

# 2017 North Carolina Medicaid Community-Based Long Term Services and Supports



## Program Eligibility and Benefits Reference Guide



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# NORTH CAROLINA MEDICAID

## NC Medicaid

Medicaid is a health insurance program for certain low-income individuals or families who are in need of medical care. It is governed by federal and state laws and regulations. Medicaid is administered by the North Carolina Division of Medical Assistance and monitored by the U.S. Centers for Medicare and Medicaid Services. There are two major program areas in Medicaid: 1) Aged (MAA), Blind (MAB), and Disabled (MAD) and 2) Families and Children. There are some other Medicaid programs that only provide limited services.

### What does Medicaid Cover?

#### The Medicaid State Plan must cover:

- Ambulance
- Durable Medical Equipment
- Family Planning
- Federally Qualified Health Centers
- Health Check
- Home Health
- Hospitalizations - Inpatient/Outpatient
- Nurse Midwife/Nurse Practitioner
- Nursing Facility
- Labs and X-rays
- Physicians
- Rural Health Clinics

#### For Children Only:

- Dental Services
- Hearing Aids
- Routine Eye Exams and Visual Aids
- Early and Periodic Screening

#### A State may also elect to cover:

- Case Management
- Chiropractor Services
- Dental Services/Dentures for Adults
- Eye Care for Adults
- Home Infusion Therapy
- Hospice
- Intermediate Care Facilities
- Mental Health Services
- Non-Emergency Transportation
- Orthotics and Prosthetics
- Personal Care Services
- Physical, Occupational and Speech Therapy
- Podiatry
- Prescription Drugs
- Private Duty Nursing
- Rehabilitative Services
- Respiratory Care

#### Important Considerations:

North Carolina Medicaid is constantly changing. It is very important to regularly check for changes to Medicaid programs. A good way to stay informed is by reading the Medicaid Provider Bulletins which can be found at :<http://www.ncdhhs.gov/dma/bulletin/index.htm>

#### For More Information About Medicaid:

Go to the N.C. Division of Medical Assistance Website - <http://www.ncdhhs.gov/dma/>

Call the N.C. Division of Medical Assistance at (919) 855-4000

Go to U.S. Centers for Medicare and Medicaid Services Website - <http://www.medicaid.gov>

# WHO IS ELIGIBLE FOR MEDICAID?

## Basic Medicaid Eligibility

### General Eligibility Requirements include:

- being a North Carolina resident and U.S. citizen or certain qualified non-citizens;
- not being an inmate of a public institution, except for individuals incarcerated in a NC DOP facility requiring inpatient hospitalization and have their Medicaid benefits placed in suspension;
- meeting income criteria;
- having assets at or below the allowable limits;
- providing verification of all health insurance; and,
- having a Social Security Number or applying for one.

Recipients of Supplemental Security Income (SSI) and State/County Special Assistance are automatically entitled to Medicaid. No separate Medicaid application or Medicaid eligibility determination is required.

### How to Apply:

- In person at the local department of social services in the county where the individual resides. An appointment is not necessary, although one may be requested.
- By mail or fax — Applications are available at [www.ncdhhs.gov/dma/medicaid/applications.htm](http://www.ncdhhs.gov/dma/medicaid/applications.htm)
- By telephone through your local DSS <http://www.ncdhhs.gov/dss/local/>
- Online at [www.ePASS.nc.gov](http://www.ePASS.nc.gov)

*Representatives may apply on behalf of individuals unable to apply for themselves.*

### What information may be needed to determine eligibility?

- Social Security Card
- Medicare Card
- Proof of Identity
- Proof of N.C. State Residency
- Bank Statements
- Life Insurance Policies
- Medical Bills
- Proof of Income
- Health Insurance Information
- Proof of Citizenship or immigration status
- Guardianship or Power of Attorney Papers (if acting on someone else's behalf)

### Important Consideration:

- Even when an individual qualifies for Medicaid, it does not always mean they qualify for a specific Medicaid program. Most Community-Based Long-Term Services and Supports programs have criteria in addition to the requirements for basic eligibility.

**For More Information About Medicaid Eligibility, Call DHHS Customer Service (800) 662- 7030 or go to: <https://dma.ncdhhs.gov/medicaid/get-started/eligibility-for-medicaid-or-health-choice>**

## ADULT MEDICAID ELIGIBILITY REQUIREMENTS

# Financial Eligibility

When applying for Medicaid, monthly income is calculated by subtracting certain deductions from the household's gross income. Social Security, veteran's benefits, wages, pensions and other retirement income are counted. Deductions vary with each Medicaid program. For the countable monthly income and resource limits, go to:

[https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/BASIC\\_MEDICAID\\_INCOME\\_ELIGIBILITY\\_CHART\\_2017\\_03\\_10.pdf](https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/BASIC_MEDICAID_INCOME_ELIGIBILITY_CHART_2017_03_10.pdf)

Resources include cash, bank accounts, retirement accounts, stocks and bonds, cash value of life insurance policies, and other investments. The value of the primary residence, one car, home furnishings, clothing and jewelry are not counted.

### There are two Medicaid coverage groups:

- **Categorically Needy (CN):** Provides full Medicaid coverage for individuals whose income and resources are at or below allowable limits.
- **Medically Needy (MN):** Allows individuals whose income is higher than the CN limit to qualify for Medicaid by meeting a deductible.

### Aged, Blind, and Disabled Coverage Categories:

- **MAA** - Individuals aged 65 or older
- **MAD, MAB** - Individuals under the age of 65 who are disabled or blind according to Social Security standards.
- **MQB** - Limited coverage for Medicare beneficiaries

### Medicaid Deductible:

If the family income is over the limits, but there is a high cost for medical bills, the recipient may still qualify for Medicaid and have to incur medical expenses to meet a Medicaid deductible. Medical expenses include: 1) hospitalizations; 2) doctor, dentist or therapist; 3) clinic and laboratory charges; 4) Rx; 5) OTC drugs with receipts; 6) medical supplies; 7) equipment (e.g. dentures, eyeglasses, hearing aids, walkers, wheelchairs, etc.); 8) prescribed vitamins or supplements; 9) medical transportation; and 10) private insurance premiums. Individuals with deductibles who live in the community will have to spend down. Go to:

[https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/BASIC\\_MEDICAID\\_INCOME\\_ELIGIBILITY\\_CHART\\_2017\\_03\\_10.pdf](https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/BASIC_MEDICAID_INCOME_ELIGIBILITY_CHART_2017_03_10.pdf)

and see page 2 under deductible/spend down.

### Important Considerations:

- When an individual lives in a nursing facility and has a spouse living at home, a portion of the income of the spouse in the facility may be protected to bring the income of the spouse at home up to a level specified by federal law. The amount protected for the at-home spouse is not counted in determining the eligibility of the spouse living in the nursing facility.
- Additionally, the countable resources of a couple are combined and a portion is protected for the spouse at home. That portion is half the total value of the countable resources within a certain range. The amount protected for the at-home spouse is not countable in determining the eligibility of the spouse living in the facility. For spouse income and resource allowance amounts go to:

<https://www.medicaid.gov/medicaid/eligibility/downloads/spousal-improvement/2017-ssi-and-spousal-improvement-standards.pdf>

When a person gives away resources and does not receive compensation with a value at least equal to that of the resources given away, he/she may be penalized. Medicaid will not pay for care in a nursing facility or care provided under the Community Alternative Program or other in-home health services and supplies for a period of time that depends on the value of the transferred resource.

## COMMUNITY ALTERNATIVES PROGRAM

# CAP/DA

**What is CAP/DA?** This program is designed to provide an alternative to institutionalization for eligible individuals who prefer to be in their homes and who would be at risk of nursing facility placement without services. CAP/DA supplements rather than replaces the formal and informal services and supports already available to an individual. These services are intended for situations where no household member, relative, caregiver, landlord, community/volunteer agency, or third party payer is able or willing to meet the complete needs of the individual. CAP/DA benefits include Adult Day Health, personal care aide, home accessibility and adaptation, meal preparation and delivery, institutional respite services, non-institutional respite services, Personal Emergency Response Services, specialized medical equipment and supplies allowable under the waiver, participant goods and services, transition services, training and education services, assistive technology and case management.

### Important Considerations:

- The CAP/DA Lead Agency completes a needs assessment to identify the appropriate service and funding level for each applicant. The cost for LTSS Medicaid services cannot exceed the monthly cost limit.
- Recipients may live in an institutional setting at the time of application and screening, but must be discharged to a private residence before receiving services from the program.
- If the individual has a Medicaid deductible, medical expenses that meet the deductible must be incurred before CAP/DA will pay for services.
- Services suspended during a short-term nursing facility or rehab center stay lasting no more than 90 days are eligible to be reinstated into the program upon discharge.
- For most Adult Care Home residents, CAP/DA is not a good consideration to support a transition because they do not meet the Nursing Facility Level of Care criteria.

### For more about CAP/DA services and eligibility, go to:

CAP/DA Clinical Coverage Policy;  
[https://files.nc.gov/ncdma/documents/files/3K2\\_1.pdf](https://files.nc.gov/ncdma/documents/files/3K2_1.pdf)

Or

Call the Home and Community Care Section of the N.C. Division of Medical Assistance: phone 919-855-4340

### Who Qualifies for CAP/DA?

To be eligible for CAP/DA, the individual must:

- Be 18 years of age or older.
- Reside in or intend to transition to a private residence.
- Be eligible for Long Term Services and Supports (LTSS) Medicaid under one of the Medically Needy Categories. This is determined by the county Department of Social Services where the individual resides.
- Be determined to need Nursing Facility Level of Care.
- Have a documented medical condition that supports the need for services provided under CAP/DA.
- Be at risk of institutionalization within 30 calendar days.
- Require two waiver services monthly (excluding incontinence supplies, personal emergency response services and meal preparation and delivery).
- Be compliant with the established Plan of Care. Non-compliance by the individual and the identified primary caregiver creates a health, safety and well-being risk.

This process begins with the completion of the Service Request Form (SRF) and a signed Physician's Attestation form.

### To Access CAP/DA services:

Contact the county CAP/DA Lead Agency-  
<http://dma.ncdhhs.gov/document/capda-lead-agency-list>

Contact the DSS in the county where the individual resides-  
<http://www.ncdhhs.gov/dss/local/>

DSS staff will coordinate transfers for Medicaid recipients transitioning from one county to a home in a different county.

# CAP/CHOICE

**What is CAP/CHOICE?** CAP/CHOICE is a self-directed care option under the Community Alternatives Program for Disabled Adults (CAP/DA) for individuals who wish to remain at home and have increased control over their services and supports. CAP/CHOICE allows participants to more fully direct their care by selecting and managing a personal assistant and by having more flexibility in tailoring plans to meet their care requirements. In addition to the services available under CAP/DA, CAP/CHOICE offers personal assistance services, financial management services (FMS), and a care advisor. The personal assistant is hired by the recipient to provide personal and home maintenance tasks. FMS, known as a fiscal intermediary, is available to: 1) conduct background checks and verifications on prospective personal assistants, 2) maintain a separate account on each recipient's services, 3) pay the personal assistants and withhold/calculate appropriate taxes, 4) create monthly payroll statements, and 5) file claims for work completed by the personal assistant with the funding agency. The care advisor is a specialized case manager who focuses on empowering participants to define and direct their own personal assistance needs and services, supporting the individual, rather than directing and managing their plan.

## Important Considerations

- Individual must demonstrate ability and willingness to self-direct through a self-assessment questionnaire.
- Based on the outcome of the self-assessment, the individual may be encouraged to enroll in CAP/DA first.
- Self-direction is not for everyone. If the person is not appropriate for or comfortable with the responsibilities associated with CAP/CHOICE he/she will be re-enrolled in traditional CAP/DA services.

**For more about CAP/CHOICE services and eligibility, go to:**  
CAP/DA Clinical Coverage Policy  
[https://files.nc.gov/ncdma/documents/files/3K2\\_1.pdf](https://files.nc.gov/ncdma/documents/files/3K2_1.pdf)

OR

Call the Home and Community Care Section of the N.C. Division of Medical Assistance: phone 919-855-4340

## Who Qualifies for CAP/CHOICE?

In addition to meeting the eligibility requirements for CAP/DA, the individual must:

- Understand the rights and responsibilities of directing one's own care.
- Be willing and capable of assuming the responsibilities for self-directed care, or select a representative who is willing and capable to assume the responsibilities to direct the recipient's care.

The prospective recipient or their designated representative will be given a self-assessment questionnaire to determine the recipient's ability to direct care or identify training opportunities to build competencies to aid in self-direction.

## Access to the CAP/CHOICE program occurs:

Through the county CAP/DA Lead Agency-  
<http://dma.ncdhhs.gov/document/capda-lead-agency-list>

Through the DSS in the county where the individual resides-  
<http://www.ncdhhs.gov/dss/local/>

# Innovations

**What is the Innovations Waiver?** The North Carolina Innovations Waiver is a resource for funding services and supports for people with intellectual and other related developmental disabilities that are at risk for institutional care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). The Innovations waiver is designed to provide an array of community-based services and supports to promote choice, control, and community membership. These services provide a community-based alternative to institutional care for persons who require an ICF-IID level of care and meet additional eligibility criteria for this waiver. Services include Assistive Technology, Community Living and Support, Community Navigator, Community Networking, Community Transition, Crisis Services, Day Supports, Respite, Financial Support Services, Home Modifications, Individual Goods and Services, Natural Supports Education, Residential Supports, Supported Living, Supported Employment, and Vehicle Modifications.

## Important Considerations:

- There are times an individual with an intellectual disability (ID) is residing in a nursing facility.
- An individual cannot receive two waiver services at the same time.
- When a person is identified as having an ID diagnosis, it is essential to get the LME/MCO involved as quickly as possible. Waiver services can only be accessed through the LME/MCO network.
- At times it may not be clear if the individual is appropriate for services or if they will qualify. The LME/MCO must conduct assessments and make all mental health related eligibility determinations.

**For more about Innovations services and eligibility go to:**

**DMA's Innovations Waiver Page -**

<https://www2.ncdhhs.gov/ncinnovations/>

**Clinical Policy**

<https://files.nc.gov/ncdma/documents/files/8p.pdf>

<https://files.nc.gov/ncdma/documents/files/8E.pdf>

**Contact the local LME/MCO  
Call the NC Division of Medical Assistance Behavioral Health  
Section: phone 919-855-4290**

**Who Qualifies for Innovations?** The individual must: 1) meet the requirements for ICF-IID level of care 2) live in an ICF-IID facility or be at high risk of placement in an ICF-IID facility; 3) be able to stay safe, healthy and well in the community while using NC Innovations Waiver services 4) need and use NC Innovations services per the person-centered Individual Support Plan at least once a month; 5) want to use NC Innovations Waiver services instead of living in an ICF-IID.

To meet ICF-IID (Intermediate Care Facility) Level of Care, a person must require active treatment and have a diagnosis of Intellectual Disability (ID) as characterized by significant limitations in both intellectual functioning and in adaptive behavior and the disability manifests before age 18 OR have a closely related condition. A closely related condition refers to individuals who have a severe, chronic disability that is attributable to cerebral palsy or epilepsy and occurred before the age of 22, OR any condition, other than mental illness, found to be closely related to Intellectual Disability because the condition results in impairment of general functioning OR adaptive behavior similar to a person with ID and is manifested before the age of 22. This condition is likely to continue indefinitely and it results in functional limitations to three or more of the following: 1) self-care; 2) understanding/use of language; 3) learning; 4) mobility; 5) self-direction; or 6) capacity for independent living.

## Access to the Innovations program occurs through:

The Local Mental Health—Entity Managed Care Organization (LME/MCO) -

<http://www.ncdhhs.gov/dma/lme/LME-Contact-Info.html>



# PROGRAMS OF ALL-INCLUSIVE CARE FOR THE

# PACE

**What is PACE?** The Program of All-inclusive Care for the Elderly (PACE) is a managed care model centered around the belief that it is better for the well-being of seniors with chronic care needs, and their families to be served in the community when possible. PACE can provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as safely possible. Medical care is provided by an Inter-Disciplinary Team (IDT) led by a PACE physician. This team is familiar with the history, needs and preferences of each participant. PACE services include delivery of all needed medical and supportive services, medical specialists (e.g. cardiology, dentistry, optometry), adult day health care, physical, occupational, speech and recreational therapies, nutritional counseling by a registered dietician, social work and social services, hospital and nursing home care when necessary, home health care and personal care, all necessary prescription drugs and respite care.

## Important Considerations:

- All services are provided directly by the program or through its provider network
- PACE will only pay for services which have been pre-approved by the Interdisciplinary Team (IDT)
- While enrolled in PACE, providers will no longer be able to bill Medicare or Medicaid
- Individuals enrolled in PACE who move outside the service area will no longer be eligible for PACE services, unless the move is to another program's service area.
- PACE IDT members can perform assessments while the individual is in the nursing facility

## For more information about PACE services and eligibility go to:

North Carolina PACE Association  
<http://ncpace.org>

NC PACE Programs List  
[https://ncdma.s3.amazonaws.com/s3fs-public/NC\\_PACE\\_Contacts\\_2016\\_08.pdf](https://ncdma.s3.amazonaws.com/s3fs-public/NC_PACE_Contacts_2016_08.pdf)

National PACE Association site  
<http://www.npaonline.org>

PACE Clinical Coverage Policy  
<https://files.nc.gov/ncdma/documents/files/3B.pdf>

Call the Home and Community Care Section of the NC Division of Medical Assistance: phone 919-855-4340

## Who Qualifies for PACE?

To be eligible for PACE, the individual must:

- Be 55 years of age or older.
- Live in a PACE program service area.
- Be determined by a physician to need Nursing Facility Level of Care.
- Be able to live safely in the community at the time of enrollment.

Only a small percentage of PACE participants reside in a nursing facility, even though *all* must be certified to need nursing facility level of care. If a PACE recipient needs nursing facility care, as determined by the IDT's assessments, the PACE program will pay for it and continue to coordinate the individual's care with the facility.

## To Access PACE:

- A referral can be made to the PACE program that has a service area covering the address where the individual resides. The program will assess the individual and facilitate the enrollment process for those determined eligible.
- Medicaid recipients and individuals who are dually-eligible may request PACE services through their local DSS  
<http://www.ncdhhs.gov/dss/local/>

**What is PCS?** For eligible Medicaid beneficiaries, PCS provides hands-on assistance in the beneficiary's living arrangement by paraprofessional aides. Hands-on assistance is provided for the five qualifying activities of daily living (ADLs) which include bathing, dressing, mobility, toileting, and eating. The amount of approved service is based on an assessment conducted by an independent entity to determine the beneficiary's ability to perform their ADLs. A beneficiary under 21 years of age may be authorized to receive special provisions under EPSDT. Beneficiaries age 21 years and older may be authorized to receive up to 80 hours of service per month.

## Important Considerations

### **PCS:**

- The beneficiary shall be notified of the assessment results within 14 business days of a completed PCS assessment.
- Does not require nursing facility level of care for participation.
- Must be ordered by a physician, nurse practitioner, or physician assistant.
- Is appropriate for individuals whose needs can be met safely in the home by family members and other informal caregivers, with support by scheduled visits from specially trained PCS aides.
- Does not provide enough assistance to replace facility-based services for individuals who require ongoing care, supervision, or monitoring by a nurse or other health care professional.
- Cannot duplicate in-home aide services provided under Medicaid waiver programs, private duty nursing, state block grants, and other state and local programs that provide hands-on assistance with ADLs.
- Cannot be provided by an individual whose primary private residence is the same as the beneficiary's primary private residence, legally responsible person, spouse, child, parent, siblings, grandparent, grandchild, or equivalent step or in-law relationship to the beneficiary.

**For more information about PCS services and eligibility go to:**

<http://dma.ncdhhs.gov/providers/programs-services/long-term-care/personal-care-services>

OR

Call the Home and Community Care Section of the N.C. Division of Medical Assistance: phone 919-855-4360 OR [PCS\\_Program\\_Questions@dhhs.nc.gov](mailto:PCS_Program_Questions@dhhs.nc.gov)

## **Who Qualifies for PCS?**

Medicaid covers the cost of PCS if:

- The individual qualifies for Medicaid
- The individual has either 1) three of five ADLs which require limited hands-on assistance; 2) two ADLs, one of which requires extensive assistance; or 3) two ADLs, one of which requires complete assistance
- PCS is linked to a documented physical or developmental disability, cognitive impairment, or chronic health condition.
- The individual is under the ongoing direct care of a physician for the medical condition(s) causing the functional limitations
- The individual is medically stable and does not require continuous monitoring by a licensed nurse or other licensed health care professional
- The home or residential setting is safe for the beneficiary and the PCS provider(s) and is adequately equipped to implement needed services
- There is no available, willing, or able family, household member or other informal caregiver to provide ADL assistance at the time when services are provided
- There is no other third-party payer responsible for covering PCS

Eligible individuals may live in a primary private living arrangement, a licensed adult care home, a combination home, a licensed group home or a supervised living facility for two or more adults whose primary diagnosis is mental illness, a developmental disability, or substance abuse dependency.

## **To Access PCS:**

The individual's primary care or attending physician, physician assistant, or nurse practitioner must make the referral for the individual to be assessed for PCS.

# PRIVATE DUTY NURSING

# PDN

**What is Private Duty Nursing?** PDN is a skilled nursing service comparable to the care provided by hospital nursing or skilled nursing facility staffs, but is provided in the individual's private residence. PDN is based upon a written individualized plan of care approved by an attending physician. Case Management is not provided with this service. PDN must be provided by a licensed registered nurse (RN) or licensed practical nurse (LPN) employed by a licensed home care agency. Eligible individuals may receive up to 112 hours per week.

## Important Considerations

- PDN services may be used outside the home for normal life activities, such as supported or sheltered work settings, licensed child care, school, school related activities, and religious services/activities.
- It is recommended that there be a second trained informal caregiver for instances when the primary informal caregiver is unavailable due to illness, emergency, or need for respite.
- Individuals may receive expanded PDN services if they qualify for PDN services and either: 1) use a respiratory pacer; 2) have dementia or a cognitive deficit and are otherwise alert or ambulatory; 3) require IV, PICC or central line infusions; 4) require a licensed nurse for assessment and interventions using Diastat, oxygen, etc for seizures; 5) have a primary caregiver 80 years or older or who has a disability that interferes with the ability to provide care; or, 6) Adult Protective Services has determined that additional hours would help ensure health, safety and welfare. Beneficiaries receiving expanded PDN services are eligible for more hours of care within the program maximum of 112 hours per week.

## For more about PDN services and eligibility go to:

PDN Clinical Coverage Policy

[https://files.nc.gov/ncdma/documents/files/3G-1\\_0.pdf?GlwK.mlon9Q7AhIEZTLN6YvONUOim7oo](https://files.nc.gov/ncdma/documents/files/3G-1_0.pdf?GlwK.mlon9Q7AhIEZTLN6YvONUOim7oo)

Call the Home and Community Care Section of the N.C. Division of Medical Assistance: phone 919-855-4100

## Who Qualifies for PDN?

To be eligible for PDN standard nursing services, the individual must:

- Be eligible for Medicaid under one of the Medically Needy Categories as determined by the local county Department of Social Services where the individual resides.
- Reside in a private residence.
- Have a documented medical need for skilled nursing care in the home, with a prior approval from the individual's attending physician.
- Have at least one trained, informal caregiver to provide direct care to the beneficiary during planned or unplanned absences of PDN staff.
- Be ventilator-dependent for at least eight hours per day, or meet four of the following criteria: 1) unable to wean from a tracheostomy; 2) require nebulizer treatments at least two scheduled times per day and one as needed; 3) require pulse oximetry readings every nursing shift; 4) require skilled nursing or respiratory assessments every shift due to a respiratory insufficiency; 5) require oxygen as needed or rate adjustments at least two times per week; 6) require daily tracheal care; 7) require PRN tracheal suctioning requiring a suction machine and a flexible catheter; or 8) at risk for requiring ventilator support.

## To Access PDN Services:

The individual must ask a primary care or attending physician to make a referral for PDN.

Nurse Consultants at the North Carolina Division of Medical Assistance provide prior approval determinations for PDN.

# DURABLE MEDICAL EQUIPMENT AND SUPPLIES

## DME

**What is DME?** Durable medical equipment (DME) refers to the following categories of equipment and related supplies for use in a Medicaid recipient's home:

- Inexpensive or Routinely Purchased Items
- Capped Rental/Purchased Equipment
- Enteral Nutrition Equipment
- Oxygen and Oxygen Equipment
- Related Medical Supplies
- Service and Repair
- Other Individually Priced Items
- Equipment Requiring Frequent and Substantial Servicing

DMA has designated Roche Diagnostics Corporation Diabetes Care as the preferred manufacturer for glucose meters, test strips, control solutions, lancets and lancing devices. Additional information on ACCU-CHEK diabetic supplies is available under the "What's New" provider section on the DMA website. Questions should be directed to ACCU-CHEK Customer Care at 1-877-906-8969.

**What Qualifies as DME?** There are two DME categories for equipment and related supplies for use in a beneficiary's home: 1) *Inexpensive or Routinely Purchased* are items purchased for a beneficiary and 2) *Capped Rental or Purchased Equipment* are rented or purchased as follows:

- The item is **rented** if the physician, physician assistant, or nurse practitioner documents that the anticipated need is six months or less.
- The item may be **rented** or **purchased** if the physician, physician assistant, or nurse practitioner documents that the anticipated need exceeds six months. Once rental is initiated on an item, a subsequent request for prior approval of purchase of that item will be denied. The item becomes the property of the beneficiary when the accrued rental payments reach NC Medicaid (Medicaid) allowable purchase price.

**The following requirements must be met before an item can be considered DME:**

It 1) can withstand repeated use; 2) is primarily and customarily used to serve a medical purpose; 3) is not useful to a beneficiary in the absence of a disability, illness, or injury; 4) is suitable for use in any non-institutional setting in which normal life activities take place\*; and, 5) is reusable or removable. All requirements above must be met before an item can be considered medical equipment. The item becomes the property of the beneficiary when the accrued rental payments reach the NC Medicaid allowable purchase price.

**Medical supplies are non-durable supplies that:** 1) are consumable or disposable, or cannot withstand repeated use by more than one individual\*; 2) are required to address an individual medical disability, illness, or injury\*; and 3) are ordered or prescribed by a physician, physician assistant, or nurse practitioner.

For a list of covered Durable Medical Equipment, reference the most recent DME Fee Schedule:

<https://dma.ncdhhs.gov/providers/programs-services/medical/durable-medical-equipment> **Please note that items listed with an asterisk require prior approval.**

**For more information** - DME Clinical Coverage Policy <https://dma.ncdhhs.gov/document/medical-equipment-clinical-coverage-policies> Or Call (919) 855-4310

\* Revised wording potentially effective July 1, 2017

# EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND

# EPSDT

North Carolina Medicaid’s health insurance plan for its beneficiaries under 21 years of age is known as EPSDT, or “Early Periodic Screening, Diagnostic and Treatment”. Under its EPSDT benefit, Medicaid provides a broad menu of preventive, diagnostic and treatment services for its covered children and youth, as specified in Federal Medicaid Act, 42 U.S.C. §1396d(r) [§1905(r), Social Security Act].

***The EPSDT benefit is working at all times, for each and every child beneficiary.***

More comprehensive than the Medicaid benefit for adults, the EPSDT benefit is designed to assure that children receive the preventive services, early care, acute care and ongoing, long-term treatment and services they need so that health problems are averted, or diagnosed and treated as early as possible. *The goal of EPSDT is to assure that Medicaid’s infants, children and adolescents get the health care they need when they need it – the right care to the right child at the right time in the right setting.* Through the EPSDT benefit, children’s health problems should be addressed before they become advanced and life-limiting, and before treatment becomes more complex, difficult and costly.

## Important Considerations:

- There is no ‘waiting list’ for a service covered by the Medicaid EPSDT benefit. However, Medicaid cannot insure that its enrolled providers will not have time limitations or wait lists when scheduling appointments.
- There is no monetary cap, set list or copays on medically necessary care for Medicaid’s children.
- Medicaid’s EPSDT benefit for children is not driven by policy limits or restrictions, so long as the service is included in Social Security’s Medicaid Act at §1905 (a)(r) .

### For coverage, the treatment or service must be:

- Coverable under §1905 (a)(r),
- Medical in nature,
- Not experimental or investigational,
- Accepted method of medical treatment (standard of care),
- Proven safe,
- Effective (Evidence-based) to correct/ameliorate the individual’s documented health condition,
- Least costly treatment among equally effective alternatives.

### For more information about NC’s EPSDT benefit, visit:

<https://dma.ncdhhs.gov/providers/programs-services/medical/Health-Check-Early-and-Periodic-Screening-Diagnosis-and-Treatment>

## EPSDT supports every covered child, at all times.

*EPSDT is Medicaid’s health benefit package for children.* It is not a free-standing funding source or a program of specialized services. Written into federal Medicaid law at §1905 (a) (r) of the Social Security Act, EPSDT guarantees a scope of health benefits for Medicaid’s enrolled children unmatched by any private health insurance policy. The EPSDT benefit requires that state Medicaid agencies provide directly or arrange for (through agreements with appropriate agencies, organizations, or individuals) any rehabilitative service meeting federal EPSDT criteria for medical necessity.

The EPSDT benefit requires coverage of any requested remedial service, product or treatment listed at §1905 (a) (r) of the Social Security Act when a review of the request by EPSDT criteria finds that service medically necessary to “correct or ameliorate a defect, physical or mental illness, or health condition”, *regardless of its coverage in an individual state’s Medicaid Plan.* The EPSDT benefit also covers medical and behavioral health services when an EPSDT review finds that the service is required in greater quantities, more often or for a longer period of time than a state plan’s policy limits or exclusions allow, or when the beneficiary fails to meet strict state policy criteria for service authorization.

## Accessing Services Coverable Under The EPSDT benefit:

Care providers may request services by contacting the agency/vendor charged with prior authorization of the specific product, treatment or service needed. For a listing of prior authorization agents, please choose the ‘Prior Approval Fact Sheet’ link found at:

<https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training/fact-sheets.html>

## “Health Check” Early Periodic Screening Program and Wellness Visits.

*Health Check* is North Carolina Medicaid’s program of Early Periodic Screening for children. Supporting a foundation of good health while insuring the earliest possible diagnosis and treatment of health problems, *Health Check* offers access to routine preventive care. Wellness visits, including physical assessments, vision and hearing testing, developmental/mental health screenings, vaccines and follow-up care are encouraged at intervals recommended by the *American Academy of Pediatrics*. Local Health Check Program Coordinators assist and support families to link with care providers and to access these services.

**What is Community Care of North Carolina/Carolina Access?** It is a statewide managed care program with 14 regional networks serving all 100 counties and more than 1 million Medicaid recipients. Participating network primary care physicians receive a per-member-per month fee to provide a medical home to Carolina Access enrollees and participate in disease management and quality improvement programs. CCNC links recipients to a primary care medical home and creates networks that: 1) join primary care homes with other segments of the local health care system (e.g. hospitals, health departments, mental health agencies, social services); 2) are responsible for managing recipient care; 3) support a patient-centered medical home; and 4) provide critical supports during care transitions.

## Important Considerations:

- If a medical home is not chosen by the enrollee, one may be assigned.
- The medical home provides treatment and/or medical advice 24 hours a day, 7 days a week.
- CCNC has care managers (nurses and social workers) who can assist enrollees with understanding a physician's instructions, making appointments, explaining how to take medications and teaching the recipient how to manage chronic care needs.
- The PCP will make referrals to specialists as needed.

## For More Information About CCNC/CA go to:

CCNC Website:

<https://www.communitycarenc.org/>

## Contact a CCNC Regional Managed Care Consultant :

<https://dma.ncdhhs.gov/regional-managed-care-consultant>

**Call the N.C. DMA Managed Care Program:** 919-855-4780

## Who Qualifies For CCNC?

Enrollment in CCNC/CA is mandatory for the majority of Medicaid recipients. Recipients in some Medicaid eligibility categories are exempt from enrollment, or, enrollment is optional. Recipients may also be exempt from enrollment for certain medical conditions. Reasons for exemption include a terminal illness, active chemotherapy or radiation therapy (until the completion of the therapy), and impaired mental/cognitive status that makes it impossible for the adult recipient to comprehend and participate in the program. Other diagnoses and information is considered on a case-by-case basis. CCNC/CA enrollees are enrolled with a Primary Care Provider (PCP) and have a designated medical home.

CCNC targets enrolled beneficiaries with complex medical needs for care management services, especially those transitioning between health care settings. These services can include face-to-face visits, medication management and coordination of community resources/services. CCNC has a standardized care management process to provide critical interventions that empower the individual/caregiver with self-management skills. The ultimate goals for all CCNC care management interventions are to promote better health outcomes for individuals served and to decrease utilization of unnecessary inpatient and emergency department services.

## Access to CCNC can occur through:

The Departments of Social Services (DSS) in the county where the individual resides-<http://www.ncdhhs.gov/dss/local/>. Local DSS offices have a complete list of participating primary care physicians.