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SECTION 13  
INITIALS, CNR'S, REVISIONS,  
TERMINATIONS, ABSENCES,  
AND TRANSFERS

Learning Objectives

1. Identify which documents need to be submitted for initials, CNRs, and revisions.
2. Identify when a revision does or does not need to be submitted to DMA.
3. Identify when DMA should be notified that a patient has not had staff.
4. Identify how long a client may be without CAP/C staffing before DMA and possibly DSS need to be notified.
5. State the best time to transfer a client to a different county or program.

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## INITIALS – NORMAL PROCESS

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- The initial assessment/plan of care for a potential new recipient must be received by DMA no later than 60 days after the date of the FL-2 approval.
- Paperwork to be submitted includes
  - the FL-2
  - the assessment
  - the plan of care
  - if SC with Nurse or HC, the physicians request form
  - any supporting documentation available, such as the CMS-485 form, nurses notes, the MAR, or a hospital discharge summary

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## INITIALS – EXPEDITED PROCESS

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### Only for:

- Children who are in the hospital and otherwise would have to be discharged to PDN and transfer to CAP/C later
- Children currently out of state who have complex medical needs such as ventilators or trachs, and need services in place as soon as they arrive in state.

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## INITIALS – EXPEDITED PROCESS, continued

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Submit the following information:

- The CAP/C referral form
- The telephone-approved FL-2
- The anticipated discharge/start of service date
- The family's demographic information (section 1 of the assessment)
- The home environment assessment (section 8 of the assessment), which may be completed by interviewing the family using the questions in chapter 9 of the CAP/C manual
- a list of services the child currently receives and those services he/she is currently being referred to
- a preliminary cost summary
- a preliminary 24 hour coverage schedule

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## INITIALS – EXPEDITED PROCESS, continued

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- The DMA Consultant will prioritize these reviews.
- If it is approved, the approval will be for six weeks only.
- 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, should be received at DMA.
- 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.

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## INITIALS – EXPEDITED PROCESS, continued

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- The case manager and the nurse if not the case manager should be at the recipient's home upon arrival to ensure health, safety, and well-being.
- The case manager should follow up by phone or visit approximately one week later to assess the provision of services and addresses any needs or issues that have arisen due to caring for the child at home.

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## CNR DATES

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- The month during which the CNR is completed is known as the “CNR month”. It is the anniversary month of the original FL-2 approval.
- CNR activities may begin no earlier than the month prior to the CNR month.
- The CNR must be received by DMA no later than the 5<sup>th</sup> of the month following the CNR month.

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The CNR date never changes, even if a new FL-2 is approved. The CNR due date is noted on the initial and CNR approval letters that you receive from DMA.

## CNR PAPERWORK

Items to be submitted with the CNR include

- the FL-2
- the assessment
- the plan of care
- if SC with a nurse or HC, the CAP/C physician's request form
- if HC, the CMS-485, 3-5 days of nurses notes, and the MAR (Medication Administration Record)
- any other supporting documentation you would like to send.

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For HC clients:

The CMS-485 is valid for a 60 day certification period. Ideally, you would submit the CMS-485 that corresponds to the CNR month, and the MAR and nurses notes would correspond with the dates of that CMS-485 as well (although preferably they would correspond more specifically with the CNR month).

Ask for the nurses notes which reflect the most care the child needed during that time period: i.e., when the child was his/her sickest.

If there is seasonal variation in the child's acuity level; for instance, his CNR is due in the summer, but during the winter he is usually much sicker due to respiratory infections, then submit two sets of nurses notes – one for summer and one for winter.

# REVISIONS

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- Revisions must be received by DMA no later than 30 days after the effective date.
- Items to be submitted with a revision include
  - the plan of care
  - any supporting documentation such as letters of medical necessity from the physician

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## REVISIONS, CONT'D.

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Revisions DO need to be submitted for

- Any change in any waiver service or supply

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## REVISIONS, CONT'D.

Revisions do NOT need to be submitted for

- A change in the unit rate of a supply or service, as long as the client is still within budget
- A change in provider agencies
- Temporary, one-time changes
- Removal of services for which the proration period has expired

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If the unit rate of a supply or service increases, recalculate the budget. If the budget is still within the limit for the client's level of care, you do not need to submit the revision. Be sure the changes are reflected on the next revision that you do submit. If the unit-rate increase causes the child to be over-budget, revise and submit the plan of care to get the budget back within the limit.

For a change in provider agencies, obtain a written, signed statement from the caregiver that states the name of the new agency and the date that the new agency will start services. Keep that statement in your files. Make sure the change is noted on the next plan of care that is submitted to DMA.

## REVISIONS, CONT'D.

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- Revisions ALWAYS need to be signed by the case manager
- Revisions need to be signed by the caregiver (and legal guardian if applicable) for any change in any waiver service. Changes only to regular Medicaid services and supplies do not require a caregiver signature.

(Initials and CNRs always require the signature of both the case manager and the caregiver.)

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# TERMINATIONS

CAP/C services may be terminated because of:

- Age
- Transfer to a different program
- Lack of Medicaid eligibility due to hospitalization or nursing facility admission
- Lack of approved FL-2
- Health, safety, and well-being cannot be met
- The cost limit is exceeded
- Lack of physician's order for services
- Move out of a private and primary residence
- Services no longer needed

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Lack of Medicaid eligibility due to hospitalization or nursing facility admission:

Hospitalizations, particularly of 30 days or longer, may affect the client's Medicaid eligibility. Contact your local DSS worker to find out if or when the CAP indicator code will need to be removed. If the CAP indicator code needs to be removed, CAP/C services will need to be terminated on that day. The client will need to reapply for CAP/C at time of discharge.

Health, safety, and well-being can not be met:

There are 4 reasons to terminate for inability to meet health, safety, and well-being:

- 1) The client's living situation presents needs that can not be met
- 2) The client or responsible party refuses to accept needed services
- 3) The client or responsible party fails to comply with care requirements
- 4) Enrolled providers are not available to render needed services. This may be due to insufficient resources in the county or agencies refusing to provide care. Thirty days is also the benchmark used here. After 30 days without staffing, notify your DMA Nurse Consultant.

## TERMINATIONS, CONT'D.

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- Voluntary

Have the caregiver/legal guardian sign a voluntary termination (located on the web at <http://www.ncdhhs.gov/dma/formsprov.htm>) and submit it to your DMA Nurse Consultant.

- Involuntary

DMA will issue a letter explaining the reason for the termination, the effective date, and the client's appeal rights.

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## ABSENCES

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Any absence of 30 days places the client at risk for losing Medicaid eligibility. For planned absences, such as custody visitations, contact your local DSS eligibility worker and notify him/her of the situation.

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## TRANSFERS WITHIN CAP/C, TO A DIFFERENT COUNTY

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- The receiving agency should not place the client on a waiting list if at all possible. If the receiving agency can not accept the client within 14 days, the client will lose their CAP/C services, and have to reapply.
- The receiving agency acts according to its written policies as to whether it
  - Accepts the existing assessment and plan of care
  - Does a new assessment and plan of care

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## TRANSFERS WITHIN CAP/C, TO A DIFFERENT COUNTY CONT'D.

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- At a minimum, DMA needs updated sections 1, 3, and 8 of the assessment (identification, coordinating care physician, home environment assessment). This should be done immediately, not with the next CNR.
- For Medicaid and case management billing purposes, it is always preferable for the last day of services in the old county to be the last day of the month, and the first day of services in the new county to be the first day of the month.

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## TRANSFERS TO A DIFFERENT PROGRAM

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- Have caregiver/legal guardian sign voluntary termination form
- For Medicaid and case management billing purposes, it is always preferable for the last day of CAP/C to be the last day of the month, and the first day of services in the new program to be the first day of the month.

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## SUMMARY

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- In addition to the FL-2, assessment, and plan of care, you may need to submit supporting documentation such as the physician's request form, CMS-485, nurse/nurse aide notes, the MAR, or quotes for supplies.
- A revision needs to be submitted any time a waiver service or supply is changed.
- A revision needs to be signed by the parent when the change involves a waiver service.
- A lack of services for 30 days, whatever the reason, places the client at risk for termination from CAP/C.
- Transfers should occur at the end of one month/beginning of the next month.

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## REVIEW QUESTIONS

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

1. For the CNR on an IC level client, which of the following does NOT need to be submitted?
  - The FL-2
  - The assessment
  - The plan of care
  - The physician's request form
  
2. A revision needs to be submitted for
  - A. An increase in the number of nursing hours
  - B. A decrease in the amount of a supply
  - C. A change in a provider agency
  - D. A one-time extra hour provided because of a family emergency
  
3. A lack of services for \_\_\_\_\_ days places the client at risk for termination of CAP/C services.
  
4. The best time for a client to transfer to a different county or a different program is\_\_\_\_\_.

## REVIEW ANSWERS

1. D. the Physician's Request Form.. The physician's request form only needs to be submitted for clients staffed with a nurse.

2. A, an increase in the number of nursing hours. Nursing is a waiver service, and a revision needs to be submitted for any change in a waiver service.

3. 30

4. the end of one month/beginning of the next month