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

December 2005

NORTH CAROLINA HEALTH CHOICE (NCHC) CHILDREN AGES BIRTH THROUGH 5 MOVE TO MEDICAID

Introduction

Session Law 2005-276 mandated the North Carolina Health Choice (NCHC) program to limit participation to eligible children ages 6 through 18 beginning January 1, 2006. This session law also mandated the Medicaid program to provide coverage for children birth through the age of five with family incomes equal to or less than 200 percent of the federal poverty level beginning January 1, 2006.

As a result of this legislation, current NCHC children ages birth through five will be moved to the Medicaid program on January 1, 2006.

Any Medicaid enrolled provider currently providing services to NCHC children ages birth through 5 must bill North Carolina Medicaid for dates of service beginning January 1, 2006. If a service was prior approved for a NCHC recipient age birth through 5, the provider must request a new prior approval with Medicaid. Some Medicaid services require prior approval that did not require prior approval under the NCHC Program. Please refer to the Prior Approval Section of this bulletin for detailed information.

Eligibility

Children who are currently covered by NCHC and are between the ages birth through five will be covered by Medicaid effective January 1, 2006. During the month of December, a letter will be mailed to families affected by this change. This letter will inform the families of the termination of coverage through NCHC and the approval of Medicaid benefits. Families will receive Medicaid identification cards (MID) in early January.

Note: Some families may have an NCHC identification card for their children ages birth through 5 with an expiration date beyond January 1, 2006. However, the card will no longer be valid after December 31, 2005. As a provider, it is critical to verify coverage to ensure that claims are submitted to the appropriate payer.

Verifying Eligibility

Although the recipient's MID card is the most expedient method for eligibility verification, eligibility can be verified using the Automated Voice Response (AVR) system at 1-800-723-4337. Please refer to the AVR system instructions on DMA's website at http://www.dhhs.state.nc.us/dma/prov.htm for additional information on using the AVR system to verify eligibility.

Medicaid Identification Card

A blue MID card will be issued for the child each month. The card will indicate:

1. The benefit category as "MIC" and a classification of "1."

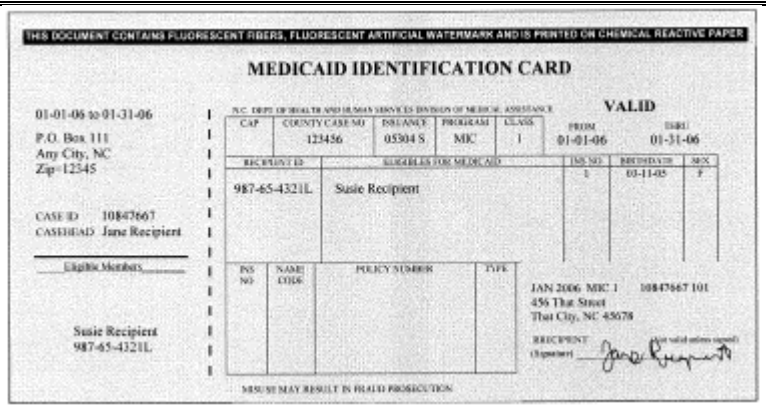
2. The MID number.

Note: The MID number will be different from the identification number used for NCHC. The child's MID number must be used on claims submitted to Medicaid for reimbursement.

3. The name of the child's primary care provider (PCP) if enrolled in Carolina ACCESS.

Note: Because the MID card for the month of January will be issued prior to assigning a PCP for the child, the January 2006 MID card will not indicate the name of the child's PCP. See Managed Care section on the next page for further information.

Blue MID Card


THIS DOCUMENT CONTAINS FLUORESCENT FIBERS, FLUORESCENT ARTIFICIAL WATERMARK AND IS PRINTED ON CHEMICAL REACTIVE PAPER

MEDICAID IDENTIFICATION CARD

01-01-06 to 01-31-06

P.O. Box 111
Any City, NC
Zip=12345

CASE ID 10847667
CASEHEAD Jane Recipient

Eligible Members

Susie Recipient
987-65-4321L

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

VALID

CAP	COUNTY CASE NO	ISSUANCE	PROGRAM	CLASS	FROM	THRU
	123456	05304 S	MIC	1	01-01-06	01-31-06

RECIPIENT ID	ELIGIBLES FOR MEDICAID	INS NO	BIRTHDATE	SEX
987-65-4321L	Susie Recipient	1	03-11-05	F

INS NO	NAME CODE	POLICY NUMBER	TYPE

JAN 2006 MIC 1 10847667 101
456 That Street
That City, NC 45678

RECIPIENT (Signature) Jane Recipient

MISUSE MAY RESULT IN FRAUD PROSECUTION

Special Needs

Currently, all NCHC children with special health care needs who meet the legislative definition for special needs services must be identified by a Physician Certification Form signed by a physician in order to receive necessary services beyond the core package (i.e. services identical to services in the State Employee's Health Plan). The certification is effective for one year from the date it is signed and wraparound services above the core package cannot be reimbursed for a child with special health care needs until this form is submitted.

As NCHC children with special health care needs ages birth through 5 move to Medicaid in January 2006, providers will no longer be required to identify these children using the Physician Certification Form. However, providers will continue to certify those children with special health care needs ages 6 through 18 who remain in the Health Choice program.

Health Choice providers who have submitted a prior approval (PA) request for treatments such as physical therapy, occupational therapy or speech therapy may be in the middle of an authorization for treatment when NCHC children ages birth through 5 transition to Medicaid. All authorizations obtained under NCHC will terminate December 31, 2005, and providers will have to obtain prior approval through Medicaid before continuing treatment beyond that time.

Managed Care

As mandated by Session Law 2005-276, Medicaid will provide services to children ages birth through 5 currently enrolled in the NCHC Program through Community Care of North Carolina (CCNC) and Carolina ACCESS. The legislation states that CCNC providers will be paid for services as allowed by the Medicaid program.

The DMA Managed Care Section will make every effort to link these children with a PCP as soon as possible after the January 1, 2006, transition. As of January 1, 2006, PCPs will see these children as regular Medicaid until the patient is linked with a Carolina ACCESS provider. Managed Care staff will be working with providers to assist in linking the patients as quickly as possible. Several different outreach efforts will be made to ensure these individuals make an informed choice.

If you have any questions about getting a recipient linked with a Carolina ACCESS PCP, please contact your local Department of Social Services or the DMA Managed Care Section at 919-647-8170.

Covered Services

For additional information regarding recipient eligibility criteria for specific clinical service coverage, refer to the clinical coverage policies on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm. Sections 2.0 (Eligible Recipients) and 3.0 (When the Service is Covered) of each policy provides additional details on eligibility and coverage requirements for Medicaid recipients.

Medicaid Prior Approval Requirements

All NCHC prior approved (PA) services will end December 31, 2005. Medicaid covered services and PA requirements are different from NCHC. Retroactive PA will not be authorized for any recipient who does not have Medicaid coverage at the time of the service except when a recipient is later approved for Medicaid with a retroactive eligibility date. Beginning December 5, 2005, Medicaid providers may submit PA for services that will be needed beginning January 1, 2006.

Medicaid providers who expect to treat children who will be disenrolled from the NCHC program should refer to the *Basic Medicaid Billing Guide* on DMA's website at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm for general information on the services requiring PA, the PA process, and PA forms. Appendix E of this document includes information on where to obtain PA forms. For specific Medicaid service coverage information and clinical coverage criteria refer to the clinical coverage policies on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

For children that have been covered by NCHC and have received Community Based Rehabilitation Services (CBRS) and Targeted Case Management for children ages 0 through 3, a referral from the Children's Developmental Services Agency is required in block 19 on the CMS-1500 claim form.

For children ages 0 through 3 who reside in the Piedmont catchment area, the providers will bill Medicaid and follow all Medicaid rules and regulations. For children ages 4 and 5, the providers will receive authorization for all mental health/substance abuse or developmental disabilities services through the Piedmont local management entity (LME) and the Piedmont waiver.

In accordance with federal Early Periodic Screening, Diagnostic and Treatment (EPSDT/Health Check) requirements, limits on Medicaid covered services are not applicable to recipients under 21 years of age when the service is medically necessary to prevent, correct or ameliorate the recipient's condition. Please note that if the service requires PA, the fact that the recipient is under age 21 does **NOT** eliminate the requirement for PA.

In addition, Medicaid recipients under the age of 21 may also receive health care services that are not covered under the North Carolina Medicaid State Plan. **However, only services that may be covered under federal Medicaid law can be considered.** Please refer to DMA's EPSDT/Health Check policy statement at http://www.dhhs.state.nc.us/dma/prov.htm for additional information. If the recipient needs a service not covered by North Carolina Medicaid, the provider should submit a request for the non-covered service on behalf of the recipient 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

Examples of non-covered services might include, but are not limited to, requests for certain durable medical equipment (DME), therapies beyond established limits, and oral formula for recipients not receiving Community Alternatives Program (CAP) services.

Highlighted below are some of the covered services that require Medicaid PA.

Behavioral Health Services

Providers are encouraged to review the inpatient and outpatient clinical coverage policies at the web address indicated above.

Inpatient Services

Prior approval is required for inpatient behavioral health services. Hospitals must contact ValueOptions at 1-888-510-1150 for authorization of services within 48 working hours of

admission. Federal regulations require that a Certification of Need (CON) be completed for individuals through the age of 21 on or prior to admission to a Psychiatric Residential Treatment facility when the recipient is Medicaid-eligible or Medicaid is pending.

Outpatient Services
Coverage is limited to 26 unmanaged outpatient visits per calendar year for recipients under 21 years of age. Visits beyond 26 per calendar year require a written order by a medical doctor, licensed psychologist (doctorate level), nurse practitioner or physician assistant and must be prior approved by calling ValueOptions at 1-888-510-1150.

Durable Medical Equipment and Orthotic and Prosthetic Devices

Providers are encouraged to review the clinical policies at the http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for a complete listing of those items that require PA. Providers must submit their PA request on the Certificate of Medical Necessity/Prior Approval (CMN/PA) form. DMA's fiscal agent, EDS, will return an approved copy of the CMN/PA forms to the provider that will indicate the time period for which a PA is valid. If the provider (e.g., physician, physician assistant or nurse practitioner) decides that an item is needed for a longer period of time, a new CMN/PA form must be submitted requesting an extension of the approved time period.

Hearing Aid Services

Providers must submit their PA request for all hearing aids, FM systems, ear molds, accessories, repairs, replacement parts and for batteries on the general Request for Prior Approval form (372-118).

Surgical Services

It is recommended that providers call the Automated Voice Response (AVR) system at 1-800-723-4337 to verify whether a surgical procedure requires PA. The primary surgeon is responsible for obtaining PA from Medicaid for certain surgical procedures. PA requests should be submitted on the general Request for Prior Approval form (372-118). In order to ensure claim payment, hospital personnel should confirm that the physician (i.e., primary surgeon) has completed all of the necessary PA forms and has obtained the necessary prior approval authorization.

Optical Services and Visual Aids

Medicaid covers one routine eye examination with refraction per year for Medicaid recipients through age 20. However, it is recommended that providers call the AVR system at 1-800-723-4337 to obtain a confirmation number, which ensures that the service limit has not been exceeded. PA for additional examinations must be requested on the general Request for Prior Approval form (372-118).

All visual aids require PA and must be submitted on the Prior Approval Request for Visual Aids form (372-017). Providers must not dispense visual aids until PA is obtained.

Outpatient Specialized Therapies

Providers are encouraged to review the Outpatient Specialized Therapies clinical coverage policy at the web address indicated above. Providers must submit their PA request to MRNC on the PA Request for Outpatient Specialized Therapy Services form that is available on MRNC's website at http://www.MRNC.org.

Outpatient Specialized Therapies are occupational, physical, speech language/audiology and respiratory therapy services. Medicaid covers six unmanaged visits, per discipline, per provider type. The six unmanaged visits are limited to once per lifetime, per discipline, per provider type. PA is required for all treatment services after six unmanaged visits. Evaluations do not require prior approval.

In some cases, a child who is transitioning from NCHC to Medicaid may have been previously covered by Medicaid. To ensure that these children have not already reached the lifetime limit of six unmanaged visits, it is recommended that providers request prior approval before rendering any outpatient specialized therapies.

Transplants

Providers are encouraged to review the transplant clinical coverage policies at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for a complete description of PA requirements. Providers must submit their transplant PA request and clinical packet to:

Debbie Garrett, RNC, CMSRN
Hospital/Transplant Consultant
Division of Medical Assistance
919-855-4357
919-715-0051 FAX

When a hospital transplant team determines that a patient requires a transplant (solid organ or stem cell), a complete clinical packet with supporting documentation justifying the medical necessity for the procedure must be sent to the Clinical Policy and Programs section at DMA for PA if Medicaid will be the primary payer.

Authorizations for solid organ transplants remain effective for one year. Authorizations for stem cell transplants are effective for six months. Transplant procedures that have not been completed during the authorization period must be reauthorized. A complete clinical packet must be resubmitted with each new request.

An Overview of Medicaid Covered Services

Covered Services	Service Limitations	Prior Approval and Service Authorization Requirements	Other Information You Need to Know
Optical Services			
Routine Eye Examinations	Eye examinations are limited to once per year.	Routine eye examinations do not require prior approval.	Prior approval is required if a recipient has a medical condition that requires more frequent examinations.
Glasses	One pair of glasses is covered each year.	Prior approval is required.	Frames and lenses are limited to a pre-approved selection.
Contact Lenses	Contact lenses are only covered when there is a medical need for them.	Prior approval is required.	
Durable Medical Equipment			
Wheelchairs, Hospital Beds, Walkers, etc. Oxygen and Oxygen Equipment Medical Supplies Enteral Nutrition Products	There are limits on how often an item can be replaced or many items are covered each year.	The recipient's physician must write an order for each item that is needed. Some items require prior approval.	
Orthotic and Prosthetic Devices			
Artificial Limbs, Compression Garments, Artificial Eyes, Splints, etc.	There are limits on how often an item can be replaced or many items are covered each year.	The recipient's physician must write an order for each item that is needed. Some items require prior approval.	
Surgical Procedures			
Transplants	Transplants are limited to patients who meet the medical criteria for transplant surgery.	Prior approval is required.	
Other Surgeries	All surgeries must be medically necessary.	Most surgical procedures require prior approval.	
Lab Services			
	Lab services are limited to those tests and blood work that is ordered by your Medicaid provider.	Prior approval is not required.	
X-rays			
	X-rays are limited to those that are ordered by your Medicaid provider.	Prior approval is not required.	

Covered Services	Service Limitations	Prior Approval and Service Authorization Requirements	Other Information You Need to Know
Dental Services			
Oral Examinations Cleanings Fluoride Treatments	Limited to two visits in a 12-month period.	Prior approval is not required.	
X-rays	X-rays are limited to a full mouth series once in a 5-year period.	Prior approval is not required.	
Sealants	Sealants are limited to once per lifetime per tooth.	Prior approval is not required.	
Routine Restorations (Fillings)	Routine restorations are limited to medically necessary services as determined by the Medicaid dental provider.	Prior approval is not required.	
Root Canals	Root canals are limited to all primary teeth, permanent premolars and first and second molars.	Prior approval is not required.	
Crowns and Caps	Crowns and caps are limited to prefabricated resin and stainless steel crowns for all primary teeth, permanent premolars and first and second molars.	Prior approval is not required.	
Emergency Services	Emergency services that are necessary to control bleeding, relieve pain, treat infections or to treat injuries to the teeth or mouth or to prevent the loss of a tooth are covered.	Prior approval is not required.	
Dentures and Partials	Dentures and partials are limited to one full set every 10 years. Relines are allowed only at 5-year intervals.	Prior approval is required.	
Complex or Extensive Treatment	Complex dental treatments or extensive dental work must be medically necessary services.	Prior approval is required.	
Space Maintainers	Space maintainers are limited to replacements of primary molars, canines, and permanent first molars	Prior approval is not required.	
Orthodontic Services (Braces)			
	Braces are only covered when they are needed to correct a severe alignment problem. Braces are limited to once per lifetime.	Prior approval is required.	Medicaid will cover the evaluation and assessment that is needed as part of the prior approval process even if it the request for braces is denied.

Covered Services	Service Limitations	Prior Approval and Service Authorization Requirements	Other Information You Need to Know
Hearing Aids			
Hearing Aid Devices	Monaural or binaural hearing aids are covered once every four years. In the ear aids are limited to children age 12 and older.	Prior approval is required.	The recipient must undergo a hearing evaluation.
Hearing Aid Accessories (cords, replacement tubes, garments, garment bags, harnesses, baby covers, "Huggies)	Accessories are limited to necessary items as documented by the Medicaid hearing aid provider.	Prior approval is required.	Requests for hearing aid accessories are reviewed for necessity on a case-by-case basis.
Hearing Aid Batteries	Medicaid allows for up to six claims per year for batteries not to exceed $35 per claim.	Prior approval is required for additional batteries beyond the limit.	Requests for hearing aids batteries in excess of established limits are reviewed on a case-by-case basis.
Pharmacy Services			
Prescriptions	No limitations.	Prior approval is not required for most prescription drugs.	
Over-the-Counter Medications	Over-the-counter medications are limited to certain medications and products that have been approved by the Medicaid program.	Prior approval is not required.	Over-the-counter medications must be prescribed by the recipient's physician.
Outpatient Specialized Therapies			
	Six visits per lifetime are allowed for each of the following types of therapy: speech therapy physical therapy respiratory therapy occupational therapy audiological therapy	Prior approval is required for services that continue beyond the six initial visits for each type of therapy.	
Personal Care Services			
	Personal care services are limited to those personal tasks and housekeeping tasks that are needed for patients with a medical condition that requires ongoing care. Service is limited to no more than 3.5 hours per day and no more than 60 hours per month.	The recipient's physician must write an order for the services and approve the personal care services agency's plan of care.	The personal care services agency must request prior approval for additional hours of service.

Covered Services	Service Limitations	Prior Approval and Service Authorization Requirements	Other Information You Need to Know
Hospital Services			
Inpatient Services	A semiprivate room is covered for an inpatient hospital stay.	Prior approval is not required for the room.	A private room may be covered if it is medically necessary or if a semiprivate room is not available.
Behavioral Health			
Outpatient Services	Outpatient behavioral health services are limited to 26 visits per calendar year.	Prior approval is required for services that continue beyond 26 visits per calendar year.	A referral by an LME, the Carolina ACCESS PCP or a Medicaid enrolled psychiatrist is required prior to the first visit.
Inpatient Services	Inpatient services are limited to medically necessary interventions for the treatment of acute psychiatric or substance abuse problems.	Prior approval is required before the date of admission or for emergencies or within 2 working days of admission.	
Residential Treatment Services	Residential treatment services provide a medically necessary structured, therapeutic and supervised environment for patients with behavioral health problems.	Prior approval is required before the date of admission and a CON (Certification of Medical Necessity) is required prior to admission.	
Psychiatric Residential Treatment Services	Service is limited to medically necessary non-acute inpatient facility care for recipients who have a mental illness and/or substance abuse/dependency and need 24-hour supervision and specialized interventions.	Prior approval is required before the date of admission.	
School-Based Services			
Psychological Services	Up to six early intervention visits and a total of 26 unmanaged visits are allowed per calendar year.	Prior approval is required for services that continue beyond 26 visits per calendar year.	A referral by an LME, the Carolina ACCESS PCP or a Medicaid enrolled psychiatrist is required prior to the first visit.
Home Health Services			
	Home health services are limited to skilled nursing services, specialized therapies, home health aide services, and medical supplies that are appropriate for use in the home.	The recipient's physician must write an order for the services and approve the Medicaid home health agency's plan of care.	Prior approval is required for specialized therapies provided through the home health agency (see Outpatient Specialized Therapies).

Covered Services	Service Limitations	Prior Approval and Service Authorization Requirements	Other Information You Need to Know
Private Duty Nursing			
	Private duty nursing services are limited to medically necessary services that can only be performed by a nurse for a patient who needs continuous care.	The recipient's physician must write an order for the services and approve the Medicaid private duty nurse's plan of care.	
Chiropractic Services			
	Chiropractic services are limited to medically necessary manual manipulation of the spine.	Prior approval is not required.	An x-ray taken within six months of the date the service is provided must confirm the condition.
Early Intervention Services			
Services Provided through the Children's Development Service Agencies	Services are limited to Medicaid-eligible children from birth to age 3 who are referred to and/or determined to be eligible for the Infant-Toddler Program. Evaluation services and community-based rehabilitative services may be provided to 3- and 4-year olds who are transitioning from the N.C. Infant-Toddler Program to preschool services when requested by the Local Education Agency. Services must be medically necessary and provided according to the child's Individualized Family Service Plan.	Prior approval is required for specialized therapies (see Outpatient Specialized Therapies). Prior approval is required for mental health and behavioral health and behavioral health counseling after the first 26 visits.	
Hospice Services			
	Hospice services are limited to medical and support services recipients who are diagnosed with a terminal illness with a life expectancy of six months or less. Services are authorized for an initial 90-day period, followed by a second 90-day period and then in 60-day intervals.	The recipient's physician must certify in writing to the hospice agency that your life expectancy is six months or less if the disease follows its expected course. A new certification is required at the beginning of each benefit period.	The hospice benefit covers all medical services that pertain to the treatment of the illness. This includes medicines, medical supplies, medical equipment (hospital beds, wheelchairs, etc.), counseling, nursing and aide services. The recipient is not eligible for Medicaid reimbursement for these services from other providers if they are for the treatment of the terminal illness.

Covered Services	Service Limitations	Prior Approval and Service Authorization Requirements	Other Information You Need to Know
Home Infusion Therapy			
Drug Therapies Total Parenteral Nutrition Therapies Enteral Nutrition Therapies	Home infusion therapies are limited to infusions that are medically necessary and can be self-administered in your home.	The recipient's physician must write an order for the services and approve the Medicaid home infusion service's plan of care.	
Podiatry Services			
	Podiatry services are limited to medical, mechanical or surgical procedures involving the foot.	Prior approval is not required.	Medicaid does not cover routine foot care unless it is medically necessary for a patient who is under the active care of a physician for the systemic condition.
Early Periodic Screening, Diagnosis and Treatment (EPSDT)			
	EPSDT may cover some services that are not covered for recipients over the age of 21. Services must be ordered by the recipient's physician or other licensed clinician. The services cannot be experimental/investigational, unsafe, or ineffective. Prior approval from the Division of Medical Assistance (DMA) may be required for some services or procedures before they can be provided. If approval is denied or services reduced or terminated, the recipient or his/her representative can appeal the decision.		

Submitting Claims

Claims for services provided prior to January 1, 2006, should be filed with NCHC, through the State Health Plan (the Plan) claims processing administrator Blue Cross/Blue Shield of North Carolina (BCBSNC).

Claims for services provided on or after January 1, 2006, should be filed with Medicaid, through EDS using existing Medicaid guidelines. EDS can be contacted at 919-851-8888 or at 1-800-688-6696 for billing questions.

Claims for inpatient hospital services that span the transition period (i.e., a child who was admitted prior to January 1, 2006, and discharged on or after January 1, 2006) should be submitted to NCHC through BCBS.

Refer to the *Basic Medicaid Billing Guide* on DMA's website at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm for additional information on claim submission.

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