North Carolina
Department of Health and Human Services
Division of Medical Assistance
Recipient Services EIS
1985 Umstead Drive • 2501 Mail Service Center • Raleigh, N.C. 27699-2501

Dear Interested Resident:

In an effort to provide information about the Adult Medicaid programs, we developed this handbook, **A Consumer's Guide to North Carolina Medicaid Programs for the Aged, Blind, and Disabled**. While this handbook does not answer all questions, it does give an overview of the programs, eligibility requirements, and the covered services.

If any information in this handbook conflicts with the General Statutes, federal regulations or policies of the Division of Medical Assistance, the General Statutes, federal regulations and policies will prevail.

Please keep this book as a reference. You may wish to write the phone number of your local county department of social services on the inside cover so it will be readily available. The people at your local agency work hard to ensure our citizens receive all benefits for which they are eligible.

The Division of Medical Assistance is also committed to providing the best information on available Medicaid programs and services. We are proud of what our legislators have allowed us to provide to the residents of this State.

If you have questions regarding Medicaid Programs for Families and Children, there is a handbook, **A Consumer's Guide to North Carolina Medicaid Health Insurance Programs for Families and Children**. There is also a handbook for residents who are on Medicare, **A Consumer's Guide to Medicare Savings Programs within North Carolina Medicaid**. To receive those handbooks, you may contact your local department of social services or the CARE-LINE Information and Referral Service that is referenced in this book and ask to speak to a representative in the Recipient and Provider Services Section, Medicaid Eligibility Unit. They also may be viewed on the Internet at **www.dhhs.state.nc.us/dma/consinfo.htm.**

Thank you for your interest in our programs. We hope this information will be helpful.

Division of Medical Assistance

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Medicaid Health Insurance Programs for the Aged, Blind, and Disabled

Welcome to "A Consumer's Guide to the North Carolina Medicaid Health Insurance Programs for the Aged, Blind, and Disabled." This information will help you understand what Medicaid is and what it covers. This book is for:

- Elderly individuals or couples
- Visually-impaired people
- The physically or mentally disabled
- Health care providers
- Others seeking information about Medicaid

THIS BOOKLET IS ONLY A SUMMARY

To get more information or find out if you qualify for Medicaid, call your local Department of Social Services (DSS). The phone number will be in your local phone book. Look under the County Government section. If you still can't find it, call the CARE-LINE Information and Referral Service at 1-800-662-7030. In the Triangle area, call 919-855-4400. Hearing impaired callers may call either of the above numbers or the TTY dedicated line at 877-452-2514 or in the Triangle area at 919-733-4851 or toll free 877-452-2514. CARE-LINE is available Monday through Friday 8 a.m. to 5 p.m. except state holidays. A bilingual information and referral specialist is available for Spanish-speaking callers.

What is Medicaid?

Medicaid is a health insurance program for those whose income is below amounts set by the federal and state government. Medicaid is governed by federal and state laws and regulations. To receive Medicaid, you must meet the requirements. To find out if you qualify, look at pages 10 and 11.

What You Can Expect from Medicaid

- Individuals on Medicaid receive a Medicaid Identification (MID) card, which is their insurance card.
- There are co-payments for some services.
- Medicaid has several different types of coverage for people with different needs.
- To receive Medicaid, you don't have to go through a physical or other type of exam. However, if you are applying because you say you are disabled, a medical exam may be required. You must be disabled according to the definition given by the Social Security Administration.You can't be rejected for Medicaid because of a health condition you already have. Instead, Medicaid is based on your family's financial need. You do not have to have a current medical need.
- Medicaid managed care provides a medical home if you are enrolled in Carolina ACCESS or Southcare. Your primary care provider will help you get the medical services you need.

Medicaid Programs

The following are the most common programs you will hear your caseworker refer to:

Medicaid for Older Citizens (MAA)—Health care coverage for people 65 or older whose income is below the limits in the list on page 10.

Medicaid for the Blind or Visually Impaired (MAB)—Health care coverage for blind or visually impaired people of any age who are blind according to the definition given by the Social Security Administration (see definition on page 7) and meet the income requirements given on page 10.

Medicaid for Disabled Citizens (MAD)—Health care coverage for people of any age who are unable to work due to a disability that is expected to last at least 12 months (see definition on page 6) and meet the income requirements on page 10.

Lifeline/Link-up Assistance Program

The Lifeline/Link-up Assistance Program is for low-income individuals. The program serves recipients of the Food Assistance, Work First Family Assistance, Medicaid and Low Income Home Energy Assistance Programs, which includes the Low Income Energy Assistance Program, Crisis Intervention Program and Weatherization.

Lifeline can help pay a portion of your local telephone bill. If you are eligible, Lifeline will give you a credit each month on your local telephone bill.

Link-up is a program that can help pay to connect your telephone service.

If you are interested in applying for either one of these programs, contact your County Department of Social Services or your telephone carrier.

Terms and Definitions

Blind	As defined by the Social Security Administration (SSA), you are considered legally blind if your vision cannot be corrected to better than 20/200 in your better eye, or if your visual field is 20 degrees or less, even with a corrective lens. If you do not meet the legal definition of blindness, you may qualify for benefits if your vision problems alone or coupled with other health problems prevent you from doing substantial work.
Case Management	A plan of service to identify and find resources that are needed to help patients who have ongoing chronic problems.
Categorically Needy	Individuals and families whose income is so low that they do not need to meet a deductible.
Copayment (or copay)	Part of the covered treatment charge that a recipient may have to pay.
Coverage Category	The type of Medicaid coverage that you have with the package of medical services that are covered.
Covered Services	Medical, mental health, dental, preventive, long-term care, or other treatment needs that are covered under Medicaid.
Deductible (or spenddown)	The amount of medical expenses the individual is responsible for before qualifying for Medicaid coverage. Usually required for people whose income is above the limit. If you are told that your income is too high to get Medicaid, and you have medical bills you have to pay, ask your DSS caseworker how much of them you will have to pay before you can get Medicaid.
Department of Social Services (DSS)	Under state law, county departments of social services (DSS) are responsible for the administration of all Medicaid programs, including NC Health Choice for Children. The phone number will be in your local phone book. Look under the county government section or call the CARE-LINE. See page 4 for the telephone numbers.
Division of Medical Assistance (DMA)	The NC State Medicaid agency responsible for administration of the Medicaid program.
Disability	As defined by the Social Security Administration (SSA), a physical or mental impairment of such severity that it prevents the applicant from engaging in substantial gainful activity for at least a year or is expected to result in death.
Estate Recovery	When you receive certain medical services, your estate will be subject to Estate Recovery if you are permanently institutionalized or 55 or older. Estate recovery is a process in which the Division of Medical Assistance files a claim against the estates of certain individuals to recover Medicaid dollars paid on behalf of the individuals. Recovery is not initiated until the recipient's death and, in some cases, may be waived.

If you have questions, please call the CARE-LINE, Information and Referral Service. See page 4 for telephone numbers.

Low Income Subsidy: For individuals with income less than 150% of the federal poverty level. The LIS subsidy provides assistance with the premium payment of the prescription drug plan premium. Eligibility for this subsidy is based on income and resources. Subsidy amount may vary depending on income.

Managed Care Medicaid Managed Care offers to recipients a state network of primary care doctors known as Carolina ACCESS. In Mecklenburg county a commercial Health Maintenance Organization (HMO) coverage is also available. Managed Care means you have a primary care provider who is responsible for providing or arranging for medical services to meet your health care needs.You may hear your primary care provider or caseworker refer to Community Care of North Carolina (CCNC). This is another name for Caroina ACCESS.

Medically Needy Individuals and families who have too much income or assets to automatically qualify as Categorically Needy. Individuals and families in this group often will qualify for Medicaid after meeting a deductible.

Medicare Part D: A voluntary prescription drug program through Medicare that provides all Medicare beneficiaries with prescription drug assistance. Medicare beneficiaries must also enroll in a prescription drug plan (PDP) to have prescription coverage. The Low Income Subsidy is part of the Medicare D program. Medicaid recipients that receive Medicare receive prescription drug coverage through Part D.

NC Health Choice for Children Health insurance program for children age 6 through age 18 with family income below or at 200% of the federal poverty level. Children cannot be eligible for Medicaid or be covered by private health insurance.

Noncovered Services Certain medical, mental health, dental, preventive, long-term care, or other services not paid by Medicaid.

Preexisting Condition A medical condition or problem that you had before you applied for Medicaid.

Prescription Drug: A drug that can only be bought with a doctor's written prescription. Medicaid does not cover drugs that are experimental. The drug must be approved by the Federal Drug Administration (FDA). Prescription drug coverage is not a covered benefit for Medicare beneficiaries. Medicaid will only cover prescription drugs for Medicare beneficiaries under certain circumstances.

Prescription Drug Plan (PDP): Prescription drug coverage that is offered under a policy, contract, or plan that has been approved by Centers for Medicare and Medicaid Services. A PDP provides insurance coverage for prescriptions.

Primary Care Provider (PCP)	A medical provider for Carolina ACCESS who either provides or arranges medical services to meet your health care needs.
Prior Approval	Process that makes sure that certain types of services are medically necessary before the service is provided. Some services which require prior approval include dental, vision, psychiatric services, and nursing facility placement.
Program Limits	*Income limits* include the highest amount of gross countable monthly income you can receive and still qualify for Medicaid. *Coverage limits* include how many times and how often Medicaid will pay for a covered service. There may also be limitations on the kind of doctors or medical professionals who can prescribe or render care. For example, adults can receive eyeglasses only once every 2 years. *Resource Limits include the highest amount of countable resources or assets you can have and still qualify for Medicaid.*

You Can Get Medicaid if...

- You are a U.S. citizen or qualified alien, and
- You live in North Carolina, and
- You have a Social Security Number or have applied for one

and...

A. You receive a check for one of these:

1. Supplemental Security Income (SSI)
2. Work First Family Assistance (WFFA)
3. State/County Special Assistance for the Aged or Disabled (SAA or SAD)
4. Special Assistance to the Blind (SAB)

or...

B. Your countable income falls within the limits for one of the following categories (see below for income limits):

1. Aged (65 or older), blind or disabled persons (Financial resources must also be below a certain amount. See chart below.)
2. Families with children under age 19. (Refer to A Consumer's Guide to North Carolina Medicaid Health Insurance Programs for Families and Children. The Dear Interested Resident letter at the beginning of this handbook tells you how to obtain a copy.)

Income Levels

Since Medicaid is health coverage for people with income below certain levels, you must receive a check from one of the programs listed in A. above, **or** your yearly income cannot be above the amounts listed below. These income amounts change every April, so ask your social services caseworker what they are. This chart shows income amounts for April 1, 2006 through March 31, 2007.

Applicant	Income per year	
	Categorically Needy	Medically Needy
Individual	$9,800	$2,904
Couple	$13,200*	$3,804*

*Combined income

If your income is more than one of the amounts listed for categorically needy, you may still qualify if you have medical bills you cannot pay or expect that you will need medical treatment in the near future. You may have to meet a deductible before Medicaid will pay the bills. Call your local DSS to find out what the deductible would be in your case.

In addition, if you are applying alone, you cannot have more than $2000 in assets such as savings in the bank. If you are applying as a couple, you cannot have more than $3000 in combined assets. Assets not included in this amount are your homesite if you are living in it and funds designated for burial. There are different rules when one spouse is in a nursing facility and the other remains at home.

Applying for Medicaid

As with any health insurance, you will need to fill out an application. To get an application, call your local department of social services.

When you go to the department of social services to apply or apply by mail...

You will need to provide items to prove you qualify for Medicaid. If possible, have everything on this checklist when you go to apply. If you can't get all of these items, please apply anyway. You can provide information after you apply, and the caseworker can help if you need assistance.

- ✓ Birth certificates or other legal proof of age for children under 21;
- ✓ A copy of all pay stubs for last month;
- ✓ Your social security card, or proof that you have applied for one for yourself or anyone you are applying for;
- ✓ Copies of all medical or life insurance policies you have for yourself and the members of your family who want Medicaid;
- ✓ A list of all cars, trucks, motorcycles, or other vehicles you or anyone in your household own;
- ✓ Most recent financial statements from financial institutions (such as bank statements);
- ✓ Current financial statements from other sources of family income, such as social security, retirement benefits or pensions, veteran benefits, SSI, child support, or other sources.
- ✓ A list of all real property you own.
- ✓ Proof of state residency.

Your local department of social services will determine if you are eligible for Medicaid. While they are deciding your eligibility, you may be asked to give them more information. Once you have given them all the information they have asked for, you will receive a notice in the mail that will tell you whether or not you can receive Medicaid. This notice will also give you information regarding your right to appeal the decision made by the agency.

Any time your case is changed, or you no longer meet the requirements, you will receive a notice in advance saying why it is being changed or terminated and explaining your right to appeal.

> If your income or assets change, you get married or divorced, your spouse dies, or you give or sell assets to someone else, you must tell your worker within 10 days. Before you transfer any kind of property, money, or other assets, talk to your caseworker.

After you qualify, you get a Medicaid Identification (MID) card...

Your caseworker will mail you a notice to tell you if your application was approved. Each month you will get a Medicaid ID card in the mail.

You must take your **CURRENT** card with you every time you or a member of your family goes to the doctor, hospital, or any medical provider including the pharmacist. Your Medicaid card is your proof that you have coverage, just like insurance.

If you or your family member do not show your card to the person treating you or your family member, the person will not know you are covered by Medicaid. You may then be responsible for paying the full cost of the treatment or prescription drug.

As long as you are eligible, every month you will receive a new card for that month.

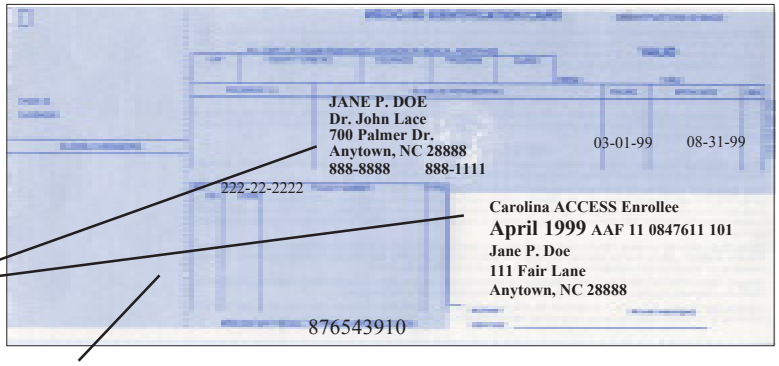
ALWAYS TAKE YOUR CARD WITH YOU

What Your Medicaid Card Will Look Like

You will receive a blue card.

A BLUE card means you have the typical Medicaid coverage.

If you are enrolled in Carolina ACCESS (CA) or a commercial health plan (HMO), the name of your Carolina ACCESS doctor or your HMO and phone numbers will be printed on your card.



(Pharmacy Stub--see next page)

Estate Recovery

Estate Recovery is a claim filed against the estate of a deceased Medicaid recipient when Medicaid has paid for certain medical services. A lien may also be placed on property owned by the recipient. The claim or lien is filed to recover Medicaid dollars paid on behalf of the individual.

Federal and State laws require the Division of Medical Assistance (DMA) to place a lien on property owned by the Medicaid recipient, or file a claim against the estate of individuals to recover the amount paid by the Medicaid program during the time the individual received assistance with certain medical services. Ask your Medicaid case worker for specific information regarding which services are applicable to estate recovery.

When You Need to Get a Prescription Filled

(This does not apply if you are a Medicare Recipient)*

When you receive your monthly Medicaid card, it will have a stub that your chosen pharmacist will need to keep in his files. When you receive prescription drugs, **you must go to the same pharmacist all month and show your card each time you have a prescription filled.** You can change pharmacists the following month when you get a new card with a new stub.

Only medicines that require a doctor's written prescription are covered by Medicaid. If you are buying a Federal legend drug or insulin, you must have a prescription if you want Medicaid to pay for it. If you can buy the drug without a written prescription, such as vitamins or ibuprofen, Medicaid will not pay for it.

*Medicare beneficiaries must be enrolled in a prescription drug plan in order to receive prescription durg coverage. Medicaid will not pay for drugs for Medicare Beneficiaries. (Drugs excluded by Medicare may be covered under Medicaid in certain circumstances.)

6 Prescription Limit

Anyone over 21 who does not have a life threatening illness can only receive 6 prescriptions per month. **See page 44 for exceptions.**

Prescription Copayment

Anyone over 21 must pay a $3.00 copayment for each generic prescription and name brand prescription. Pregnant women are exempt from copayments. There is no copayment when a prescription is purchased for a child (except for birth control pills). **See page 26 for other exceptions.**

Medicaid **WILL NOT** pay for the following:

1. Drugs that the Federal Drug Administration (FDA) does not approve
2. Non-rebatable drugs (made by a company that has not signed a rebate agreement with the state Medicaid agency)
3. Over-the-counter drugs like aspirin, cold medicines, vitamins

If You Don't Receive Your Card...

By the 10th of the month, contact your caseworker to make sure your card has been issued. If you and your caseworker cannot find the card, request the caseworker to issue you a replacement card. The replacement may not have the pharmacy stub attached. Since limits on services don't apply to children under 21, replacement cards for children may still have the stub attached.

If You Lose Your Card...

Before the end of the month, contact your county department of social services and ask for a replacement card.

THE REPLACEMENT CARD MAY NOT HAVE THE PHARMACY STUB ATTACHED. ASK YOUR CASEWORKER HOW TO GET YOUR PRESCRIPTIONS COVERED.

Carolina ACCESS (Managed Care)

Definition:

Carolina ACCESS is a managed health care plan which links you to a primary care provider (PCP) whom you choose or if you do not choose, one will be assigned for you. Your PCP will provide services to meet your health care needs. If you need medical services your PCP cannot provide, he will refer you to someone who can. All PCPs must meet certain requirements to be part of Carolina ACCESS which provides you with additional benefits when you are enrolled. Another name for Carolina ACCESS is Community Care of North Carolina (CCNC).

Who Qualifies:

You must participate in this program unless you receive Medicaid as a pregnant woman, as a child in foster care, or receive Medicare. You must join a Managed Care Plan (either Carolina ACCESS or an HMO in Mecklenburg county) if you receive Medicaid under any of the following Medicaid programs:

Work First Family Assistance (WFFA)
Medicaid for Families and Children (MAF)
Medicaid for Infants and Children (MIC)

You can choose whether or not to join a Managed Care Plan if you receive Medicaid for Pregnant Women (MPW) or if you are eligible for both Medicaid and Medicare.

If you receive assistance as a refugee or as a non-citizen (alien), you cannot have a Managed Care Plan.

Benefits of Carolina ACCESS:

As a Carolina ACCESS member you will have:

- access to case management Services if you meet the criteria for this service;
- a medical provider who will either provide or arrange for services to meet your health care needs;
- access to medical advice 24 hours per day;
- the opportunity to select a primary care provider from a list of participating providers. Each family member may have a different PCP.
- a Medicaid card with your PCP's name, address, and telephone numbers on the front;
- better access to regular preventive medical services because of having an established relationship with your PCP; and
- access to education about the plan and how you get medical services from your county and your PCP.
- no longer need to go to the emergency room unless you have a life threatening condition.

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Carolina ACCESS (Managed Care)

Exempt Services: Services which do not require PCP authorization/referral when your doctor's name is printed on your Medicaid card. Services include:

- Ambulance
- Anesthesiology
- At-Risk Case Management
- CAP Services
- Certified Nurse Anesthetist
- Child Care Coordination
- Dental
- Developmental Evaluation Centers
- Routine Eye Exams and treatment of conjuntivitis
- Family Planning (including Norplant)
- Health Department Services
- Hearing Aids (under age 21)
- Hospice
- Independent and Hospital Lab Services
- Maternity Care Coordination
- Optical Supplies/Visual Aids
- Pathology Services
- Pharmacy
- Psychiatric/Mental Health
- Radiology (only includes services billed under a radiologist provider number)
- Services Provided by Schools and Head Start programs

If you need help with any of these services, contact the Office of Citizen Services' CARE-LINE Information and Referral Service at 919-855-4400 for local calls or toll free at 1-800-662-7030 (English/Espanol;). For TTY call 919-733-4851 for local calls or toll free 1-877-733-4851.

At Initial Enrollment:

- When you receive your Medicaid card in the mail, make sure the PCP listed on your card is correct. If it is not correct, it is very important to call your caseworker at the Department of Social Services to ask that it be corrected.
- Call the PCP on your Medicaid card immediately to make an appointment to get established if you have not seen this provider in the last 12 months. This is important since your doctor will want to see you before he authorizes another provider to see you.
- Do not got to a specialist until you have seen your PCP unless you are getting a service that does not require your PCP to authorize. These services are listed above in "Exempt Services".

If you need to change your Primary Care Provider listed on your card, please call your caseworker at your county department of social services

North Carolina ACCESS is making a few changes to improve your health care. In some areas of the state, Medicaid patients are getting case managers to help them in managing a disease or to act as their health advocates. As these changes go statewide next year, ACCESS will change its name to Community Care.

MANAGING YOUR HEALTH CARE NEEDS:
You are responsible for making sure you get regular preventive health care. You are also responsible for contacting your PCP when you are sick. Following these guidelines will help you manage your own heath care:

- Whenever you go for medical care, always take your Medicaid card. It has information your doctor needs to bill Medicaid for your visit.
- Except for services not requiring PCP authorization, always call your PCP before going to another doctor. Your PCP will have to authorize another doctor to treat you and it may be a service that your PCP can provide.
- Only go to the emergency room when you have a life-threatening problem; otherwise call your PCP before going. If you need medical advice after the office closes, call the PCP's after hours' number on your card.

HMO Options (Managed Care)

Definition: An HMO (Health Maintenance Organization) contracts with the state to provide medical services to recipients in **Mecklenburg county**. This list is subject to change.

What Medicaid Will Pay For: All Medicaid services are covered for those enrolled in an HMO, although some are not provided through the HMO. In some cases, the HMO offers additional coverage above the minimum required. HMO enrollees do not make routine copayments for services provided by the HMO.

Out of Plan Benefits: Out-of-plan benefits do not require a referral from your PCP. If you need help with any of these services, call the member services telephone number on your Medicaid card. **Out-of-plan benefits include but are not limited to:**

- Dental
- Prescription Drugs
- School-related and Head Start therapies

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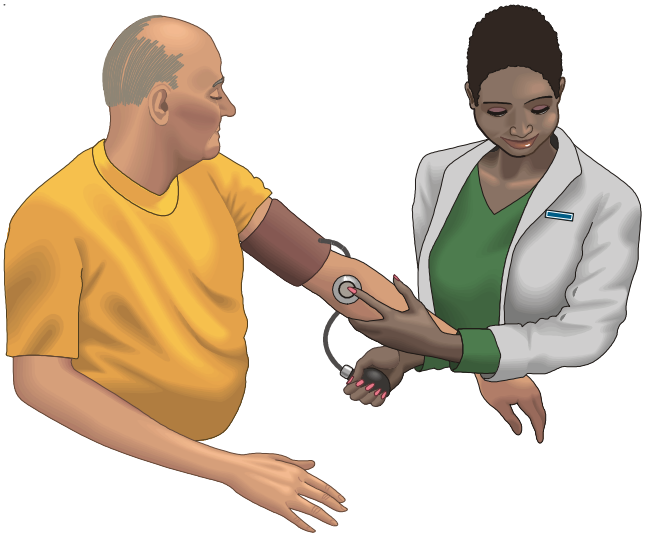
HMO Options (Managed Care)

At Initial Enrollment:

- Get established with your PCP IMMEDIATELY
- Take your current Medicaid card and your HMO card when seeking any medical service
- Call your PCP before going to any other doctor
- Call your PCP before going to the emergency room if the condition is not an emergency
- Go to the emergency room only when there is an emergency
- Get your PCP's approval before seeking any specialty care
- Some services do not need PCP approval, e.g., dental, mental health, etc. (Patient handout includes complete list of exempt services)
- Go for preventive care, i.e., Health Check, immunizations, checkups
- If you cannot keep your appointment, call as soon as possible to cancel.

If you need to change your Primary Care Provider or the HMO plan listed on your card, please call your caseworker at your county department of social services.



MEDICARE PART- D (Medicare Prescription Drug Coverage)

Definition: Medicare Part D is prescription drug coverage through a Prescription Drug Plan or Medicare Advantage Plan. There is a monthly premium paid to the prescription drug plan. Under Medicare D, Medicaid recipients covered through a prescription drug plan will not have a limit on the number of prescriptions allowed per month.

All Medicare beneficiaries are entitled to Medicare Part D; however, eligible individuals must enroll in a plan to get prescription coverage. Medicaid individuals who are entitled to Medicare and choose not to enroll in Medicare D will not have prescription coverage through Medicaid.

Medicaid will only pay for prescription drugs for individuals who are not entitled to Medicare Part A or enrolled in Medicare Part B. Although Medicare Part D is voluntary, all Medicare beneficiaries receiving Medicaid services, including prescription drug coverage, must enroll in a Medicare D Prescription Drug Plan to receive prescription drug coverage.
All Medicare beneficiaries can also apply for the Low Income Subsidy (LIS). This subsidy is often called “extra help”. The subsidy provides assistance with the premium payment and a reduction in the deductible and co-pays. The subsidy may be 100%, 75%, 50% or 25% of the Part D premium depending on the individual’s income. The Low Income Subsidy is for individuals who:

- Are entitled to Part A or enrolled in Part B
- Have income less than150% of the federal poverty level
- Have resources below $10,000 for an individual or $20,000 for a couple
- Apply for this extra help

Medicare recipients may apply for extra help at the Social Security Administration, at the local Medicaid office, or on the internet (on-line) at www.socialsecurity.gov. Medicaid recipients and Medicare Savings Plan recipients are automatically eligible for the LIS and do not need to apply.

For assistance in enrolling in a PDP or additional questions regarding Medicare contact: Medicare at 1(800) MEDICARE or on the internet at: www.medicare.gov, or the North Carolina Senior Health Insurance Information Program (SHIIP) at 1-800-443-9354.

Other Coverage Options

Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (CAP/MR/DD)

Definition: CAP/MR/DD is designed to give persons with mental retardation/developmental disabilities a cost-effective alternative to care in an intermediate care facility (ICF). The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) is the lead agency for this program with the Division of Medical Assistance (DMA) overseeing its operation.

Who Qualifies: CAP/MR/DD participation depends on the availability of "slots" and services as well as meeting the criteria for ICF-MR/DD Level of Care. Prior approval is required for this level of care. To qualify, the individual must:

- Require active treatment necessitating the ICF-MR/DD level of care
- Have a diagnosis of mental retardation or a condition that is closely related to mental retardation (MR)
- Have MR or a related condition that is manifested before the individual reaches age 22
- Have MR or a related condition resulting in great functional limitations in 3 or more major life areas

What Medicaid Will Pay For:

- Augmentative Communication Devices
- Adult Day Care
- Adult Day Health Care
- CAP-MR/DD In-Home Aide Services (Level 1)
- CAP-MR/DD Personal Care
- Community Inclusion
- Crisis Stabilization
- Developmental day care
- Prevocational services
- Family training
- Respite care
  - Institutional
  - Non-institutional/community based
  - Non-institutional/nursing based
- Supported employment
  - Individual
  - Group
- Supported living services
- Supplies and equipment
- Vehicle adaptations
- Environmental accessibility adaptations

Other Coverage Options

Piedmont Cardinal Health Plan (PCHP)

Definition:

Piedmont Cardinal Health Plan (PCHP) is a public Mental Health/Developmental Disability/Substance Abuse Services (MH/DD/SAS) organization providing Mental health, Developmental Disability, Substance Abuse, CAP-MR/DD, ICF/MR, and inpatient psychiatric care services to Medicaid recipients who live in Cabarrus, Davidson, Rowan, Stanly or Union counties.

The CAP-MR/DD program in these five counties is called "Innovations." Recipients who currently received CAP-MR/DD in these five counties will continue to receive services through PCHP under Innovations.

What PCHP pays for:

PCHP pays for all Mental Health, Developmental Disabiilty, Substance Abuse, CAP-MR/DD, ICF/MR, Psychiatric Residential Treatment Facility (PRTF) and inpatient psychiatric care services for Medicaid recipients who live in one of the five counties.

This also includes intermediate care facilities for the Mentally Retarded (ICF-MR), Psychiatric Residential Treatment Facility (PRTF), Community Alternatives Program for the Mentally Retarded-Developmentally Disabled (CAP/MR-DD), and Inpatient Psychiatric Care.

Other Coverage Options:

Family Planning Waiver (FPW)

Definition: A waiver program for men and women to receive family planning services, that will end 5 years from October 1, 2005 unless it is extended.

Who Qualifies: Men age 19 through 60 and women age 19 through 55 who are of reproductive age with incomes at or below 185% of the federal poverty level and are not eligible for coverage through another Medicaid program.

What Medicaid Will Pay For:

- Family Planning eduction and contraception services
- Annual physical exams
- Pap tests
- Pregnancy tests
- HIV/STD testing and counseling
- Sterilization for women and men
- Referral services

Community Alternatives Program for Disabled Adults (CAP/DA)

Definition:

CAP/DA is a special Medicaid program that provides an alternative to nursing facility care for disabled persons who are 18 years of age or older and live in a private residence. There is a local lead agency designated by the county commissioners that operates the program in each county. The county department of social services has the name of the lead agency for that county. The Department of Medical Assistance's CAP Unit can also provide that information. Due to a federal limit on the number of participants, each county has a limit on how many individuals it may serve.

Who Qualifies:

Besides Medicaid eligibility and the need for nursing facility care, other qualifications include:

- The need for CAP/DA services
- The resources available to meet the person's home care needs
- Whether the needed community care can be provided cost-effectively compared to the Medicaid cost of nursing facility care. The person must be maintained safely in the home within a monthly cost limit.

What Medicaid Will Pay For:

A CAP/DA client has a case manager who arranges, coordinates, and monitors CAP/DA services as well as other aspects of the client's home care. In addition to case management, potential CAP/DA services are:

- Adult Day Health Care
- CAP/DA Waiver Supplies (Reusable incontinence undergarments with disposable liners, oral nutritional supplements and medication dispensing boxes)
- Home delivered meals
- Home Mobility Aids (Wheelchair ramps, safety rails, non-skid surfaces, handheld showers, grab bars and widening of doorways for wheelchair access)
- In-Home Aide Services (Level II and Level III-Personal care)
- Respite Care (In-home and institutional)
- Telephone Alert (Emergency response systems)

NOTE:
CAP Services do not need Primary Care Provider authorization for Carolina Access recipients.

Other Coverage Options:

Community Alternatives Program for Persons with AIDS (CAP/AIDS)

Definition:

CAP/AIDS is a special Medicaid program that provides an alternative to nursing facility care for persons with AIDS as well as children who are HIV-positive and meet other criteria. The person must live in a private residence. CAP/AIDS is a cooperative effort with the AIDS Care Unit in the Division of Public Health. The AIDS Care Unit handles the program operation, with DMA providing oversight. Local CAP/AIDS case management agencies are the entry point. There is a federal limit on how many people may participate each year.

Who Qualifies:

Besides Medicaid eligibility, the medical diagnosis and the need for nursing facility care, other requirements include:

- The need for CAP/AIDS services
- The resources available to meet the individual's home care needs
- Whether the needed care can be provided cost-effectively in relation to the Medicaid cost of nursing facility care. The individual must be maintained safely in the home within a monthly cost limit.

What Medicaid Will Pay For:

A CAP/AIDS client has a case manager who arranges, coordinates, and monitors CAP/AIDS services as well as other aspects of the client's home care. In addition to case management, the potential CAP/AIDS services are:

- Adult Day Health Care
- CAP/AIDS Waiver Supplies (Reusable Incontinence Undergarments with Disposable Liners, Oral Nutritional Supplements and Medication Dispensing Boxes)
- Home Mobility Aids (Wheelchair ramps, safety rails, non-skid surfaces, handheld showers, grab bars and widening of doorways for wheelchair access)
- In-Home Aide Services (Level II and Level III-Personal Care)
- Respite Care (In-home and institutional)
- Personal Emergency Response Systems

NOTE:

CAP Services do not need Primary Care Provider authorization for Carolina Access recipients. If you have questions about CAP/AIDS, call the AIDS Care Unit at 919-715-3169, DMA's Community Alternatives Section at 919-855-4380 or through the CARE-LINE Information and Referral Service at 1-800-662-7030.

Other Coverage Options:

Cost of Care in a Nursing Faciility

Definition: A nursing facility is a licensed nursing facility (NF). Medicaid contributes to the payment of cost of care (room and board) in a NF for people who meet certain eligibility requirements. Medicaid also pays for other medical expenses.

Who Qualifies: Persons must meet certain Medicaid eligibility requirements. In addition:

- Medicaid will pay only for nursing care in beds reserved for Medicaid patients which have been approved by a State licensure agency.
- A Prior Approval Form (FL2) must be completed by the attending physician to describe the medical condition and need for nursing care in a licensed nursing facility. Medicaid must approve the need for care in a nursing facility before the program will pay cost of care.
- A Medicaid recipient must use his or her income to help pay for nursing care. Medicaid pays the difference between the income of the recipient and the nursing facility rate.
- Each recipient keeps $30 of his or her income for personal needs not provided by the nursing facility's services. Also, the recipient may keep some income to pay for medical services not covered by Medicaid or other health insurance. The amount the recipient must pay is called the "patient monthly liability" or "pml."

What Medicaid Will Pay For: Some nursing facility services included in the Medicaid payment are:

- Room charge
- All general nursing, dietary, medical, and psychiatric services
- Personal items such as shampoo, combs, razor blades, soap, and lotions
- Medical supplies such as diapers, bandages, dressings, aspirin, and antacids
- Laundry services
- Reusable items/equipment such as ice bags, canes, crutches, walkers, and wheelchairs.
- Hair trimming which is hygienic. (There may be fees for permanents, hair coloring, or special styles.)
- Special dietary supplements used for tube or oral feeding such as a supplemental high nitrogen diet, even if written as a prescription item by a physician.

NOTE: Items not included are TV's, private telephone, private duty nurses or sitters, or tobacco products.

When You Need Prior Approval

Your provider will need **PRIOR APPROVAL** before Medicaid will cover some services. Your doctor or other health care provider (therapist, etc.) must request that Medicaid approve the service. The types of services needing prior approval are listed below. If prior approval is not given by Medicaid, you may not receive the service or may have to pay for the service. You have the right to appeal if Medicaid denies your request for medical service. You will get a letter telling you why the request was denied and how to appeal the denial.

Medicaid must make a decision promptly when a request is made for approval of services you need. If you don't get a decision within fourteen business days from the date the service was requested, call your doctor or other medical provider to ask about the request. Make sure your provider hasn't caused the delay. You have the right to appeal Medicaid's failure to act on the request promptly.

For more information about prior approval and the service appeal process, visit www.dhhs.state.nc.us/dma/ or call CARE-LINE at 1-800-662-7030.

The following services require prior approval (Note: this is not an all-inclusive list as there are changes from time-to-time):

- Medical services such as:
  - — Visual aids
  - — Hearing Aids (for those under age 21)
  - — Surgical transplants, except for bone, tendon and corneal
  - — Non-emergency out-of-state services beyond a 40 mile radius of the NC border
  - — Certain in patient hospitalizations and surgeries (such as reconstructive surgery, breast reduction, craniofacial surgery)
  - — Excision of keloids

- Behavioral Health Services, such as:
  - — Outpatient psychiatric visits after the first eight visits for adults, after the 26th visit for children under age 21
  - — All out-of-state psychiatric services
  - — Residential placement
  - — Inpatient Psychiatric Services

- Outpatient therapies after 6 unmanaged visits
  - — Speech Therapy, Respiratory Therapy, Occupational Therapy, Physical Therapy and Audiologoical Services

- Dental work such as:
  - ✓ Gum treatment or periodontal services
  - ✓ Orthodontic services for under age 21
  - ✓ Complex oral surgical procedures
  - ✓ Full dentures
  - ✓ Partial dentures
  - ✓ Dentures relines

- Some durable medical equipment and oxygen equipment
  - ✓ Repair for durable medical equipment items
  - ✓ Some prosthetic or orthotic devices

- Private duty nursing
- Some prescription drugs such as oxycontin
- Personal care services under the PCS-Plus program
- Community Alternatives Programs (CAP-DA, CAP-MR/DD, CAP/C, CAP-AIDS)
- Nursing facility care

Copayments

Some services covered by Medicaid require you to pay a small fee at the time you receive services.

There is NO copayment for:

— Intermediate care facility for the mentally retarded
— Mental hospital and mental health centers
— Emergency room services
— Non-hospital dialysis facility services
— Nursing facility services
— Services covered by both Medicare and Medicaid
— Services provided by a commercial HMO contracted to provide medical services
— HMO enrollees
— Inpatient hospital stay
— Participants in a Community Alternatives Program
— Durable medical equipment
— Orthotic and prosthetic devices

NOTE: Recipients in a nursing facility may be required to pay a portion of their monthly income towards their nursing home care.

Services that require copayments include the following:

$3.00 for physician
$3.00 for dentist (only one copay for services requiring more than one visit)
$3.00 for generic prescriptions
$3.00 for brand name prescriptions
$2.00 for chiropractic care
$3.00 for podiatrist
$3.00 for optometrist
$2.00 for optical supplies and services
$3.00 for outpatient visits

If a provider visits you while you are an inpatient, you may have to pay a copayment. If you do not have the money for the copayment at the time you receive services, the provider should not refuse to provide services.

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) AND HEALTH CHECK

COMPLETE CHECK-UPS AND TREATMENT FOR CHILDREN

Definition: **Health Check** is the N.C. Medicaid program of **E**arly and **P**eriodic **S**creening, **D**iagnosis, and **T**reatment. EPSDT services are covered free of charge. EPSDT covers:

- Regular medical check-ups. Check-ups prevent illness and find problems early.
- Dental services. Your child should go to the dentist every six months.
- Mental health services
- Rehabilitative services for children with disabilities
- In-home nursing, personal care, therapy, and medical equipment.
- Any other medical or remedial care needed to reduce your child's disability, improve or maintain his/her condition, or restore his/her functioning

Who Qualifies: Medicaid recipients are eligible from birth through age 20.

How Often Will My Child Be Seen: With Health Check, your child should have regular screening (medical exams) as follows:

Within 1st month	9 or 15 months	3 years	9 years
2 months	12 months	4 years	12 years
4 months	18 months	5 years	15 years
6 months	2 years	6 years	18 years

The EPSDT medical screening exam should include:

- a health history and physical exam;
- measuring height and weight;
- check on developmental level and mental health;
- immunizations (shots);
- other tests, including tuberculosis and lead poisoning; and
- health education.

If your child needs to have exams on a different schedule, the visits are still covered.

What Treatment Services Will EPSDT Pay For:

EPSDT covers most of the treatments a child needs to stay as healthy as possible. This includes some services that Medicaid does not provide for adults. EPSDT services do not have many of the restrictions that the Community Alternatives Programs (CAP-waivers) have, such as waiting lists or upper limits on the total cost of treatment. The treatment services for each child will be determined by the child's individual needs. To be covered by Medicaid, many EPSDT services must be prescribed by your doctor or another licensed clinician. Prior approval from the N.C. Medicaid agency, the Division of Medical Assistance, may be needed for some treatment services. EPSDT can cover services that your child needs to correct a health problem, improve the problem, prevent it from getting worse, or help the child live with the problem. Even if the service won't cure your child's condition, it must be covered if the service is necessary to improve or maintain your child's functioning or symptoms. If your child needs a specialized treatment, that treatment must be covered, so long as it is not experimental. If your child has a Medicaid card, and your doctor or other clinician says your child needs treatment, there is:

- no waiting list for EPSDT services
- no upper limit on the total cost of treatment,
- no upper limit on the number of hours necessary health care services are provided,
- no limit on the number of visits to a doctor or therapist,
- no requirement that the service or equipment your child needs has to be on our usual list of covered services,
- no co-payment or other cost to you,
- coverage for services that are never covered for adults, and
- coverage for services not listed in the N.C. Medicaid State Plan.

Following is a list of some of the services that can be covered by EPSDT if needed to correct or ameliorate a child's health problem:

- Inpatient and outpatient hospital services
- Laboratory and x-ray services
- Family planning (birth control), including sexually transmitted disease screening
- Physician services (including pediatricians and pediatric specialists)
- Vision screening and eye glasses
- Hearing testing and hearing aide(s)
- Home health care services
- Therapy services—physical, occupational, and speech/language
- Private duty nursing services
- Clinic services (including rural health clinics)
- Prescribed and over-the-counter drugs
- Dental care, including preventive and restorative care
- Durable medical equipment, including wheelchairs

and assistive devices

- Case management
- Medical or remedial services recommended for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level (rehabilitation)
- Intermediate care facilities for the mentally retarded
- Inpatient psychiatric hospital services for individuals under age 21
- Maternity care
- Respiratory care
- Personal care services
- Substance abuse services
- Transportation services

For more information about EPSDT Treatment Services, visit:

http://www.dhhs.state.nc.us/dma/epsdt_policy.pdf

How Do I Get These Services For My Child:

You can ask for Health Check or EPSDT services by contacting your child's doctor, your local Mental Health Authority, or any health care provider who accepts Medicaid. Health Check can also help with:

- Getting transportation
- Setting up appointments
- Finding a doctor or dentist

You or your health care provider can also request EPSDT services by writing directly to the agency below.

Assistant Director for Clinical Policy and Programs
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501

Covered Services

While the following pages contain information on covered and non-covered services, the list is not all-inclusive. Also, this list does change, so for accurate information, ask your medical provider or pharmacist. You may also call CARE-LINE Information and Referral Service at 1-800-662-7030. In the Triangle area, call 919-855-4400. Hearing impaired callers may call either of the above numbers or the TTY dedicated line at 919-733-4851 or toll free 877-452-2514. CARE-LINE is available Monday through Friday 8 a.m. to 5 p.m. except for state holidays. A bilingual information and referral specialist is available for Spanish-speaking callers.

You may also access information on covered services at http://www.dhhs.state.nc.us/dma/consinfo.htm

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Service	Brief Explanation of Coverage	Restrictions (in brief)
Physician (doctor)		
Diagnosis and Consultation	Covered. $3.00 copayment per visit. See page 26 for exceptions.	Visits limited to 24 per year (July 1-June 30) per person. Not applicable to children under 21.
Therapy	Covered. Some supplies usually given by physician during treatment may be covered.	Coverage of B-12, ACTH, and steroid injections depend on diagnosis.
Surgery	**Prior approval required** for some surgical procedures. See page 21. For Carolina ACCESS (CA) recipients, all visits to a specialist's office, including therapists or surgeons, need primary care physician authorization.	See page 44 for other coverage information.
Clinic Services	All services have the same coverage and restrictions as the same services given in a non-clinic setting.	
Hospital Services: Inpatient	Some restrictions apply to family planning services.	See page 46 for more coverage information.
Room and board	Semiprivate room covered, except when private room is medically necessary or all that is available.	Primary Care Physician (PCP) authorization for CA.
Other medical services	Services that are medically necessary and are covered by Medicaid.	In Plan for HMO.
Hospital Services: Outpatient	Covered for physician or dental visits. $3.00 copayment per visit. Visits are counted toward 24 visit limit, **EXCEPT** for emergency room visit. Emergency room services are exempt from $3.00 copayment. $3.00 co-payment for non-emergency room visits.	See page 47 for other coverage information.

Service	Brief Explanation of Coverage	Restrictions (in brief)
Nursing facility services	Covered. Physician visits not counted toward 24 visit limit. No copayment is required after patient liability is paid. Prior approval is required for all admissions to a nursing facility.	Recipients admitted to a nursing facility are not required to participate in any managed care program. See page 48 for more coverage information.
Mental Health Centers	Covered services include prevention, diagnoses, therapy, rehabilitation, and maintenance. No copayment. Prior approval not required.	Recipient must be a patient of the area program or its contract agency. Must have a current diagnosis, treatment plan, and goals on record. Mental health services do not require Carolina ACCESS Primary Care Physician referral and are not provided through any HMO.
Psychiatric and Psychological Services	Services by a psychiatrist are covered. **Prior approval required for outpatient visits after the first eight visits for adults and after the 26th visit for children under age 21.** Ask your physician to get approval. $3.00 copayment per visit. Psychiatrist services count toward the 24 visit limit unless the person is under 21.	Service must be provided by a psychiatrist, a licensed clinical social worker, clinical nurse specialist or a psychologist employed by a physician, an Area Mental Health program, or an agency or person that the Area Mental Health contracts with. These services do not require CA PCP referral.

Service	Brief Explanation of Coverage	Restrictions (in brief)
Case Management for the Mentally ill *The items below describe the service of case management* Assessment Coordination and Referral Monitoring	Covered **ONLY** for mentally ill adults 18 or older, emotionally disturbed youth under 18, substance abusers, and persons with developmental disabilities. Client's strengths, weaknesses, and services needed must be assessed. Then a service plan is developed. Resources are identified and coordinated, and the patient is then referred. Patient is monitored to ensure services are received and adequate for his or her needs.	These services do not require CA PCP referral. Must need assistance with two or more conditions (i.e., medical, social, vocational). Diagnosis must fit into one of the covered groups. The recipient cannot be receiving waiver services or live in a Medicaid covered facility or institution.
Mental Hospitals	Covered for patients 65 and older or 21 and younger. A recipient who turns 21 as an inpatient will be covered until age 22.	People under 21 must have a certification of need form to be admitted to a psychiatric hospital. These services do not require CA PCP referral.
NC Specialty Hospitals	Covered for inpatient care for chronic diseases (like tuberculosis)	

Service	Brief Explanation of Coverage	Restrictions (in brief)
Dental Services Routine services (incomplete list) Prior Approval Services (incomplete list)	Routine services include exams, cleanings and fluoride treatments, restorations, sealants, x-rays, and extractions. Stainless steel crown for baby teeth and permanent premolars and first and second molars up to age 21. Stainless steel space maintainer for baby tooth that is removed prematurely, up to age 21. Periodontal work covered with some limits. **Prior approved services** include: — Orthodontic services for children up to age 21 with severe alignment problems. — Complex oral surgeries. — Complete and partial dentures once every 10 years. — Relining of dentures 6 months after delivery and then no more than once every 5 years.	These services do not require CA PCP referral. See page 49 for more coverage information. Out-of-Plan services if you are covered by an HMO.
Chiropractic Services	Only manual manipulation of the spine to correct a spinal injury or degeneration. $2.00 copayment with exceptions. Office visits count toward 24 visit limit.	Problem must be proven by an x-ray dated within 6 months of the date of services and an appropriate diagnosis. See page 50 for more coverage information.
Podiatrists	Covers any medical, mechanical, or surgical procedure involving the foot. $3.00 copayment per visit. Office visits are counted toward 24 visit limit.	Routine foot care limited to specific diagnosis. See page 51 for more coverage information.

Service	Brief Explanation of Coverage	Restrictions
Hospice	Hospice is a package of medical and support services for terminally ill individuals. An individual is considered terminally ill if he or she has a medical prognosis of six months or less to live. The hospice services are related to the terminal illness. The services are provided in a private residence, an adult care home, a hospice residential care facility, or a hospice inpatient unit. They also may be provided in a hospital or nursing facility arranged by the hospice agency. Covered services include: ● Nursing care. ● Certain physicians' services provided by a licensed doctor of medicine or doctor of osteopathy. ● Medical social services. ● Counseling services for the patient, family members and others caring for the patient. Counseling, including dietary counseling, may be given to train the patient's family or unpaid caregiver to provide care. It also may be provided to help the patient and caregivers adjust to the patient's approaching death. ● Physical therapy, occupational therapy, and speech-language pathology services for the purposes of symptom control or to help the patient keep functioning. ● Short-term inpatient care (general and respite) in a hospice inpatient unit, or a hospital or nursing facility under contract with the hospice agency. ● Medical appliances and supplies, including drugs and biologicals. The drugs are those used primarily for pain relief and symptom control related to the terminal illness. Appliances include medical equipment as well as other self-help and personal comfort items related to the management of the patient's terminal illness. ● Ambulance services related to the management of the patient's terminal illness.	The patient must be terminally ill–that is, have a life expectancy of six months or less–as certified by his physician. A patient or the patient's representative elects Hospice coverage for a "benefit period"–a specific period of time for the coverage to be provided. During the time a patient elects Hospice, the patient waives Medicaid coverage of most other services for the treatment of the terminal illness and related conditions, since the Hospice package is designed to meet all of the patient's needs. These services do not require CA PCP referral.

Service	Brief Explanation of Coverage	Restrictions (in brief)
Durable Medical Equipment (DME)	Medicaid has a list of covered DME and related supplies. Medical necessity for the use of these items within your home must be documented by your physician.	**Prior approval is required** for some DME. Patients receiving Hospice funding may not receive DME coverage for items related to the treatment of the terminal illness. Patients receiving drug infusion therapy through HIT (home infusion therapy) coverage may not receive DME coverage for items related to the HIT coverage.
Orthotics and Prosthetics	Medicaid has a list of covered orthotic and prosthetic devices. Medical necessity for these items must be documented by your physician.	**Prior approval is required** for some of these devices. Available only to patients from birth through age 20.
Oxygen and Oxygen Equipment	Medical necessity for this equipment must be documented by your physician. The established coverage criteria must be met.	**Prior approval is required.**
Equipment Repair	Medicaid will pay for repair of patient-owned DME.	**Prior approval is required.** See page 52 for more information.

Service	Brief Explanation of Coverage	Restrictions (in brief)
Home Health Services	Covers the following services when they are medically necessary to help restore, rehabilitate, or maintain a patient in the home according to Medicaid guidelines and provided by a **Medicare-certified home health agency:** ● Skilled nursing visits ● Physical therapy ● Speech pathology and audiology services ● Occupational therapy services ● Home health aide services ● Medical supplies included on Medicaid's list of approved supplies	A Home Health service must be needed by a patient for care in the patient's home–which must be either a private residence or the adult care home where the patient resides. Home health aide services may not be provided to a patient in an adult care home. A Medicare or Medicaid Hospice patient may not receive Home Health Services related to the terminal illness.

Service	Brief Explanation of Coverage	Restrictions (in brief)
Personal Care Services (PCS)	Covers an in-home aide going to the private residence where the patient lives to perform: ● Personal care tasks for the patient who, due to a medical condition, needs help with such activities as bathing, toileting, moving about and keeping track of vital signs. ● Housekeeping and home management tasks that are essential, although secondary to the personal care tasks necessary for maintaining the patient's health.	The patient must: ● Have a medical condition that requires the direct and ongoing care of the physician prescribing PCS, ● Be medically stable at the maintenance level, ● Need help with personal care tasks due to the medical condition. Personal Care Services (PCS) must be the most cost-effective and appropriate form of care. PCS is to assist, not replace, the help available from family members and community resources. A patient may receive a maximum of 3 1/2 hours of PCS per day, up to 60 hours each calendar month according to the plan of care authorized by the patient's doctor. PCS may not be received on the same day as other Medicaid aide services. PCS may not be received by Medicare or Medicaid Hospice patients.
Personal Care Services Plus (PCS-Plus)	Same as PCS	Same as PCS with the following exceptions: ● A patient may receive up to 80 hours of PCS-Plus each calendar month (no daily limit) according to the plan of care authorized by the patient's doctor. ● Prior approval is required.

Service	Brief Explanation of Coverage	Restrictions (in brief)
Home Infusion Therapy (HIT)	Covers the following self-administered infusion therapies in a patient's home when the therapy is medically necessary: ● Total Parenteral Nutrition ● Enteral Nutrition ● Chemotherapy for cancer treatment (intrathecal and intravenous) ● Antibiotic therapy (intravenous) ● Pain management therapy (subcutaneous, epidural, intrathecal and intravenous) HIT is for patients who live in a private residence or an adult care home (like a rest home or family care home). "Self-administered" means that a patient and/or an unpaid caregiver is capable, able and willing to administer a therapy following appropriate teaching and with adequate monitoring. If the therapy cannot be self-administered, the care may be available under Home Health Services. Drug therapies include the equipment, supplies, nursing services, and pharmacy services needed for the administration of the drug. The package does not pay for the drug. It must be billed through the Medicaid Drug program. Nutrition therapy coverage includes the equipment, supplies, and formulas/solutions.	Medicare and Medicaid Hospice patients may not receive Home Infusion Therapy related to the terminal illness. This is covered under Hospice.

Service	Brief Explanation of Coverage	Restrictions (in brief)
Private Duty Nursing	PDN is medically necessary continuous, substantial, and complex nursing services by a licensed nurse (RN or LPN) that is needed by a patient for care in the patient's home. It is for patients who live in private residences. A patient must require substantial and complex continuous nursing care by a licensed nurse as documented by the patient's attending physician. This means: ● A patient care task can be done by only a licensed nurse, and ● The tasks must be done so frequently that the need is continuous--these are not tasks that could be reasonably handled by home health skilled nursing visits.	Medicare and Medicaid Hospice patients may not receive Private Duty Nursing. Prior approval is required. Having a nurse monitoring a patient in case something happens is not considered "continuous nursing care" that qualifies for PDN coverage.
Hearing and Visual Aids		
Hearing Aids	Covers conventional monaural or binaural hearing aids. Also covers supplies and batteries related to hearing aid. **Prior approval required for all services except batteries.** Coverage is only for individuals under age 21.	Must be ordered by a doctor, and patient must undergo a hearing evaluation. In-the-ear aids limited to children age 12 or older.
Eyeglasses	Covers routine eye exams by an ophthalmologist or optometrist and eyeglasses.**Prior approval required for all visual aids.** Contact lenses covered in special circumstances. Exams and visits are counted toward the 24 visit limit, **EXCEPT** for pick-up of glasses and supplies. Repairs over $5.00 are covered. **Prior approval required.** Copayments: $2.00 per pair of eyeglasses and supplies $2.00 per repair over $5.00 $3.00 per visit to opthalmologist $3.00 per visit to optometrist	Medicaid will pay only for frames designated by the program. Pink, gray and photochromic tints are generally covered for conditions that cause photophobia. Glass or plastic eyeglass lenses must have a prescription strength above a certain criteria to be covered. Vision services do not require CA PCP authorization.

Service	Brief Explanation of Coverage	Restrictions (in brief)
Lab Services	Covers lab work (blood, urine) ordered by a physician or other licensed practitioner. *Outpatient lab work or work done by an independent lab is not counted toward the 24 visit limit.*	Does not cover labs for routine physicals for adults. Paternity testing is not covered. Lab services do not require Carolina ACCESS primary care physician authorization.
X-rays	Covers all x-ray services. .	Does not cover x-rays taken during a routine physical. Must be ordered by a physician. These services do not require CA PCP authorization.
Therapy by Independent Practitioners	Covers physical therapy, occupational therapy, respiratory therapy, speech/language therapy, and audiology services. Prior approval required for treatment, but not for assessment. Services must be provided in the following settings: office, home, school, Head Start, or day care.	Must be ordered by a physician. Limited to recipients under 21.

Service	Brief Explanation of Coverage	Restrictions (in brief)
Anesthesia	Covered if medically necessary and provided by an anesthesiologist or a Certified Registered Nurse Anesthetist (CRNA).	These services do not require CA PCP referral.
Family Planning		
Basic Services	Covers consultation, examination, and treatment by a physician, nurse midwife, or nurse practitioner. Covers lab exams and tests.	
Birth Control	Covers pills, IUD, Norplant, Depoprovera. Covers natural family planning.	Hysterectomy for sterilization not covered.
Sterilization	Includes tubal ligation and vasectomy. Covered only if patient is mentally competent and over 21. Claim must be accompanied by a completed Medicaid consent form signed at least 30 days before the surgery. Exceptions are emergency abdominal surgery and premature delivery.	Sterilization reversals are not covered. For abdominal surgery, consent form must be signed at least 72 hours before surgery. For premature delivery, consent form must be signed at least 30 days prior to expected date of delivery and at least 72 hours prior to surgery.
Hysterectomy	Covered only if medically necessary. Claim must be accompanied by signed statement of the patient.	Family planning services do not require CA PCP referral.
Abortion	Covered only in cases of endangerment to the mother's life, incest, or rape. Claim must be accompanied by an abortion statement signed by the physician.	
Adult Health Screening	Covers annual physical exams, lab tests, and counseling and intervention for persons over 21 to prevent illness. $3.00 copayment per visit. Counts toward 24 visit limit.	Covers only one screening per calendar year. For Carolina ACCESS recipients, services must be provided by primary care physician.

Service	Brief Explanation of Coverage	Restrictions (in brief)
Medical Transportation		Referral by a CA PCP is not required for medically necessary transportation.
Non-Ambulance Services	Covers non-ambulance transportation to medical appointments for eligible people who have no other available means of transportation. Covers non-ambulance medically necessary transportation for recipients living in their homes. Recipients should apply for transportation through the local department of social services.	
Ambulance Services	Covers transportation by ambulance if individual's condition is such that any other means would endanger the individual's health or requires transport by stretcher.	Not covered if any other form of transportation is possible. See page 55 for other coverage rules.
Air Ambulance Transportation	Covers fixed wing or helicopter when medically and physically necessary. Must be to the nearest hospital with appropriate facilities.	
State-To-State Transportation	Covers non-emergency medically necessary transportation (ground or air) for out-of-state services or to return to North Carolina. **Prior approval must be given by DMA's fiscal agent before the service.**	
Dialysis Services	Covered if provider is either a Medicaid-enrolled provider or independently enrolled.	
Nursing Services		
Nurse-Midwife	Covered if practice is under the supervision of a doctor licensed to practice obstetrics.	
Nurse Practitioners	Covered if practice is with a licensed physician or independent practitioner in collaboration with a licensed physician.	

When you go to the doctor (physician)

Under Medicaid, you are usually allowed only 24 visits per year. This includes specialists, chiropractors, etc.

However, for some situations, you are allowed MORE than just 24 yearly visits to the doctor. Here are some possible exceptions:

- You are under 21.
- You see a doctor while in a hospital, nursing facility, or intermediate care facility for mentally retarded, or you live in an adult care home.
- You go to the dentist.
- You participate in a Community Alternative Program.

You can have more than 24 doctor's visits and more than 6 prescriptions if you have one of the following diseases:

1. End stage renal disease
2. Chemotherapy and radiation therapy for cancer
3. Acute sickle cell disease
4. End stage lung disease
5. Unstable diabetes (cannot be controlled by pills, diet, or insulin shots)
6. Hemophilia (blood can't clot properly)
7. Any life threatening illness or terminal stage of any illness

When you go to the doctor (physician)

Some of the things covered under this service include:

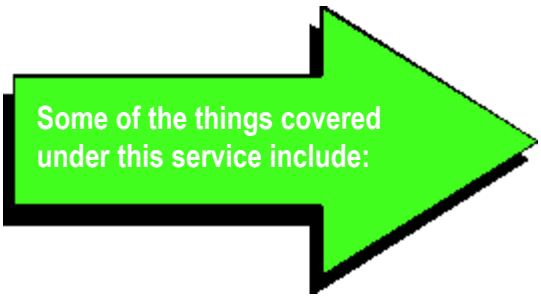
- Any services that are determined by a physician to be medically necessary and given in the office, your home, a hospital, a nursing facility, etc.
- Diagnosis, therapy, surgery, and consultation.

Make sure you have authorization or referral if your physician's name or HMO plan is printed on your Medicaid card!

- Injections if you can take the medicine by mouth.
- Routine foot care.
- Experimental drugs and procedures.
- Routine physicals and related tests, except through adult health screening, family planning, or nursing facility or adult care home.
- Incidental appendectomy.
- Sex transformation surgery.
- Sterilization reversal.
- Procedures or services for infertility.

Some things NOT covered under this service include:

When your doctor admits you to the hospital



- Bed and board in a semi-private room, except when a private room is medically required or the only room available.
- Regular nursing services.
- Any hospital facilities you use.
- Medical social services.
- Drugs and blood tests that you have or use while in the hospital.
- Supplies, appliances, or equipment that is used for your care while in the hospital.
- Medically necessary services that people get while they are in the hospital that are covered by Medicaid.

Make sure you have authorization or referral if your physician's name or HMO plan is printed on your Medicaid card!

- Private rooms when they are not necessary.
- Telephone bill.
- Use of the television.
- Private duty nurses or sitters.
- Noncovered services such as private duty nursing, take home supplies, leave days, etc.
- The day you are discharged.
- Any bills you may have for being discharged late because it was more convenient.
- Tests or surgery that is experimental.

When you go to the hospital and go home the same day

Some of the things covered under this service include:

- Any services you have from a physician or dentist in the hospital.
- Outpatient diagnostic services.
- Physical therapy or speech pathology.
- For therapy or rehabilitation, covers the use of the hospital facilities, clinic services, and emergency room services.

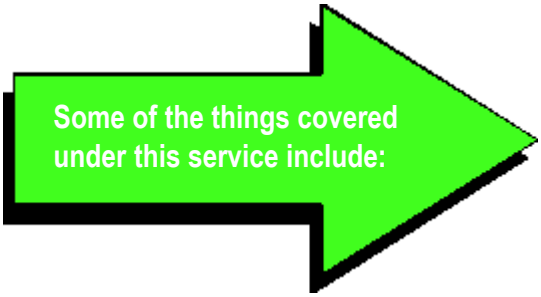
Make sure you have authorization or referral if your physician's name or HMO plan is printed on your Medicaid card!

- Supplies or equipment that you take home, unless it is a very small quantity of a supply or drug you need to use until you can get a continuing supply elsewhere.

Some things NOT covered under this service include:

When you or your family member is in a nursing facility

These are included in the regular payment to the nursing facility:



- A semi-private or private room that is ordered by your physician because it is medically necessary.
- Therapeutic leave days (only 60 days per calendar year).
- Over the counter drugs, such as aspirin, milk of magnesia, etc.
- Personal hygiene items and services.
- Personal laundry services.
- Any medically necessary vaccine or test you need to have while you are in the facility.
- Antiseptics, dressings, and medications.
- Equipment like walkers, wheelchairs, canes, air mattresses, bed pans, etc.
- Any physical, speech, or occupational therapy.
- Other items that may need to be used for your feeding, health, or safety.

- Private rooms when they are unnecessary.
- Reserving a bed while you are not there.
- Private duty nurses or sitters.
- Any amount that the county DSS tells you that you have to pay with your savings or monthly income.
- Telephones, televisions, or anything that you bring into the facility yourself.
- Hair care that you would not get under ordinary circumstances, such as a permanent, hair color, or a set.

When you go to the dentist

Dental Care for your Child: Most children need to have a dental check-up every six months. Your child may also need other dental care. Medicaid will pay for check-ups and needed treatment. (Not all services are covered by Medicaid.) Call 1-800-662-7030, in the triangle area 919-733-4261 or TTY dedicated line or 919-733-7851, to learn more about Medicaid dental services. You can also call this number if you need help finding or getting a dentist.

Some of the things covered under this service include:

- Routine exams, cleanings, restorations, and extractions.
- Full mouth x-rays once every 5 years.
- Root canals for front teeth for all recipients.
- Periodontal surgery if you have gum disease caused by an underlying medical condition.
- One full mouth scaling and root planing per year.
- Complete and partial dentures once every 10 years.
- Relining of dentures 6 months after delivery and then no more than once every 5 years.
- Facial reconstruction for birth defects or after a serious accident.

Dental services do not require authorization by your Carolina ACCESS physician.

- Fixed bridgework.
- Experimental procedures.
- Prescription drugs the dentist gives you while you're in his office.
- Implants or transplants.
- Cosmetic procedures.
- Night guards or occlusal splints.
- Gold or porcelain restorations or crowns.
- Temporary dentures.
- Space maintainers that are removable, and retainers for braces that are not included in the orthodontic package.

Some things NOT covered under this service include:

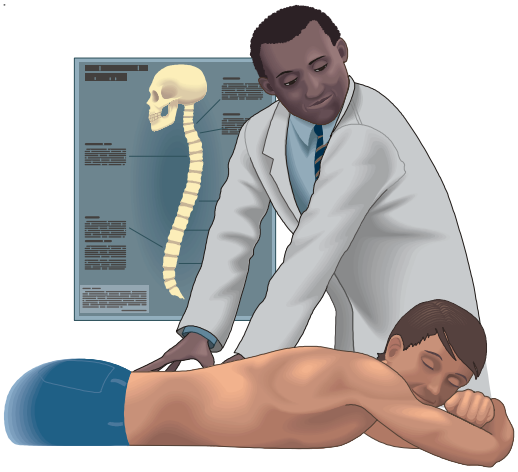
When you go to the chiropractor

Some of the things covered under this service include:

- Any manual manipulation of the spine to correct a misalignment.
- Most x-rays.

Some things NOT covered under this service include:

- Office visits.
- Nutritional supplements.
- Physical therapy.
- Any diagnostic or therapeutic service not involving a misalignment.



When you go to the podiatrist (foot doctor)

Some of the things covered under this service include:

- Any procedure connected to the surgical, medical, or mechanical treatment of the foot.
- Routine foot care ONLY IF you have a disease such as diabetes mellitus or peripheral vascular disease. You must be under the care of a physician for the condition and have documentation to support the need for the service.

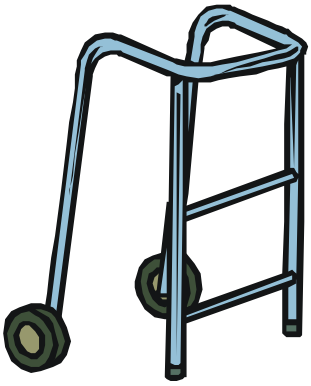
- Procedures that don't have anything to do with your feet.
- Routine foot care, like removal of corns or calluses, cutting toenails, including ingrown toenails, club nails, or mycotic nails, and cleaning or soaking the feet.
- Orthotic devices.
- Arch supports, pads, or shoe inserts.

Some things NOT covered under this service include:

When you need durable medical equipment (DME)

Some of the things covered under this service include:

- Wheelchairs, walkers, canes, hospital beds, and other medically necessary equipment which is on the Medicaid list.
- Oxygen and oxygen equipment.
- Related medical supplies which are on the Medicaid list.



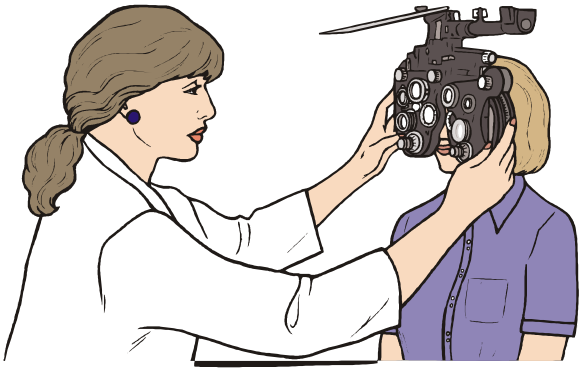
Some things NOT covered under this service include:

- Items not required for function within your home.
- Items you use for your convenience.
- Equipment for someone in a nursing facility. This should be covered in your per diem rate for the home.

When you need eyeglasses

Some of the things covered under this service include:

- One eye exam per year, and one pair of eyeglasses per year or other visual aids in plastic or combination plastic/metal frames if you are under age 25.
- One eye exam and one pair of glasses every 2 years if you are 25 or over.
- Repairs on glasses over $5.00.
- Lenses when the prescription is over a certain strength.
- Contact lenses if you are a child in school, have keratoconus, progressive myopia, or aphakia.
- Pink-tinted lenses if medically necessary.



Some things NOT covered under this service include:

- Artificial eyes.
- Wire or rimless frames.
- Safety glasses.
- Extended wear or disposable contact lenses, and contact lens supplies.
- Tinted lenses unless medically necessary.
- Prescription sunglasses.
- Sport straps, straps, or chains
- Initials or names on frames or lenses.
- Magnifying glasses you get at the store.
- Repairs that cost under $5.00.
- Cosmetic lenses.
- Visual training therapy and training devices.

When you need a hearing aid

Some of the things covered under this service include:

- One initial care kit.
- Custom ear molds.
- Receivers, accessories, batteries.
- Repairs and loaners.
- Dispensing or trial rental fees.

- Battery chargers or testers.
- Adapters for telephones, television, or radios.
- Shipping/handling fees, postage, or insurance.
- Loss or damage insurance.
- Hearing aids for anyone over 21.

Some things NOT covered under this service include:

When you need assistance with transportation to medical providers

Some of the things covered under this service include:

- Ambulance transportation for emergencies.
- Transportation by helicopter when approved.
- State to state transportation.
- Transport to Medicaid covered service.

Some things NOT covered under this service include:

- Transport for maintenance dialysis unless medically necessary.
- Ambulance transport for convenience.
- Transport to a medical service that is not covered by Medicaid.
- Transport to a more distant physician at the individual's request.
- Transport of a dead person who has been pronounced dead before the ambulance is called.
- Transport to services for which DMA already includes cost of transportation in reimbursement rate.

If a Medicaid claim is denied...

If you receive a bill for a service that Medicaid covers after you were told you qualified for Medicaid, and your doctor agreed to accept Medicaid payment, you are not responsible for the bills. You have the right to a "reconsideration review" if Medicaid denies payment of a bill. If you want a reconsideration review, you have to ask for it no later than 60 days after the first bill.

Send the bill to:

Claims Analysis
N.C. Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501

You also should write a letter and send that in with the bill. In the letter, please have:

1. The reason you are requesting the review.
2. Your Medicaid identification number.

Your review will take place within 20 days after Claims Analysis gets your letter. They will send you their decision in writing.

Frequently Asked Questions

1. How long can I receive Medicaid services after being determined eligible?

Benefits continue as long as you meet the qualifications. Your worker will review your status every 6 to 12 months depending on what type of Medicaid you have.

2. Where do I get my Medicaid card, and what do I do if I lose it?

You will receive your Medicaid card every month through the mail. Most people receive their card by the 5th of the month. The card is good only for the month printed on the bottom right of the card. You must show the card whenever you get medical treatment or go to the drug store.

If you lose your Medicaid card, call your local DSS and request a replacement card. However, the replacement card will not have the pharmacy stub attached. Ask your caseworker how to get your prescriptions covered.

3. What if my Medicaid card doesn't come?

If you do not receive your card, contact your county DSS. If the card came but cannot be located, the county will issue you another card. The replacement card does not have the pharmacy stub attached. Ask your caseworker how to get your prescriptions covered.

Frequently Asked Questions

4. If my income is too high for me to receive Medicaid, is there another health care program I can have?

Your children may qualify for the North Carolina Health Choice for Children program if they are under age 19 and don't have any other health insurance. You can call 1-800-367-2229 to learn more about this program to see if you might be eligible.

If your income is over the income limit, you may still qualify for Medicaid if you can meet a deductible. See page 10.

5. How do I find my local Department of Social Services?

To find the telephone number, look in the county government section of your phone book. These pages are usually blue. You can also call directory assistance or call the CARE-LINE Information and Referral Service at 1-800-662-7030. In the Triangle area, call 919-855-4400. Hearing impaired callers may call either of the above numbers or the TTY dedicated line at 919-733-4851. CARE-LINE is available Monday through Friday 8 a.m. to 5 p.m. except state holidays. A bilingual information and referral specialist is available for Spanish-speaking callers.

6. Do I have to join a Managed Care Plan?

You must join a Managed Care Plan (either Carolina ACCESS or an HMO, in Mecklenburg county) if you receive Medicaid under any of the following Medicaid programs:

Work First Family Assistance (WFFA)
Medicaid for Families and Children (MAF)
Medicaid for Infants and Children (MIC)

You can choose whether or not to join a Managed Care Plan if you are eligible for both Medicaid and Medicare.

If you receive assistance as a refugee or as a non-citizen (alien), you cannot have a Managed Care Plan.

7. Is there someplace I can email my questions?

You can email questions regarding Medicaid to either the Division of Social Services website at dssweb@ncmail.net or the Office of Citizen Services CARE-LINE, Information and Referral Service, website at care.line@ncmail.net. Medicaid can answer your email electronically but the email is not secure. Therefore, when you email your question please indicate if you want your reply via email or U.S. Postal Service. If you want it through the U.S. Postal Service, ensure we have your mailing address.

8. Do I have to join a prescription drug plan if I have Medicare and Medicaid?

You must enroll in a prescription drug plan to have prescription coverage. Medicaid recipients who are entitled to Medicare will no longer receive prescription coverage through Medicaid as of January 1, 2006.

North Carolina Medicaid
NOTICE OF PRIVACY PRACTICES

Effective Date:
April 14, 2003
NC Division of Medical Assistance

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR PRIVACY RIGHTS, OUR RESPONSIBILITIES

Medicaid collects and maintains health information about you and is required by law to protect the privacy of your health information and to provide you with this Notice of Privacy Practices. This *Notice* describes how Medicaid may use and share your health information and explains your privacy rights. Medicaid will use or disclose your health information only as described in this *Notice.* We do, however, reserve the right to change our privacy practices and the terms of this *Notice* and to make new notice provisions effective for all health information that we maintain. Revised notices will be sent to you and will be available through the Medicaid contact. (See Contact Information on reverse page.) We will not change our privacy practices before you are sent a revised *Notice* unless the change is required by law.

When you were approved for Medicaid, the County Depart-ment of Social Services sent your health information to the Division of Medical Assistance so that Medicaid could pay for your health care. This information included your name, address, birth date, phone number, social security number, Medicare number (if applicable) and health insurance policy information. It may also have included information about your health condition. When your health care providers send claims to Medicaid for payment, the claims include your diagnoses and the medical treatment and supplies you received. For certain medical treatments, your health care provider must send additional medical information such as doctor's statements, x-rays or lab test results.

If at any time, you have questions or concerns about the information in this *Notice* or about our agency's privacy policies, procedures or practices; you may contact the Medicaid Privacy Official. (See Contact Information on reverse page.)

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION WITHOUT AUTHORIZATION

There are some services Medicaid provides through contracts with other agencies such as your County department of Social Services and through private contractors that process your health care provider claims. When services are contracted, Medicaid must share enough information about you with their contractors so that they can perform the job that Medicaid has asked them to do.

To further protect your health information Medicaid will only disclose your health information after making sure in writing that its contractors will safeguard your information the same way that Medicaid does.

This agency may use or disclose your health information to provide Medicaid services to you

FOR Payment: Medicaid may use or disclose your health information to its contractors who provide payment services for Medicaid. (EXAMPLE: In order for your health care provider's claim to be paid, the contractor who processes claims for payment must have enough health information about you to verify and pay for the services you received).

Treatment: To determine if your treatment is medically necessary and is covered under Medicaid, we may use or disclose your health information to other health care professionals. These professionals have specific medical expertise so that they can give an opinion on your treatment as being medically necessary.

Health Care Operations: Medicaid may use or disclose your protected health information to perform a variety of business activities that we call "health care operations." These operations ensure that you receive quality care; the charges are appropriate for the service that you received, and that your health care providers are paid promptly. (EXAMPLE: We may contract with a private company to review the care and services our clients have received to ensure that quality care was provided.) Other "operations" that may require your protected health

information to be shared are to:

- Review and evaluate the skills, qualifications and performance of health care providers that are taking care of you.
- Provide training programs for students, trainees, professional and non-professional staff to allow them to use under supervision the skills they have learned.
- Provide information to certifying and licensing agencies so that staff may fulfill professional requirements.
- Plan our agency's future operations.
- Enhance investigations conducted by administration whenever a staff member within our agency files a grievance, or protests a particular issue.
- Provide information to other health plans and federal agencies to determine if you are enrolled as their member or covered by them.

Other Circumstances:

- Cooperate with other government agencies and outside organizations that conduct health oversight activities for the purposes allowed under federal law.
- Comply with court orders, subpoenas, administrative orders, lawsuits related to administration of Medicaid.

Contacting You:

- Contact you personally to keep you informed, such as appointment reminders, other treatment opportunities when necessary or available under certain selected public agency benefit programs.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION THAT REQUIRES YOUR AUTHORIZATION

Medicaid will not use, communicate or disclose your protected health information without your authorization except as allowed in the circumstances mentioned above. For all other uses or disclosures, we will ask you to sign a written authorization to allow us to share or request your protected health information. You may cancel such authorization by notifying our agency Privacy Official.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Medicaid clients have certain rights about their protected health care information.

YOU HAVE THE RIGHT TO:

- **Receive a copy of this *Notice*:** You have a right to a paper copy of this notice. You may also obtain a copy of this *Notice* by accessing Medicaid's web site at **http://www.dhhs.state.nc.us/dma** **Click** "Consumer".
- **Request confidential communications:** You have a right to request that Medicaid communicate with you in a certain way or at a certain location, such as calling you at work rather than at home.
- **Inspect and copy:** You have a right to request in writing to see your records and obtain a copy within 30 days at a reasonable fee. There are some exceptions to this right such as impending court actions. If this right is denied, you will be notified in writing of the reason for denial and your right to request review of the denial.
- **Request amendment:** You have a right to request in writing that portions of your Medicaid records be corrected when you feel information is incorrect or incomplete. We may deny your request if the information was not created by this agency or if we believe the information is accurate. You may then file a statement of disagreement that will be included in any future disclosures if you request it.
- **An accounting of disclosures:** You have the right to request in writing and receive a written list of certain disclosures of your protected health information made after April 14, 2003. Exceptions from this list include those disclosures regarding treatment, payment or other health care operations or disclosures allowed by certain laws, or disclosures authorized by you.
- **Request restrictions on uses and disclosures of your protected health information:** You have a right to request restrictions on the information Medicaid uses or discloses about you. Medicaid is not required to agree to your re

quested restriction, but it will consider your request and the possibility of accommodating it.

- **Complain:** If you feel we have violated your privacy rights, you may contact either of the agencies listed below. If you file a complaint, we will not take any action against you or change our treatment of you.

COMPLAINT ADDRESSES

NC Department of Health and Human Services

Operates an information and referral service located in the Office of Citizen Services, known as **CARE-LINE**, which receives and documents complaints and concerns regarding the privacy practices, policies and procedures related to the protection of individually identifiable health information. Contact information is as follows:

CARE-LINE Email: care.line@ncmail.net
2012 Mail Service Center
Raleigh, NC 27699-2012
Voice Phone: 1-800-662-7030 (Toll Free)
(919) 855-9400 (Triangle Area)
FAX: (919) 715-8174
TTY (919) 733-4851

Secretary, US Department of Health & Human Services

You may also send a written complaint to the Secretary of the United States Department of Health and Human Services. Contact information is as follows:

Office for Civil Rights
U.S. Department of Health & Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
Voice Phone (404) 562-7886
FAX (404) 562-7881
TDD (404) 331-2867

CONTACT FOR FURTHER INFORMATION

Medicaid Privacy Official
c/o DHHS CARE-LINE Email:
care.line@ncmail.net
2012 Mail Service Center
Raleigh, NC 27699-2012
Voice Phone: 1-800-662-7030 (Toll Free)
(919) 855-4400 (Triangle Area)
FAX: (919) 715-8174
TTY (919) 733-4851

YOUR RIGHT TO APPEAL A DECISION ABOUT YOUR MEDICAID SERVICES

If you are denied medical care or services because Medicaid did not approve the care, you will receive a letter explaining the decision and telling you how you can appeal the denial.

Medicaid may also decide to reduce or stop the services you are getting. You will receive a letter before the change happens. If you appeal the decision by the deadline in the letter, your services will continue during the appeal. The letter will explain how to appeal.

HOW TO APPEAL: You have the choice of two ways to appeal if you don't agree with the decision to deny or change your Medicaid services or if a decision on your request for services is not made within a reasonable time:

1. You can ask for an **INFORMAL APPEAL** with the Division of Medical Assistance. **YOU HAVE 11 DAYS FROM THE DATE OF THE NOTICE OF DENIAL OR CHANGE TO ASK FOR THIS APPEAL**.

OR

2. You can file a **FORMAL APPEAL** with the Office of Administrative Hearings. **YOU HAVE 60 DAYS FROM THE DATE OF THE NOTICE OF DENIAL OR CHANGE TO FILE THIS APPEAL**.

IF YOU DO NOT GET A WRITTEN NOTICE:

Medicaid must make a decision promptly when your doctor or other medical provider requests Medicaid approval for services you need. If you don't get a decision within fourteen business days after when the service was requested, call your doctor or other medical provider to ask about the request. If your provider didn't cause the delay, you have the right to appeal Medicaid's failure to act on the request promptly.

Medicaid also must send you a written notice before the services paid for by Medicaid can be stopped or reduced.

If Medicaid has not sent you a notice but has not approved your request for services or has stopped or reduced your services, you can file an informal or formal appeal within a reasonable time after you requested the service and learned of your right to appeal. If services have been reduced or stopped, the services will be reinstated pending your appeal.

HOW TO ASK FOR AN INFORMAL APPEAL:

• To ask for an informal appeal, complete and return the **informal appeal** form a sample is included at the end of this booklet (See Page 63). **Attach a copy of the notice of denial or change**. You can fax the form or mail it. See the instructions on the form.
• **DMA must receive the form no later than eleven days from the date of the notice of denial or change, unless you have good cause for delay.**
• In an informal appeal, you can have a hearing in person (in Raleigh, NC) or by telephone. A hearing officer at the Division of Medical Assistance decides informal appeals.
• You may speak for yourself, or be represented by an attorney, relative, or other spokesperson. You can ask witnesses such as your doctor to be part of the hearing or to write a letter. You will get a written decision from the hearing officer.
• If you still disagree with the hearing officer's decision, you can ask for a formal appeal after you get the decision. You will get written instructions with the decision on how to do that.

HOW TO FILE A FORMAL APPEAL:

• Formal appeals are before a judge from the Office of Administrative Hearings.
• To file a formal appeal, you must send in a contested case petition form. You can get that form by calling the DMA Hearing Office at (919) 647-8200 or 1-800-662-7030. Or you can call the Office of Administrative Hearings at 919-733-2698. You must mail the contested case petition form to **both** the Office of Administrative Hearings **AND** Legal Counsel, NC Department of Health and Human Services, 6714 Mail Service Center, Raleigh, NC 27699. **Attach a copy of the notice of denial or change.**
• **The contested case form must be filed with the Office of Administrative Hearings no later than sixty (60) days from the date of the notice of denial or change.**
• An administrative law judge will make a decision in your case. The agency then reviews that decision.
• Further appeal to court is allowed after the agency decision.
• You may represent yourself in this process, or you may hire a lawyer.
• If you ask for an informal appeal within the eleven day deadline, you can still ask for a formal appeal after your informal appeal is over. You will have 60 days after the informal appeal decision to ask for a formal appeal.

To learn more about the informal appeal process, call the DMA Hearing Office at (919) 647-8200. To learn more about the formal appeal process, call the Office of Administrative Hearings at (919) 733-2698. You may also call the toll free CARELINE at 1-800-662-7030. **Free legal aid may be available to assist with your appeal**. Contact your nearest Legal Aid or Legal Services office. Or you can call 1-877-694-2464 to find out the phone number of the Legal Aid office that serves your community.

YOUR RIGHT TO CONTINUED SERVICES PENDING AN APPEAL:

If you appeal a decision to stop or reduce your services, the service you were getting will continue during the appeal, so long as you remain otherwise eligible for that service. Medicaid will continue to pay for the services you received before the change until the end of the appeal process, unless you give up that right. If you lose a formal appeal, you may be required to pay for the services that continue because of the appeal.

FOR MORE INFORMATION about the service appeal process, visit
http:// www.dhhs.state.nc.us/dma or call CARE-LINE at 1-800-662-7030.

INFORMAL APPEAL REQUEST FORM

To ask for an **informal** appeal, please complete the following information and send it by mail or fax to the following address:

Hearing Office
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
FAX NUMBER: 919-715-6394

If you can, include a copy of the notice you want to appeal. But keep a copy of that notice.
We must receive this form no later than ELEVEN (11) days from date of the attached notice.

[Insert name of Medicaid recipient]
[Insert address of Medicaid recipient]
[Insert MID number]

I would like to appeal the denial of [Insert Service being denied/reduced].

Check which type of hearing you want:

☐ In-person hearing in Raleigh, North Carolina.

☐ Telephone hearing, using the telephone number listed below.

_____ _____
Signature of Medicaid Recipient or Responsible Party Date

Relationship to recipient: _____
Phone Number (with area code): ( ) _____
Address (if different than above): _____

Fill out the next section if you have a lawyer or other representative to assist you in this appeal:

I authorize the following person to represent the above recipient. Upon request, I authorize you to release any and all medical records and other documents and confidential information which may pertain to the hearing.

Name of Representative: _____
Address: _____
_____
Phone: ( ) _____

_____ _____
Signature of Medicaid Recipient or Responsible Party Date

To ask for a formal appeal, do NOT use this form. Follow the instructions on the attached notice. You have **SIXTY DAYS** from the date of the attached notice to ask for a **formal** appeal. If you have questions, you may call the toll-free CARELINE at 1-800-662-7030. Ask for the DMA Hearing Office.

SAMPLE ONLY Not For Use.