North Carolina
Department of Health and Human Services
Division of Medical Assistance
Recipient Services EIS
801 Ruggles Drive – 2501 Mail Service Center - Raleigh, N.C. 27699-2501
Courier Number 56-20-06

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Gary H. Fuquay, Director
(919) 855-4000

December 20, 2004

Re: Electronic FL2e

Dear County Director of Social Services:

With the continuing expansion of the new electronic FL2 (FL2e), there have been a number of questions regarding this document and its process. The FL2e does not look like the paper FL2, and workers have stated they do not know how to read the form and may miss important information.

EDS and ProviderLink have worked to make the cover sheet that comes with the FL2e easier to read. Attached to this letter is a sample copy of what the county department of social services will receive when EDS faxes the approved FL2e.

There will be a cover memo that gives the decision on the prior approval request. The upper right corner of the memo identifies that it concerns the FL2. The memo contains:

- The patient's name, date of birth, and, if the FL2e is approved, the prior approval number;
- The date the FL2e was sent, which is also the date the decision was made to approve or deny;
- A prominent message telling the worker that the FL2e is attached;
- If approved, the "from" date of the prior approval authorization, and
- "Viewable Comments" advises that the patient is approved for nursing facility care.

If prior approval is denied, the statements on the attached sample will indicate prior approval was denied.

Following the cover memo are two copies of the FL2e: one that is not signed and one that is signed. The unsigned copy is included due to concerns that the signed copy is not fully legible. The FL2e is not marked to indicate that the prior approval request is approved or denied. That information is contained on the cover memo.

Overall, the nursing facility prior approval process has not changed. The person completing the FL2 (e.g. physician, hospital discharge planner, social worker, etc.) should advise the facility that he or she is initiating an FL2 requesting prior approval for nursing facility care. Pre-Admission Screening and Annual Resident Review (PASARR) must be completed and the PASARR number entered on the FL2 prior to submitting the FL2 for review.

All completed FL2's (electronic or paper) must be sent to EDS. The FL2e is sent via ProviderLink. The paper FL2 is sent via the mail. When a decision is made on the prior approval request, EDS sends the FL2 to the county department of social services. If the FL2 is electronic, it is sent to the county via FAX. If it is a paper FL2, two copies are mailed to the county department of social services.

When the county department of social services receives the FL2e, it should send a copy of the Fax Cover Page, the Cover Memo, and the signed and unsigned FL2e to the nursing facility. If the county receives the two copies of the paper FL2, it should forward one copy to the facility.

Note that with the implementation of the case mix nursing facility reimbursement system, the FL2 is only used for <u>new</u> nursing facility admissions. There are no longer level of care changes within the nursing facility. Designating the two levels of care – Skilled Nursing (SN) and Intermediate Care (IC) – no longer exists. There is only one designation – Nursing Facility (NF). These changes have resulted in a significant reduction in the use of the FL2.

For your information, the Division of Medical Assistance did explore the possibility of county departments of social services having free access to the ProviderLink system. That proved not to be possible.

It is our hope that these changes in the electronic FL2 will help the county departments of social services. If you have any questions, please contact your Medicaid Program Representative.

Sincerely,

Gary H. Fuquay

To: Income Maint Caseworker
County DSS Office
Fax: 919-861-6751
Phone:

From: **Julie Simmons**
Medicaid-NCFL2
Phone: 919.465.1855

Patient Name: Belle Beauty **DOB:** 10/10/2000

Subject: FW:Auth Posted - 01020101020202 **Sent:** 11/23/2004 4:43 PM

Message:

--------You are forwarding the following message--------
Subject: Auth Posted - 01020101020202
Sent: 11/23/2004 4:22 PM
Text: Authorization Creator: Julie Simmons at Medicaid-NCFL2:
Authorization Recipient: GeneralHospital
Patient: Belle Beauty Approval: Approved Admission Date:
Auth: 01020101020202 From: 11/23/2004 To:
Review date:
Review Notes:
Viewable Comments: NF Approved

NORTH CAROLINA MEDICAID FL2
LEVEL OF CARE SCREENING TOOL
("JXQF2M")

Assessment Type: **Initial Request**		Current Setting - LOC:	Hospital - Acute
		Requested Placement:	SN

PATIENT INFORMATION

Beauty, Belle	Medicaid #: 111222233A	SSN: 111-22-2233	Gender: F
DOB: 10/10/2000	County: 011 - Buncombe	PASARR #: 1234567	
Medicare #:	Other Insurance:		

CURRENT LIVING ARRANGEMENT

General Hospital	Admission Date: 11/10/2004
Provider #: 12345678	Phone #: 919-465-1855

RECEIVING FACILITY INFORMATION

Happy Trails SNF	Phone #:828-555-1212

SECTION I

Diagnosis

Sick
Tired

SECTION II

Mental Status - Orientation	Oriented to Person: **Yes**	Oriented to Place: **No** Oriented to Time: **Yes**
Mood Indicators - Behavioral Symptoms	Wandering: **No** Physically Abusive: **No**	Verbally Abusive: **Yes** Dangerous to Self, Others, or Property: **No**
Activities of Daily Living	Ambulatory: **Yes** Eating: **Independent**	Dressing: **Independent** Bathing: **Independent**
Continence	Bladder: **Continent** Bowel: **Continent**	
Vision	Adequate	
Hearing	Adequate	
Nutritional/Oral	Height 60 inches Special nutritional needs: **Yes** Feeding Tube: **No** Therapeutic Diet: **Yes** Specify: ADA Parenteral / IV: **No**	Weight 130 lbs.
Skin	Wounds/Ulcers Skin tears	
Special Treatments	Special Care Received During Last 7 Days: Insulin Stable	
Therapies	Physical; Start Date: 11/10/2004, 3 times per week.	

SECTION III

Identify and report all prescription medications that will continue upon admission to the Nursing Facility Level of Care.

Medication	Dose	Route of Administration	Frequency	New Drug	New Dosage
yellow pills	2	PO	bid	false	false
red pills	2	PO	bid	false	false

Patient Name: Beauty, Belle Patient DOB: 10/10/2000

ADDITIONAL INFORMATION

ADDITIONAL INFORMATION OR COMMENTS

PHYSICIAN INFORMATION

Welby, Marcus

I certify that the above information reflects this patient's condition and I am submitting this to the Medicaid program (EDS) for review for nursing facility level care.

Physician Signature **Date**

Complete the following if any medical information (sections 1-4) was supplied by someone other than the physician.

Name	Title	Agency
Jane Adams	MSW, RN	GeneralHospital

This information must be submitted to EDS within 10 days to be effective.

NORTH CAROLINA MEDICAID FL2
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Physician Signature **Date** 11/10/04

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Name	Title	Agency
Jane Adams	MSW, RN	GeneralHospital

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