Community Care
OF NORTH CAROLINA

North Carolina Medicaid Benefits

A Resource Guide for CCNC Care Managers

NC Medicaid Services

A Reference Guide for Care Managers

The purpose of this guide is to assist you in caring for North Carolina's Medicaid population. Since policies and procedures change periodically, hyperlinks to online information sources are provided wherever possible. Our aim is to make the most up-to-date information readily available.

Please note that this publication is not intended as a billing guide.

Providers seeking billing guidance should consult the Basic Medicaid and NC Health Choice Billing Guide on the Division of Medical Assistance (DMA) website:
http://www.ncdhhs.gov/dma/basicmed/Compilation_1012.pdf

Prior Approval Guidance:
http://www.ncdhhs.gov/dma/provider/priorapproval.htm

Current Fee Schedules:
http://www.ncdhhs.gov/dma/fee/index.htm

Current Clinical Coverage Policies:
http://www.ncdhhs.gov/dma/mp/index.htm

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Detailed Services Information

Medicaid Eligibility Categories

1) For the Medicaid Eligibility Chart, see: http://www.ncdhhs.gov/dma/medicaid/medicaideligchart.pdf

2) For information on how to verify Medicaid Eligibility (including free web tool and Automated Voice Response), see: http://www.ncdhhs.gov/dma/provider/RecipEligVerify.htm

3) **"Beneficiary Eligibility"** Section 2 of the Basic Medicaid Billing Guide includes information on the Medicaid ID card, a chart of Medicaid Eligibility program category codes, information on copayments and copayment exemptions, and a summary of all Medicaid coverage programs. See: http://www.ncdhhs.gov/dma/basicmed/index.htm

Child Health (under age of 21), including EPSDT and Health Check

1) For information on Early Intervention Services: http://www.ncdhhs.gov/dma/services/earlyintervention.htm

2) For information on EPSDT policy, training, Non-Covered Services Request form and instructions: http://www.ncdhhs.gov/dma/epsdt/index.htm

3) For information on Health check policy, including policy, Health Check Coordinator Directory, AINS information and participation data: http://www.ncdhhs.gov/dma/healthcheck/index.htm

4) For information on NC Health Start Foundation, order source for Health Check/NC Health Choice Fact Sheet http://www.nchealthystart.org/catalog/hchc.htm

5) For detailed information on required components of the Health Check exam: http://www.ncdhhs.gov/dma/healthcheck/coding_matrix.pdf

Health Choice
For information regarding NC Health Choice Clinical Policies and contact information: http://www.ncdhhs.gov/dma/providerhc/index.htm

Care Coordination for Children
For information regarding CC4C program: http://www.ncdhhs.gov/dma/services/csc.htm

Pregnancy Medical Home
For policy, training and forms: http://www.ncdhhs.gov/dma/services/pmh.htm

Asthma Products and Services

1) For specific requirements/limitation regarding coverage of RAD (respiratory assist device) and cough-stimulating device (mechanical insufflator—exsufflator)

   http://www.ncdhhs.gov/dma/hcmp/NCHC-Medical-Equipment-Supplies.pdf
2) For information regarding the North Carolina Asthma Program: http://www.asthma.ncdhhs.gov/
3) For information regarding the NHLBI guidelines for the Diagnosis and Treatment of Asthma: http://www.nhlbi.nih.gov/guidelines/asthma/index.htm

4) For non-invasive pulse oximetry: http://www.ncdhhs.gov/dma/mp/1a3.pdf

5) For information on Respiratory Therapy: http://www.ncdhhs.gov/dma/mp/10D.pdf

6) For information on Allergy Testing: http://www.ncdhhs.gov/dma/mp/1N1.pdf

Diabetes Products and Services

1) For information regarding the North Carolina Diabetes Prevention and Control Branch: http://www.ncdiabetes.org/

2) For information regarding Diabetes Outpatient Self-Management Education: http://www.ncdhhs.gov/dma/mp/1A24.pdf

3) For information on Bioengineered Skin: http://www.ncdhhs.gov/dma/mp/1G2.pdf

4) For information on Podiatry Services: http://www.ncdhhs.gov/dma/mp/1C1.pdf

5) For information on Pancreas Transplant: http://www.ncdhhs.gov/dma/hcmp/NCHC-Pancreas-Transplant-Policy.pdf

6) For information on Hyperbaric Oxygenation Therapy: http://www.ncdhhs.gov/dma/mp/1a8.pdf

7) For information on Surgery for Clinically Severe or Morbid Obesity: http://www.ncdhhs.gov/dma/mp/1a15.pdf

8) For information on Dietary Evaluation and Counseling: http://www.ncdhhs.gov/dma/mp/1-I.pdf

Additional Medicaid Covered Services Information

1) **Durable Medical Equipment (DME)**
For Policy, bulletins, oral nutrition form and fee schedules: http://www.ncdhhs.gov/dma/mp/dmepdf.pdf

2) **Home Health**
For policy, bulletins and fee schedules: http://www.ncdhhs.gov/dma/services/homehealth.htm

3) **Orthotics and Prosthetics**
For information regarding Orthotic and Prosthetic devices including policy, prior approval forms and fees: http://www.ncdhhs.gov/dma/services/oandp.htm

4) **Vision Services**

   a. Routine eye exams and visuals aids are not covered for adult beneficiaries (age 21 and up). For information regarding Routine Eye Exams and Visual aids for beneficiaries under the age of 21: http://www.ncdhhs.gov/dma/mp/6A.pdf

   b. For information regarding select vision care services including visual field examination and cataract surgery: http://www.ncdhhs.gov/dma/optical/4.pdf

   c. For information regarding Eye Refractions and Office Visits for Diabetic patients: http://www.ncdhhs.gov/dma/bulletin/1100Bulletin.htm#remindereye

d. For an index of Bulletin articles related to Optical Services: http://www.ncdhhs.gov/dma/bulletin/optical.htm

5) **Dental and Orthodontic Services**

a. For general information including forms and see schedules http://www.ncdhhs.gov/dma/services/dental.htm

b. For dental services policy (Clinical Coverage Policy 4A), including information on prior approval, and criteria and limitations for diagnostic services, preventive dental services, restorative services, endontics, periodontics, prosthodontics (dentures), prosthetics, implants and surgery: http://www.ncdhhs.gov/dma/mp/1dental.pdf

c. For information on Orthodontic Services: http://www.ncdhhs.gov/dma/mp/2ortho.pdf

d. For information on Physician Fluoride Varnish Services: http://www.ncdhhs.gov/dma/mp/1A23.pdf

Family Planning Waiver ("Be Smart") For information on providers, including covered services, fees and training, see: http://www.ncdhhs.gov/dma/services/familyplanning.htm

OB/GYN Services http://www.ncdhhs.gov/dma/services/obgyn.htm

Behavioral Health Services

1) **Outpatient Behavioral Health Services**, including link to Clinical Policy 8C, bulletins, forms, fee schedules and Questions and Answers from the November 2011 Outpatient Seminars: http://www.ncdhhs.gov/dma/services/outpatientbh.htm

2) **Local Management Entities/ Managed Care Organizations, including LME/MCO state map showing member counties current and proposed as of January 2013 and a list of contacts and crisis numbers by county: http://www.ncdhhs.gov/mhddsas/lmeonblue.htm**

3) **Behavioral Health Services fee schedules** and forms: http://www.ncdhhs.gov/dma/services/behavhealth.htm

Hearing Aid Services policy and fee schedules: http://www.ncdhhs.gov/dma/services/hearingaids.htm

Community Alternatives Program (CAP): http://www.ncdhhs.gov/dma/services/cap.htm

Program of All–Inclusive Care for the Elderly (PACE): Program definition and policy: http://www.ncdhhs.gov/dma/services/pace.htm

End Stage Renal Services

1) General Information: http://www.ncdhhs.gov/dma/services/endstagerenal.htm

2) Kidney transplant services http://www.ncdhhs.gov/dma/mp/11B4.pdf

3) Index of Bulletin articles related to dialysis http://www.ncdhhs.gov/dma/bulletin/dialysis.htm

Maternal Support Services (Baby Love): maternal support services including childbirth education and newborn home visit: http://www.ncdhhs.gov/dma/services/babylove.htm

Money Follow the Person Program: Demonstration project that assists Medicaid beneficiaries who live in inpatient facilities to move into their own home with community supports: http://www.ncdhhs.gov/dma/MoneyFollows/index.htm

Outpatient Pharmacy

1) **Medicaid Preferred Drug List** (PDL): http://www.ncmedicaidpbm.com/

2) **Medicaid Enhanced Pharmacy Program** (site for PDL, Prior Approval criteria and forms): http://www.ncmedicaidpbm.com/

3) **DMA index of Pharmacy Links** including A+KIDS Registry, Document for Safety, a list of DMA Pharmacy Program contacts and other issues http://www.ncdhhs.gov/dma/pharmacy/index.htm

4) **Over-the-Counter Products** (including medications, syringes, diabetic testing supplies) this list is found on the Medicaid Preferred Drug List (PDL). The policy is found at: http://www.ncdhhs.gov/dma/mp/A2.pdf

NC Substance Abuse Reporting System website
http://www.ncdhhs.gov/MHDDSAS/controlledsubstance/

Radiology Services

1) **Radiology policy and fees:** http://www.ncdhhs.gov/dma/services/radiology.htm

2) **MedSolutions** website for prior approval: https://www.medsolutionsonline.com/portal/server.pt/community/medsolutions_online/223

4) **Outpatient Specialized Therapies (OT/PT/ST)**

1) For policies and information specific to the provision of service and the service setting: http://ncdhhs.gov/dma/services/outpatientspectherapy.htm

2) **Carolina Center for Medical Excellence** (CCME) website for prior approval:

Billing and Reports

1) Step-by-step instructions for **HP Enterprises Webtool** for billing claims, accessing RAs or verifying beneficiary eligibility http://www.ncdhhs.gov/dma/bulletin/pdfbulletin/0909SpecBull3.pdf

2) **County Specific Snapshots** – County level information on poverty levels, uninsured numbers, number of Medicaid beneficiaries, average costs for Medicaid beneficiaries by aid program, mental health services utilization and more: http://www.ncdhhs.gov/dma/countyreports/index.htm

3) **CA reports**: http://www.ncdhhs.gov/dma/ca/casecurity.pdf (Note: providers receive the CA enrollment report by mail, but the CA Referral Report, Emergency Room Report and Utilization report are only available on-line. To review CA reports on-line, providers must complete a Provider Confidential Information and Security Agreement.

Forms:

1) For DMA forms: http://www.ncdhhs.gov/dma/provider/forms.htm

2) For CCNC/CA forms, including override form and beneficiary enrollment form: http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm

Annual Legislative Visit Limits

Visits are divided into two categories—Mandatory Services and Optional Services

1) **Mandatory Services** include the following provider types:
   Health Departments Nurse Practitioner Nurse Mid-Wife
   FQHC Rural Health Clinics Physician (except those with specialty of oncology, radiology, nuclear medicine)

2) **Optional Services** include the following provider types:
   Chiropractors Podiatrists Optometrists

The **Legislative Visit Limit is 30 visits** (22 mandatory visits and 8 optional visits). Note: Preventive medicine visits are covered once every 365 days for adults and **do not** count toward the visit limit.

The **Annual Visit Limit** period is from July 1 through June 30 of each year.

Specific CPT Codes that **will** count toward the annual legislative visit limit are available on the Medicaid website at http://www.ncdhhs.gov/dma/provider/VisitLimitCPTCodesList.xls, and include:

1) Core visit code--T1015
2) Ophthalmological service codes--92002, 92004, 92012, 92014
3) Chiropractic codes--98940-98943
4) Narcosynthesis for psychiatric diagnosis and therapeutic purposes--90865
5) Physician Office Visit/consultation codes--99201-99205, 99211-99215, 99241-99245
6) Physician Domiciliary or rest home visit codes--99324-99328, 99334-99337
7) Physician Home visit codes--99341-99350

There are specific **Diagnosis Codes** that will bypass the audit and allow the claim to pay without counting toward the visit limit. If a provider sees a patient for an office visit that would normally count, but lists one of the excluded diagnosis codes in block 21 of the claim form, then Medicaid will process the claim without counting that visit as one of their legislative visits. The list of diagnosis codes is available at: http://www.ncdhhs.gov/dma/provider/VisitLimitDiagnosesList.xls. **This list is very specific**. **A provider must use at least one of the specific codes from this list in order for the visit to be excluded from the visit limit.**

VISIT LIMIT TIP: Providers who do not provide OB services may significantly reduce the size of this list by removing the pregnancy related diagnosis codes before saving to their desktop.

Community Care of North Carolina (CCNC) network providers have access to a "Provider Portal" which will identify the number of visits used by any CCNC enrolled Medicaid patient. This information is up to date within approximately two weeks of the date the provider checks the system.

Exceptions to the Annual Visit Limitation:

1) Beneficiaries not subject to this Limitation include under age 21; those with Medicare or enrolled in CAP; and those receiving prenatal and pregnancy-related services.

2) **A provider may request an exception** when additional, medically necessary, care is anticipated for a specific condition. **Requests should be made prior to rendering services**.

   a. **Submit the General Request for Prior Approval Form** and records documenting the reason for the request: http://www.ncdhhs.gov/dma/forms/prior.pdf)

b. Complete Box 2 through 7, 12, and 14 through 16 of the form. For “Type of Request”, check the box by “05” and write in “visit limit.” The form will be returned to the provider confirming approval or denial.
c. If a claim is denied for exceeding the visit limit, the provider may submit a Medicaid Claim Adjustment form (http://www.ncdhhs.gov/dma/forms/ma.pdf) with a copy of the patient’s medical record documenting the visit with the specific condition and medical necessity of the visit to actively manage or treat the condition. A corrected claim and copy of the Remittance and Status Report RA must be attached to this request. (The Remittance and Status Report (RA) is a computer-generated document showing the status of all claims submitted to HP Enterprise Services, along with a detailed breakdown of payment. The RA is produced at the same time electronic funds transfers are generated.)

Adult Preventive Medicine Assessment

A preventive medicine health assessment consists of a comprehensive unclothed physical examination, comprehensive health history, anticipatory guidance/risk factor reduction interventions, and the ordering of gender- and age-appropriate laboratory and diagnostic procedures.

Suggested screening information is available at the US Preventive Services Task Force website, http://www.ahrq.gov/clinic/uspstfix.htm.

Preventive Medicine CPT Codes

CODE	DESCRIPTION	AGE	Non Facility Rate
99385	Initial preventive medicine	21 through 39 years	$96.83
99386	Initial preventive medicine	40 through 64 years	$113.48
99387	Initial preventive medicine	65 years and over	$124.40
99395	Periodic preventive medicine, established patient	21 through 39 years	$84.13
99396	Periodic preventive medicine, established patient	40 through 64 years	$92.08
99397	Periodic preventive medicine, established patient	65 years and over	$103.31

Preventive medicine specifics:

- One preventive medicine assessment is allowed every 365 days for Medicaid patients age 21 and over.
- No modifier is used for billing this service.
- Diagnosis code V70.0 required.
- If an FP modifier is used to denote a family planning preventive medicine exam, then diagnosis code V25.0-V25.2 or V25.4 - V25.9 is required.
- Ancillary studies involving laboratory, radiology, and injectable medications are the ONLY separately reimbursable on the same date of service.
    - Vaccine administrations are not separately reimbursable on the same date of service
- When a recipient is scheduled for an annual health assessment and an illness is detected during the screening, the provider may continue with the screening **or** bill a sick visit. **The annual health assessment and sick visit cannot be billed on the same date of service.**
- Physicians, clinics and non-physician practitioners enrolled in the N.C. Medicaid program, functioning within their scope of practice, who perform this service may bill for this service.
- Providers should always bill their usual and customary charges.
- Preventive medicine visits DO NOT count toward the annual visit limit.
- Complete clinical policy is available at http://www.ncdhhs.gov/dma/mp/1a2.pdf.

Community Care of NC/Carolina ACCESS

The North Carolina Division of Medical Assistance operates a statewide Primary Care Case Management (PCCM) program for the state's Medicaid beneficiaries called Carolina ACCESS.

The Carolina ACCESS (CA) program was initiated in 1991 and successfully increased access to medical homes. By enrolling beneficiaries into a medical home, the need for beneficiaries to seek primary care services and basic sick care in hospital emergency departments is reduced.

- In 1998, Community Care of North Carolina (CCNC) was created using the existing infrastructure and established fourteen community networks that created local systems of care designed to achieve long-term quality, cost, access, and utilization objectives in the management of care for Medicaid beneficiaries.
- These fourteen regional networks cover all one hundred North Carolina counties. Each network has an administrative entity that contracts with the Division of Medical Assistance.
- North Carolina continues to operate the original Carolina ACCESS PCCM program; however, most primary care providers are now members of a regional network and a majority of Medicaid beneficiaries are enrolled with a provider.
- Population management, care management, and coordination of treatment and prevention are provided to beneficiaries enrolled with a network provider.
- Networks and providers receive increases in the per-member/per month (PM/PM) management fee for subsets of populations that are high-risk, high acuity, high cost, and frequently have complex co-morbid conditions so that enhanced care management services can be provided.

More information on network initiatives and goals may be found at www.communitycarenc.com.

More information on the history of Managed Care in NC may be found at http://www.ncdhhs.gov/dma/ca/overviewhistory.htm

Please note that this web link contains historical information. For **current** policies and web links, please refer to the information included in this Resource Guide.

Provider Requirements for Participation in Carolina ACCESS/Community Care of NC

To be approved as a CA/CCNC PCP, providers must meet the requirements outlined in Section 6 of the Basic Medicaid and Health Choice Billing Guide under **Requirements for Participation in Primary Care Case Management Program. See:** http://www.ncdhhs.gov/dma/basicmed/SECTION6_1012.pdf

Standards of Appointment Availability

PCPs must meet the following standards for appointment availability:

- Emergency care – immediately upon presentation or notification
- Urgent care – within 24 hours of presentation or notification
- Routine sick care – within 3 days of presentation or notification
- Routine well care – within 90 days of presentation or notification (15 days if beneficiary is pregnant)

CCNC/CA providers agree to **provide or arrange for** medically necessary services according to these standards. If the appointment availability standard cannot be met, the PCP must make a referral to another provider and request documentation of the services provided for the enrollee's medical record. Follow-up care must be referred to the PCP.

Standards for Office Wait Times

PCPs meet the following standards for office wait times:

- Walk-ins – within 2 hours, or schedule an appointment within the standards of appointment availability
- Scheduled appointment – within 1 hour
- Life-threatening emergency – must be managed immediately

The CCNC/CA provider may make referrals for sick/urgent medical care when the CCNC/CA **Standards for Wait Times** cannot be met. Referral must be made to an appropriate medical setting and documentation of the services provided. Follow-up care should be referred to a CCNC/CA PCP. Referral to the emergency department for non-emergent medical conditions does **not** meet this requirement.

When a situation occurs in the course of business that prevents adherence to these standards, the provider's front desk staff must notify the enrollee immediately and advise them of the estimated wait time, explain the reason for the delay and offer to reschedule the appointment or refer the patient to another medical provider for urgent conditions. Referral to the emergency department for non-emergent medical conditions does not meet this requirement.

Beneficiary Enrollment in CCNC/CA

The county department of social services (DSS) is responsible for enrolling beneficiaries with a medical home. Enrollment requirements are based on the beneficiary's Medicaid program aid category and classification of eligibility.

The tables on the following page identify recipients by program aid category for whom enrollment is mandatory or optional, and those who are ineligible for enrollment as of October 2012.

Enrollment Status

MANDATORY
AAF/Work First-Cash Assistance with Medicaid
MIC (N) and MIC (1)-Medicaid for Infants and Children
MAF-Medicaid for Families
MAABD –Medicaid for the Aged, Blind or Disabled (Without Medicare)
SAD –Special Assistance for the Disabled (Without Medicare)
SAA-Special Assistance for the Aged (Without Medicare)
MIC-J and MIC-K children enrolled in Health Choice *
Native Americans

OPTIONAL
MPW-Medicaid for Pregnant Women
HSF-State Foster Home Fund
IAS-Medicaid with IV-E Adoption Subsidy and Foster Care
End Stage Renal Disease Patients
SSI beneficiaries under age 19
Native Americans (members of a Federally Recognized Tribe)
MAABD –Medicaid for the Aged, Blind or Disabled (With Medicare)
SAA-Special Assistance for the Aged (With Medicare)
SAD – Special Assistance for the Disabled (With Medicare)
Benefit Diversion Cases

INELIGIBLE
MQB and RRF/ MRF
Beneficiaries in “Deductible” status
CAP Cases with a monthly deductible
Aliens eligible for Emergency Medicaid only
Nursing Facility residents [does not include ICF-MR]
MAF-D-Family Planning Waiver
MIC-L-Health Choice Re-Enrollment Buy In
MAF-W-Breast and Cervical Cancer Medicaid

Beneficiaries in any of the mandatory categories that receive Medicare become optional for enrollment.

How Beneficiaries Are Enrolled

- Beneficiaries whose enrollment is mandatory are informed about the CCNC/CA program and enrolled during the Medicaid application process.

- Beneficiaries are strongly encouraged to select a medical home from the list of PCPs serving their county of residence. This honors their right to choose their medical provider.

- Beneficiaries who do not choose a medical home are assigned by the county DSS based on location, medical history, and restrictions of the provider. Each family member may have a different medical home.

- Beneficiaries in the mandatory groups are not able to opt out of the program. However, they may request an exemption based on their medical needs.

Making a Provider Change

- Enrollees in either the Medicaid or Health Choice program may request to change their medical home without cause at any time by contacting the county DSS. This can be done verbally or in writing.

- The county DSS is responsible for processing an enrollee's change request. Changes are effective the first day of the month following the change in the system, pursuant to processing deadlines.

- A request to change providers will not be denied; however, the requested provider must be available to see the patient within the restrictions the provider identified on the application to enroll as a PCP in CCNC/CA.

Enrolling Dual (Medicare/Medicaid) Beneficiaries in a Medical Home

- North Carolina has chosen to enroll beneficiaries of Medicaid and Medicare (known as duals, or dually eligible beneficiaries), when the beneficiary is in a category that grants full Medicaid coverage, on an opt out basis.

- This means that dual beneficiaries are notified that they have been enrolled and the name of the medical home to which they have been enrolled.

- They are also notified that they should contact the local DSS to choose a different provider or to declare their intention to opt out of the program. *(Providers may not charge copayments for services covered by both Medicare and Medicaid. A dual beneficiary may be charged a copayment if required for services that are not covered by Medicare but are covered by Medicaid. Refer to Section 2, Beneficiary Eligibility, for complete copayment information.)*

Enrolling Foster Care and Adoption Subsidy Beneficiaries in a Medical Home

- Although federal regulations state that foster children must remain optional for enrollment in a managed care program, the "Fostering Connections to Success and Increasing Adoption Act of 2008" requires each state to provide a plan to ensure ongoing oversight and coordination of health care for foster children.

- North Carolina is meeting this need by enrolling foster children in a medical home through the CCNC/CA program. Guardians of children in foster care can choose to withdraw a foster child from enrollment or change PCPs at any time by notifying the department of social services verbally or in writing.

Enrolling Beneficiaries in CA/CCNC Medical Home at the Provider's Office

In order to maximize enrollment, providers may enroll their patients at the practice by following these procedures:

- Inform patients of their right to choose any CCNC/CA primary care provider who is accepting new patients and their right to change PCPs at any time pursuant to processing deadlines.

- For optional beneficiaries, providers must also inform the beneficiary of their right to declare their intention not to enroll at any time in the future.

- Complete the enrollment form and send to the Carolina ACCESS contact at the department of social services in the county in which the beneficiary resides. The form can be found on the DMA website at www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm. For a listing of all the county DSS offices, please refer www.ncdhhs.gov/dss/local/.

- Provide the Medicaid beneficiary with a Carolina ACCESS Member handbook. Handbooks can be obtained by contacting DMA at 919-855-4780. A copy of the handbook is also available on DMA's website at www.ncdhhs.gov/dma/pub/consumerlibrary.htm#ca.

Education to be Provided to Beneficiaries

Providers should inform each enrollee about the following:

- The availability of medical advice 24 hours a day, 7 days a week, and the preferred method for contacting the PCP
- The enrollee's responsibility to bring his/her Medicaid identification (MID) card to each appointment
- The need to contact the PCP for a referral before going to any other doctor
- The need to contact the PCP before going to the emergency department, unless the enrollee feels that his or her life or health is in immediate danger
- The importance of regular preventative care visits, such as Health Check screenings for children, immunizations, checkups, mammograms, cholesterol screenings, adult health assessments, and diabetic screenings
- The availability of additional information for enrollees from the county DSS
- Copayment requirements

Services Exempt from CCNC/CA Authorization

Enrollees may obtain the following services from Medicaid providers without first obtaining authorization from their PCPs:

- Ambulance services
- At-risk case management

- Care management provided by the Community Care of North Carolina network
- Community Alternatives Program services
- Dental care

Note: *CCNC/CA enrollees are instructed to contact their PCP for assistance in locating dental providers enrolled with the Medicaid program. A list of dental providers is available on DMA's website at www.ncdhhs.gov/dma/dental/dentalprov.htm. Beneficiaries can also be referred to their county DSS (for a list of all the county DSS offices, please refer to www.ncdhhs.gov/dss/local/ or to the DHHS Customer Service Center, at 1-800-662-7030 or 919-855-4400 (English and Spanish). Area Health Check Coordinators also maintain a list of dentists that provide services to the under age 21 population. For a list of Health Check Coordinators, refer to www.ncdhhs.gov/dma/provider/provcontacts.htm.*

- Developmental evaluations
- Emergency department services and inpatient hospital services when admitted from the emergency department. Physician services provided in the inpatient setting still require authorization from the PCP.
- Eye care services [limited to CPT codes 92002, 92004, 92012, 92014, 92015, and 92018 and diagnosis codes related to conjunctivitis (370.3, 370.4, 372.0, 372.1, 372.2, and 372.3)]
- Family planning (including Norplant)
- Health department services
- Hearing aids (for beneficiaries under the age of 21)
- Hospice
- Independent and hospital lab services
- Optical supplies/visual aids
- Pathology services
- Pharmacy
- Radiology (only services billed under a radiologist provider number)
- Services provided by a certified nurse anesthetist
- Services performed in a psychiatric hospitals and psychiatric facilities (see note below)
- Services provided by schools and programs directly billed by the school
- Outpatient behavioral health services provided to beneficiaries age 21 and older

Note: *Outpatient behavioral health services provided to beneficiaries under the age of 21 require a referral from a Carolina ACCESS PCP, or alternatively from a Medicaid-enrolled psychiatrist or the Medicaid utilization review contractor - MCO*

Process for Referring a Beneficiary to another Provider

Coordination of care is a required component of CCNC/CA. **Authorization for payment of services to another provider must be considered for medically necessary or urgent services even when an enrollee has failed to establish a medical record with the PCP.**

- All authorizations and consultations, including services authorized retroactively, are at the discretion of the PCP.

- If the PCP authorizes multiple visits for a course of treatment specific to the diagnosis, the specialist does not need to obtain additional authorizations for each treatment visit. The same authorization referral number is used for each treatment visit.

- **If the specialist receives authorization to treat an enrollee and then needs to refer the enrollee to a second specialist for the same diagnosis, the enrollee's PCP should be notified prior to the referral. The same authorization referral number must be used by both specialists.** If the treating provider identifies a need for treatment for a diagnosis other than the

original diagnosis, the patient must be referred back to the PCP for treatment or coordination of care.

- Authorization is not required for services provided in an urgent care center billing with a hospital provider number.

- Recommendations for referral to a specialist for follow-up care after discharge from any urgent care center must be made to the CCNC/CA primary care provider for their assessment and authorization.

- Authorization is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. **The physician component for inpatient services does require authorization.** Referrals for routine follow-up care after discharge from a hospital must be made to the PCP. Referrals to a specialist for follow-up care after discharge from a hospital require PCP authorization and should be coordinated through the PCP's office.

- CCNC/CA PCPs are required to refer an enrollee for a second opinion at the request of the enrollee when surgery is recommended.

- When the enrollee disagrees with the PCP's decision regarding referrals for specialty services or other care, the enrollee should be advised of their option to choose a different CCNC/CA primary care provider.

- All referrals must be documented in the enrollee's medical record. (If the PCP does not have a medical record for the patient, document the referral on the referral log. PCPs are encouraged to keep a log of all referrals for ease in management of the Referral Report).

Obtaining a CA/CCNC Emergency Authorization (Override)

- It is the provider's responsibility to obtain authorization for treatment from the PCP listed on the enrollee's MID card prior to treatment. When services have been rendered to a CCNC/CA enrollee without first obtaining authorization from the PCP and the PCP refuses to authorize retroactively, providers may request an override using the **Carolina ACCESS Override Request Form** to obtain payment.

- Override requests will be considered only for extenuating circumstances beyond the control of the responsible parties that affected access to medical care. **Overrides will not be given for mental health services.**

- Authorization for medically necessary services may be obtained from HP Enterprise Services by calling before the service is rendered (1-800-688-6696, option 3, or 919-816-4321).

- If the service has already been provided, a written override request must be submitted to HP Enterprise Services on the Carolina ACCESS Override Request Form within 6 months of the date of service. Written requests will be evaluated within 30 days of receipt. A copy of the Carolina ACCESS Override Request Form is on DMA's website at www.ncdhhs.gov/dma/provider/forms.htm. Forms that are incomplete or illegible when submitted will be returned.

Carolina ACCESS PCP Requirements

Detailed information for each requirement may be found in these documents:

Basic Medicaid Billing Guide, Section 6: http://www.ncdhhs.gov/dma/basicmed/index.htm

Health Check Billing Guide:
http://www.ncdhhs.gov/dma/healthcheck/FINAL_Health_Check_Billing_Guide.pdf

Section 4 of the Carolina ACCESS Participation Agreement:
http://www.nctracks.nc.gov/provider/forms/CCNCPartAgree.pdf

Requirements include:

- Provide primary care and patient care coordination to each enrollee
- For recipients under age 21, provide all of the components for Health Check preventive care screenings **or** have a formal agreement with the local health department (See: http://www.ncdhhs.gov/dma/ca/hcagree.pdf) and send all well-child annual assessments there.
- For recipients age 21 and older, provide all of the components of an initial preventive health assessment and periodic assessments.
- Provide or arrange for services, consultation or referral, and treatment for emergency medical conditions 24 hours/ 7 days a week, including holidays, weekends and vacations.
- Minimum of 30 office hours per week
- Maintain hospital admitting privileges or a formal arrangement (must cover all age groups enrolled)
- Arrange referrals and document in the medical record
- Transfer the medical record to new PCP within 30 days of request.
- Comply with Appointment Availability Standards
- Comply with Standards for Office Wait Times
- Refer for second opinions
- Review and use available data reports and systems (e.g. CA enrollment report)
- Refer potentially eligible recipients to WIC Program
- Provide oral interpretation services to all non-English speaking patients at no charge (Title VI, Civil Rights Act).
- PCP may not refuse to see or discharge a CA enrollee for non-payment of copays or past balances.
- Providers may not refuse to see a Medicaid or Medicare enrollee because of their inability to pay cost-sharing amounts per Federal guidelines

For assistance with the Carolina ACCESS group or individual only application, contact your CCNC-Managed Care Consultant at http://www.ncdhhs.gov/dma/ca/MCC_0212.pdf or contact the CSC/EVC Call Center at 866-844-1113.

Frequently Asked Questions

1. How can I find out if someone is eligible for Medicaid?

   Each County in the state has a Department of Social Services office. An individual must apply at the DSS office to determine if they are eligible for Medicaid or any other services.

   This is a listing of the DSS offices in each county at: http://www.ncdhhs.gov/dss/local/

2. For an adult Medicaid beneficiary, what happens if they go over their 22/8 visit limit?

   Please refer providers to the visit limit policy on the DMA website
   http://ncdhhs.gov/dma/provider/AnnualVisitLimit.htm

   The web page has a list of **CPT codes** that count toward the limit, and a list of **diagnosis codes** whose inclusion on the claim will result in exemption of an otherwise countable procedure (CPT) from the visit limit edit. Providers should be strongly encouraged to familiarize themselves and their billing staff with these lists!

   If the exempt **diagnosis code** is listed on the claim (it does not have to be the primary diagnosis), the visit will not count toward the limit nor will the claim be denied if the limit has already been reached. If a provider has a visit denied for EOB 525 and then realizes that one of the exempt diagnoses codes should have been included on the claim, they should file an electronic **VOID** and then refile the claim with the appropriate exempt diagnosis code.

   If a provider anticipates that additional care will be needed for a specific condition, and the care is medically necessary, the provider may request an exception to the annual visit limit for mandatory services. The web page above details the process for requesting an exception.

3. Do children have an office visit limit?

   No. Children under the age of 21 do not have a limit on the number of visits that they can receive each year.

4. What does Medicaid cover for Smoking Cessation?

   Medicaid covers a variety of products to aid with smoking cessation. These products do not require prior approval from Medicaid. Currently covered products are listed in the NC Medicaid and Health Choice PDL which may be accessed at http://www.ncmedicaidpbm.com/

5. What happens if the beneficiary has the wrong provider on their Medicaid card or they are not established with the PCP and they are admitted to the hospital or they have an emergency?

   If a provider is not the CA provider listed on a Medicaid beneficiary's card, they should obtain a referral or authorization from the provider before rendering any services. Failure to do this might result in the provider not getting paid for their services.

   If the beneficiary is an established patient with the wrong PCP on the card, ask the beneficiary to sign an enrollment form and send it to the DSS in the beneficiary's county of residence to correct their CA enrollment. The enrollment form and enrollment instructions are available on the DMA website:
   http://ncdhhs.gov/dma/ca/ccncproviderinfo.htm

A provider may request an override for payment for services from HP Enterprises. The provider can submit their request in writing by using this form:
http://www.ncdhhs.gov/dma/ca/CAOverrideForm.pdf

The override request is not a guarantee of payment. The treating provider should have a referral or authorization from the CCNC/CA PCP or have the patient sign a financial responsibility form to ensure payment. If a provider needs assistance, they should contact their DMA CCNC/CA Consultant.

6. How can a provider tell if the beneficiary is enrolled with Carolina Access?

CA enrollment can be verified by:

- Calling the Automated Voice Response System at 1-800-723-4337, option 6
- Beneficiary Eligibility Verification Web Tool.
- 270/271 Transactions for Real Time or Batch verification using a Value Added Network (VAN) vendor with whom HP Enterprises and DMA have agreements.
- To verify eligibility for claims for dates of service over 12 months old, contact DMA Claims Analysis at (919) 855-4045.

For step-by-step instructions on using the Web Tool, refer to the Web Tool Instruction Guide
http://www.ncdhhs.gov/dma/bulletin/NCECSWebGuide.pdf

7. How does a provider enroll in the Medicaid program?

- Providers seeking to enroll in the NC Medicaid program may contact CSC/EVC Center at 866-844-1113.
- Provider enrollment packages can be accessed from the DMA website or by going directly to: http://www.nctracks.nc.gov/
- Enrollment may be completed on-line or by downloading the enrollment package from the website.
- The initial application for participation as an individual or group provider may include enrollment for Carolina Access. Active providers can also enroll in the Carolina ACCESS program using the nctracks website .
- For questions on Carolina Access, a provider can call their Regional DMA CCNC/CA Consultant or DMA Provider Services Dept. at (919) 855-4050. A list of the DMA CCNC/CA Consultants is located on the Community Care (CCNC/CA) web page on the DMA website. http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm

8. Do all Medicaid beneficiaries have to pay a copayment for Medicaid covered services?

No. Copayments only apply to Medicaid beneficiaries age 21 and over who are not pregnant. Copayments also do not apply to beneficiaries whose primary coverage for the service is Medicare. Copayments range from $1.00 - $3.00 depending on the service. A list of the copayments and copayment exemptions is located in the Basic Medicaid Billing Guide, Section 2:
http://www.ncdhhs.gov/dma/medbillcaguide.htm

9. If a child has already had an "annual" health check, may they receive another screening as a school, kindergarten, or sports physical?

Yes. A provider may bill an interperiodic screening for providing a school, kindergarten or sports physical outside of the suggested Periodicity schedule for health check screenings.

Are there other instances when may they receive another Health Check preventive exam?

There are no limitations on the number of (Health Check) preventive exams that a Medicaid beneficiary under the age of 21 may receive. In addition to school and sports physicals, a provider may bill a screening outside of the suggested Periodicity schedule for health check screenings for follow-up visits, such as an asthma check, to establish a medical record for a new CCNC/CA enrollee, or whenever the screening is needed. If the screening is provided outside of the suggested Periodicity schedule, the provider must document the reason for the screening in the medical record.

For more information, refer to the most current Health Check Billing Guide at: http://www.ncdhhs.gov/dma/healthcheck/index.htm

10. Where can I find a quick reference sheet on the components of a Health Check Assessment?

http://www.ncdhhs.gov/dma/healthcheck/coding_matrix.pdf

11. May a provider perform a written developmental screening outside of a Health Check Screening and get reimbursed for it?

Yes. A physician may perform a developmental screening using an appropriate written screening tool and bill the 96110 procedure code with an office visit code or an E & M code.

A physician may also perform an autism screening using an appropriate written screening tool and other appropriate screenings using a validated tool and bill the 96420 procedure code with a Health Check screening, an office visit code or an E & M code. Please view the current Health Check Billing Guide for a detailed description of tools, requirements and recommendations.

12. What do I do if I suspect Medicaid fraud?

Call the **Medicaid fraud, waste and program abuse tip-line** at 1-877-DMA-TIP1 (1-877-362-8471); or Call your County Department of Social Services (DSS) office for suspected beneficiary fraud.

13. Which high cost prescription medications covered by Medicaid need prior approval?

The medication prior approval policy and procedure, prior approval forms, preferred drug lists, etc. are all available at http://www.ncmedicaidpbm.com

14. Does Medicaid cover any Over the Counter medications?

Yes. Currently covered products are listed in the NC Medicaid and Health Choice PDL which may be accessed at http://www.ncmedicaidpbm.com/

15. Who should a provider call for help and information on denied claims?

A provider should call HP Enterprises at (800) 688-6696 for any questions on filing a claim. All provider manuals, clinical policies and special and general Medicaid bulletins are available on the DMA website to help providers to bill claims correctly. An index to the manuals is located at: http://www.ncdhhs.gov/dma/provider/library.htm.

The link to the Basic Medicaid Billing Guide is: http://www.ncdhhs.gov/dma/basicmed/index.htm

The Managed Care Consultants can assist with obtaining overrides and claims denials for Carolina Access. A list of the DMA CCNC/CA Consultants is located on the Community Care (CCNC/CA) web page on the DMA website at: http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm

16. How can I find out if a service is covered by Medicaid or if something requires Prior Approval?

Excellent resources are located on the DMA website at: http://www.ncdhhs.gov/dma/provider/priorapproval.htm

This webpage includes information on Due Process, a link to Prior Approval policies, a list of current utilization review contractors for each service that requires Prior Approval, links to applicable review criteria, link to Prior Approval forms, and FAQs. The list of review contractors includes web links, phone numbers and fax numbers.

A provider may also call the Clinical Policy Department at DMA at (919) 855-4260.

17. What is a National Provider Identifier (NPI) number?

The National Provider Identifier (NPI) is a standard 10-digit number used by health care providers for electronic submission of HIPAA standard transactions. All health care providers must obtain an NPI number to identify themselves.

More information on NPIs is on web at: http://www.ncdhhs.gov/dma/NPI/index.htm

18. Does a health care provider need to report this NPI number to Medicaid?

Yes. This number has to be reported to Medicaid for claims processing. There is more information regarding reporting requirements on the DMA website at: http://www.ncdhhs.gov/dma/NPI/index.htm

19. What IS EPSDT?

Federal law requires that Medicaid-eligible children under the age of 21 receive any medically necessary health care service covered by the federal Medicaid law, even if the service is not normally included in the N.C. State Medicaid Plan.

This requirement is called **E**arly and **P**eriodic **S**creening, **D**iagnosis and **T**reatment (EPSDT). All children covered by N.C. Medicaid are entitled to receive periodic screening, vision, dental, and hearing services. A full explanation of the EPSDT policy and how to obtain approval for services can be found at: http://www.ncdhhs.gov/dma/epsdt/index.htm

20. How should a practice evaluate specialty services requested by the parent/guardian of a pediatric beneficiary or requested by an adult beneficiary?

- Make sure phone staff, front desk, everyone understands that every request for specialty referral from a beneficiary or their parent/guardian should be evaluated by clinical staff.
- With regard to requests for referral to or from any service provider it is appropriate to ask for documentation that indicates the need for services. It is sometimes advisable to authorize ONE visit for evaluation only – not treatment – depending on the diagnosis.
- The clinical staff should then review the documentation that is received from the service provider and make a decision based on their best medical judgment, study findings, treatment guidelines, etc.
- Phrase any denial of treatment in those terms with both the beneficiary or parent/guardian and the service provider.
- Offer alternative treatment to the beneficiary or parent/guardian.
- If necessary, remind the beneficiary or parent/guardian that they may seek a new medical home provider who may agree with the beneficiary or parent/guardian's treatment preference.

Medicaid Resources

Issue	Who Can Help	Phone Number/Fax or link
Override is needed immediately[1]	DMA Customer Services or HP Enterprises	PH: 1-919-855-4780 (option 8) PH: 1-919-851-8888
Override is needed but the service has already been provided [2]	HP Enterprises	FAX: 1-919-816-4220 Link to form: http://www.ncdhhs.gov/dma/ca/CAOverrideForm.pdf
CCNC Carolina ACCESS: provider information changes, provider policy questions, etc.	Regional Consultant	http://www.ncdhhs.gov/dma/ca/MCC_0212.pdf[3]
Beneficiary or anyone reports Provider Fraud	DMA Program Integrity Intake	PH: 1-919-814-0181
Beneficiary reports a need for Medical exemption	Beneficiary's doctor must complete form	Link to form doctor must complete: http://info.dhhs.state.nc.us/olm/forms/dma/dma-9002.pdf
Pharmacy Lock-In[4] request by **Beneficiary or Provider**	Pharmacy Lock In Program or DMA OP Pharmacy	1-877-479-1872 / 1-919-855-4300
Pharmacy Prior Approval (Enhanced Pharmacy Program) Medicaid	Xerox (ACS) Clinical Call Center	1-866-246-8505, http://www.ncmedicaidpbm.com/ (or contact the local CCNC network Pharmacist)
Provider enrollment, verification, and credentialing activities	Computer Science Corporation (CSC)	EVC Call Center, 1-866-844-1113 CSC NC Tracks Website, http://www.nctracks.nc.gov/
Medicaid covered services question **(Beneficiaries)**	DHHS Customer Service Center[5]	PH: 1-800-662-7030
Medicaid covered services question (providers)	DMA website or Regional CA consultant	http://www.ncdhhs.gov/dma/provider/index.htm A to Z Provider Topics; Library (Medicaid Clinical Policies, Bulletins and Billing Guides); Programs and Services;
General Prior approval questions from providers	HP Enterprises	1-800-688-6696
Radiology and Ultrasound PA [6]	Med-Solutions	1-888-693-3211
Prior approval for Outpatient Specialized **Therapies** (PT/OT/ST); and **PCS** Assessment (personal care services)	CCME (Carolinas Center for Medical Excellence)	1-800-228-3365
Prior approval for HIV case management	CCME	1-919-461-5500
Prior approval for Health Choice Beneficiary	HP Enterprises	1-888-245-0179
Diabetic Supplies (Medicaid **Beneficiaries** and providers)	Roche Diagnostics Corporation	1-877-906-8969
Behavioral Health Issues related to LME/MCO expansion	DMA Clinical Policy: Behavioral Health	919-855-4290
Mental Health Services	Mental Health (MCO/LME)	For Phone numbers and contact information , please see http://www.ncdhhs.gov/mhddsas/lmeonblue.htm

[1] All requests for CA referral/authorization including overrides must come from the treating provider.
[2] All requests for CA referral/authorization including overrides must come from the treating provider.
[3] After MCC and before **0212**, this is not a space but an underscore _
[4] Beneficiary, Pharmacy or Prescriber may call; must provide Beneficiary MID# and return phone number.
[5] Formerly, CARELINE
[6] Only the medical provider can initiate the PA request; beneficiaries may call to inquire re: status of the request.

Medicaid Resources (cont.)

Provider verification of Beneficiary's eligibility and PCP	HP Enterprises	Automated Voice Response 1-800-723-4337 Electronic Commerce Service (on-line verification) 1-919-851-8888, option 1
Provider verification of eligibility with DOS > than 12 months; claim denials for eligibility	DMA Claims Analysis Unit	1-919-855-4045 or Time Limit Overrides Contact
Children with Special Needs Help Line		1-800-737-3028
Medical Insurance Premium Payment (Medicaid beneficiaries only)	Health Insurance Premium Payment	1-855-696-2447 or complete on-line application at CustomerService@MyNCHIPP.com
Medicare status (beneficiaries and providers)	NC Buy-In Program	1-919-855-4031
Corrections to Presumptive Eligibility file[7]	HP Enterprises	1-919-816-3143
Provider Contacts	DMA website	http://www.ncdhhs.gov/dma/provider/provcontacts.htm
When DSS cannot assist with enrollment change	DMA toll-free number	For beneficiaries 1-855-843-3402
NC Family Health Resource Line		1-800-367-2229 for assistance obtaining a Medicaid or Health Choice application, information on safety in Child Care Centers or to located a Child Care Center, information on special healthcare needs, or information on WIC
Immunization Program	NC DPH, Immunization Branch	http://www.immunize.nc.gov/
Other helpful information on Vaccines		http://www.vaccines.gov/ http://www.cdc.gov/vaccines/default.htm
NC State Center for Health Statistics		http://www.schs.state.nc.us/SCHS/
NC Division of Public Health Resources		http://www.ncdhhs.gov/health/index.htm
NC Sickle Cell Syndrome Program		http://www.ncsicklecellprogram.org/SC_Parent.htm
NC Division of Public Health – State Laboratory		http://slph.ncpublichealth.com/
NC Lead Poisoning Prevention Program		http://www.deh.enr.state.nc.us/Children_Health/Lead/lead.html also 919-707-5854
NC Lead – Lead Surveillance System		http://www.deh.enr.state.nc.us/Children_Health/NCLEAD/nclead.htm also 888-251-5543
Health Check Coordinators	Statewide Directory	http://www.ncdhhs.gov/dma/healthcheck/Health_Check_Staff_Directory_092112.pdf
Diabetes Hotline		**1-877-362-2678**
QUIT Line	Support for smoking cessation	**1-800-QUIT-NOW**
Find a Medicaid Doctor or Dentist		http://www.ncdhhs.gov/dma/medicaid/finddoctor.htm
NC DPH, Early Intervention Branch CDSA - Be Early/ NC Infant Toddler Program		http://www.beearly.nc.gov/ (Note: "Be Early" home page has option to search for CDSA by county

[7] Provider use only and only for corrections to the PE file