North Carolina
Department of Health and Human Services
Division of Medical Assistance
Recipient Services EIS
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Courier Number 56-20-06

Michael F. Easley, Governor
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RE: Inserts in the September Cards for
Medicare and Medicaid Recipients

Dear County Director of Social Services:

Effective October 1, 2002, Medicaid will change the way it pays for services for Medicaid recipients who are dually eligible for Medicare and Medicaid. This is being done as a cost containment measure.

When the Qualified Medicare Beneficiaries Program (MQB-Q) began in January 1989, Medicaid paid Medicare premiums, deductibles, and coinsurance for charges covered by Medicare. This included some services not covered by the Medicaid Program. An example of a Medicare service that is not covered by Medicaid is diabetic shoes. The Medicare participating physicians and suppliers that accepted Medicaid were required to file all Medicare claims and to accept Medicare assignment if the Medicare beneficiary was dually eligible on the date of service. These Medicare claims were automatically "crossed over" to Medicaid and Medicaid paid the coinsurance and deductibles on these charges. Medicaid will no longer pay these as cross over claims. Now Medicare will be treated as any other third party liability. These changes apply to all Medicaid recipients who are also Medicare beneficiaries.

Effective October 1, the Medicare participating physician or supplier must file the claim to Medicare. Once he received the Explanation of Medicare Benefits (EOMB) from Medicare, he must file a separate Medicaid claim for the service. The provider will show the Medicare payment as a third party payment on the claim form. If Medicare pays more than Medicaid would pay on the service, the provider will no longer receive Medicaid payment for the coinsurance amount. Also if the service is covered by Medicare but is not covered by Medicaid, Medicaid will no longer pay the coinsurance on the claim. The provider is not required to accept Medicaid assignment, but he must inform his patients in advance of the treatment if he will not accept Medicaid.

Medicaid has a 24-doctor/outpatient-visit limit per State fiscal year. Visits for Medicare/Medicaid recipients were previously exempt. This 24-visit limit will now apply to recipients who are dually eligible for Medicare and Medicaid. Exemptions to the 24-visit limit still include:

- Recipients being treated for end stage renal disease, chemotherapy and radiation therapy for malignancy, acute sickle cell disease, hemophilia or other blood clotting disorders;
- Services rendered to recipients under 21;
- Services related to pregnancy;
- Dental services;
- Physician inpatient visits to patients in intermediate care facilities or skilled nursing facilities;
- Area Mental Health Clinic visits (State supported);
- Recipients receiving Community Alternatives Programs (CAP) services.

Attached is an insert that will be included in the September Medicaid cards regarding the changes to recipients who are eligible as Medicare and Medicaid. We have tried to highlight what is important to the recipient. We will change the wording on the October Medicare-Aid cards to reflect these changes.

Medicaid will continue to pay the Medicare Part B premium for all eligible recipients. However, it is very important that counties continue to ensure that all eligible recipients are evaluated for dual beneficiary classification since the State and county receive higher federal financial participation on the payment of Part B premiums for dual beneficiaries. This is still required in the Aged, Blind, and Disabled Medicaid manual and under federal regulations.

Also included in the September Medicaid card is an insert to remind Carolina Access Enrollees to establish a relationship with their Primary care Provider. It also reminds them that if they go to another provider without their PCP's knowledge, they may be responsible for the bill.

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

Nina Yeager

IF YOU HAVE MEDICARE, PLEASE READ

In October, there will be a change in the way Medicaid pays for services if you have both Medicare and Medicaid. This change means the amount you have to pay to medical providers may increase.

Medicaid will no longer pay for Medicare covered services that are not covered by Medicaid such as prosthetics and diabetic shoes. Medicaid has a 24 doctor/outpatient visit limit per year. Medicare will continue to pay for your doctor/outpatient visits; however, after the 24-visit limit is reached, Medicaid will no longer cover the 20% that Medicare does not pay.

Medicaid will continue to pay your monthly Medicare premium. If you have any questions, please contact the Medicaid Eligibility Unit through the toll-free CARE-LINE, Information and Referral Service. The number is 1-800-662-7030. In the Triangle area, the number is 919-733-4261.

ATTENTION: CAROLINA ACCESS ENROLLEES

Carolina ACCESS is a Medicaid program that links you with a personal doctor. This doctor is called your Primary Care Provider or PCP. The PCP listed on your Medicaid card is responsible for providing your medical care and referring you to specialists if you need them. The PCP is required to provide access to medical care 24 hours a day seven days a week. His telephone number is also listed on your Medicaid card. If you go to another provider without your doctor's knowledge, you may be responsible for the bill.

If you have not seen the doctor listed on your Medicaid card, call his office and make an appointment to be seen to establish a medical record. Do not wait until you are sick to make this appointment.