North Carolina Department of Health and Human Services
Division of Medical Assistance

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Beverly Eaves Perdue, Governor
Lanier M. Cansler, Secretary
Craigan L. Gray, MD, MBA, JD, Director

April 4, 2011

Subject: Recipient Notice regarding appeal rights, medical services general information and changes

Dear County Director of Social Services:

During the month of April, a mass mailing regarding appeal rights, general information, and changes in medical services will be sent to all Medicaid and Health Choice recipients. One notice will be mailed to each case head/payee, regardless of how many cases are in EIS. The language of the notice (English or Spanish) is determined by the language preference in EIS for the case head. An English version of the notice has been posted on the website at http://www.ncdhhs.gov/dma/pub/consumerlibrary.htm and is also attached. A Spanish version of the notice is being translated and will be posted upon completion.

If you have any questions regarding this information, please contact your Medicaid Program Representative.

Sincerely,

Craigan L Gray, MD, MBA, JD, Director

CLG/sr
Attachments

Recipient Notices, April 2011

This notice is being sent to <u>all</u> Medicaid and NC Health Choice recipients so that everyone knows about the important information and changes. You may not be receiving any of these services.

Important Information For Medicaid Recipients Under Age 21

<u>This pertains to all services mentioned in this notice</u>. Children under age 21 who have Medicaid are entitled to medically necessary screening, diagnostic and treatment services that are needed to "correct or ameliorate defects and physical and mental illnesses and conditions" under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, regardless of whether the requested service is covered under the Medicaid State Plan. For more information about EPSDT, please refer to: http://www.dhhs.state.nc.us/dma/epsdt. EPSDT does not apply to children who have NC Health Choice.

IMPORTANT INFORMATION FOR MEDICAID AND NORTH CAROLINA HEALTH CHOICE FOR CHILDREN RECIPIENTS

This notice is to let you know about important information and changes that are going to be taking place in Medicaid and NC Health Choice medical services over the next several months.

<u>Child Residential Services</u>

Reminder: Parents and legal guardians should participate in treatment team meetings with your provider to help determine what services are best for you or your child. It is especially important to be involved in these meetings if the treatment team is considering an out of home treatment for a child. The treatment team should meet with you throughout the treatment to monitor progress and to plan for discharge back into the community.

<u>Behavioral Health Services</u>

Independent assessments for some behavioral health services may be recommended for you or your child in order to make sure that you or your child are receiving the most effective services.

Remember to contact your LME if you need to locate behavioral health services, especially if your agency closes. If you need assistance in locating the LME in your area or a contact number for the LME, please call the DHHS Hotline at CARE-LINE Information and Referral Service (Help finding the programs and people to help you): 1-800-662-7030.

Please contact Medicaid Behavioral Health Unit at 919-855-4290 if you have any other questions.

<u>Incontinence Supplies</u>

Effective May 1, 2011, Neil Medical Group, Kinston, NC, is the designated preferred supplier for incontinence products (diapers) and gloves. There will be no change in the way you receive your supplies. You can contact the Neil Medical Group at 1/800-735-9111 or1/800-758-1050.

IMPORTANT INFORMATION FOR NORTH CAROLINA MEDICAID RECIPIENTS

This notice is to let you know about important information and changes that are going to be taking place in Medicaid medical services over the next several months.

Do You Need an Eye Exam AND Medicaid glasses?

NOT ALL EYE DOCTORS FIT MEDICAID EYEGLASSES! If you are eligible for a Medicaid eye exam and glasses, make sure your eye doctor will do both for you. If not, he may offer a list of places you can go for your Medicaid glasses, but many places will not fill Medicaid eyeglasses prescriptions from another doctor, even if they are on the list. You may have difficulty finding a different doctor who will make your Medicaid glasses. BEFORE scheduling your eye exam ALWAYS ask, "Can I get my eye exam AND Medicaid glasses at your office?" If you can't get both, you have the right to make your appointment with a different doctor who will provide an eye exam AND Medicaid glasses.

If you need help finding an eye doctor, please call the CARE-LINE Information & Referral Service at 1-800-662-7030. Remember to always ask if the doctor will provide a Medicaid eye exam AND Medicaid glasses.

Brand-name drug versus Generic drug

In the near future, when requesting a brand-name drug, if the brand-name drug has an equal generic, the doctor may be required to get prior authorization before the brand-name drug can be dispensed.

Antipsychotics in North Carolina Children – Keeping It Documented for Safety (A+KIDS)

Starting in early April, when prescribing an antipsychotic drug for a patient age 17 and under, the doctor will be requested to provide information to Medicaid about safety monitoring done while the recipient is on the medication. The doctor is responsible to provide the information to Medicaid. Some names of antipsychotics are Abilify, Geodon, Risperdal (risperidone) and Seroquel.

Coverage of Prescription Vitamins and Mineral Products for North Carolina Medicaid Recipients

Effective April 13, 2011 Medicaid will no longer pay for certain prescription vitamin and mineral products. Prescription prenatal vitamin and fluoride products will continue to be covered for Medicaid patients only. If you are dual-eligible (meaning you have both Medicare and Medicaid), Medicaid will not pay for any vitamin or mineral products.

Life Line/Link Up Discount Telephone Service

Link-Up provides a 50% discount, up to $30, off the cost of having a telephone installed. Lifeline provides up to $13.50 off the monthly cost of local telephone service.

Medicaid recipients are eligible for Lifeline/Link-Up benefits. Contact a telephone company of your choice. Request a LIFELINE/LINK-UP SELF-CERTIFICATION FORM. Complete the SELF-CERTIFICATION FORM and return it to the telephone company, and make an application for local telephone service. If you are eligible for Lifeline/Link-Up benefits, you will receive the installation discount and the monthly local service discount. **Note**: If your telephone service has been disconnected for unpaid bills, you may still be able to obtain local telephone service and these discounts. Ask your telephone company for details.

Attorney General Roy Cooper, Chair of the Lifeline/Link-Up Task Force, urges you to contact your local telephone company to learn more about these discounts.

Who to Contact With Questions About Information in This Notice: For questions or concerns please contact the CARE-LINE Information & Referral Service at 1-800-662-7030 (English/Spanish) or 1-877-452-2514 (this is a TTY number and only those with TTY equipment can talk to a person when this number is dialed). The CARE-LINE is available to assist you Monday – Friday 8 am to 5 pm.

THIS INFORMATION DOES NOT APPLY TO HEALTH CHOICE RECIPIENTS.

MEDICAID PRIOR APPROVAL AND MEDICAID RECIPIENT APPEAL PROCESSES

Medicaid is an entitlement program, and it is a recipient's constitutional right to appeal a Medicaid decision that denies, reduces, terminates, or suspends a request for Medicaid services. This document provides a summary of the Medicaid prior approval and recipient hearing processes.

MAKING A REQUEST FOR SERVICES: If the service requires prior approval from Medicaid, the request must be sent to Medicaid for review and approval by the recipient's physician, psychiatrist, psychologist, other licensed clinician, or provider before the service starts. It is the provider's responsibility to fully document the request to demonstrate medical necessity. The provider may submit additional information such as recent evaluation reports from clinicians, recent treatment records, and letters signed by treating clinicians which explain why the service is medically necessary. It is important to note that Medicaid may need to talk with the recipient, recipient's physician, psychiatrist, psychologist, or other licensed clinician, or provider about the service request. The purpose of these contacts is to obtain additional clinical information about the request. During these contacts, Medicaid will not discourage a recipient or provider from continuing with the request that has been submitted for review or ask a recipient or provider to withdraw a request or modify a request to accept a lower amount, level, or type of service.

AUTHORIZING PAYMENT FOR SERVICES WHILE A REQUEST FOR CONTINUED SERVICE IS UNDER REVIEW BY MEDICAID: Some important points appear below.

- If the provider submits the reauthorization or continuing service request at least 10 calendar days **PRIOR** to the end of the current authorization period, services will continue without interruption even if Medicaid is unable to make a decision prior to the end of the current authorization period. **EXCEPTION:** Requests for Community Alternatives Programs (CAP), inpatient or emergent services are not subject to this 10 calendar day requirement. If submitted prior to the expiration of the authorization period, services must continue without interruption.
- If the provider does not request reauthorization of a service at least 10 calendar days prior to the end of the current authorization period, there may be a break in payment authorization for the service if Medicaid is unable to complete the review by the time the current authorization expires.
- If the request is submitted after the end of the current authorization period, the request will be treated as an initial request. That means payment for the service stops when the current authorization period ends and resumes effective the date the notice is mailed.

ISSUING A DECISION ABOUT A SERVICE REQUEST: When a request is submitted, Medicaid will review the request to be sure it understands who is to receive the service, who is to provide the service, and what service is being requested. If Medicaid cannot make this determination or if any documents or forms required by state or federal law are not submitted with the request, the request will be returned to the provider as "unable to process". Appeal rights do not apply as no decision could be made about the request. A new request for service may be submitted at any time.

On occasion, a provider may submit a request without including required clinical information that explains why the recipient needs the service requested. This is an incomplete request, and it will be denied. Appeal rights apply; however, a new request with the needed documentation may be submitted at any time.

When Medicaid receives a complete request, it will approve, deny, reduce, terminate, or suspend the request. If the request is denied, reduced, terminated, or suspended, the recipient and provider will be notified in writing. The letter (notice) will state the action taken, specify the reasons for the action, and explain how to appeal Medicaid's decision. The recipient's mailing will contain the notice and an appeal request form and will be mailed by trackable mail to the last address filed by the recipient with his/her county Department of Social Services. **It is important for the recipient to update his/her address with the county Department of Social Services as this is the address Medicaid uses to communicate information about the Medicaid program. It is also important for the recipient to accept trackable mail from Medicaid as the mailing often contains news about services requested on his/her behalf.**

If a notice is lost or never received, duplicate notices may be obtained by contacting the CARE-LINE Information and Referral Service at 1-800-662-7030 (English/Spanish) or 1-877-452-2514. (Note: this is a TTY number that is only answered for deaf or hearing impaired callers). In the Triangle area, call 919-855-4400 (English/Spanish) or 919-733-4851 (TTY for hearing impaired). The CARE-LINE is open from 8:00 a.m. until 5:00 p.m., Monday - Friday.

Please note the following:

- Should the notice have been addressed to the wrong person or address, or for some other error made by Medicaid, a new notice with an updated date MUST be issued.
- Should the notice have been properly addressed to the right person at the latest address on file with the recipient's county Department of Social Services, a new notice will be issued upon request by the recipient or his/her legal guardian, but the date will not be updated.

FILING A RECIPIENT HEARING REQUEST FORM: Medicaid recipients or their personal representatives have the right to appeal adverse decisions of the State Medicaid agency and to receive a fair hearing in accordance with the Social Security Act, 42 C.F.R. 431.200 *et seq.* and the North Carolina General Statutes, N.C.G.S. §108A-70.9. If the recipient decides to appeal Medicaid's decision to deny, terminate, reduce, or suspend the services requested by his/her provider, the recipient or his/her personal representative must sign and date the appeal request form and send it to the Office of Administrative Hearings (OAH) by mail or fax within **30 days of the date the notice was mailed**. The mailing address and telephone and fax numbers for OAH are located on the appeal request form. Providers may not file appeals on behalf of recipients unless the recipient lists the provider as the representative on the appeal request form.

UNDERSTANDING THE APPEAL PROCESS: If the recipient chooses to appeal, he/she may represent himself/herself during the appeal process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for them. The recipient's case will begin as soon as the completed recipient hearing request form is **received** by the OAH. The recipient will be contacted by OAH or the Mediation Network of North Carolina to discuss his/her case and to be offered an opportunity for mediation in an effort to resolve the appeal. Contact is made by telephone or **trackable mail**. So, it is important to accept all **trackable mail** from OAH or the mediation center.

New information about the recipient's request that was not provided to Medicaid previously may be submitted at any time during the mediation and appeal processes. While mediation is an informal process, **it is confidential and legally binding.**

If the recipient does not accept the offer of mediation or the results of mediation, the case will proceed to hearing and will be heard by an administrative law judge with OAH. The recipient will be notified by **trackable mail** of the date, time, and location of the hearing. The administrative law judge will make a decision and will send it to Medicaid for a final agency decision. The petitioner(s) will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision by **trackable mail**. The recipient and provider should not act on the administrative law judge's decision because Medicaid must review the decision and issue the final agency decision. If the recipient does not agree with Medicaid's final agency decision, he/she may ask for a judicial review in superior court. The hearing process must be completed within 90 days of OAH's receipt of the completed Recipient Hearing Request Form.

***IMPLEMENTING THE FINAL AGENCY DECISION*: THE RECIPIENT SHOULD NOTIFY THE PROVIDER WHEN THE FINAL AGENCY DECISION FROM MEDICAID IS RECEIVED.**

The final agency decision shall be implemented no later than three business days from the date the decision was mailed to the petitioner(s). If the service is approved, the notice will state the conditions under which the service will be provided and when new requests for services should be submitted.

PROVIDING SERVICES DURING THE APPEAL PROCESS (Maintenance of Services): Maintenance of services means that a recipient is entitled to receive services during the pendency of the appeal when a request for a continuing service is denied, reduced, terminated, or suspended. Maintenance of services will be provided as described below as long as the recipient remains otherwise Medicaid eligible, unless he/she gives up this right.

- If the recipient appeals within **10 days of the date the notice was mailed**, payment authorization for services will continue without a break in service. Authorization for payment must be at the level required to be authorized on the day immediately preceding the adverse determination or the level requested by the provider, whichever is less.
- If the recipient appeals more than ten calendar days but within 30 calendar days of the date the notice is mailed, authorization for payment must be reinstated, retroactive to the date the completed appeal request form is received by the OAH. Authorization for payment must be at the level required to be authorized on the day immediately preceding the adverse determination or the level requested by the provider, whichever is less.

Maintenance of services (authorization of payment during the pendency of the appeal) will **not** be authorized if:

- The recipient appeals more than 30 days after the date the notice was mailed.
- The recipient's service request was submitted after his/her current authorization for services expired. Medicaid will treat this request as an initial rather than a reauthorization or continuing request.

Note: Maintenance of services ends after the final agency decision.

CHANGING PROVIDERS: Medicaid recipients have the right to change providers as indicated below.

During the Appeal Process, Going Out of Business, CAP services, Other Long Term Services

1. For Medicaid recipients who:
    a. have appealed an adverse decision, or
    b. whose provider agency is going out of business, or
    c. have changed providers for CAP services or
    d. are changing providers for another service with an authorization period of six months or more, the current authorization for services will transfer to the new provider within five (5) business days of notification by the new provider to the appropriate utilization review vendor and upon submission of written attestation that provision of the service meets Medicaid policy and the recipient's condition meets coverage criteria and acceptance of all associated responsibility; and either written permission of recipient or legal guardian for transfer; or copy of discharge from previous provider.
2. Authorization shall be effective the date the new provider submits a copy of the written attestation.
3. Following the appeal or prior to the end of the current authorization period, the new provider must submit a request for reauthorization of the service in accordance with the clinical coverage policy requirements and these procedures.

At Any Other Time

Medicaid recipients may change providers at any other time. However, the discharging provider and the new provider must follow all policy requirements and these procedures.

OBTAINING LEGAL ASSISTANCE: For questions regarding legal assistance, recipients or their personal representatives may contact Legal Aid of North Carolina at 919-856-2564 or toll-free at 1-866-369-693. Recipients with disabilities may also contact Disability Rights of North Carolina at 1-877-235-4210.

QUESTIONS ABOUT THE MEDICAID PRIOR APPROVAL AND MEDICAID RECIPIENT HEARING PROCESSES: For questions concerning the decision Medicaid makes about the provider's request for service, please contact Medicaid or visit the Your Rights web page specified below.

http://www.ncdhhs.gov/dma/medicaid/rights.htm

Questions about the appeal process may be addressed to OAH or the Appeals Unit, Division of Medical Assistance (Medicaid). Agency contact information appears on the Your Rights web page.

02/18/11