

State/Territory: North Carolina

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): All

---

The following ambulatory services are provided.

- (a) Chiropractic services
- (b) Dental services
- (c) Drugs, legend and insulin
- (d) EPSDT
- (e) Eyeglasses and visual aids
- (f) Family planning services
- (g) Hearing aids
- (h) Optometric services
- (i) Podiatry services
- (j) Outpatient hospital
- (k) Physician office visits
- (l) Rural health clinics
- (m) Free standing ambulatory surgical centers

Rural Health Clinic services are subject to limitations of the Physician's services program.

Other ambulatory services are subject to the limitations of each specific service program.

\*Description provided on attachment.

State/Territory: North Carolina

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): \_\_\_\_\_

- 
1. Inpatient hospital services other than those provided in an institution for mental diseases.  
X Provided:    No Limitations X With Limitations\*
- 2.a. Outpatient hospital services.  
X Provided:    No Limitations X With Limitations\*
- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise covered under the Plan)  
X Provided:    No Limitations X With Limitations\*
- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-PUB. 45-4).  
X Provided:    No Limitations X With Limitations
3. Other laboratory and x-ray services.  
X Provided:    No Limitations X With Limitations\*
- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.  
X Provided:    No Limitations X With Limitations\*
- b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.\*  
X Provided: X No Limitations    With Limitations\*
- c. Family planning services and supplies for individuals of child-bearing age.  
X Provided: X No Limitations    With Limitations\*

\*Description provided on attachment.

State/Territory: North Carolina

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY  
GROUP(S): \_\_\_\_\_

4. d. 1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

(i) By or under supervision of a physician;

(ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; or\*

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

\*describe if there are any limits on who can provide these counseling services

2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided:  No limitations\*       With limitations\*\*

\*The State is providing at least four (4) counseling sessions per quit attempt.

\*\* Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt should be explained below.

Please describe any limitations:

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided:  No Limitations       With limitations\*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided:  No Limitations       With limitations:

\*Description provided on attachment.

State/Territory: North Carolina

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): all

---

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

X Provided:    No Limitations X With Limitations\*

b. Optometrists' Services

X Provided:    No Limitations X With Limitations\*

c. Chiropractors' Services

X Provided:    No Limitations X With Limitations\*

d. Other Practitioners' Services

X Provided:    No Limitations X With Limitations\*

Nurse Practitioner criteria described in Appendix 5 of Att. 3.1-A.

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

X Provided:    No Limitations X With Limitations\*

b. Home health aide services provided by a home health agency.

X Provided:    No Limitations X With Limitations\*

c. Medical supplies, equipment, and appliances suitable for use in the home.

X Provided:    No Limitations X With Limitations\*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

X Provided:    No Limitations X With Limitations\*

\*Description provided on attachment.

State/Territory: North Carolina

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): all

- 
8. Private duty nursing services.  
 Provided:  No Limitations  With limitations\*
9. Clinic services.  
 Provided:  No Limitations  With limitations\*
10. Dental services.  
 Provided:  No Limitations  With limitations\*
11. Physical therapy and related services.
- a. Physical therapy.  
 Provided:  No Limitations  With limitations\*
- b. Occupational therapy.  
 Provided:  No Limitations  With limitations\*
- c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.  
 Provided:  No Limitations  With limitations\*
12. Prescribed drugs, dentures, prosthetic devices and eyeglasses prescribed by a physician skilled in disease of the eye or by an optometrist.
- a. Prescribed drugs.  
 Provided:  No Limitations  With limitations\*
- b. Dentures  
 Provided:  No Limitations  With limitations\*

\*Description provided on attachment.

State/Territory: North Carolina

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): All

- c. Orthotic and Prosthetic devices.  
 Provided:  No Limitations  With limitations\*
- d. Eyeglasses.  
 Provided:  No Limitations  With limitations\*
13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.
- a. Diagnostic services.  
 Provided:  No Limitations  With limitations\*
- b. Screening services.  
 Provided:  No Limitations  With limitations\*
- c. Preventive services.  
 Provided:  No Limitations  With limitations\*
- d. Rehabilitative services.  
 Provided:  No Limitations  With limitations\*
14. Services for individuals age 65 or older in institutions for mental diseases.
- a. Inpatient hospital services.  
 Provided:  No Limitations  With limitations\*
- b. Skilled nursing facility services.  
 Provided:  No Limitations  With limitations\*

\*Description provided on attachment.

State/Territory: North Carolina

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): All

- 
- c. Intermediate care facility services.  
 Provided:  No Limitations  With limitations\*\*
- 15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.  
 Provided:  No Limitations  With limitations\*
- b. Including such services in a public institution (or distinct art thereof) for the mentally retarded or persons with related conditions.  
 Provided:  No Limitations  With limitations\*
16. Inpatient psychiatric facility service for individuals under 21 years of age.  
 Provided:  No Limitations  With limitations\*
17. Nurse-midwife services.  
 Provided:  No Limitations  With limitations\*
18. Hospice care (in accordance with section 1905(o) of the Act).  
 Provided:  No limitations  Provided in accordance with section 2302 of the Affordable Care Act  
 With limitations\*

\*Description provided on attachment.

---

TN. No. 13-007  
Supersedes  
TN. No. 00-23

Approval Date 12-16-13

Eff. Date 07/01/2013

HCFA ID: 0140P/0102A

State/Territory: NORTH CAROLINA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): \_\_\_\_\_

---

19. Case management services and Tuberculosis related services

- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

Provided:  With limitations\*

Not provided.

- b. Special tuberculosis (TB) related services under section 1902(z) (2)(F) of the Act.

Provided:  With limitations\*

Not provided.

20. Extended services for pregnant women.

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

Provided:  Additional coverage <sup>+</sup> <sup>++</sup>

- b. Services for any other medical conditions that may complicate pregnancy.

Provided:  Additional coverage <sup>+</sup> <sup>++</sup>  Not provided.

21. Certified pediatric or family nurse practitioners' services.

Provided:  No limitations  With limitations\*

Not provided.

<sup>+</sup> Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

<sup>++</sup> Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

\*Description provided on attachment.

---

---

**20. DESCRIPTION OF EXTENDED SERVICES TO PREGNANT WOMEN**

Pregnancy related and postpartum services include:

Physician  
Clinic, including rural health and migrant health  
In-patient hospital  
Outpatient hospital  
Prescription drugs

The above services are provided to all Medicaid eligibles. The restrictions specified in ATTACHMENT 3.1-A.1 apply to all eligibles including pregnant women. Services available to pregnant women do not exceed the scope of services available to other eligible individuals or groups.

Pregnancy Medical Home:

Pregnancy Medical Home (PMH) services are managed care services to provide obstetric care to pregnant Medicaid recipients with the goal of improving the quality of maternal care, improving birth outcomes, and providing continuity of care. Requirements for PMH services are specified in Attachment 3.1-F.

Qualified providers must:

- be currently enrolled with the N.C. Medicaid Program;
- meet Medicaid's qualifications for participation;
- bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity; and
- meet the Division of Medical Assistance qualifications for enrollment as a PMH provider.

PMH providers include:

1. Individual physicians or physician groups enrolled with NC Medicaid as:
  - General/family practice
  - Obstetrics/Gynecology
  - Multi-specialty
2. Federally Qualified Health Clinics (FQHC)
3. Rural Health Clinics (RHC)
4. Nurse Practitioners
5. Nurse Midwives

=====

**20. DESCRIPTION OF EXTENDED SERVICES TO PREGNANT WOMEN, CONT'D**

**Childbirth Education Classes**

Childbirth education classes include a series of classes designed to prepare pregnant women and their support person for the labor and delivery experience. These classes are based on a written curriculum that outlines the course objectives and specific content to be covered in each class as approved and published in Medicaid Clinical Coverage Policies at the NC Division of Medical Assistance website,

[www.dhhs.state.nc.us/dma/mp/mpindex.htm](http://www.dhhs.state.nc.us/dma/mp/mpindex.htm).

Qualified providers must:

- be enrolled with the N.C. Medicaid Program; and
- be certified as a childbirth educator by a nationally recognized organization for childbirth education or meet State-approved childbirth education program requirements; and be a licensed practitioner operating within the scope of their practice as defined under State law or
- be under the personal supervision of an individual licensed under State law to practice medicine.

TN No.: 10-035A  
Supersedes  
TN No.: NEW

Approval Date: 03-21-11

Effective Date: 3/01/2011

### **Dietary Evaluation and Counseling**

Dietary Evaluation and Counseling, when provided by a qualified nutritionist to Medicaid eligible pregnant and postpartum women identified as having high risk conditions by their prenatal care provider include but is not limited to:

- Nutrition assessment
- Development of an individualized care plan
- Diet therapy
- Counseling, education about needed nutrition habits/skills and follow-up
- Communication with the WIC Program, Baby Love Program and prenatal care provider as appropriate.

The high risk indicators used to assess pregnant and postpartum women's medical need for the services are as follows:

1. conditions that impact the length of gestation or the birth weight, where nutrition is an underlying cause, such as:
  - a. severe anemia (HGB<10M/DL or HCT<30)
  - b. pre-conceptionally underweight (<90% standard weight for height)
  - c. inadequate weight gain during pregnancy
  - d. intrauterine growth retardation
  - e. very young maternal age (under the age of 16)
  - f. multiple gestation
  - g. substance abuse
2. metabolic disorders such as diabetes, thyroid dysfunction, maternal PKU, or other inborn errors of metabolism
3. chronic medical conditions such as cancer, heart disease, hypertension, hyperlipidemia, inflammatory bowel disease, malabsorption syndromes, or renal disease
4. auto-immune diseases of nutritional significance such as systemic lupus erythematosus
5. eating disorders such as severe pica, anorexia nervosa, or bulimia nervosa
6. obesity when the following criteria are met:
  - BMI >30 in same woman pre-pregnancy and post partum
  - BMI >35 at 6 weeks of pregnancy
  - BMI >30 at 12 weeks of pregnancy
7. a documented history of a relative of the first degree with cardiovascular disease and/or possessing factors that significantly increase the risk of cardiovascular disease such as a sedentary lifestyle, elevated cholesterol, smoking, high blood pressure, greater than ideal body weight

Provider Qualifications

Medicaid enrolled providers who employ licensed dietitians/nutritionists or registered dietitians are eligible to provide dietary evaluation and counseling. It is the responsibility of the provider agency to verify in writing that staff meet the following qualifications:

1. a dietitian/nutritionist, currently licensed by the N.C. Board of Dietetics/Nutrition (provisional license is not acceptable)
2. a registered dietitian, currently registered with the Commission of Dietetic Registration (registration eligibility is not acceptable).

Coordination with WIC

This nutrition service is not intended to replace WIC nutrition education contacts. All individuals receiving this service must be referred to WIC to receive the two WIC nutrition education contacts.

Other Services

Other services described in this attachment and restrictions described in Attachment 3.1-A.1 apply to all pregnant women except those that are entitled as optionally categorically needy pregnant women. For this latter category of pregnant women only pregnancy-related services and family planning services are available.

State/Territory: North Carolina

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): All

---

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).
- Provided:  No limitations  With limitations\*
- Not provided.
23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
- a. Transportation.
- Provided:  No limitations  With limitations\*
- b. Services of Christian Science nurses
- Provided:  No limitations  With limitations\*
- c. Care and services provided in Christian Science sanitoria.
- Provided:  No limitations  With limitations\*
- d. Skilled nursing facility services provided for patients under 21 years of age.
- Provided:  No limitations  With limitations\*
- e. Emergency hospital services.
- Provided:  No limitations  With limitations\*
- f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.
- Provided:  No limitations  With limitations\*

State/Territory: North Carolina

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): ALL

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

Provided  Not Provided

25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

Provided:  State Approved (Not Physician) Service Plan Allowed

Services Outside the Home Also Allowed

Limitations Described on Attachment

Not Provided

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

LIMITATIONS ON AMOUNT  
DURATION AND SCOPE OF SERVICES  
MEDICALLY NEEDY

Services covered for medically needy individuals are equal in amount, duration and scope to services covered for the categorically needy. Limitations are described in Attachment 3.1-A.1.

State Plan Under Title XIX of the Social Security Act  
Medical Assistance Program  
State: NORTH CAROLINA

Medicaid Program: Requirements Relating to Covered Outpatient Drugs for the Medically Needy  
**12.a. PRESCRIBED DRUGS**

---

---

Citation (s)	Provision (s)
USC 1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

State Plan Under Title XIX of the Social Security Act  
Medical Assistance Program  
State: NORTH CAROLINA

Medicaid Program: Requirements Relating to Covered Outpatient Drugs for the Medically Needy

**12.a. PRESCRIBED DRUGS** *continued*

Citation (s)	Provision (s)
USC 1927(d)(2) and 1935(d)(2)	<p>The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.</p> <p>(1) The following excluded drugs are covered:</p> <p><input checked="" type="checkbox"/> (a) Non-prescription drugs</p> <p>North Carolina (NC) will only cover selected rebateable over the counter (OTC) products when not covered by the prescription drug plans (PDPs). Examples of OTC drugs covered are: Non-sedating antihistamines e.g. Loratadine OTC and Claritin OTC, proton pump inhibitors e.g. Prilosec OTC</p>

TN No.: 14-011  
Supersedes  
TN No.: 13-005

Approval Date: 05-29-14

Effective Date: 01/01/2014

State Plan Under Title XIX of the Social Security Act  
Medical Assistance Program  
State: NORTH CAROLINA

Medicaid Program: Requirements Relating to Covered Outpatient Drugs for the Medically Needy

**12.a. PRESCRIBED DRUGS *continued***

Citation (s)	Provision (s)
	(2) The following excluded drugs are not covered: <ul style="list-style-type: none"><li>(a) Agents when used for anorexia, weight loss, weight gain</li><li>(b) Agents when used to promote fertility</li><li>(c) Agents when used for cosmetic purposes or hair growth</li><li>(d) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee</li><li>(e) Agents when used for the symptomatic relief of cough and colds. All legend products that contain expectorants or cough suppressants. Examples are: expectorant/antitussive combination, antihistamine/decongestant/antitussive combination, antihistamine/decongestant/ expectorant combination, antihistamine/decongestant/ expectorant/antitussive combination, antihistamine/expectorant combination, antihistamine/antitussive, antitussive/decongestant/ analgesic/expectorant, and antitussive/decongestant/ analgesic.</li><li>(f) All legend vitamins and mineral products, except prenatal vitamins and fluoride.</li></ul>

TN No.: 12-021  
Supersedes  
TN No.: 09-026

Approval Date: 02-07-13

Effective Date: 01-01-2013

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM

Attachment 3.1-C

State North Carolina

STANDARDS AND METHODS TO ASSURE HIGH QUALITY CARE

---

---

Institutional care will be provided by facilities qualified to participate in Title XVIII and/or Title XIX.

Physicians' services are those services provided within the scope of practice, as defined by State law, by or under the personal supervision of an individual licensed under State law to practice medicine, osteopathy, podiatry, and optometry. Those services, as required by State statute, performed by a licensed optometrist or podiatrist which fall within the scope of services performed by a doctor of medicine are the only podiatric and optometric services which may be covered.

Drugs will be provided only on the written prescription of a licensed practitioner qualified to prescribe and will be dispensed through registered or licensed pharmacies except for remote areas where pharmaceutical services are not available, except when dispensed by the physician.

Independent laboratories and x-ray facilities, including such facilities in a physician's office, furnishing outpatient diagnostic services must meet the standards prescribed for participation under Title XVIII.

Home health agencies must meet the standards prescribed for participation in Title XVIII.

Consultants in pharmacy, dentistry, nursing, and medicine, with advice and counsel of committees representing professional provider groups and advisory council, will participate in program planning, establishing standards, and program evaluations.

Provisions will be made for obtaining recommended medical care and services regardless of geographic boundaries.

Long term care of patients in medical institutions will be provided in accordance with procedures and practices that are based on the patient's medical and social needs and requirements.

Standards in other specialized high quality programs such as Crippled Children's Services will be incorporated as appropriate.

Rec'd 12/26/73

OPC-11# 73-45

Dated 12/21/73

R.O. Action 7/19/74

Eff. Date 10/1/73

Obsoleted by \_\_\_\_\_

Dated \_\_\_\_\_

State Plan Under Title XIX of the Social Security Act  
Medical Assistance Program  
State: NORTH CAROLINA

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Limitations in the Amount, Duration and Scope of Certain Items of Provided Medical and Remedial Care and Services are Described Below:

<u>CITATION</u>	Medical and Remedial	Methodologies for medically necessary ambulance
42 CFR	Care and Services	transportation are found in Attachment 3.1-A.1, page 18.
431.53	Item 24.a	Transportation services for categorically needy are
	Transportation	defined in Attachment 3.1-A and transportation services
		for medically needy are defined in Attachment 3.1-B.

An amount to reimburse nursing facilities, ICF-MR and Adult Care Homes for non-ambulance non-emergency transportation is included in Medicaid payments to those facilities.

Methods of Assuring Transportation

The North Carolina Division of Medical Assistance, or its designated agent, shall assure that necessary NEMT services are provided for beneficiaries who have a need for assistance with transportation. The designated agent is the county departments of social services. The distance to be traveled, transportation methods available, treatment facilities available, and the physical condition and welfare of the beneficiary shall determine the type of NEMT authorized. The type of transportation available may vary by region because of rural and urban conditions.

State Plan Under Title XIX of the Social Security Act  
Medical Assistance Program  
State: NORTH CAROLINA

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Any appropriate means of transportation which can be secured without charge through volunteer organizations, public services, recipient relatives or friends will be used. If transportation is not available without charge, payment will be made for the least expensive appropriate means of transportation available, including personal vehicle, multi-passenger van, wheelchair van, bus, taxi, train, ambulance, and other forms of public and private conveyance. Beneficiaries, family members and volunteers using their own vehicles to provide transportation are provided gas vouchers or mileage reimbursement. Mileage costs incurred shall not exceed the current IRS business rate. Mileage costs incurred by recipients and financially responsible persons shall not exceed half the current IRS business rate. Payments to beneficiaries, financially responsible individuals and volunteers are provided as an administrative service and reimbursement for these services is claimed at the administrative rate.

Transportation to in-state or out-of-state locations, that are not within the beneficiary's normal service area, shall be covered when it has been determined, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are not able to be provided by a provider/facility within the state or within the beneficiary's normal service area.

Services ancillary to NEMT shall include meals and lodging. Reimbursement for related travel expenses may not exceed the state mileage, subsistence and lodging reimbursement rates.

State Plan Under Title XIX of the Social Security Act  
Medical Assistance Program  
State: NORTH CAROLINA

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Attendants, including family members, are entitled to reimbursement of expenses incurred during transportation at the least expensive rate that is appropriate to the beneficiary's circumstances. Attendants, other than family members, may charge for their time when an attendant is medically necessary. Maximum reimbursement for an attendant's time shall not exceed the state hourly wage rate, nor shall an attendant be reimbursed for time spent in travel without the beneficiary. A medical professional who serves as an attendant and administers medical services during the trip may bill Medicaid for that service, but cannot also charge for his time.

Applicants/ beneficiaries are made aware of NEMT services by the following methods:

- Information on applications/re-enrollment forms
- Rights and Responsibilities Handout/Mailing
- Department of Social Services contact
- Beneficiary Handbook
- DMA Website

Compliance with NEMT policy is assured through county and state monitoring and state auditing.

Counties are required to track each trip request from intake through disposition. Effective April 1, 2012, counties are required by policy to audit 2% of the trips made each month using a state compliance monitoring tool. Reports are maintained at the county and must be provided to the state upon request and at a time of state audits.

In March 2012, a contract was executed by the state with a vendor to perform audits of the county NEMT programs based on policy. The state meets at minimum biweekly with the vendor to review

State Plan Under Title XIX of the Social Security Act  
Medical Assistance Program  
State: NORTH CAROLINA

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

findings and take action. Counties are required to submit a corrective action plan for issues identified through the audits and to payback funds as necessary. Implementation of corrective action plan is monitored and can result in withholding of funding or termination of provider status. The audit does not affect the recipients' coverage.

---

TN No. 12-011  
Supersedes  
TN No. NEW

Approval Date: 12-07-12

Eff. Date 10/01/2012

State/Territory: North Carolina

I. Coverage of Transplant Services

Subject to the specifications, conditions, and limitations established by the State Medicaid Agency, transplant services are covered as follows:

- Coverage is limited to transplant services that are specified in the North Carolina Division of Medical Assistance Medicaid Clinical Coverage Policies. Additionally, the criteria for determining a recipient's clinical eligibility for transplantation are specified in the Medicaid Clinical Coverage Policies as well. The North Carolina Division of Medical Assistance Medicaid Clinical Coverage Policies can be located on the web at [www.dhhs.state.nc.us/dma/mp/mpindex.htm](http://www.dhhs.state.nc.us/dma/mp/mpindex.htm).
- Organs procured from outside the transplanting facility must be obtained from an organ procurement organization meeting the standards described in Section 1138 of the Social Security Act. The North Carolina Division of Medical Assistance Medicaid Clinical Coverage Policies further specifies organ procurement requirements. These policies are available on the Division's website located at [www.dhhs.state.nc.us/dma/mp/mpindex.htm](http://www.dhhs.state.nc.us/dma/mp/mpindex.htm).
- The transplant facility must meet the requirements contained in Section 1138 of the Social Security Act.
- Donor expenses are covered for certain transplants as specified in the North Carolina Division of Medical Assistance Medicaid Clinical Coverage Policies that are available on the Division's website located at [www.dhhs.state.nc.us/dma/mp/mpindex.htm](http://www.dhhs.state.nc.us/dma/mp/mpindex.htm).

State/Territory: North Carolina

II. Solid Organ Transplants

A. Medically necessary solid organ transplants and other related procedures are covered for adults and children, with prior approval. These include the following:

- Heart transplant
- Heart/lung transplant
- Lung transplant
- Liver transplant
- Kidney transplant
- Pancreas transplant
- Islet cell transplant
- Small bowel, small bowel/liver and multi-visceral transplant
- Ventricular assist device (VAD)
- Extracorporeal membrane oxygenation (ECMO), Extracorporeal life support (ECLS)
- Implantable cardioverter defibrillator (ICD)
- Biventricular Pacemaker for congestive heart failure (CHF)

Revision: HCFA-PM-87-4 (BERC)  
March 1987

Attachment 3.1-E  
Page 3  
OMB No. 0938-0193

State/Territory: North Carolina

B. Definitions

1. Cadaveric/deceased donor is a person who has been declared dead and his/her family has offered one or more organs to be used for transplantation or is a dying person that has self-declared that he/she will offer one or more organs to be used for transplantation.
2. Living donor is a living person who donates an organ or part of an organ to another person.
3. Xenotransplantation refers to the surgical transfer of cells, tissues or whole organs from one species to another.

State/Territory: North Carolina

C. Clinical Packet requirements for Prior Approval

All clinical transplant packets submitted for review should include the documentation delineated below. Incomplete clinical transplant packets will not be approved. Documentation should include:

1. Letter from recipient's physician requesting solid organ transplant and summarizing the recipient's clinical history.
2. All lab results including: Human Immunodeficiency Virus (HIV), Rapid Plasma Reagin (RPR), Hepatitis panel, Prothombin Time (PT), International Normalized Ratio (INR), infectious disease serology, inclusive of Cytomegalovirus (CMV) and Epstein-Barr Virus (EBV).
3. All diagnostic and procedure results.
4. Complete psychosocial evaluation with documentation of post-transplant care needs.
5. Psychiatric evaluation, if psychiatric history is documented.
6. Where the recipient has a history of substance abuse, completion of a substance abuse treatment program and sequential screenings for relevant substances. Specific requirements may be found in the Medicaid Clinical Coverage Policies for transplants located on the Division of Medical Assistance's website at [www.dhhs.state.nc.us/dma/mp/mpindex.htm](http://www.dhhs.state.nc.us/dma/mp/mpindex.htm).
7. Any additional clinical documentation that is requested by the North Carolina Division of Medical Assistance and/or that is required by specific Medicaid Clinical Coverage Policies.

Revision: HCFA-PM-87-4 (BERC)  
March 1987

Attachment 3.1-E  
Page 5  
OMB No. 0938-0193

State/Territory: North Carolina

D. Other

- The NC Division of Medical Assistance will consider coverage for other transplants based on clinical trials reported in peer reviewed journals, new technology assessments and medical necessity.
- Additional information regarding solid organ transplantation medical coverage criteria and donor fees has been specified in the North Carolina Division of Medical Assistance Medicaid Clinical Coverage Policies. These policies are available on the Division's website located at [www.dhhs.state.nc.us/dma/mp/mpindex.htm](http://www.dhhs.state.nc.us/dma/mp/mpindex.htm).

State/Territory: North Carolina

III. Stem Cell/Bone Marrow/Umbilical Cord Transplants

- A. Medically necessary Stem Cell/Bone Marrow/Umbilical Cord transplants and other related procedures are covered for adults and children, with prior approval. Current stem cell transplants and related procedures include:
- High Dose Chemotherapy (HDC) +/- Total Body Irradiation (TBI) including autologous/allogeneic stem cell for acute lymphocytic leukemia
  - HDC +/- TBI including autologous/allogeneic stem cell for acute myelogenous leukemia
  - HDC +/- TBI including autologous/allogeneic stem cell for chronic myelogenous leukemia
  - HDC +/- TBI including autologous/allogeneic stem cell for germ cell tumors
  - HDC +/- TBI including autologous/allogeneic stem cell for Hodgkins disease
  - HDC +/- TBI including autologous/allogeneic stem cell for Multiple Myeloma and Primary Amyloidosis
  - HDC +/- TBI including /allogeneic stem cell for Myelodysplastic diseases
  - HDC +/- TBI including /allogeneic stem cell for genetic diseases and acquired anemias
  - HDC +/- TBI including autologous stem cell for Primitive Neuroectodermal Tumors (PNET) and Ependymoma
  - HDC +/- TBI including autologous/allogeneic stem cell for Non-Hodgkins Lymphoma
  - HDC +/- TBI including autologous for ovarian cancer and germ cell tumors arising in the ovaries
  - HDC +/- TBI including autologous/allogeneic stem cell for solid tumors of childhood
  - Placental and Umbilical Cord Blood as a source of stem cells
  - Non-Myeloablative Allogeneic stem cell (Mini-Transplant, Mini-Allograft Reduced Intensity Conditioning) for the treatment of malignancies
  - Donor Leukocyte, Donor Lymphocyte or Buffy Coat Infusion for hematologic malignancies that relapse or are at high risk for relapse after allogeneic stem cell transplant
  - Photophresis for Solid Organ Rejection, Autoimmune Disease and Graft-Versus Host Disease (GVHD)
  - Bone Morphogenic Protein-2 Allograft

State/Territory: North Carolina

B. Definitions

1. Autologous means the new marrow comes from the patient/recipient. The marrow or stem cells are collected, stored and reinfused to the patient/recipient.
2. Allogeneic refers to new cells which arise from an appropriately matched donor.
3. Bone marrow transplant means a technique in which bone marrow is transplanted from one individual to another or removed from and transplanted to the same individual in order to stimulate production of blood cells. It is used to treat malignancies, certain forms of anemia and immunologic deficiencies.
4. Stem cell transplant restores stem cells, also called peripheral stem cell. The donor can be related or unrelated. The stem cells used in peripheral blood stem cell transplantation (PBSCT) come from the bloodstream. A process called apheresis or leukapheresis is used to obtain peripheral blood stem cells (PBSCs) for transplantation.
5. Mini-transplant is a type of allogeneic transplant and uses lower, less toxic doses of chemotherapy and/or radiation. It may also be called a non-myeloablative or reduced-intensity transplant.
6. Tandem transplant is a type of autologous transplant. The patient/recipient receives two sequential courses of high-dose chemotherapy with stem cell transplant.
7. Umbilical cord blood transplant is the injection of umbilical cord blood to restore an individual's own blood production system suppressed by anticancer drugs, radiation therapy.

State/Territory: North Carolina

C. Clinical Packet requirements for Prior Approval:

All clinical transplant packets submitted for review should include the documentation delineated below. Incomplete clinical transplant packets will not be approved. Documentation should include:

1. Letter from recipient's physician requesting solid organ transplant and summarizing the recipient's clinical history.
2. All prior chemotherapy regimen and dates
3. All lab results including: HIV, RPR, Hepatitis panel, PT, INR, infectious disease serology, inclusive of CMV and EBV.
4. All diagnostic and procedure results inclusive of bone marrow aspiration.
5. Complete psychosocial evaluation with documentation of post-transplant care needs.
6. Psychiatric evaluation, if psychiatric history is documented.
7. Where the recipient has a history of substance abuse, completion of a substance abuse treatment program and sequential screenings for relevant substances. Specific requirements may be found in the Medicaid Clinical Coverage Policies for transplants located on the Division of Medical Assistance's website at [www.dhhs.state.nc.us/dma/mp/mpindex.htm](http://www.dhhs.state.nc.us/dma/mp/mpindex.htm).
8. Any additional clinical documentation that is requested by the North Carolina Division of Medical Assistance and/or that is required by specific Medicaid Clinical Coverage Policies.

Revision: HCFA-PM-87-4 (BERC)  
March 1987

Attachment 3.1-E  
Page 9  
OMB No. 0938-0193

State/Territory: North Carolina

D. Other

- The NC Division of Medical Assistance will consider coverage for other transplants based on clinical trials reported in peer reviewed journals, new technology assessments and medical necessity.
- Additional information regarding stem cell/bone marrow/umbilical cord transplantation medical coverage criteria and donor fees has been specified in the North Carolina Division of Medical Assistance Medicaid Clinical Coverage Policies. These policies are available on the Division's website located at [www.dhhs.state.nc.us/dma/mp/mpindex.htm](http://www.dhhs.state.nc.us/dma/mp/mpindex.htm).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE North Carolina

COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII

---

---

The following method is used to provide benefits under Part A and Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

A. Part B buy-in agreements with the Secretary of HHS. This agreement covers:

1.  Individuals, receiving SSI under title XVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

Yes  No

2.  Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-a plan, who are categorically needy under the State's approved title XIX plan.

Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

Yes  No

3.  All individuals eligible under the State's approved title XIX plan.

4.  Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

B. Part A group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

C. Payment of Part A and Part B deductible and coinsurance costs. Such payments are made in behalf of the following groups:

1. Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.
2. Categorically and Medically Needy
- 3.

TITLE VI  
MONITORING REPORT

Name of Provider \_\_\_\_\_ Date of Visit \_\_\_\_\_  
Address \_\_\_\_\_ Monitor's Name \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Monitor's Title \_\_\_\_\_

Information Desired:

1. The use of signs:

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

2. Dual Facilities:

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

3. The Provider's policy with respect to the order of seeing patients:

- Appointments Only
- Walk-in Only
- Appointments and Walk-in
- Procedure for logging walk-in patients? \_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

4. Does the Provider have a policy regarding the use of courtesy titles?

\_\_\_\_\_

\_\_\_\_\_

ADDITIONAL COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Effective Date 10/1/75