

# North Carolina Medicaid Special Bulletin

*An Information Service of the Division of Medical  
Assistance*

Please visit our website at [www.dhhs.state.nc.us/dma](http://www.dhhs.state.nc.us/dma)



**January**

**2006**

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## **Prior Approval Process and Request for Non-Covered Services**

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## **Introduction**

The purpose of this special bulletin is to highlight for providers the significant changes in Medicaid's prior approval process. The Division of Medical Assistance (DMA) is implementing these changes to ensure that DMA staff and contractors provide consistent, prompt processing of all requests for prior approval of Medicaid services. Providers continue to play a vital role in Medicaid's prior approval process.

## **PRIOR APPROVAL PROCESS**

Prior approval is required for many Medicaid services, products, and procedures to verify medical necessity. Prior approval must be obtained before delivering a service, product or procedure that requires prior approval. Requests for prior approval must be submitted as specified in the clinical coverage policies on DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>. Requests for mental health, developmental disability or substance abuse services must be done so in accordance with the published policies of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS).

Due to the number of prior approval requests that Medicaid receives each day, only those requests that are completed and submitted in accordance with DMA's clinical coverage policies are reviewed. To facilitate consistent and prompt processing of prior approval requests, providers are asked to submit the request on the appropriate prior approval form. However, if the request is complete and submitted in accordance with DMA's clinical coverage policies, it will be reviewed even if it is not submitted on the designated form.

Although the information that must be entered on the prior approval form varies from form to form, a proper request for prior approval must include the recipient's name, address, Medicaid identification (MID) number, and date of birth as well the provider's contact information (including signature, if required) and provider number, the date of the request, and clinical information pertinent to the product, service, or procedure being requested. If the prior approval form does not contain a field for any component of the above required information, do **NOT** write the information on the form. Provide the information, for example, recipient address, on a separate page and include it with the request form. Relative to the American Dental Association's (ADA) claim form, the recipient's address must be provided in field 12 along with the recipient's name (last, first, middle initial, and suffix). If a request does not contain the information specified above, it is an improper request, and the request will be returned to the provider.

When Medicaid receives a complete request for prior approval submitted in accordance with its published procedures, Medicaid processes the request promptly. If the request is approved, Medicaid notifies the provider of the approval so that the provider can make arrangements to promptly provide the requested service, product, or procedure to the recipient.

If, based upon the information submitted, the request cannot be approved, Medicaid may deny or reduce/change the request. Both the recipient and provider will receive written notification of Medicaid's decision. The notice will also explain how the recipient may appeal Medicaid's decision in the event he/she thinks Medicaid's decision is wrong. (See **Attachments A and B**).

If a request for prior approval does not contain sufficient information for Medicaid to determine whether the request should be approved or denied, Medicaid notifies the recipient and provider in writing that the request lacks the necessary documentation to review the request. The provider must submit additional documentation as specified by Medicaid staff or contractors within 15 business days of the date of the notice for additional information. (See **Attachment C**).

Medicaid recognizes that there may be situations when 15 business days are not sufficient time for a response. If a provider is unable to submit the additional information within 15 business days from the date of the request, he/she must contact Medicaid or its contractors to request a time extension. It is not necessary for the provider to explain the reason for the time extension. Medicaid allows the provider no more than an additional 15 business days from the date of the contact to submit the requested information. If there is no response from the provider or if the provider does not submit the additional information within the 15 business day time period, the provider and recipient are notified in writing that the request was denied for insufficient information.

**Note:** Any service or procedure that allows for verbal approval must be followed-up in writing using the appropriate form with all documentation attached according to the requirements specified in the clinical coverage policy for that service or procedure. General information on the prior approval process and services that require prior approval is available in the *Basic Medicaid Billing Guide* on DMA's website at <http://www.dhhs.state.nc.us/dma/medbillcaguide.htm>. If the documentation is incongruent with the verbal information or if the documentation is not received by the due date, the request will be denied, and the recipient will be notified.

## REQUESTING NON-COVERED SERVICES

Providers should encourage recipients to review Medicaid's *Consumer Guides* for information on services that are covered by Medicaid. Each recipient receives a copy of the *Consumer Guide* when approved for Medicaid. The *Consumer Guides* are also available on DMA's website at <http://www.dhhs.state.nc.us/dma/consinfo.htm>.

If the provider considers a service medically necessary but it is not a covered benefit, the recipient's physician or other licensed clinician may submit a Non-covered Services Request form (**Attachment D**) to:

Director  
c/o Assistant Director for Clinical Policy and Programs  
Division of Medical Assistance  
2501 Mail Service Center  
Raleigh, NC 27699-2501  
919-715-7679 FAX

A copy of the Non-covered Services Request form is available on DMA's website at <http://www.dhhs.state.nc.us/dma/forms.html>. Recipients may also obtain a request form by calling the CARE-LINE Information and Referral Services, Monday-Friday, except state holidays, at the numbers specified below.

- Outside Triangle Area: 1-800-662-7030 (English/Spanish)
- Outside Triangle Area: 1-877-452-2514 (TTY number for the deaf or hearing impaired)
- Inside Triangle Area: 919-855-4400 (English/Spanish)
- Inside Triangle Area: 919-733-4851 (TTY number for the deaf or hearing impaired)

**Note:** A recipient under the age of 21 may receive a medically necessary service not included in the North Carolina Medicaid State Plan **only** when the service may be covered under federal Medicaid law and when it will “correct or ameliorate” a diagnosed condition in accordance with Federal Medicaid law at 42 U.S.C. § 1396d(a) and (r) of the Social Security Act.

Once a request for the non-covered service is received, the request will either be approved or denied or additional information requested within 15 business days of receipt of the request. The recipient and provider are notified in writing if additional information is requested. Additionally, should the request be denied, the recipient and provider are notified in writing. The denial notice also explains how the recipient may appeal Medicaid's decision in the event he/she thinks Medicaid's decision is wrong. (See **Attachments A and B**).



North Carolina  
Department of Health and Human Services  
**Division of Medical Assistance**  
2501 Mail Service Center - Raleigh, N.C. 27699-2501  
Courier Number 2501

Michael F. Easley, Governor  
Carmen Hooker Odom, Secretary

L. Allen Dobson, Jr., M.D., Assistant Secretary  
for Health Policy and Medical Assistance

**ATTACHMENT A**

**Notice of Denial of Service Request (DMA-2001)**

Date [insert date]

[Recipient Name]

[Medical Provider]

[Recipient Address]

[Provider Address]

[Recipient MID #]:

Dear [insert name of recipient or parent/guardian/authorized representative]:

On [insert date], [insert name of physician, recipient or other person who requested service] asked Medicaid to pay for [insert specific service/product/procedure requested and time period if relevant]. Medicaid **denied** this request. This letter explains why this request was denied and tells you how to appeal this decision if you disagree.

Medicaid denied the request because [insert specific reason]. The law or policy the denial is based on is [insert NCAC citation, C.F.R. citation, or other applicable law or title of specific medical policy supporting the decision]. Medicaid’s medical policies can be found at <http://www.dhhs.state.nc.us/dma/prov.htm>.

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION.** You have the choice of two ways to appeal this decision:

1. You can ask for an **INFORMAL APPEAL** with the Department of Health and Human Services (DHHS). **YOU HAVE 11 DAYS FROM THE DATE OF THIS NOTICE 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 THIS NOTICE TO FILE THIS APPEAL.**

**HOW TO ASK FOR AN INFORMAL APPEAL:**

- To ask for an informal appeal, complete and return the enclosed **informal appeal** form and **attach a copy of this letter**. You can fax the form or mail it. See the instructions on the form.
- **DHHS must receive the form no later than 11 days from the date of this notice.**
- In an informal appeal, you can have a hearing in person (in Raleigh, NC) or by telephone. A hearing officer at the Department of Health and Human Services 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 DHHS 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, 101 Blair Drive, Raleigh, NC 27603. **Attach a copy of this letter to that notice.**
- **The contested case form must be filed with the Office of Administrative Hearings no later than 60 days from the date of this notice.**
- 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 in the next 11 days, 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 DHHS Hearing Office at (919) 647-8200. To learn more about the formal appeal process, call the Office of Administrative Hearings at (919) 733-2698. To learn more about Medicaid's reasons for denying this request for services, call the person whose name appears below. You may also call the toll free **CARE-LINE, Information and Referral Services, 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 telephone number of the Legal Aid office that serves your community.

Sincerely,

[Name and telephone number of contact]

Enclosure: Informal Appeal Request Form, DMA 2003

C: Provider



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

2501 Mail Service Center - Raleigh, N.C. 27699-2501  
Courier Number 2501

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L. Allen Dobson, Jr., M.D., Assistant Secretary  
for Health Policy and Medical Assistance

**ATTACHMENT B**

**Notice of Change in Medicaid Services (DMA-2002)**

Date [insert date]

[Recipient Name] [Medical Provider]  
[Recipient Address] [Provider Address]  
[Recipient MID #]:

Dear [insert name of recipient or parent/guardian/authorized representative]:

Medicaid will no longer pay for your [insert service and, if applicable, frequency]. [Insert service] will be [stopped/reduced (describe reduction)] as of [insert effective date]. Medicaid will pay for [insert approved level of services]. This letter explains why this decision was made and tells you how to appeal if you disagree. If you appeal, this service will continue during the appeal, so long as you remain otherwise eligible for this service.

The reason Medicaid decided to [stop/reduce] Medicaid coverage for [insert service] is because [insert specific reason for termination or reduction]. Medicaid's decision is based on [insert NCAC citation, C.F.R. citation, or other applicable law or title of specific medical policy supporting decision]. Medicaid's medical policies can be found at <http://www.dhhs.state.nc.us/dma/prov.htm>.

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION.** You have the choice of two ways to appeal this decision:

1. You can ask for an **INFORMAL APPEAL** with the Department of Health and Human Services (DHHS). **YOU HAVE 11 DAYS FROM THE DATE OF THIS NOTICE 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 THIS NOTICE TO FILE THIS APPEAL.**

**HOW TO ASK FOR AN INFORMAL APPEAL:**

- To ask for an informal appeal, complete and return the enclosed **informal appeal** form. You can fax the form or mail it. See the instructions on the form.
- **DHHS must receive this form no later than 11 days from the date of this notice.**
- In an informal appeal, you can have a hearing in person (in Raleigh, NC) or by telephone.
- Informal appeals are decided by a hearing officer at DHHS.
- You may speak for yourself or through 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. You will get written instructions with the informal decision on how to do that.
- If you appeal, and remain otherwise Medicaid eligible for the service, Medicaid will continue to pay for the services you now receive until the hearing officer makes a decision on your appeal.

**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 from the Department of Health and Human Services 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, 101 Blair Drive, Raleigh, NC 27603.
- **The contested case form must be filed with the Office of Administrative Hearings no later than 60 days from the date of this notice.**
- 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 appeal and remain otherwise Medicaid eligible for the service, Medicaid will continue to pay for the services you now receive until the end of the appeal process, unless you give up that right. If you lose your formal appeal, you may be required to pay for the services that continue because of the appeal.
- If you ask for an informal appeal, you can still ask for a formal appeal after your informal appeal is over. You will have 60 days after the informal decision to ask for a formal appeal.

To learn more about the informal appeal process, call the DHHS Hearing Office at (919) 647-8200. To learn more about the formal appeal process, call the Office of Administrative Hearings at (919) 733-2698. To learn more about the reasons Medicaid will no longer pay for the above

service, call the person whose name appears below. You may also call the toll free **CARE-LINE, Information and Referral Services, at 1-800-662-7030.**

**Free legal aid may be available to assist with your appeal.** Contact your nearest Legal Aid/Legal Services office. You can call 1-877-694-2464 to find out their telephone number.

Sincerely,

[Name and telephone number of contact]

Enclosure: Informal Appeal Request Form, DMA 2003

C: Provider



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

2501 Mail Service Center - Raleigh, N.C. 27699-2501  
Courier Number 2501

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L. Allen Dobson, Jr., M.D., Assistant Secretary  
for Health Policy and Medical Assistance

**ATTACHMENT C**

**Notice of Request for Additional Information  
(Provider Notification)**

Date: [Insert Date]

Recipient Name: [Insert Recipient Name]

Recipient MID #: [Insert MID #]

Dear Provider:

Our office has received your Prior Approval request and more information is needed to determine whether to approve your request. Please submit the information specified below.

You must submit the required information within 15 business days from the date of this notice **or** contact us at (XXX) XXX-XXXX to provide a reasonable date that you can return the information to our office. **Failure to respond to this notice within the required timeframe will result in a denial of your prior approval request.**

A separate notification has been sent to the Medicaid recipient regarding our request for more information. The recipient has been informed that the Prior Approval request will be denied if you do not respond within 15 business days.

Prior Approval Unit  
Fiscal Agent for the North Carolina Division of Medical Assistance (Medicaid)



North Carolina  
Department of Health and Human Services  
**Division of Medical Assistance**  
2501 Mail Service Center - Raleigh, N.C. 27699-2501  
Courier Number 56-20-06

Michael F. Easley, Governor  
Carmen Hooker Odom, Secretary

L. Allen Dobson, Jr., M.D., Assistant Secretary  
for Health Policy and Medical Assistance

## ATTACHMENT D

### REQUESTING NON-COVERED SERVICES

To make a request for a service that Medicaid does not usually cover, your physician or other provider must submit a Non-covered Services Request form to verify your need for the service requested. If you have questions about the process to request a non-covered service, review the *Consumer Guide* given to you at the time you applied for Medicaid and available on DMA's website at <http://www.dhhs.state.nc.us/dma/consinfo.htm> or call the **CARE-LINE Information and Referral Service** Monday-Friday, except state holidays, at the numbers specified below.

- Outside Triangle Area: 1-800-662-7030 (English/Spanish)
- Outside Triangle Area: 1-877-452-2514 (TTY number for the deaf or hearing impaired)
- Inside Triangle Area: 919-855-4400 (English/Spanish)
- Inside Triangle Area: 919-733-4851 (TTY number for the deaf or hearing impaired)

Ask your physician or other provider to send the completed form by fax or mail as indicated on the form.

### REVIEW PROCESS FOR REQUESTS FOR NON-COVERED SERVICES

If the request is approved, Medicaid will notify the provider of the approval so that the provider can make arrangements with you to promptly provide the requested service, product, or procedure. If, based upon the information submitted, the request cannot be approved, Medicaid must deny the request. Both you and the provider will receive written notification of Medicaid's decision. The notice will also explain how you may appeal Medicaid's decision in the event you think Medicaid's decision is wrong. Should Medicaid be unable to make a decision to approve or deny the request because insufficient information was submitted, Medicaid will notify you in writing that the request lacks necessary documentation to approve or deny the request. Additionally, a copy of this notice will also be sent to the provider. The provider must submit additional documentation as specified by Medicaid staff or vendors/contractors within 15 business days of the date of the notice for additional information.

Medicaid recognizes that there may be situations where 15 business days may not allow sufficient time for a response. Medicaid will extend the deadline up to an additional 15 business days as long as the provider telephones within the 15 business days and requests additional time. If there is no response from the provider within the 15 business day time period or if the provider does not submit the additional information by the agreed upon date, you and the provider will be notified in writing that the request is

denied for insufficient information. The denial notice will explain why the request is denied and how you may appeal Medicaid's decision in the event you think Medicaid's decision is wrong.



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

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

L. Allen Dobson, Jr., M.D., Assistant Secretary
for Health Policy and Medical Assistance

NON-COVERED SERVICES REQUEST FORM

RECIPIENT INFORMATION: Must be completed by recipient's physician or other provider.

NAME:
DATE OF BIRTH: / / (mm/dd/year) MEDICAID NUMBER:
ADDRESS:

MEDICAL NECESSITY: Must be completed by physician or other provider.

PROVIDER NAME: PROVIDER NUMBER:
ADDRESS:
TELEPHONE NUMBER: ( ) FAX NUMBER: ( )
BEST TIME TO CALL:

IN WHAT CAPACITY HAVE YOU TREATED THE RECIPIENT (incl. length of time you have
cared for recipient and nature of the care):

PAST HEALTH HISTORY (incl. chronic illness):

NAME OF PROCEDURE, PRODUCT, OR SERVICE THAT YOU ARE REQUESTING.
PROVIDE A BRIEF DESCRIPTION (incl. all applicable codes):

OVER

**RECIPIENT DIAGNOSIS(ES) RELATED TO THIS REQUEST (incl. onset, course of the disease, and recipient's current status):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**TREATMENT RELATED TO DIAGNOSIS(ES) ABOVE (incl. previous and current treatment regimens, duration, treatment goals, and recipient response to treatment(s):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IS THIS REQUEST FOR:**

• **EXPERIMENTAL/INVESTIGATIONAL TREATMENT:**  YES  NO  
(IF YES, PLEASE EXPLAIN): \_\_\_\_\_

• **CLINICAL TRIALS:**  YES  NO (List trial/sponsor number: \_\_\_\_\_)  
(IF YES, PLEASE EXPLAIN): \_\_\_\_\_

**PROVIDE OBJECTIVE INFORMATION TO SUBSTANTIATE MEDICAL NECESSITY (incl. expected duration, if applicable, safety and efficacy, expected outcomes, types of alternative treatment(s) and discussion specifying why alternatives are inappropriate, and evidence base to support request):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ADDITIONAL INFORMATION MUST BE SUBMITTED ON PROVIDER'S LETTERHEAD.**

\_\_\_\_\_  
**PROVIDER SIGNATURE AND CREDENTIALS**

\_\_\_\_\_  
**DATE**

**MAIL OR FAX COMPLETED FORM TO:**

Assistant Director  
Clinical Policy and Programs  
Division of Medical Assistance  
2501 Mail Service Center  
Raleigh, NC 27699-2501  
FAX: 919-715-7679

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Mark T. Benton, Senior Deputy Director and  
Chief Operating Officer  
Division of Medical Assistance  
Department of Health and Human Services



Cheryll Collier  
Executive Director  
EDS

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