1. 126

2. last

3. False. Medicaid pays only for repairs. If an item requires frequent routine maintenance, Medicaid rents that item so that the provider agency is responsible for the routine maintenance.

4. True.

5. False. You may submit a request for non-covered services, or a request to exceed a quantity limitation. The decision to approve or deny the request will be based mainly on medical necessity.