

**A Consumer's Guide to
North Carolina Medicaid
Health Insurance Programs
for the Aged, Blind, and
Disabled**



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

Recipient Services EIS

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Dear Interested Resident:

In an effort to provide information about the Adult Medicaid programs, we developed this handbook, **A Consumer's Guide to North Carolina Medicaid Programs for the Aged, Blind, and Disabled**. While this handbook does not answer all questions, it does give an overview of the programs, eligibility requirements, and the covered services.

If any information in this handbook conflicts with the General Statutes, federal regulations or policies of the Division of Medical Assistance, the General Statutes, federal regulations and policies will prevail.

Please keep this book as a reference. You may wish to write the phone number of your local county department of social services on the inside cover so it will be readily available. The people at your local agency work hard to ensure our citizens receive all benefits for which they are eligible.

The Division of Medical Assistance is also committed to providing the best information on available Medicaid programs and services. We are proud of what our legislators have allowed us to provide to the residents of this State.

If you have questions regarding Medicaid Programs for Families and Children, there is a handbook, **A Consumer's Guide to North Carolina Medicaid Health Insurance Programs for Families and Children**. There is also a handbook for residents who are on Medicare, **A Consumer's Guide to Medicare Savings Programs within North Carolina Medicaid**. To receive those handbooks, you may contact your local department of social services or the CARE-LINE Information and Referral Service that is referenced in this book and ask to speak to a representative in the Recipient and Provider Services Section, Medicaid Eligibility Unit. They also may be viewed on the Internet at www.dhhs.state.nc.us/dma/consinfo.htm.

Thank you for your interest in our programs. We hope this information will be helpful.

Division of Medical Assistance

Table of Contents

What is Medicaid?	4
What You Can Expect from Medicaid	5
Medicaid Programs	5
Terms and Definitions	6
You Can Get Medicaid if.....	8
Income Levels	8
Applying for Medicaid	9
Your Medicaid Identification (MID) card.....	10
What Your Medicaid Card Will Look Like	10
When You Need to Get a Prescription Filled	11
If You Don't Receive Your Card.....	12
If You Lose Your Card.....	12
Carolina ACCESS (Managed Care)	13
HMO Options (Managed Care)	15
Other Coverage Options: Community Alternatives Program for Persons with Mental Retardation/ Developmental Disabilities (CAP/MR/DD)	17
Other Coverage Options: Community Alternatives Program for Disabled Adults (CAP/DA)	18
Other Coverage Options: Community Alternatives Program for Persons with AIDS (CAP/AIDS)	19
Other Coverage Options: Cost of Care in a Nursing Facility	20
When You Need Prior Approval	21
Copayments	22
Covered Services	23
When you go to the doctor (physician)	37
When your doctor admits you to the hospital	39
When you go to the hospital and go home the same day	40
When you or your family member is in a nursing facility	41
When you go to the dentist	42
When you go to the chiropractor	43
When you go to the podiatrist (foot doctor)	44

Table of Contents (continued)

When you need durable medical equipment (DME)	45
When you need eyeglasses	46
When you need a hearing aid	47
When you need assistance with transportation to medical providers	48
If a Medicaid claim is denied... ..	49
Frequently Asked Questions	49
Notice of Privacy Practices	51
Notes.....	53

Medicaid Health Insurance Programs for the Aged, Blind, and Disabled



Welcome to "A Consumer's Guide to the North Carolina Medicaid Health Insurance Programs for the Aged, Blind, and Disabled." This information will help you understand what Medicaid is and what it covers. This book is for:

- Elderly individuals or couples
- Visually-impaired people
- The physically or mentally disabled
- Health care providers
- Others seeking information about Medicaid

THIS BOOKLET IS ONLY A SUMMARY

To get more information or find out if you qualify for Medicaid, call your local Department of Social Services (DSS). The phone number will be in your local phone book. Look under the County Government section. If you still can't find it, call the CARE-LINE Information and Referral Service at 1-800-662-7030. In the Triangle area, call 919-733-4261. Hearing impaired callers may call either of the above numbers or the TTY dedicated line at 919-733-4851. CARE-LINE is available Monday through Friday 8 a.m. to 5 p.m. except state holidays. A bilingual information and referral specialist is available for Spanish-speaking callers.

What is Medicaid?

Medicaid is a health insurance program for those whose income is below amounts set by the federal and state government. Medicaid is governed by federal and state laws and regulations. To receive Medicaid, you must meet the requirements. To find out if you qualify, look at pages 8 and 9.

What You Can Expect from Medicaid

- Individuals on Medicaid receive a Medicaid Identification (MID) card, which is their insurance card.
- There are co-payments for some services.
- Medicaid has several different types of coverage for people with different needs.
- To receive Medicaid, you don't have to go through a physical or other type of exam. However, if you are applying because you say you are disabled, a medical exam may be required. You can't be rejected for Medicaid because of a health condition you already have. Instead, Medicaid is based on your family's financial need. You do not have to have a current medical need.



The following are the most common programs you will hear your caseworker refer to:

Medicaid for Older Citizens (MAA)—Health care coverage for people 65 or older whose income is below the limits in the list on page 8.

Medicaid for the Blind or Visually Impaired (MAB)—Health care coverage for blind or visually impaired people of any age who are blind according to the definition given by the Social Security Administration (see definition on page 6) and meet the income requirements given on page 8.

Medicaid for Disabled Citizens (MAD)—Health care coverage for people of any age who are unable to work due to a disability that is expected to last at least 12 months and meet the income requirements on page 8.

Terms and Definitions

Blind	As defined by the Social Security Administration (SSA), you are considered legally blind if your vision cannot be corrected to better than 20/200 in your better eye, or if your visual field is 20 degrees or less, even with a corrective lens. If you do not meet the legal definition of blindness, you may qualify for benefits if your vision problems alone or coupled with other health problems prevent you from doing substantial work.
Categorically Needy	Individuals and families whose income is so low that they do not need to meet a deductible.
Copayment (or copay)	Part of the covered treatment charge that a recipient may have to pay.
Coverage Category	The type of Medicaid coverage that you have with the package of medical services that are covered.
Covered Services	Medical, mental health, dental, preventive, long-term care, or other treatment needs that are covered under Medicaid.
Deductible (or spenddown)	The amount of medical expenses the individual is responsible for before qualifying for Medicaid coverage. Usually required for people whose income is above the limit. If you are told that your income is too high to get Medicaid, and you have medical bills you have to pay, ask your DSS caseworker how much of them you will have to pay before you can get Medicaid.
Department of Social Services (DSS)	Under state law, county departments of social services (DSS) are responsible for the administration of all Medicaid programs, including NC Health Choice for Children. The phone number will be in your local phone book. Look under the county government section or call the CARE-LINE. See page 4 for the telephone numbers.
Division of Medical Assistance (DMA)	The NC state Medicaid agency responsible for administration of the Medicaid program.
Disability	As defined by the Social Security Administration (SSA), a physical or mental impairment of such severity that it prevents the applicant from engaging in substantial gainful activity for at least a year or is expected to result in death.
Estate Recovery	When you receive nursing home, CAP or personal care services, your estate will be subject to Estate Recovery if you are 55 or older. Estate recovery is a process in which the Division of Medical Assistance files a claim against the estates of certain individuals to recover Medicaid dollars paid on behalf of the individuals. It does not include placing a lien on a recipient's property. Recovery is not initiated until the recipient's death and, in some cases, may be waived.

If you have questions, please call the CARE-LINE, Information and Referral Service. See page 4 for telephone numbers.

Managed Care	Medicaid Managed Care offers to recipients a state network of primary care doctors known as Carolina ACCESS. In Mecklenburg county a commercial Health Maintenance Organization (HMO) coverage is also available. Managed Care means you have a primary care provider who is responsible for providing or arranging for medical services to meet your health care needs.
Medically Needy	Individuals and families who have too much income or assets to automatically qualify as Categorically Needy. Individuals and families in this group often will qualify for Medicaid after meeting a deductible.
NC Health Choice for Children	Health insurance program for children through age 18 with family income below or at 200% of the federal poverty level. Children cannot be eligible for Medicaid or be covered by private health insurance.
Noncovered Services	Certain medical, mental health, dental, preventive, long-term care, or other services not paid by Medicaid.
Preexisting Condition	A medical condition or problem that you had before you applied for Medicaid.
Prescription Drug	A drug that can only be bought with a doctor's written prescription. Medicaid does not cover drugs that are experimental. The drug must be approved by the Federal Drug Administration (FDA).
Primary Care Provider (PCP)	A medical provider for Carolina ACCESS who either provides or arranges medical services to meet your health care needs.
Prior Approval	Process that makes sure that certain types of services are medically necessary before the service is provided. Some services which require prior approval include dental, vision, psychiatric services, and nursing home placement.
Program Limits	<p><i>Income limits</i> include the highest amount of gross countable monthly income you can receive and still qualify for Medicaid.</p> <p><i>Coverage limits</i> include how many times and how often Medicaid will pay for a covered service. There may also be limitations on the kind of doctors or medical professionals who can prescribe or render care. For example, adults can receive eyeglasses only once every 2 years.</p> <p><i>Resource Limits</i> include the highest amount of countable resources or assets you can have and still qualify for Medicaid.</p>

You Can Get Medicaid if...

- You are a U.S. citizen or qualified alien, and
 - You live in North Carolina, and
 - You have a Social Security Number or have applied for one
- and...

A. You receive a check for one of these:

1. Supplemental Security Income (SSI)
2. Work First Family Assistance (WFFA)
3. State/County Special Assistance for the Aged or Disabled (SAA or SAD)
4. Special Assistance to the Blind (SAB)

or...

B. Your countable income falls within the limits for one of the following categories (see below for income limits):

1. Aged (65 or older), blind or disabled persons (Financial resources must also be below a certain amount. See chart below.)
2. Families with children under age 19. (Refer to A Consumer's Guide to North Carolina Medicaid Health Insurance Programs for Families and Children. The Dear Interested Resident letter at the beginning of this handbook tells you how to obtain a copy.)

Income Levels

Since Medicaid is health coverage for people with income below certain levels, you must receive a check from one of the programs listed in A. above, **or** your yearly income cannot be above the amounts listed below. These income amounts change every April, so ask your social services caseworker what they are. This chart shows income amounts for April 1, 2005 through March 31, 2006.

Applicant	Income per year	
	Categorically Needy	Medically Needy
Individual	\$9,570	\$2,904
Couple	\$12,830*	\$3,804*

*Combined income

If your income is more than one of the amounts listed for categorically needy, you may still qualify if you have medical bills you cannot pay or expect that you will need medical treatment in the near future. You may have to meet a deductible before Medicaid will pay the bills. Call your local DSS to find out what the deductible would be in your case.

In addition, if you are applying alone, you cannot have more than \$2000 in assets such as savings in the bank. If you are applying as a couple, you cannot have more than \$3000 in combined assets. Assets not included in this amount are your homesite if you are living in it and funds designated for burial. There are different rules when one spouse is in a nursing facility and the other remains at home.

Applying for Medicaid

As with any health insurance, you will need to fill out an application. To get an application, call your local department of social services.



When you go to the department of social services to apply...

You will need to provide items to prove you qualify for Medicaid. If possible, have everything on this checklist when you go to apply. If you can't get all of these items, please apply anyway. You can provide information after you apply, and the caseworker can help if you need assistance.

- ✓ Birth certificates or other legal proof of age for children under 21;
- ✓ A copy of all pay stubs for last month;
- ✓ Your social security card, or proof that you have applied for one for yourself or anyone you are applying for;
- ✓ Copies of all medical or life insurance policies you have for yourself and the members of your family who want Medicaid;
- ✓ A list of all cars, trucks, motorcycles, or other vehicles you or anyone in your household own;
- ✓ Most recent financial statements from financial institutions (such as bank statements);
- ✓ Current financial statements from other sources of family income, such as social security, retirement benefits or pensions, veteran benefits, SSI, child support, or other sources.
- ✓ A list of all real property you own.
- ✓ For applicants who are not citizens, proof of residency status.

Your local department of social services will determine if you are eligible for Medicaid. While they are deciding your eligibility, you may be asked to give them more information. Once you have given them all the information they have asked for, you will receive a notice in the mail that will tell you whether or not you can receive Medicaid. This notice will also give you information regarding your right to appeal the decision made by the agency.

Any time your case is changed, or you no longer meet the requirements, you will receive a notice in advance saying why it is being changed or terminated and explaining your right to appeal.

If your income or assets change, you get married or divorced, your spouse dies, or you give or sell assets to someone else, you must tell your worker within 10 days. Before you transfer any kind of property, money, or other assets, talk to your worker.

After you qualify, you get a Medicaid Identification (MID) card...

Your caseworker will mail you a notice to tell you if your application was approved. Each month you will get a Medicaid ID card in the mail.

You must take your **CURRENT** card with you every time you or a member of your family goes to the doctor, hospital, or any medical provider including the pharmacist. Your Medicaid card is your proof that you have coverage, just like insurance.

If you or your family member do not show your card to the person treating you or your family member, the person will not know you are covered by Medicaid. You may then be responsible for paying the full cost of the treatment or prescription drug.

As long as you are eligible, every month you will receive a new card for that month.



What Your Medicaid Card Will Look Like

A BLUE card means you have the typical Medicaid coverage.

If you are enrolled in Carolina ACCESS (CA) or a commercial health plan (HMO), the name of your Carolina ACCESS doctor or your HMO and phone numbers will be printed on your card.

MEDICAID IDENTIFICATION CARD										(INSTRUCTIONS ON BACK)	
N.C. DEPT. OF HUMAN RESOURCES DIVISION OF MEDICAL ASSISTANCE										VALID	
CAP	COUNTY CASE NO.	ISSUANCE	PROGRAM	CLASS	FROM	THRU	RES. NO.	BIRTH DATE	SEX	MID 10/01/00	
CASE ID. CASEHEAD	222-22-2222	JANE P. DOE Dr. John Lace 700 Palmer Dr. Anytown, NC 28888 888-8888 888-1111									
ELIGIBLE MEMBERS		Carolina ACCESS Enrollee April 1999 AAF 11 0847611 101 Jane P. Doe 111 Fair Lane Anytown, NC 28888			876543910						
MISUSE MAY RESULT IN FRAUD PROSECUTION										RECIPIENT SIGNATURE _____ (See note above signed)	

(Pharmacy Stub--see next page)

When You Need to Get a Prescription Filled

When you receive your monthly Medicaid card, it will have a stub that your chosen pharmacist will need to keep in his files. When you receive prescription drugs, **you must go to the same pharmacist all month and show your card each time you have a prescription filled.** You can change pharmacists the following month when you get a new card with a new stub.

Only medicines that require a doctor's written prescription are covered by Medicaid. If you are buying a Federal legend drug or insulin, you must have a prescription if you want Medicaid to pay for it. If you can buy the drug without a written prescription, such as vitamins or ibuprofen, Medicaid will not pay for it.



6 Prescription Limit

Anyone over 21 who does not have a life threatening illness can only receive 6 prescriptions per month. See page 37 for exceptions.

Prescription Copayment

Anyone over 21 must pay a one dollar copayment for each generic prescription and a three dollar copayment for each name brand prescription. Pregnant women are exempt from copayments. There is no copayment when a prescription is purchased for a child (except for birth control pills). See page 22 for other exceptions.

Medicaid **WILL NOT** pay for the following:

1. Drugs that the Federal Drug Administration (FDA) does not approve
2. Non-rebatable drugs (made by a company that has not signed a rebate agreement with the state Medicaid agency)
3. Over-the-counter drugs like aspirin, cold medicines, vitamins

If You Don't Receive Your Card...

By the 10th of the month, contact your caseworker to make sure your card has been issued. If you and your caseworker cannot find the card, request the caseworker to issue you a replacement card. The replacement may not have the pharmacy stub attached. Since limits on services don't apply to children under 21, replacement cards for children may still have the stub attached.

If You Lose Your Card...

Before the end of the month, contact your county department of social services and ask for a replacement card.

THE REPLACEMENT CARD MAY NOT HAVE THE PHARMACY STUB ATTACHED. ASK YOUR CASEWORKER HOW TO GET YOUR PRESCRIPTIONS COVERED.



Carolina ACCESS (Managed Care)

Definition: Carolina ACCESS is a managed care plan that allows you to choose your own primary care provider (PCP). Your PCP will either provide or arrange most of the medical services you will need including preventive services like check ups for adults and children, pap smears, and mammograms when appropriate. Your PCP must provide certain services before he or she can join Carolina ACCESS. These services are important if you need to talk with a health care provider after the office closes or if you have to be hospitalized. If you need medical services that your provider cannot provide he or she will refer you to a specialist.

Who Qualifies: You must participate in this program unless you receive Medicaid as a pregnant woman, as a child in foster care, or receive Medicare. You must join a Managed Care Plan (either Carolina ACCESS or an HMO in Mecklenburg county) if you receive Medicaid under any of the following Medicaid programs:

- Work First Family Assistance (WFFA)
- Medicaid for Families and Children (MAF)
- Medicaid for Infants and Children (MIC)

You can choose whether or not to join a Managed Care Plan if you receive Medicaid for Pregnant Women (MPW) or if you are eligible for both Medicaid and Medicare.

If you receive assistance as a refugee or as a non-citizen (alien), you cannot have a Managed Care Plan.

Benefits of Carolina ACCESS: As a Carolina ACCESS member you will have:

- a medical provider who will either provide or arrange for services to meet your health care needs;
- access to medical advice 24 hours per day;
- the opportunity to select a primary care provider from a list of participating providers. Each family member may have a different PCP.
- a Medicaid card with your PCP's name, address, and telephone numbers on the front;
- better access to regular preventive medical services because of having an established relationship with your PCP; and
- access to education about the plan and how you get medical services from your county and your PCP.

(continued on next page)

Carolina ACCESS (Managed Care)

Exempt Services: Services which do not require PCP authorization/referral when your doctor's name is printed on your Medicaid card. Services include:

- Ambulance
- Anesthesiology
- At-Risk Case Management
- CAP Services
- Certified Nurse Anesthetist
- Child Care Coordination
- Dental
- Developmental Evaluation Centers
- Routine Eye Exams and treatment of conjunctivitis
- Family Planning (including Norplant)
- Health Department Services
- Hearing Aids (under age 21)
- Hospice
- Independent and Hospital Lab Services
- Maternity Care Coordination
- Optical Supplies/Visual Aids
- Pathology Services
- Pharmacy
- Psychiatric/Mental Health
- Radiology (only includes services billed under a radiologist provider number)
- Services Provided by Schools and Head Start programs

If you need help with any of these services, contact the managed care recipient hotline at 1-888-245-0179.

- At Initial Enrollment:**
- Get established with your PCP IMMEDIATELY
 - Take your current Medicaid card when seeking any medical service
 - Call your PCP before going to any other doctor or seeking specialty care
 - Call your PCP before going to the emergency room if the condition is not an emergency
 - Go to the emergency room only when there is an emergency
 - Some services do not need PCP approval, e.g., dental, mental health, etc.
 - Go for preventive care, i.e., Health Check, immunizations, checkups
 - If you cannot keep your appointment, call as soon as possible to cancel.

If you need to change your Primary Care Provider listed on your card, please call your caseworker at your county department of Social Services

North Carolina ACCESS is making a few changes to improve your health care. In some areas of the state, Medicaid patients are getting case managers to help them in managing a disease or to act as their health advocates. As these changes go statewide next year, ACCESS will change its name to Community Care.

HMO Options (Managed Care)

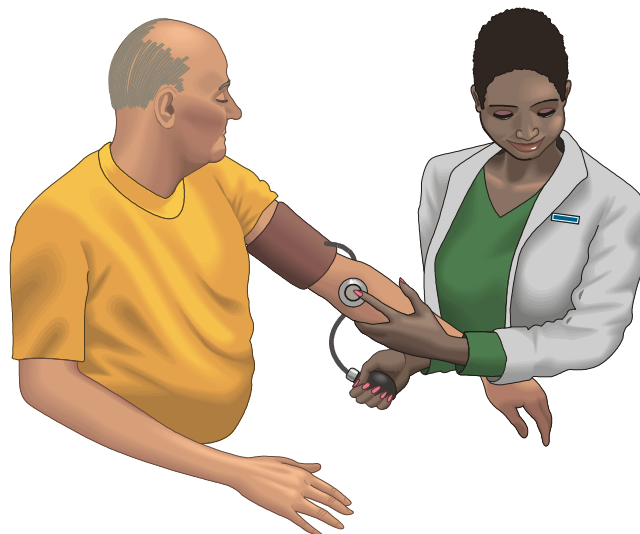
- Definition:** An HMO (Health Maintenance Organization) contracts with the state to provide medical services to recipients in **Mecklenburg county**. This list is subject to change.
- What Medicaid Will Pay For:** All Medicaid services are covered for those enrolled in an HMO, although some are not provided through the HMO. In some cases, the HMO offers additional coverage above the minimum required. HMO enrollees do not make routine copayments for services provided by the HMO.
- Out of Plan Benefits:** Out-of-plan benefits do not require a referral from your PCP. If you need help with any of these services, call the member services telephone number on your Medicaid card. **Out-of-plan benefits include but are not limited to:**
- Dental
 - Prescription Drugs
 - School-related and Head Start therapies

(continued on next page)

HMO Options (Managed Care)

- At Initial Enrollment:
- Get established with your PCP IMMEDIATELY
 - Take your current Medicaid card and your HMO card when seeking any medical service
 - Call your PCP before going to any other doctor
 - Call your PCP before going to the emergency room if the condition is not an emergency
 - Go to the emergency room only when there is an emergency
 - Get your PCP's approval before seeking any specialty care
 - Some services do not need PCP approval, e.g., dental, mental health, etc. (Patient handout includes complete list of exempt services)
 - Go for preventive care, i.e., Health Check, immunizations, checkups
 - If you cannot keep your appointment, call as soon as possible to cancel.

If you need to change your Primary Care Provider or the HMO plan listed on your card, please call your caseworker at your county department of social services.



Other Coverage Options

Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (CAP/MR/DD)

Definition: CAP/MR/DD is designed to give persons with mental retardation/developmental disabilities a cost-effective alternative to care in an intermediate care facility (ICF). The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) is the lead agency for this program with the Division of Medical Assistance (DMA) overseeing its operation.

Who Qualifies: CAP/MR/DD participation depends on the availability of "slots" and services as well as meeting the criteria for ICF-MR/DD Level of Care. Prior approval is required for this level of care. To qualify, the individual must:

- Require active treatment necessitating the ICF-MR/DD level of care
- Have a diagnosis of mental retardation or a condition that is closely related to mental retardation (MR)
- Have MR or a related condition that is manifested before the individual reaches age 22
- Have MR or a related condition resulting in great functional limitations in 3 or more major life areas

What Medicaid Will Pay For:

- Augmentative Communication Devices
- Adult Day Care
- Adult Day Health Care
- CAP-MR/DD In-Home Aide Services (Level 1)
- CAP-MR/DD Personal Care
- Community Inclusion
- Crisis Stabilization
- Developmental day care
- Prevocational services
- Family training
- Respite care
 - Institutional
 - Non-institutional/community based
 - Non-institutional/nursing based
- Supported employment
 - Individual
 - Group
- Supported living services
- Supplies and equipment
- Vehicle adaptations
- Environmental accessibility adaptations

Other Coverage Options

Community Alternatives Program for Disabled Adults (CAP/DA)

- Definition:** CAP/DA is a special Medicaid program that provides an alternative to nursing facility care for disabled persons who are 18 years of age or older and live in a private residence. There is a local lead agency designated by the county commissioners that operates the program in each county. The county department of social services has the name of the lead agency for that county. The Department of Medical Assistance's CAP Unit can also provide that information. Due to a federal limit on the number of participants, each county has a limit on how many individuals it may serve.
- Who Qualifies:** Besides Medicaid eligibility and the need for nursing facility care, other qualifications include:
- The need for CAP/DA services
 - The resources available to meet the person's home care needs
 - Whether the needed community care can be provided cost-effectively compared to the Medicaid cost of nursing facility care. The person must be maintained safely in the home within a monthly cost limit.
- What Medicaid Will Pay For:** A CAP/DA client has a case manager who arranges, coordinates, and monitors CAP/DA services as well as other aspects of the client's home care. In addition to case management, potential CAP/DA services are:
- Adult Day Health Care
 - CAP/DA Waiver Supplies (Reusable incontinence undergarments with disposable liners, oral nutritional supplements and medication dispensing boxes)
 - Home delivered meals
 - Home Mobility Aids (Wheelchair ramps, safety rails, non-skid surfaces, handheld showers, grab bars and widening of doorways for wheelchair access)
 - In-Home Aide Services (Level II and Level III-Personal care)
 - Respite Care (In-home and institutional)
 - Telephone Alert (Emergency response systems)

NOTE:

CAP Services do not need Primary Care Provider authorization for Carolina Access recipients.

Other Coverage Options:

Community Alternatives Program for Persons with AIDS (CAP/AIDS)

- Definition:** CAP/AIDS is a special Medicaid program that provides an alternative to nursing facility care for persons with AIDS as well as children who are HIV-positive and meet other criteria. The person must live in a private residence. CAP/AIDS is a cooperative effort with the AIDS Care Unit in the Division of Public Health. The AIDS Care Unit handles the program operation, with DMA providing oversight. Local CAP/AIDS case management agencies are the entry point. There is a federal limit on how many people may participate each year.
- Who Qualifies:** Besides Medicaid eligibility, the medical diagnosis and the need for nursing facility care, other requirements include:
- The need for CAP/AIDS services
 - The resources available to meet the individual's home care needs
 - Whether the needed care can be provided cost-effectively in relation to the Medicaid cost of nursing facility care. The individual must be maintained safely in the home within a monthly cost limit.
- What Medicaid Will Pay For:** A CAP/AIDS client has a case manager who arranges, coordinates, and monitors CAP/AIDS services as well as other aspects of the client's home care. In addition to case management, the potential CAP/AIDS services are:
- Adult Day Health Care
 - CAP/AIDS Waiver Supplies (Reusable Incontinence Undergarments with Disposable Liners, Oral Nutritional Supplements and Medication Dispensing Boxes)
 - Home Mobility Aids (Wheelchair ramps, safety rails, non-skid surfaces, handheld showers, grab bars and widening of doorways for wheelchair access)
 - In-Home Aide Services (Level II and Level III-Personal Care)
 - Respite Care (In-home and institutional)
 - Personal Emergency Response Systems

NOTE:

CAP Services do not need Primary Care Provider authorization for Carolina Access recipients. If you have questions about CAP/AIDS, call the AIDS Care Unit at 919-715-3169 or DMA's Community Care Section at 919-857-4021.

Other Coverage Options:

Cost of Care in a Nursing Facility

- Definition:** A nursing facility is a licensed nursing facility (NF). Medicaid contributes to the payment of cost of care (room and board) in a NF for people who meet certain eligibility requirements. Medicaid also pays for other medical expenses.
- Who Qualifies:** Persons must meet certain Medicaid eligibility requirements. In addition:
- Medicaid will pay only for nursing care in beds reserved for Medicaid patients which have been approved by a State licensure agency.
 - A Prior Approval Form (FL2) must be completed by the attending physician to describe the medical condition and need for nursing care in a licensed nursing facility. Medicaid must approve the need for care in a nursing facility before the program will pay cost of care.
 - A Medicaid recipient must use his or her income to help pay for nursing care. Medicaid pays the difference between the income of the recipient and the nursing home rate.
 - Each recipient keeps \$30 of his or her income for personal needs not provided by the nursing home's services. Also, the recipient may keep some income to pay for medical services not covered by Medicaid or other health insurance. The amount the recipient must pay is called the "patient monthly liability" or "pml."
- What Medicaid Will Pay For:** Some nursing home services included in the Medicaid payment are:
- Room charge
 - All general nursing, dietary, medical, and psychiatric services
 - Personal items such as shampoo, combs, razor blades, soap, and lotions
 - Medical supplies such as diapers, bandages, dressings, aspirin, and antacids
 - Laundry services
 - Reusable items/equipment such as ice bags, canes, crutches, walkers, and wheelchairs.
 - Hair trimming which is hygienic. (There may be fees for permanents, hair coloring, or special styles.)
 - Special dietary supplements used for tube or oral feeding such as a supplemental high nitrogen diet, even if written as a prescription item by a physician.
- NOTE:** Items not included are TV's, private telephone, private duty nurses or sitters, or tobacco products.

When You Need Prior Approval

Medicaid will cover some services ONLY AFTER the provider (e.g., doctor) gets approval for them. If you do not get prior approval for these services, you may have to pay the whole cost.

Your doctor, or whoever provides the service, must get prior approval for the following services (not a complete list):

- Medical services such as:
 - Visual aids
 - Hearing Aids (for those under age 21)
 - Reconstructive surgery
 - Surgical transplants, except for bone, tendon, corneal, and renal
 - Non-emergency out-of-state services beyond a 40 mile radius of the NC border
 - Surgical procedures for morbid obesity, such as abdominal bypass surgery
 - Excision of keloids
 - Breast reduction
 - Craniofacial surgery
 - Outpatient psychiatric visits after the first eight visits for adults, after the 26th visit for children under age 21 and all out-of-state psychiatric services
 - Outpatient specialized therapies
- Dental work such as:
 - Gum treatment or periodontal services
 - Orthodontic services for under age 21
 - Complex oral surgical procedures
 - Full dentures
 - Partial dentures
 - Denture relines
- Some durable medical equipment and oxygen equipment
- Repair for durable medical equipment items
- Some prosthetic or orthotic device
- Private duty nursing
- Some prescription drugs such as oxycontin

Copayments

Some services covered by Medicaid require you to pay a small fee at the time you receive services.

There is NO copayment for:

- Intermediate care facility for the mentally retarded
- Mental hospital and mental health centers
- Emergency room services
- Non-hospital dialysis facility services
- Nursing facility services (skilled and intermediate)
- Services covered by both Medicare and Medicaid
- Services provided by a commercial HMO contracted to provide medical services
- HMO enrollees
- Inpatient hospital stay
- Participants in a Community Alternatives Program
- Durable medical equipment
- Orthotic and prosthetic devices

NOTE: Recipients in a nursing facility may be required to pay a portion of their monthly income towards their nursing home care.

Services that require copayments include the following:

\$3.00 for physician

\$3.00 for dentist (only one copay for services requiring more than one visit)

\$1.00 for generic prescriptions

\$3.00 for brand name prescriptions

\$1.00 for chiropractic care

\$1.00 for podiatrist

\$2.00 for optometrist

\$2.00 for optical supplies and services

\$3.00 for outpatient visits

If you do not have the money for the copayment at the time you receive services, the provider should not refuse to provide services.

Covered Services

While the following pages contain information on covered and non-covered services, the list is not all-inclusive. Also, this list does change, so for accurate information, ask your medical provider or pharmacist. You may also call CARE-LINE Information and Referral Service at 1-800-662-7030. In the Triangle area, call 919-733-4261. Hearing impaired callers may call either of the above numbers or the TTY dedicated line at 919-733-4851. CARE-LINE is available Monday through Friday 8 a.m. to 5 p.m. except for state holidays. A bilingual information and referral specialist is available for Spanish-speaking callers.

You may also access information on covered services at <http://www.dhhs.state.nc.us/dma/depth98.htm>.

Index

	Page
Physician Services	24
Clinic Services	24
Hospital Inpatient	24
Hospital Outpatient	24
Nursing Facility Services	25
Mental Health Centers	25
Psychiatric & Psychological Services	25
Case Management for Mentally ill	26
Mental Hospitals	26
NC Specialty Hospitals	26
Dental Services	27
Chiropractic Services	27
Podiatrists	27
Hospice	28
Durable Medical Equipment	29
Home Health Services	30
Personal Care Services	31
Home Infusion Therapy	32
Private Duty Nursing	33
Hearing and Visual Aids	33
Lab Services	34
X-Rays	34
Therapy by Independent Practitioners	34
Anesthesia	35
Family Planning	35
Adult Health Screening	35
Medical Transportation	36
Dialysis Services	36
Nursing Services	36

Service	Brief Explanation of Coverage	Restrictions (in brief)
<p>Physician (doctor)</p> <p>Diagnosis and Consultation</p> <p>Therapy</p> <p>Surgery</p>	<p>Covered.</p> <p>\$3.00 copayment per visit. See page 21 for exceptions.</p> <p>Covered. Some supplies usually given by physician during treatment may be covered.</p> <p>Prior approval required for some surgical procedures. See page 21.</p> <p>For Carolina ACCESS (CA) recipients, all visits to a specialist's office, including therapists or surgeons, need primary care physician authorization.</p>	<p>Visits limited to 24 per year (July 1-June 30) per person. Not applicable to children under 21.</p> <p>Coverage of B-12, ACTH, and steroid injections depend on diagnosis.</p> <p>See page 38 for other coverage information.</p>
<p>Clinic Services</p>	<p>All services have the same coverage and restrictions as the same services given in a non-clinic setting.</p>	
<p>Hospital Services: Inpatient</p> <p>Room and board</p> <p>Other medical services</p>	<p>Some restrictions apply to family planning services.</p> <p>Semiprivate room covered, except when private room is medically necessary or all that is available.</p> <p>Services that are medically necessary and are covered by Medicaid.</p>	<p>See page 39 for more coverage information.</p> <p>Primary Care Physician (PCP) authorization for CA.</p> <p>In Plan for HMO.</p>
<p>Hospital Services: Outpatient</p>	<p>Covered for physician or dental visits.</p> <p>\$3.00 copayment per visit.</p> <p>Visits are counted toward 24 visit limit, EXCEPT for emergency room visit.</p> <p>Emergency room services are exempt from \$3.00 copayment.</p>	<p>See page 40 for other coverage information.</p>

Service	Brief Explanation of Coverage	Restrictions (in brief)
Nursing facility services	<p>Covered. Physician visits not counted toward 24 visit limit.</p> <p>No copayment is required after patient liability is paid.</p> <p>Prior approval is required for all admissions to a nursing facility.</p>	<p>Recipients admitted to a nursing facility are not required to participate in any managed care program.</p> <p>See page 41 for more coverage information.</p>
Mental Health Centers	<p>Covered services include prevention, diagnoses, therapy, rehabilitation, and maintenance.</p> <p>No copayment.</p> <p>Prior approval not required.</p>	<p>Recipient must be a patient of the area program or its contract agency.</p> <p>Must have a current diagnosis, treatment plan, and goals on record.</p> <p>Mental health services do not require Carolina ACCESS Primary Care Physician referral and are not provided through any HMO.</p>
Psychiatric and Psychological Services	<p>Services by a psychiatrist are covered. Prior approval required for outpatient visits after the first eight visits for adults and after the 26th visit for children under age 21. Ask your physician to get approval.</p> <p>\$3.00 copayment per visit.</p> <p>Psychiatrist services count toward the 24 visit limit unless the person is under 21.</p>	<p>Service must be provided by a psychiatrist, a licensed clinical social worker, clinical nurse specialist or a psychologist employed by a physician, an Area Mental Health program, or an agency or person that the Area Mental Health contracts with.</p> <p>These services do not require CA PCP referral.</p>

Service	Brief Explanation of Coverage	Restrictions (in brief)
<p>Case Management for the Mentally ill <i>The items below describe the service of case management</i></p> <p>Assessment</p> <p>Coordination and Referral</p> <p>Monitoring</p>	<p>Covered ONLY for mentally ill adults 18 or older, emotionally disturbed youth under 18, substance abusers, and persons with developmental disabilities.</p> <p>Client's strengths, weaknesses, and services needed must be assessed. Then a service plan is developed.</p> <p>Resources are identified and coordinated, and the patient is then referred.</p> <p>Patient is monitored to ensure services are received and adequate for his or her needs.</p>	<p>These services do not require CA PCP referral.</p> <p>Must need assistance with two or more conditions (i.e., medical, social, vocational).</p> <p>Diagnosis must fit into one of the covered groups.</p> <p>The recipient cannot be receiving waiver services or live in a Medicaid covered facility or institution.</p>
<p>Mental Hospitals</p>	<p>Covered for patients 65 and older or 21 and younger.</p> <p>A recipient who turns 21 as an inpatient will be covered until age 22.</p>	<p>People under 21 must have a certification of need form to be admitted to a psychiatric hospital.</p> <p>These services do not require CA PCP referral.</p>
<p>NC Specialty Hospitals</p>	<p>Covered for inpatient care for chronic diseases (like tuberculosis)</p>	

Service	Brief Explanation of Coverage	Restrictions (in brief)
<p>Dental Services</p> <p>Routine services (incomplete list)</p> <p>Prior Approval Services (incomplete list)</p>	<p>Routine services include exams, cleanings and flouride treatments, fillings, sealants, x-rays, and extractions.</p> <p>Stainless steel crown for baby teeth and permanent first molars up to age 21.</p> <p>Stainless steel space maintainer for baby tooth that is removed prematurely, up to age 21.</p> <p>Periodontal work covered with some limits.</p> <p>Prior approved services include:</p> <ul style="list-style-type: none"> — Orthodontic services for children up to age 21 with severe alignment problems. — Complex oral surgeries. — Complete and partial dentures once every 10 years. — Relining of dentures 6 months after delivery and then no more than once every 5 years. 	<p>These services do not require CA PCP referral.</p> <p>See page 42 for more coverage information.</p> <p>Out-of-Plan services if you are covered by an HMO.</p>
<p>Chiropractic services</p>	<p>Only manual manipulation of the spine to correct a spinal injury or degeneration.</p> <p>\$1.00 copayment with exceptions.</p> <p>Office visits count toward 24 visit limit.</p>	<p>Problem must be proven by an x-ray dated within 6 months of the date of services and an appropriate diagnosis.</p> <p>See page 43 for more coverage information.</p>
<p>Podiatrists</p>	<p>Covers any medical, mechanical, or surgical procedure involving the foot.</p> <p>\$1.00 copayment per visit.</p> <p>Office visits are counted toward 24 visit limit.</p>	<p>Routine foot care limited to specific diagnosis.</p> <p>See page 44 for more coverage information.</p>

Service	Brief Explanation of Coverage	Restrictions
Hospice	<p>Hospice is a package of medical and support services for terminally ill individuals. An individual is considered terminally ill if he or she has a medical prognosis of six months or less to live. The hospice services are related to the terminal illness. The services are provided in a private residence, an adult care home, a hospice residential care facility, or a hospice inpatient unit. They also may be provided in a hospital or nursing facility arranged by the hospice agency.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> ● Nursing care. ● Certain physicians' services provided by a licensed doctor of medicine or doctor of osteopathy. ● Medical social services. ● Counseling services for the patient, family members and others caring for the patient. Counseling, including dietary counseling, may be given to train the patient's family or unpaid caregiver to provide care. It also may be provided to help the patient and caregivers adjust to the patient's approaching death. ● Physical therapy, occupational therapy, and speech-language pathology services for the purposes of symptom control or to help the patient keep functioning. ● Short-term inpatient care (general and respite) in a hospice inpatient unit, or a hospital or nursing facility under contract with the hospice agency. ● Medical appliances and supplies, including drugs and biologicals. The drugs are those used primarily for pain relief and symptom control related to the terminal illness. Appliances include medical equipment as well as other self-help and personal comfort items related to the management of the patient's terminal illness. ● Ambulance services related to the management of the patient's terminal illness. 	<p>The patient must be terminally ill—that is, have a life expectancy of six months or less—as certified by his physician.</p> <p>A patient or the patient's representative elects Hospice coverage for a "benefit period"—a specific period of time for the coverage to be provided. During the time a patient elects Hospice, the patient waives Medicaid coverage of most other services for the treatment of the terminal illness and related conditions, since the Hospice package is designed to meet all of the patient's needs.</p> <p>These services do not require CA PCP referral.</p>

Service	Brief Explanation of Coverage	Restrictions (in brief)
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Durable Medical Equipment (DME)

Medicaid has a list of covered DME and related supplies. Medical necessity for the use of these items within your home must be documented by your physician.

Prior approval is required for some DME.

Patients receiving Hospice funding may not receive DME coverage for items related to the treatment of the terminal illness.

Patients receiving drug infusion therapy through HIT (home infusion therapy) coverage may not receive DME coverage for items related to the HIT coverage.

Orthotics and Prosthetics

Medicaid has a list of covered orthotic and prosthetic devices. Medical necessity for these items must be documented by your physician.

Prior approval is required for some of these devices.

Available only to patients from birth through age 20.

Oxygen and Oxygen Equipment

Medical necessity for this equipment must be documented by your physician. The established coverage criteria must be met.

Prior approval is required.

Equipment Repair

Medicaid will pay for repair of patient-owned DME.

Prior approval is required.

See page 45 for more information.

Service	Brief Explanation of Coverage	Restrictions (in brief)
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Home Health Services

Covers the following services when they are medically necessary to help restore, rehabilitate, or maintain a patient in the home according to Medicaid guidelines and provided by a Medicare/Medicaid certified home health agency:

- Skilled nursing visits
- Physical therapy
- Speech pathology and audiology services
- Occupational therapy services
- Home health aide services
- Medical supplies included on Medicaid’s list of approved supplies

A Home Health service must be needed by a patient for care in the patient’s home—which must be either a private residence or the adult care home where the patient resides. Home health aide services may not be provided to a patient in an adult care home.

For all of the Home Health Services except medical supplies, the patient’s physician must certify a patient as “homebound.”

A Medicare or Medicaid Hospice patient may not receive Home Health Services related to the terminal illness.

Service	Brief Explanation of Coverage	Restrictions (in brief)
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Personal Care Services (PCS)

Covers an in-home aide going to the private residence where the patient lives to perform:

- Personal care tasks for the patient who, due to a medical condition, needs help with such activities as bathing, toileting, moving about and keeping track of vital signs.
- Housekeeping and home management tasks that are essential, although secondary to the personal care tasks necessary for maintaining the patient's health.

The patient must:

- Have a medical condition that requires the direct and ongoing care of the physician prescribing PCS,
- Be medically stable at the maintenance level,
- Need help with personal care tasks due to the medical condition.

Personal Care Services (PCS) must be the most cost-effective and appropriate form of care. PCS is to assist, not replace, the help available from family members and community resources.

A patient may receive a maximum of 3 1/2 hours of PCS per day, up to 60 hours each calendar month according to the plan of care authorized by the patient's doctor. PCS may not be received on the same day as other Medicaid aide services.

PCS may not be received by Medicare or Medicaid Hospice patients.

Service	Brief Explanation of Coverage	Restrictions (in brief)
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Home Infusion Therapy (HIT)

Covers the following self-administered infusion therapies in a patient's home when the therapy is medically necessary:

- Total Parenteral Nutrition
- Enteral Nutrition
- Chemotherapy for cancer treatment (intrathecal and intravenous)
- Antibiotic therapy (intravenous)
- Pain management therapy (subcutaneous, epidural, intrathecal and intravenous)

HIT is for patients who live in a private residence or an adult care home (like a rest home or family care home). "Self-administered" means that a patient and/or an unpaid caregiver is capable, able and willing to administer a therapy following appropriate teaching and with adequate monitoring. If the therapy cannot be self-administered, the care may be available under Home Health Services.

Drug therapies include the equipment, supplies, nursing services, and pharmacy services needed for the administration of the drug. The package does not pay for the drug. It must be billed through the Medicaid Drug program.

Nutrition therapy coverage includes the equipment, supplies, and formulas/solutions.

Medicare and Medicaid Hospice patients may not receive Home Infusion Therapy related to the terminal illness. This is covered under Hospice.

Service	Brief Explanation of Coverage	Restrictions (in brief)
Private Duty Nursing	<p>PDN is medically necessary continuous, substantial, and complex nursing services by a licensed nurse (RN or LPN) that is needed by a patient for care in the patient's home. It is for patients who live in private residences.</p> <p>A patient must require substantial and complex continuous nursing care by a licensed nurse as documented by the patient's attending physician. This means:</p> <ul style="list-style-type: none"> ● A patient care task can be done by only a licensed nurse, and ● The tasks must be done so frequently that the need is continuous--these are not tasks that could be reasonably handled by home health skilled nursing visits. 	<p>Medicare and Medicaid Hospice patients may not receive Private Duty Nursing.</p> <p>Prior approval is required.</p> <p>Having a nurse monitoring a patient in case something happens is not considered "continuous nursing care" that qualifies for PDN coverage.</p>
Hearing and Visual Aids		
Hearing Aids	<p>Covers conventional monaural or binaural hearing aids once every 4 years. Also covers supplies and batteries related to hearing aid. Prior approval required for all services except batteries.</p> <p>Coverage is only for individuals under age 21.</p>	<p>Must be ordered by a doctor, and patient must undergo a hearing evaluation.</p> <p>In-the-ear aids limited to children age 12 or older.</p>
Eyeglasses	<p>Covers routine eye exams by an ophthalmologist or optometrist, eyeglasses, and plastic or combination plastic/metal frames. Prior approval required for all visual aids.</p> <p>Contact lenses covered in special circumstances. Exams and visits are counted toward the 24 visit limit, EXCEPT for pick-up of glasses and supplies.</p> <p>Repairs over \$4.00 are covered. Prior approval required.</p> <p>Copayments:</p> <ul style="list-style-type: none"> \$2.00 per pair of eyeglasses and supplies \$2.00 per repair over \$4.00 \$3.00 per visit to ophthalmologist \$2.00 per visit to optometrist 	<p>Medicaid will pay only for frames designated by the program.</p> <p>A pink tint is the only one covered for photophobia, except in cases of post-cataract patients, albinos, etc.</p> <p>Glass or plastic eyeglass lenses must have a prescription strength above a certain criteria to be covered.</p> <p>Vision services do not require CA PCP authorization.</p>

Service	Brief Explanation of Coverage	Restrictions (in brief)
Lab Services	<p>Covers lab work (blood, urine) ordered by a physician or other licensed practitioner.</p> <p><i>Outpatient lab work or work done by an independent lab is not counted toward the 24 visit limit.</i></p>	<p>Does not cover labs for routine physicals for adults.</p> <p>Paternity testing is not covered.</p> <p>Lab services do not require Carolina ACCESS primary care physician authorization.</p>
X-rays	<p>Covers all x-ray services.</p> <p>Visits are counted toward the 24 visit limit EXCEPT if you are having radiation therapy for cancer or if a physician refers you on the same day you visit him or her.</p>	<p>Does not cover x-rays taken during a routine physical.</p> <p>Must be ordered by a physician.</p> <p>These services do not require CA PCP authorization.</p>
Therapy by Independent Practitioners	<p>Covers physical therapy, occupational therapy, respiratory therapy, speech/language therapy, and audiology services.</p> <p>Prior approval required for treatment, but not for assessment.</p> <p>Services must be provided in the following settings: office, home, school, Head Start, or day care.</p>	<p>Must be ordered by a physician.</p> <p>Limited to recipients under 21.</p>

Service	Brief Explanation of Coverage	Restrictions (in brief)
Anesthesia	Covered if medically necessary and provided by an anesthesiologist or a Certified Registered Nurse Anesthetist (CRNA).	These services do not require CA PCP referral.
<hr/>		
Family Planning		
Basic Services	Covers consultation, examination, and treatment by a physician, nurse midwife, or nurse practitioner. Covers lab exams and tests.	
Birth Control	Covers pills, IUD, Norplant, Depoprovera. Covers natural family planning.	Hysterectomy for sterilization not covered.
Sterilization	Includes tubal ligation and vasectomy. Covered only if patient is mentally competent and over 21. Claim must be accompanied by a completed Medicaid consent form signed at least 30 days before the surgery. Exceptions are emergency abdominal surgery and premature delivery.	Sterilization reversals are not covered. For abdominal surgery, consent form must be signed at least 72 hours before surgery.
Hysterectomy	Covered only if medically necessary. Claim must be accompanied by signed statement of the patient.	For premature delivery, consent form must be signed at least 30 days prior to expected date of delivery and at least 72 hours prior to surgery.
Abortion	Covered only in cases of endangerment to the mother's life, incest, and rape. Claim must be accompanied by an abortion statement signed by the physician.	Family planning services do not require CA PCP referral.
<hr/>		
Adult Health Screening	Covers annual physical exams, lab tests, and counseling and intervention for persons over 21 to prevent illness. \$3.00 copayment per visit. Counts toward 24 visit limit.	Covers only one screening per calendar year. For Carolina ACCESS recipients, services must be provided by primary care physician.

Service	Brief Explanation of Coverage	Restrictions (in brief)
Medical Transportation		Referral by a CA PCP is not required for medically necessary transportation.
Non-Ambulance Services	<p>Covers non-ambulance transportation to medical appointments for eligible people who have no other available means of transportation.</p> <p>Covers non-ambulance medically necessary transportation for recipients living in their homes.</p> <p>Recipients should apply for transportation through the local department of social services.</p>	
Ambulance Services	Covers transportation by ambulance if individual's condition is such that any other means would endanger the individual's health or requires transport by stretcher.	Not covered if any other form of transportation is possible. See page 48 for other coverage rules.
Air Ambulance Transportation	Covers fixed wing or helicopter when medically and physically necessary. Must be to the nearest hospital with appropriate facilities.	
State-To-State Transportation	<p>Covers non-emergency medically necessary transportation (ground or air) for out-of-state services or to return to North Carolina.</p> <p>Prior approval must be given by DMA's fiscal agent before the service.</p>	
Dialysis Services	Covered if provider is either a Medicaid-enrolled provider or independently enrolled.	
Nursing Services		

When you go to the doctor (physician)

Under Medicaid, you are usually allowed only 24 visits per year. This includes specialists, chiropractors, etc.

However, for some situations, you are allowed MORE than just 24 yearly visits to the doctor.

Here are some possible exceptions:

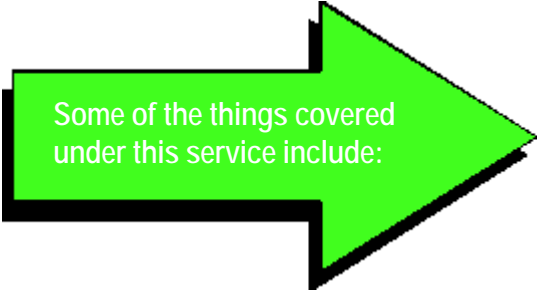
- You are under 21.
- You see a doctor while in a hospital, nursing facility, or intermediate care facility for mentally retarded, or you live in an adult care home.
- You go to the dentist.
- You participate in a Community Alternative Program.



You can have more than 24 doctor's visits and more than 6 prescriptions if you have one of the following diseases:

1. End stage renal disease
2. Chemotherapy and radiation therapy for cancer
3. Acute sickle cell disease
4. End stage lung disease
5. Unstable diabetes (cannot be controlled by pills, diet, or insulin shots)
6. Hemophilia (blood can't clot properly)
7. Any life threatening illness or terminal stage of any illness


When you go to the doctor (physician)



Some of the things covered under this service include:

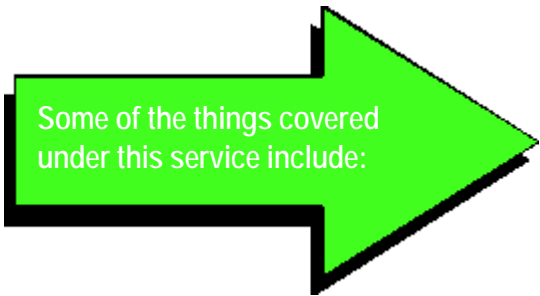
- Any services that are determined by a physician to be medically necessary and given in the office, your home, a hospital, a nursing facility, etc.
- Diagnosis, therapy, surgery, and consultation.

Make sure you have authorization or referral if your physician's name or HMO plan is printed on your Medicaid card!

- 
- Injections if you can take the medicine by mouth.
 - Routine foot care.
 - Experimental drugs and procedures.
 - Routine physicals and related tests, except through adult health screening, family planning, or nursing home or adult care home.
 - Incidental appendectomy.
 - Sex transformation surgery.
 - Sterilization reversal.
 - Procedures or services for infertility.

Some things NOT covered under this service include:

When your doctor admits you to the hospital



Some of the things covered under this service include:

- Bed and board in a semiprivate room, except when a private room is medically required or the only room available.
- Regular nursing services.
- Any hospital facilities you use.
- Medical social services.
- Drugs and blood tests that you have or use while in the hospital.
- Supplies, appliances, or equipment that is used for your care while in the hospital.
- Medically necessary services that people get while they are in the hospital that are covered by Medicaid.

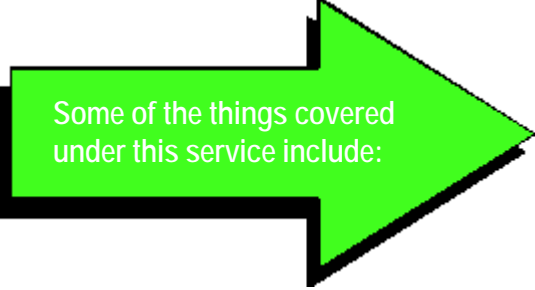
Make sure you have authorization or referral if your physician's name or HMO plan is printed on your Medicaid card!

- Private rooms when they are not necessary.
- Telephone bill.
- Use of the television.
- Private duty nurses or sitters.
- Noncovered services such as private duty nursing, take home supplies, leave days, etc.
- The day you are discharged.
- Any bills you may have for being discharged late because it was more convenient.
- Tests or surgery that is experimental.



Some things NOT covered under this service include:


When you go to the hospital and go home the same day



Some of the things covered under this service include:

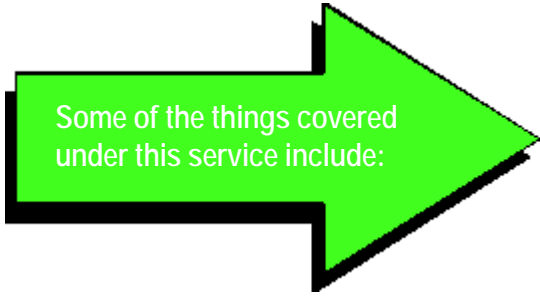
- Any services you have from a physician or dentist in the hospital.
- Outpatient diagnostic services.
- Physical therapy or speech pathology.
- For therapy or rehabilitation, covers the use of the hospital facilities, clinic services, and emergency room services.

Make sure you have authorization or referral if your physician's name or HMO plan is printed on your Medicaid card!

- 
- Supplies or equipment that you take home, unless it is a very small quantity of a supply or drug you need to use until you can get a continuing supply elsewhere.


When you or your family member is in a nursing facility

These are included in the regular payment to the nursing facility:



Some of the things covered under this service include:

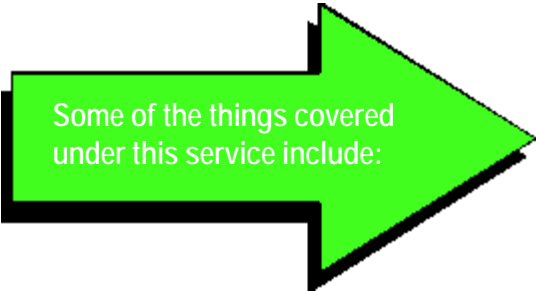
- A semi-private or private room that is ordered by your physician because it is medically necessary.
- Therapeutic leave days (only 60 days per calendar year).
- Over the counter drugs, such as aspirin, milk of magnesia, etc.
- Personal hygiene items and services.
- Personal laundry services.
- Any medically necessary vaccine or test you need to have while you are in the facility.
- Antiseptics, dressings, and medications.
- Equipment like walkers, wheelchairs, canes, air mattresses, bed pans, etc.
- Any physical, speech, or occupational therapy.
- Other items that may need to be used for your feeding, health, or safety.

- 
- Private rooms when they are unnecessary.
 - Reserving a bed while you are not there.
 - Private duty nurses or sitters.
 - Any amount that the county DSS tells you that you have to pay with your savings or monthly income.
 - Telephones, televisions, or anything that you bring into the facility yourself.
 - Hair care that you would not get under ordinary circumstances, such as a permanent, hair color, or a set.

Some things NOT covered under this service include:

When you go to the dentist

Dental Care for your Child: Most children need to have a dental check-up every six months. Your child may also need other dental care. Medicaid will pay for check-ups and needed treatment. (Not all services are covered by Medicaid.) Call 1-800-662-7030, in the triangle area 919-733-4261 or TTY dedicated line or 919-733-7851, to learn more about Medicaid dental services. You can also call this number if you need help finding or getting a dentist.



Some of the things covered under this service include:

- Routine exams, cleanings, restorations, and extractions.
- Full mouth x-rays once every 5 years.
- Root canal for front teeth for all recipients.
- Periodontal surgery if you have gum disease caused by an underlying medical condition.
- One full mouth scaling and root planing per year.
- Complete and partial dentures once every 10 years.
- Relining of dentures 6 months after delivery and then no more than once every 5 years.
- Facial reconstruction for birth defects or after a serious accident.

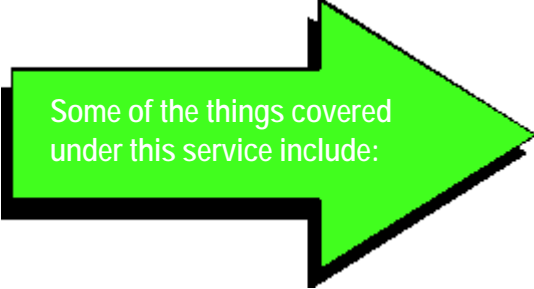
Dental services do not require authorization by your Carolina ACCESS physician.

- Fixed bridgework.
- Experimental procedures.
- Prescription drugs the dentist gives you while you're in his office.
- Implants or transplants.
- Cosmetic procedures.
- Night guards or occlusal splints.
- Gold or porcelain restorations or crowns.
- Temporary dentures.
- Space maintainers that are removable, and retainers for braces that are not included in the orthodontic package.



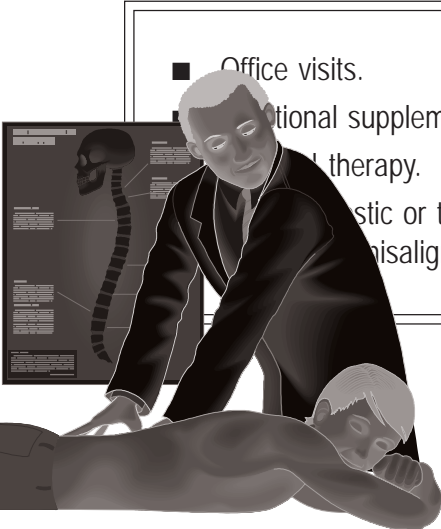
Some things NOT covered under this service include:

When you go to the chiropractor



Some of the things covered under this service include:

- Any manual manipulation of the spine to correct a misalignment.
- Most x-rays.

- 
- Office visits.
 - Nutritional supplements.
 - Physical therapy.
 - Diagnostic or therapeutic service not involving manual manipulation.



Some things NOT covered under this service include:

When you go to the podiatrist (foot doctor)

Some of the things covered under this service include:

- Any procedure connected to the surgical, medical, or mechanical treatment of the foot.
- Routine foot care ONLY IF you have a disease such as diabetes mellitus or peripheral vascular disease. You must be under the care of a physician for the condition and have documentation to support the need for the service.



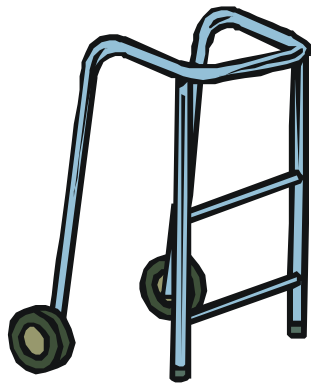
- Procedures that don't have anything to do with your feet.
- Routine foot care, like removal of corns or calluses, cutting toenails, including ingrown toenails, club nails, or mycotic nails, and cleaning or soaking the feet.
- Orthotic devices.
- Arch supports, pads, or shoe inserts.

Some things NOT covered under this service include:

When you need durable medical equipment (DME)

Some of the things covered under this service include:


- Wheelchairs, walkers, canes, hospital beds, and other medically necessary equipment which is on the Medicaid list.
- Oxygen and oxygen equipment.
- Related medical supplies which are on the Medicaid list.



- Items not required for function within your home.
- Items you use for your convenience.
- Equipment for someone in a nursing home. This should be covered in your per diem rate for the home.

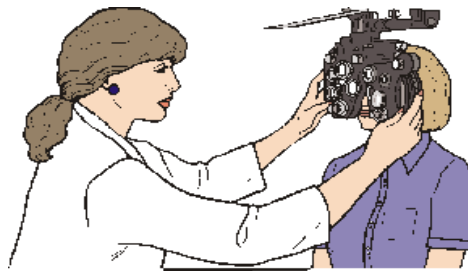
Some things NOT covered under this service include:

When you need eyeglasses



Some of the things covered under this service include:

- One eye exam per year, and one pair of eyeglasses per year or other visual aids in plastic or combination plastic/metal frames if you are under age 25.
- One eye exam and one pair of glasses every 2 years if you are 25 or over.
- Repairs on glasses over \$4.00.
- Lenses when the prescription is over a certain strength.
- Contact lenses if you are a child in school, have keratoconus, progressive myopia, or aphakia.
- Pink-tinted lenses if you are very sensitive to light.



- Artificial eyes.
- Wire or rimless frames.
- Safety glasses.
- Extended wear or disposable contact lenses, and contact lens supplies.
- Tinted lenses unless medically necessary.
- Prescription sunglasses.
- Sport straps, straps, or chains
- Initials or names on frames or lenses.
- Magnifying glasses you get at the store.
- Repairs that cost under \$4.00.
- Cosmetic lenses.
- Visual training therapy and training devices.



Some things NOT covered under this service include:

When you need a hearing aid

Some of the things covered under this service include:

- One initial care kit.
- Custom ear molds.
- Receivers, accessories, batteries.
- Repairs and loaners.
- Dispensing or trial rental fees.



- Battery chargers or testers.
- Auditory trainer components.
- Adapters for telephones, television, or radios.
- Shipping/handling fees, postage, or insurance.
- Loss, damage, or theft insurance.
- Hearing aids for anyone over 21.

Some things NOT covered under this service include:

When you need assistance with transportation to medical providers

Some of the things covered under this service include:

- Ambulance transportation for emergencies.
- Transportation by helicopter when approved.
- State to state transportation.
- Transport to Medicaid covered service.



- Transport for maintenance dialysis unless medically necessary.
- Ambulance transport for convenience.
- Transport to a medical service that is not covered by Medicaid.
- Transport to a more distant physician at the individual's request.
- Transport of a dead person who has been pronounced dead before the ambulance is called.
- Transport to services for which DMA already includes cost of transportation in reimbursement rate.

Some things NOT covered under this service include:

If a Medicaid claim is denied...

If you receive a bill for a service that Medicaid covers after you were told you qualified for Medicaid, and your doctor agreed to accept Medicaid payment, you are not responsible for the bills. You have the right to a "reconsideration review" if Medicaid denies payment of a bill. If you want a reconsideration review, you have to ask for it no later than 60 days after the first bill.

Send the bill to:

Claims Analysis
N.C. Division of Medical Assistance
2519 Mail Service Center
Raleigh, NC 27699-2519

You also should write a letter and send that in with the bill. In the letter, please have:

1. The reason you are requesting the review.
2. Your Medicaid identification number.

Your review will take place within 20 days after Claims Analysis gets your letter. They will send you their decision in writing.

Frequently Asked Questions

1. How long can I receive Medicaid services after being determined eligible?

Benefits continue as long as you meet the qualifications. Your worker will review your status every 6 to 12 months depending on what type of Medicaid you have.

2. Where do I get my Medicaid card, and what do I do if I lose it?

You will receive your Medicaid card every month through the mail. Most people receive their card by the 5th of the month. The card is good only for the month printed on the bottom right of the card. You must show the card whenever you get medical treatment or go to the drug store.

If you lose your Medicaid card, call your local DSS and request a replacement card. However, the replacement card will not have the pharmacy stub attached. Ask your caseworker how to get your prescriptions covered.

3. What if my Medicaid card doesn't come?

If you do not receive your card, contact your county DSS. If the card came but cannot be located, the county will issue you another card. The replacement card does not have the pharmacy stub attached. Ask your caseworker how to get your prescriptions covered.

Frequently Asked Questions

4. **If my income is too high for me to receive Medicaid, is there another health care program I can have?**

Your children may qualify for the North Carolina Health Choice for Children program if they are under age 19 and don't have any other health insurance. You can call 1-800-367-2229 to learn more about this program to see if you might be eligible.

If your income is over the income limit, you may still qualify for Medicaid if you can meet a deductible. See page 8.

5. **How do I find my local Department of Social Services?**

To find the telephone number, look in the county government section of your phone book. These pages are usually blue. You can also call directory assistance or call the CARE-LINE Information and Referral Service at 1-800-662-7030. In the Triangle area, call 919-733-4261. Hearing impaired callers may call either of the above numbers or the TTY dedicated line at 919-733-4851. CARE-LINE is available Monday through Friday 8 a.m. to 5 p.m. except state holidays. A bilingual information and referral specialist is available for Spanish-speaking callers.

6. **Do I have to join a Managed Care Plan?**

You must join a Managed Care Plan (either Carolina ACCESS or an HMO, in Mecklenburg county) if you receive Medicaid under any of the following Medicaid programs:

- Work First Family Assistance (WFFA)
- Medicaid for Families and Children (MAF)
- Medicaid for Infants and Children (MIC)

You can choose whether or not to join a Managed Care Plan if you are eligible for both Medicaid and Medicare.

If you receive assistance as a refugee or as a non-citizen (alien), you cannot have a Managed Care Plan.

North Carolina Medicaid
NOTICE OF
PRIVACY PRACTICES

Effective Date:
April 14, 2003
NC Division of
Medical Assistance

**THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND
DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

**YOUR PRIVACY RIGHTS, OUR
RESPONSIBILITIES**

Medicaid collects and maintains health information about you and is required by law to protect the privacy of your health information and to provide you with this Notice of Privacy Practices. This *Notice* describes how Medicaid may use and share your health information and explains your privacy rights. Medicaid will use or disclose your health information only as described in this *Notice*. We do, however, reserve the right to change our privacy practices and the terms of this *Notice* and to make new notice provisions effective for all health information that we maintain. Revised notices will be sent to you and will be available through the Medicaid contact. (See Contact Information on reverse page.) We will not change our privacy practices before you are sent a revised *Notice* unless the change is required by law.

When you were approved for Medicaid, the County Department of Social Services sent your health information to the Division of Medical Assistance so that Medicaid could pay for your health care. This information included your name, address, birth date, phone number, social security number, Medicare number (if applicable) and health insurance policy information. It may also have included information about your health condition. When your health care providers send claims to Medicaid for payment, the claims include your diagnoses and the medical treatment and supplies you received. For certain medical treatments, your health care provider must send additional medical information such as doctor's statements, x-rays or lab test results.

If at any time, you have questions or concerns about the information in this *Notice* or about our agency's privacy policies, procedures or practices; you may contact the Medicaid Privacy Official. (See Contact Information on reverse page.)

**USE AND DISCLOSURE OF PROTECTED HEALTH
INFORMATION WITHOUT AUTHORIZATION**

There are some services Medicaid provides through contracts with other agencies such as your County department of Social Services and through private

contractors that process your health care provider claims. When services are contracted, Medicaid must share enough information about you with their contractors so that they can perform the job that Medicaid has asked them to do.

To further protect your health information Medicaid will only disclose your health information after making sure in writing that its contractors will safeguard your information the same way that Medicaid does.

This agency may use or disclose your health information to provide Medicaid services to you

FOR Payment: Medicaid may use or disclose your health information to its contractors who provide payment services for Medicaid. (EXAMPLE: In order for your health care provider's claim to be paid, the contractor who processes claims for payment must have enough health information about you to verify and pay for the services you received).

Treatment: To determine if your treatment is medically necessary and is covered under Medicaid, we may use or disclose your health information to other health care professionals. These professionals have specific medical expertise so that they can give an opinion on your treatment as being medically necessary.

Health Care Operations: Medicaid may use or disclose your protected health information to perform a variety of business activities that we call "health care operations." These operations ensure that you receive quality care; the charges are appropriate for the service that you received, and that your health care providers are paid promptly. (EXAMPLE: We may contract with a private company to review the care and services our clients have received to ensure that quality care was provided.) Other "operations" that may require your protected health information to be shared are to:

- Review and evaluate the skills, qualifications and performance of health care providers that are taking care of you.
- Provide training programs for students, trainees, professional and non-professional staff to allow them to use under supervision the skills they have learned.

- Provide information to certifying and licensing agencies so that staff may fulfill professional requirements.
- Plan our agency's future operations.
- Enhance investigations conducted by administration whenever a staff member within our agency files a grievance, or protests a particular issue.
- Provide information to other health plans and federal agencies to determine if you are enrolled as their member or covered by them.

Other Circumstances:

- Cooperate with other government agencies and outside organizations that conduct health oversight activities for the purposes allowed under federal law.
- Comply with court orders, subpoenas, administrative orders, lawsuits related to administration of Medicaid.

Contacting You:

- Contact you personally to keep you informed, such as appointment reminders, other treatment opportunities when necessary or available under certain selected public agency benefit programs.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION THAT REQUIRES YOUR AUTHORIZATION

Medicaid will not use, communicate or disclose your protected health information without your authorization except as allowed in the circumstances mentioned above. For all other uses or disclosures, we will ask you to sign a written authorization to allow us to share or request your protected health information. You may cancel such authorization by notifying our agency Privacy Official.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Medicaid clients have certain rights about their protected health care information.

COMPLAINT ADDRESSES

NC Department of Health and Human Services

Operates an information and referral service located in the Office of Citizen Services, known as **CARE-LINE**, which receives and documents complaints and concerns regarding the privacy practices, policies and procedures related to the protection of individually identifiable health information. Contact information is as follows:

CARE-LINE Email: care.line@ncmail.net
 2012 Mail Service Center
 Raleigh, NC 27699-2012
Voice Phone: 1-800-662-7030 (Toll Free)
 (919) 733-4261 (Triangle Area)
FAX: (919) 715-8174
TTY (919) 733-4851

Secretary, US Department of Health & Human Services

You may also send a written complaint to the Secretary of the United States Department of Health and Human Services. Contact information is as follows:

Office for Civil Rights
 U.S. Department of Health & Human Services
 Atlanta Federal Center, Suite 3B70
 61 Forsyth Street, S.W.
 Atlanta, GA 30303-8909
Voice Phone (404) 562-7886
FAX (404) 562-7881
TDD (404) 331-2867

CONTACT FOR FURTHER INFORMATION

Medicaid Privacy Official
 c/o DHHS CARE-LINE
 Email: care.line@ncmail.net
 2012 Mail Service Center
 Raleigh, NC 27699-2012
Voice Phone: 1-800-662-7030 (Toll Free)
 (919) 733-4261 (Triangle Area) **FAX:** (919) 715-8174
TTY (919) 733-4851

Comuníquese con el Departamento de Servicios Sociales de su Condado para una versión en español de "Aviso de Normas de Privacidad". Usted puede llamar también a CATELINE al 1-800-662-7030 para ayuda en español.

NOTES



NC Department of Health and Human Services
Division of Medical Assistance

The N.C. Department of Health and Human Services does not discriminate on the basis of race, color, national origin, sex, religion, age, or disability in employment or the provision of services.

