North Carolina
Department of Health and Human Services
Division of Medical Assistance
Recipient Services MEU
801 Ruggles Drive – 2501 Mail Service Center - Raleigh, N.C. 27699-2501
(919) 855-4000

Michael F. Easley, Governor
Dempsey Benton, Secretary

William W. Lawrence, Jr., M.D., Acting Director

July 30, 2008

Re: ID Card Insert for August 2008

Dear County Director of Social Services:

Attached to this letter are the English and Spanish versions of a notice that will be included in the August 2008 Medicaid ID cards. The notice alerts the recipient to the change in the number of provider visits allowed each state fiscal year (July 1st through June 30th).

Previously the 24 visit limit included all provider types, whether it was a mandatory or an optional service. Mandatory services are those the Code of Federal Regulations (CFR) defines as the services that must be provided by each state. Optional services are those defined by the CFR as services each state may decide to cover. In Session Law 2007-323, the legislature increased the visit limitation for Medicaid recipients. However, the Centers for Medicare and Medicaid Services (CMS) stated that a visit limit may not combine both mandatory and optional services. Therefore, the visit limit changed to 22 total visits each year for mandatory services and 8 total visits each year for optional services.

Mandatory Services

Annual Visit Limit Period	Number of Visits	Provider Types Included in Visit Count
July 1 through June 30	22	1. Physicians (except for physicians enrolled in N.C. Medicaid with a specialty of oncology, radiology, or nuclear medicine) 2. Nurse practitioners 3. Nurse midwives 4. Health departments 5. Rural health clinics 6. Federally qualified health centers

Optional Services

Annual Visit Limit Period	Number of Visits	Provider Types Included in Visit Count
July 1 through June 30	8	1. Chiropractors 2. Optometrists 3. Podiatrists

There is no change as to who is exempt from the annual visitation limit. Recipients under age 21, those enrolled in a Community Alternative Program (CAP), and those pregnant recipients who are receiving prenatal and pregnancy related services remain exempt from the limitation.

A provider may request an exemption for the mandatory annual visitation limit if medically necessary treatment for a specific condition will require multiple office visits.

As in the past, it is very important for the Medicaid recipient to keep track of provider visits. The recipient may be responsible for paying for any visits over the limit. For example, a recipient may have 8 visits that fit under the optional category and none under the mandatory category. The recipient will be responsible for paying for any additional optional category visits.

If you have any questions regarding this information, please contact your Medicaid Program Representative. For any issues that are not able to be handled through that venue, Mrs. Angela Floyd, Assistant Director for Recipient and Provider Services, will be your point of contact and can be reached at (919) 855-4000.

Sincerely,

William W. Lawrence, Jr., MD

WWL:scr

Attachment

IMPORTANT INFORMATION ABOUT YOUR MEDICAID SERVICES VISIT LIMIT

The number of doctor visits you are allowed each year for Medicaid services has changed from 24 total visits each year. Beginning July 1, 2008, the limit is:

- 22 total visits each year for those such as to your regular doctor or for a hospital outpatient visit, and
- 8 total visits each year for those such as to a chiropractor, podiatrist or optometrist.

Some Medicaid services are not included in the visit limit count. Your doctor can help you decide if the service will count. Your doctor can contact Medicaid if he feels you need more visits. Children under age 21, people on the CAP program or who are pregnant do not have a visit limit.

For Medicaid, the year (12 months) begins July 1st and ends June 30th. That means you start counting your visits July 1st each year. It is very important for you to keep track of your visits. You must pay for any visits over the limit. You may want to make a note of each visit in a small notebook so you know when you are close to your limit.

For more information you may visit **http://www.dhhs.state.nc.us/dma/** or call the **CARE-LINE, Information and Referral Service at 1-800-662-7030.**

August 2008 **Division of Medical Assistance**

INFORMACIÓN IMPORTANTE SOBRE LOS LÍMITES DE VISITAS A LOS SERVICIOS DE MEDICAID

El número de visitas al doctor que se permite cada año para los servicios de Medicaid ha cambiado de 24 visitas por año. A partir del 1 de julio del 2008 los límites serán:

- 22 visitas totales por año para doctores, como por ejemplo su doctor regular o visita al hospital en el cual no sea internado, y
- 8 visitas totales por año para quiroprácticos, podiatras/podólogos o optómetras.

Algunos servicios de Medicaid no se incluyen dentro de estos límites de visitas. Su doctor puede decidirle si el servicio cuenta o no como visita. Su doctor puede contactarse con Medicaid si él piensa que usted necesita más visitas. Los niños menores de 21 años, la personas que están bajo el programa de CAP y las mujeres embarazadas no tienen un número de visitas limitadas.
Para Medicaid, el año (12 meses) comienza el 1 de julio al 30 de junio. Eso significa que usted comienza a contar sus visitas del 1 de julio de cada año. Es muy importante que usted no pierda la cuenta de sus visitas. Si usted excede el número de visitas permitidas usted será responsable de pagar por las visitas que tuvo en exceso. Usted puede anotar cada visita en un cuaderno pequeño para que así usted pueda saber cuándo usted está cerca de sus límites.

Para más información usted puede visitar **http://www.dhhs.state.nc.us/dma/** o llame a **CARE-LINE, línea de información y referencia al 1-800-662-7030.**