



## Attachment B: Criterion 5 Service Needs/Discharge Planning Status Form

<b>Criterion #5 Service Needs/Discharge Planning Status Form</b>				
<b>In order for this form to be processed, all blanks must be completed and legible.</b>				
Client Name:		Date of Birth:	Age:	Medicaid#:
Admission Date:		Decertification Date:	Current Placement:	
County of Residence:				
<b>Complete when requesting initial authorization</b>				
Check if Needed	Service	Service Available		If no, Anticipated Date of Availability
	Outpatient Treatment: <input type="checkbox"/> Individual; <input type="checkbox"/> Group	<b>Yes</b>	<b>No</b>	
	Community Support: <input type="checkbox"/> Individual; <input type="checkbox"/> Group			
	Assertive Community Treatment			
	Day Treatment			
	Residential Treatment Level I			
	Residential Treatment Level II			
	Residential Treatment Level III			
	Residential Treatment Level IV			
	PRTF (Psychiatric Residential Treatment Facility)			
	Psychiatric Evaluation and Treatment			
	Respite			
	SAIOP			
	SACOT			
	Other (Identify):			
	Other (Identify):			
	Other (Identify):			
<b>Update Information</b>				
Date	Client Status	Service Required (Checked Above)	Steps Taken to Obtain Necessary Service	Anticipated Date of Availability
Is the patient at risk of decompensating if services are not available: <input type="checkbox"/> Yes; <input type="checkbox"/> No Explain stating specific behaviors:				
Signature/Title: _____			Date: _____	
Print Name: _____ Telephone: _____			FAX: _____	
I have reviewed this form and I am aware of the efforts that the Provider is undertaking.				
Hospital: _____		Signature/Title: _____		Date: _____
UM003 <span style="float: right;">Rev11032008</span>				

## Attachment C: Certifications of Need for Inpatient Admissions for Recipients under the Age of 21

### Psychiatric Residential Treatment Facility Certification of Need: Medicaid Inpatient Psychiatric Service Under Age 21



**North Carolina**  
**Department of Health and Human Services**  
**Division of Medical Assistance**  
**Clinical Policy and Programs**  
 2501 Mail Service Center · Raleigh, N.C. 27699-2501

#### Psychiatric Residential Treatment Facility Certification of Need: Medicaid Inpatient Psychiatric Service Under Age 21

Recipient Name: \_\_\_\_\_ Facility Name: \_\_\_\_\_

Medicaid ID #: \_\_\_\_\_ Provider #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Admission Date: \_\_\_\_\_

**Type of Certification: (check 1 item)**

- Pre-admission/elective
- Emergency admission

**Medicaid Eligibility Status: (check 1 item)**

- Medicaid eligible on admission
- Pending Medicaid on admission
- No evidence of Medicaid on admission
- Applied for Medicaid during stay
- Applied for Medicaid after discharge

**At the time of admission, the interdisciplinary team certifies the following:**

1. Ambulatory care resources in the community do not meet the treatment needs of the recipient.
2. Proper treatment of the recipient's condition requires services on an inpatient basis under the direction of a physician.
3. The inpatient services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

Physician Team Member Signature	Print Name/Title	Date (Mo/Day/Yr)
---------------------------------	------------------	------------------

Other Team Member Signature	Print Name/Title	Date (Mo/Day/Yr)
-----------------------------	------------------	------------------

Submit to: [Insert Vendor Information Here]

**Certification of Need: Medicaid Inpatient Psychiatric Service under Age 21**



**North Carolina**  
**Department of Health and Human Services**  
**Division of Medical Assistance**  
**Clinical Policy and Programs**  
 2501 Mail Service Center - Raleigh, N.C. 27699-2501

**Certification of Need: Medicaid Inpatient Psychiatric Service under Age 21**

Recipient Name: \_\_\_\_\_ Hospital: \_\_\_\_\_  
 Medicaid ID #: \_\_\_\_\_ Provider #: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Admission Date: \_\_\_\_\_

**Type of Certification: (check 1 item)**

- Pre-admission/elective
- Emergency admission

**Medicaid Eligibility Status: (check 1 item)**

- Medicaid eligible on admission
- Pending Medicaid on admission
- No evidence of Medicaid on admission
- Applied for Medicaid during stay
- Applied for Medicaid after discharge

**At the time of admission, the interdisciplinary team certifies the following:**

1. Ambulatory care resources in the community do not meet the treatment needs of the recipient.
2. Proper treatment of the recipient's condition requires services on an inpatient basis under the direction of a physician.
3. The inpatient services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

Physician Team Member Signature	Print Name/Title	Date (Mo/Day/Yr)
---------------------------------	------------------	------------------

Other Team Member Signature	Print Name/Title	Date (Mo/Day/Yr)
-----------------------------	------------------	------------------

Submit to: [Insert Vendor Information Here]

**Attachment D: Recipient Eligibility File Layout**

LME Eligibility File Layout 03052009

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FD  VALUE-OPTIONS-FILE
    RECORDING MODE IS F
    LABEL RECORDS ARE STANDARD
    RECORD CONTAINS 400 CHARACTERS
    BLOCK CONTAINS 0 RECORDS.
01  VO-OUTPUT-RECORD.
    05  VO-OUT-IND-ID                PIC X(10).
    05  VO-OUT-LAST-NAME             PIC X(15).
    05  VO-OUT-SUFFIX                PIC X(03).
    05  VO-OUT-FIRST-NAME           PIC X(10).
    05  VO-OUT-MID-INIT             PIC X.
    05  VO-OUT-BIRTHDATE            PIC 9(08).
    05  VO-OUT-COUNTY               PIC 9(02).
    05  VO-OUT-RACE                  PIC X.
    05  VO-OUT-SEX                   PIC X.
    05  VO-OUT-AUTH-FM-CCYYMMDD     PIC 9(08).
    05  VO-OUT-AUTH-TO-CCYYMMDD     PIC 9(08).
    05  VO-OUT-IND-XREF-TBL OCCURS 6 TIMES
        INDEXED BY VO-OUT-XREF-INDEX.
        10  VO-OUT-IND-XREF-ID       PIC X(10).
    05  VO-OUT-MC-HMO-BDATE-1       PIC 9(8).
    05  VO-OUT-MC-HMO-EDATE-1      PIC 9(8).
    05  VO-OUT-PVDR-NAME-1         PIC X(27).
    05  VO-OUT-PVDR-OFFICE-PH-NUM-1 PIC X(10).
    05  VO-OUT-MC-HMO-BDATE-2      PIC 9(8).
    05  VO-OUT-MC-HMO-EDATE-2     PIC 9(8).
    05  VO-OUT-PVDR-NAME-2        PIC X(27).
    05  VO-OUT-PVDR-OFFICE-PH-NUM-2 PIC X(10).
    05  VO-OUT-MC-HMO-BDATE-3     PIC 9(8).
    05  VO-OUT-MC-HMO-EDATE-3     PIC 9(8).
    05  VO-OUT-PVDR-NAME-3        PIC X(27).
    05  VO-OUT-PVDR-OFFICE-PH-NUM-3 PIC X(10).
    05  VO-OUT-SPEC-COV-CODE       PIC X(2).
    05  VO-OUT-SSN                  PIC S9(9) COMP-3.
    05  VO-OUT-ADDRESS.
        07  VO-OUT-ADDR-LN1         PIC X(18).
        07  VO-OUT-ADDR-LN2.
            09  VO-OUT-ADDR-LN2-ADDR PIC X(15).
            09  VO-OUT-NURS-HOME-CD  PIC X(3).
        07  VO-OUT-CITY              PIC X(12).
        07  VO-OUT-STATE             PIC X(2).
        07  VO-OUT-ZIP-CODE         PIC S9(9) COMP-3.
    05  VO-OUT-AID-DATA            PIC X(3).
    05  VO-OUT-SSI-STATUS          PIC X.
    05  VO-OUT-MEDICAID-CLASS      PIC X.
    05  VO-OUT-PCHP-IND            PIC X.
    05  VO-OUT-PACE-IND            PIC X.
    05  VO-OUT-DATE-OF-DEATH-CYMD  PIC X(8).
    05  FILLER                      PIC X(37).

```

## Attachment E: Provider Eligibility File Layout

```

*****
*           HMVY6801
*           VALUEOPTIONS/LME
*
* THIS COPY MEMBER IS THE VALUEOPTIONS/LME PROVIDER FILE
* LISTING AS TRANSMITTED FROM EDS.
*
*
*****
01 (PREF)VALUEOPTIONS-RECORD.
05 (PREF)PROVIDER-TYPE           PIC X(10).   provider type - 3 character number that is the type
                                     of provider followed by 7 bytes of filler
05 (PREF)LAST-NAME              PIC X(20).   First 15 characters of provider name (last 5
                                     characters blank)
05 (PREF)FIRST-NAME             PIC X(15).   next 11 characters of provider name (last 4
                                     characters blank)
05 (PREF)MIDDLE-NAME           PIC X(01).   last available character of provider name
05 (PREF)PROVIDER-SSN          PIC X(09).   personal SSN if applicable
05 (PREF)MAILING-ADDR1         PIC X(25).
                                     site address line 1 (optional - really address line 2)
05 (PREF)MAILING-ADDR2         PIC X(25).
                                     site address line 2 (required - really address line 1)
05 (PREF)MAILING-CITY          PIC X(16).   site city
05 (PREF)MAILING-STATE         PIC X(02).   site state
05 (PREF)MAILING-ZIP           PIC X(10).   site zipcode
05 (PREF)DISCIPLINE-LIC-LVL    PIC X(10).   always spaces
05 (PREF)PROVIDER-SPECIALTY    PIC X(30).
                                     provider specialty - 2 character number that defines
                                     the provider specialty followed by 27 bytes of filler
01
05 (PREF)SERVICE-ADDRESS-SEQ-NO PIC X(02).   Medicaid Provider Number (not NPI)
05 (PREF)PROVIDER-NUM          PIC X(15).
05 (PREF)SERVICE-ADDR1       PIC X(25).   site address line 1 (usually blank)
05 (PREF)SERVICE-ADDR2       PIC X(25).   site address line 2 (required)
05 (PREF)SERVICE-CITY        PIC X(16).   site city
05 (PREF)SERVICE-STATE       PIC X(02).   site state
05 (PREF)SERVICE-ZIP         PIC X(10).   site zipcode
05 (PREF)SERVICE-PHONE       PIC 9(10).   site phone number
05 (PREF)SERVICE-CONTACT-NAME PIC X(20).   provider contact last first middle initial
05 (PREF)TAX-ID                PIC X(15).   IRS Tax id
05 (PREF)BILLING-ADDR1        PIC X(25).   billing address line 1 (usually blank)
05 (PREF)BILLING-ADDR2        PIC X(25).   billing address line 2 (required)
05 (PREF)BILLING-CITY         PIC X(16).   billing city
05 (PREF)BILLING-STATE        PIC X(02).   billing state
05 (PREF)BILLING-ZIP          PIC X(10).   billing zipcode
05 (PREF)PROVIDER-EFF-DATE     PIC X(08).   provider eligibility begin date
05 (PREF)PROVIDER-EXP-DATE     PIC X(08).   provider eligibility end date (if provided)
05 (PREF)ACTION                PIC X(01).   C-change, D-delete, A-add
05 (PREF)ACTUAL-LICENSE-NO     PIC X(10).   **New** provider license number when known
    
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## Attachment F: Notification of Quality of Care Memo Template

**Insert Vendor Letterhead**

To:  
From:  
Date:  
RE: Notification of QOC Complaint Received

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We received the following information as a quality of care complaint and are forwarding for your review and follow-up as necessary:

Member Name:

---

Member ID:

---

Clinical Home  
Dates of Service:

---

Service Provider:

---

Service Provider ID:

---

Service Provider Level of Care:

---

Service Provider  
Dates of Service:

---

Name of complainant:

---

Summary of  
Complaint:

---

Please contact me at \_\_\_\_\_ if you have any further questions regarding this case.

Thank you.

## Attachment G: Service Authorization Timelines

### Service Authorization Timelines, page 1

<b>Authorization Timelines</b>			
<b>SERVICE</b>	<b>INITIAL AUTHORIZATION</b>	<b>REQUIRED DOCUMENTS INITIAL</b>	<b>REQUIRED DOCUMENTS CONCURRENT</b>
<b>NON-DIRECT ADMIT SERVICES</b>			
<b>Ambulatory Detoxification</b>	<ul style="list-style-type: none"> <li>PA required first day of service</li> <li>Up to 7 day authorization</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Complete PCP with signatures</li> </ul>	<ul style="list-style-type: none"> <li>Maximum of 10 days per episode</li> <li>Updated PCP with signatures if applicable</li> </ul>
<b>Day Treatment</b>	<ul style="list-style-type: none"> <li>PA required first day of service</li> <li>Up to 60 day auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Complete PCP with signatures</li> </ul>	<ul style="list-style-type: none"> <li>Up to 60 days</li> <li>Updated PCP with signatures if applicable</li> <li>Additional information if applicable</li> </ul>
<b>Diagnostic Assessment</b>	<ul style="list-style-type: none"> <li>Pass through of 1 event per calendar year</li> </ul>	<ul style="list-style-type: none"> <li>ORF2</li> <li>Additional information if applicable</li> </ul>	<ul style="list-style-type: none"> <li>ORF2</li> <li>Additional information if applicable</li> </ul>
<b>Professional Tx Services in Facility-Based Crisis Program</b>	<ul style="list-style-type: none"> <li>Pass through of 7 days</li> <li>PA required before 8th day of service delivered</li> <li>Up to 8 days for initial auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Crisis admit: Service Order</li> <li>Planned admit: complete PCP with signatures</li> </ul>	<ul style="list-style-type: none"> <li>Maximum of 15 days per episode</li> <li>Maximum of 30 days per calendar year</li> <li>Updated PCP with signatures if applicable</li> <li>Additional information if applicable</li> </ul>
<b>Inpatient</b>	<ul style="list-style-type: none"> <li>48 hour pass through (after hrs emergency admits)</li> <li>PA required after first 48 hours</li> <li>Up to 7 day auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>CON for children/adolescents (if free standing inpatient facility)</li> </ul>	<ul style="list-style-type: none"> <li>Up to 7 days</li> <li>CON (if was included in initial request)</li> <li>Additional information if applicable</li> </ul>
<b>Mobile Crisis</b>	<ul style="list-style-type: none"> <li>Pass through of 8 hours</li> <li>PA for next 8 hours required before 9<sup>th</sup> hour of service delivered</li> </ul>	<ul style="list-style-type: none"> <li>ORF2</li> <li>Service Order</li> </ul>	<ul style="list-style-type: none"> <li>PA for final 8 hours required before 17<sup>th</sup> hour of service delivered</li> <li>Maximum 24 hrs/episode</li> <li>Service Order</li> </ul>
<b>Non-Hospital Medical Detoxification</b>	<ul style="list-style-type: none"> <li>PA required first day of service</li> <li>Up to 10 days auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Crisis admit: Service Order</li> <li>Planned admit: complete PCP with signatures</li> </ul>	<ul style="list-style-type: none"> <li>Up to 10 days</li> <li>Maximum of 30 days per calendar year</li> <li>Updated PCP with signatures if applicable</li> <li>Additional information if applicable</li> </ul>

Service Authorization Timelines, page 2

<b>Authorization Timelines</b>				
<b>SERVICE</b>	<b>INITIAL AUTHORIZATION</b>	<b>REQUIRED DOCUMENTS INITIAL</b>	<b>CONCURRENT (REAUTHORIZATION)</b>	<b>REQUIRED DOCUMENTS CONCURRENT</b>
<b>NON-DIRECT ADMIT SERVICES CONTINUED</b>				
<b>Opioid Treatment</b>	<ul style="list-style-type: none"> <li>PA required first day of service</li> <li>Up to 60 days auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Complete PCP with signatures</li> </ul>	<ul style="list-style-type: none"> <li>Up to 180 days</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Updated PCP with signatures if applicable</li> <li>Additional information if applicable</li> </ul>
<b>PH (Partial Hospitalization)</b>	<ul style="list-style-type: none"> <li>PA required first day of service</li> <li>Up to 7 days auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Complete PCP with signatures</li> </ul>	<ul style="list-style-type: none"> <li>Up to 7 days</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Updated PCP with signatures if applicable</li> <li>Additional information if applicable</li> </ul>
<b>PRTF</b>	<ul style="list-style-type: none"> <li>PA required first day of service</li> <li>Up to 14 days auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Complete PCP with signatures</li> <li>CON</li> </ul>	<ul style="list-style-type: none"> <li>Up to 30 days</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Updated PCP with signatures if applicable</li> <li>Additional information if applicable</li> </ul>
<b>PSR (Psychosocial Rehabilitation)</b>	<ul style="list-style-type: none"> <li>PA required first day of service</li> <li>Up to 90 days auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Complete PCP with signatures</li> </ul>	<ul style="list-style-type: none"> <li>Up to 180 days</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Updated PCP with signatures if applicable</li> <li>Additional information if applicable</li> </ul>
<b>Residential:</b>				
<ul style="list-style-type: none"> <li><b>II-Group</b></li> <li><b>III-5+ beds</b></li> <li><b>IV</b></li> </ul>	<ul style="list-style-type: none"> <li>PA required first day of service</li> <li>Up to 30 day auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Complete PCP with signatures</li> </ul>	<ul style="list-style-type: none"> <li>Up to 90 days</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Updated PCP with signatures</li> <li>Additional information if applicable</li> </ul>
<b>Residential II – Family (Therapeutic Foster Care)</b>	<ul style="list-style-type: none"> <li>PA required first day of service</li> <li>Up to 60 day auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Complete PCP with signatures</li> </ul>	<ul style="list-style-type: none"> <li>Up to 180 days</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Updated PCP with signatures</li> <li>Additional information if applicable</li> </ul>

**Service Authorization Timelines, page 3**

<b>Authorization Timelines</b>				
<b>SERVICE</b>	<b>INITIAL AUTHORIZATION</b>	<b>REQUIRED DOCUMENTS INITIAL</b>	<b>CONCURRENT (REAUTHORIZATION)</b>	<b>REQUIRED DOCUMENTS CONCURRENT</b>
<b>NON-DIRECT ADMIT SERVICES CONTINUED</b>				
<b>Residential III – 4 beds or fewer</b>	<ul style="list-style-type: none"> <li>PA required first day of service</li> <li>Up to 30 day auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Complete PCP with signatures</li> </ul>	<ul style="list-style-type: none"> <li>Up to 30 days</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Updated PCP with signatures if applicable</li> <li>Additional information if applicable</li> </ul>
<b>Substance Abuse Medically Monitored Community Residential</b>	<ul style="list-style-type: none"> <li>PA required first day of service</li> <li>Up to 10 days auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Complete PCP with signatures</li> </ul>	<ul style="list-style-type: none"> <li>Up to 10 days</li> <li>Maximum of 30 days per calendar year</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Updated PCP with signatures if applicable</li> <li>Additional information if applicable</li> </ul>
<b>Non-medically Monitored Community Residential</b>	<ul style="list-style-type: none"> <li>PA required first day of service</li> <li>Up to 10 days auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Complete PCP with signatures</li> </ul>	<ul style="list-style-type: none"> <li>Up to 10 days</li> <li>Maximum of 30 days per calendar year</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Updated PCP with signatures if applicable</li> <li>Additional information if applicable</li> </ul>
<b>DIRECT ADMIT SERVICES</b>				
<b>ACTT (Assertive Community Treatment Team)</b>	<ul style="list-style-type: none"> <li>PA required first day of service</li> <li>Up to 30 days auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Intro (or complete) PCP with signatures</li> </ul>	<ul style="list-style-type: none"> <li>Up to 180 days</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Complete/updated PCP with signatures</li> <li>Additional information if applicable</li> </ul>
<b>Community Support – Adult Community Support - Child</b>	<ul style="list-style-type: none"> <li>PA required first day of service</li> <li>Up to 90 days auth</li> <li>Only 416 units per 90 day period for adults</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Intro (or complete) PCP with signatures</li> </ul>	<ul style="list-style-type: none"> <li>Up to 90 days</li> <li>Only 416 units per 90 day period for adults</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Complete/updated PCP with signatures</li> <li>Additional information if applicable</li> </ul>
<b>CST (Community Support Team)</b>	<ul style="list-style-type: none"> <li>PA required first day of service</li> <li>Up to 30 days auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Intro (or complete) PCP with signatures</li> </ul>	<ul style="list-style-type: none"> <li>Up to 90 days</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Complete/updated PCP with signatures</li> <li>Additional information if applicable</li> </ul>
03192009 FINAL DRAFT				3 of 4

**Service Authorization Timelines, page 4**

<b>Authorization Timelines</b>				
<b>SERVICE</b>	<b>INITIAL AUTHORIZATION</b>	<b>REQUIRED DOCUMENTS INITIAL</b>	<b>CONCURRENT (REAUTHORIZATION)</b>	<b>REQUIRED DOCUMENTS CONCURRENT</b>
<b>DIRECT ADMIT SERVICES CONTINUED</b>				
<b>Intensive In-Home</b>	<ul style="list-style-type: none"> <li>PA required first day of service</li> <li>Up to 30 days auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Intro (or complete) PCP with signatures</li> </ul>	<ul style="list-style-type: none"> <li>Up to 60 days</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Complete/updated PCP with signatures</li> <li>Additional information if applicable</li> </ul>
<b>MST (Multisystemic Therapy)</b>	<ul style="list-style-type: none"> <li>PA required first day of service</li> <li>Up to 30 days auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Intro (or complete) PCP with signatures</li> </ul>	<ul style="list-style-type: none"> <li>Up to 120 days</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Complete/updated PCP with signatures</li> <li>Additional information if applicable</li> </ul>
<b>SAIOP (Substance Abuse Intensive Outpatient Program)</b>	<ul style="list-style-type: none"> <li>PA required first day of service</li> <li>Up to 30 days auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Intro (or complete) PCP with signatures</li> </ul>	<ul style="list-style-type: none"> <li>Up to 60 days auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Complete/updated PCP with signatures</li> <li>Additional information if applicable</li> </ul>
<b>SACOT (Substance Abuse Comprehensive Outpatient Treatment)</b>	<ul style="list-style-type: none"> <li>PA required first day of service</li> <li>Up to 60 days auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Intro (or complete) PCP with signatures</li> </ul>	<ul style="list-style-type: none"> <li>Up to 60 days auth</li> </ul>	<ul style="list-style-type: none"> <li>ITR</li> <li>Complete/updated PCP with signatures</li> <li>Additional information if applicable</li> </ul>
<b>TCM (Targeted Case Management)</b>	<ul style="list-style-type: none"> <li>8 hour pass through – once in a lifetime</li> <li>PA required after first 8 hours</li> <li>90days (non-waiver)</li> <li>365 days (waiver)</li> <li>(average of 240 units/year)</li> </ul>	<ul style="list-style-type: none"> <li>CTCM</li> <li>Intro (or complete) PCP with signatures</li> <li>MR-2</li> <li>Cost Summary</li> <li>Evidence of DD before age 22</li> </ul>	<ul style="list-style-type: none"> <li>90 days non-waiver</li> <li>Annual authorization (waiver)</li> </ul>	<ul style="list-style-type: none"> <li>New CTCM if requesting additional units</li> <li>Complete PCP with signatures</li> <li>Additional information if applicable</li> </ul>

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## Attachment H: Peer Review Form for Individuals Under the Age of 21

### Peer Review Form for Individuals Under the Age of 21, page 1

#### Peer Review Form *(Sample)* Clinical Summary *(Sample)*

#### 1. Demographic Information

*The following elements must be included:*

- Recipient
- MID
- Age
- County
- Custody/living arrangements

#### 2. History

*The following elements must be included:*

- Current Request (Units/Dates)
- Type of Review
- Current authorizations on file (Units/Dates)
- Dx Axis I-V
- Precipitating Event
- Risk to Self/Others (current, history)
- Medications
- Current Impairments
- Legal Involvement
- Sexual Abuse as victim and/or sexually offending behavior
- Neglect/Physical Abuse
- Brief Treatment History
- Past history of Peer Reviews
- Reason for referral to Peer Review

#### 3. Peer Decision

- **[Choose One] Approve** (does meet), **Deny** (does not meet), **Reduce** (partially meets)
- List approved amount & duration
- List date ranges of authorization
- **[Include sentence]** *This decision includes 30 days for transition, appeal and linkage to recommendations below for concurrent reviews.*

#### 4. Reason for Adverse Decision

- A. Does not meet DHHS Clinical Coverage Policy medical necessity guidelines for **entrance/continued stay [choose one]**.
  - Cite portion of clinical coverage policy that is not met – **SEE PAGE 3**

**Peer Review Form for Individuals Under the Age of 21, page 2****B. For recipient under age 21**

As the recipient is under 21 years of age, the federal requirements under Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) were also considered. The Division's instructions state that all EPSDT criteria must be met in order to cover a service under EPSDT.\* Those criteria appear below along with a description of the applicability to the recipient.

- a. EPSDT services must be coverable services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].
- b. The requested service must be determined to be medical in nature.
- c. The service must be safe.
- d. The service must not be experimental/investigational

**[Fill in service here]**\_\_\_\_\_ Services meet the above criteria (a-d).

- e. The service must be medically necessary to correct or ameliorate a defect, physical, or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner. By requiring coverage of services needed to correct or ameliorate a defect, physical or mental illness, or a condition [health problem], EPSDT requires payment of services that are medically necessary to sustain or support rather than cure or eliminate health problems to the extent that the service is needed to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

Evidence presented by the recipient's provider indicates treatment services at a alternate level of care are warranted and that these services would correct or ameliorate recipient's condition. No medical information was presented to refute this recommendation.

- f. The service must be generally recognized as an accepted method of medical practice or treatment.

**[Fill in service here]**\_\_\_\_\_ services are not the best practice standard in recipient's individual case. **[Add brief sentence here about best practice standard for presenting issues.]**

**SEE PAGE 3**

- g. The service must be effective.

**[Fill in service here]**\_\_\_\_\_ services are not the most efficacious service for the recipient's symptoms/behaviors. **[Add brief sentence here about most efficacious service for presenting issues.]** **SEE PAGE 3**

\*As indicated above, all of the EPSDT criteria were not met.

**Peer Review Form for Individuals Under the Age of 21, page 3****5. Alternative Treatment Recommendations**

*These alternative treatments are effective and similarly efficacious to the service requested. It is not sufficient to cover a standard, lower cost service instead of the requested service if the lower cost service is not equally effective in this individual case. The most appropriate services and interventions per Peer Review are as follows: [include sentence]*

**[Check all that apply but also add additional services that are most appropriate according to clinical best practice standards.]**

1. Immediate Psychiatric/Medical evaluation
2. Home and Community Supports
3. Personal Care Services
4. Day Supports
5. Residential Supports
6. Supported Employment
7. Respite
8. Other DD Service (specify) \_\_\_\_\_
9. Non-Waiver service (specify) \_\_\_\_\_
10. Equipment (specify) \_\_\_\_\_
11. Targeted Case Management
12. Refer to DMA for consideration of alternate Medicaid service (specify)
13. Community team meet and update PCP
14. Updated Psychiatric evaluation
15. Updated Medication evaluation
16. Psychological Evaluation
17. NeuroPsychological Evaluation
18. Psychoeducational testing to rule out learning disability
19. OT evaluation to rule out sensory integration disorder
20. Speech and Language evaluation
21. Hearing assessment
22. Team meet with school to address \_\_\_\_\_
23. Safety plan be developed for community, school, home
24. Consider DSS support/involvement
25. Parent skill development
26. Behavioral plan
27. Social skills training, ideally in a group setting
28. Family therapy
29. Individual therapy
30. Referral to outpatient therapy
31. Referral to ACTT

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**Peer Review Form for Individuals Under the Age of 21, page 4**

32. Referral to CST
33. Referral to PSR
34. Referral to SA evaluation/treatment program
35. Referral to Intensive In Home
36. Referral to MST
37. Referral to Day Treatment
38. Referral to CAP-MR/DD services
39. Link with natural supports
40. Sex Offender Risk assessment/SOSE
41. Evaluate community concern/questions related to sexualized behavior
42. Team meeting to include representatives from DJJ/Criminal Justice system
43. Consider out of home placement
44. Therapeutic Foster Care
45. Substance Abuse Services (specify)
46. Residential (specify)
47. VR Referral
48. Other

**6. Required Signatures**

*Clinician Reviewer: Name, Credentials, Date*

*Peer Reviewer: Name, Credentials, Date*

**Peer Review Form for Individuals Under the Age of 21, page 5****CITATIONS**

**Code of Federal Regulations, Chapter 42 Part 431, Subpart E  
NCGS §108A-25(b) and §108A-54  
North Carolina Administrative Code 10A NCAC 220.0301**

**Outpatient Behavioral Health Services Clinical Coverage Policy #8C**  
(<http://www.ncdhhs.gov/dma/mp/>).

**Enhanced (Community Intervention Services) Behavioral Health Services Clinical Coverage Policy #8A** (<http://www.ncdhhs.gov/dma/mp/>).

**Inpatient Behavioral Health Services Clinical Coverage Policy #8B** (<http://www.ncdhhs.gov/dma/mp/>)

**Therapeutic Foster Care Clinical Coverage Policy #8D-2** (<http://www.ncdhhs.gov/dma/mp/>).

**Residential Child Care Treatment (Levels II through IV) Facility Services Clinical Coverage Policy #8D-2** (<http://www.ncdhhs.gov/dma/mp/>).

**Psychiatric Residential Treatment Facility Services Clinical Coverage Policy #8D-1**  
(<http://www.ncdhhs.gov/dma/mp/>).

**Criterion 5 Services Clinical Coverage Policy #8B** (<http://www.ncdhhs.gov/dma/mp/>).

**CAP/MR-DD CAP/MR-DD waiver** (<http://www.ncdhhs.gov/mhddsas/cap-mrdd/>) and **CAP-MR/DD Manual** (<http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm#capmanual/>)

**Targeted Case Management Medical necessity criteria** are defined in the July 2005 Special Bulletin, *Targeted Case Management for Mentally Retarded/Developmentally Disabled (MR/DD) Individuals* (<http://www.ncdhhs.gov/dma/bulletin/>).

**Reactive Attachment Disorder Clinical Guidelines**  
([www.ncdhhs.gov/mhddsas/childandfamily/radguidelines2009.pdf](http://www.ncdhhs.gov/mhddsas/childandfamily/radguidelines2009.pdf) )

**American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters and Guidelines** ([www.aacap.org](http://www.aacap.org)) [Specify]

**American Society of Addiction Medicine (ASAM) Practice Guidelines**  
(<http://www.asam.org/PracticeGuidelines.html>)

**American Psychiatric Association Practice Guidelines**  
(<http://www.psychiatryonline.com/pracGuide/pracGuideHome.aspx>) [Specify]

## Attachment I: Peer Review Form for Individuals Over the Age of 21

### Peer Review Form for Individuals Over the Age of 21, page 1

#### Peer Review Form *(Sample)* Clinical Summary *(Sample)*

#### 1. Demographic Information

*The following elements must be included:*

- Recipient
- MID
- Age
- County
- Custody/living arrangements

#### 2. History

*The following elements must be included:*

- Current Request (Units/Dates)
- Type of Review
- Current authorizations on file (Units/Dates)
- Dx Axis I-V
- Precipitating Event
- Risk to Self/Others (current, history)
- Medications
- Current Impairments
- Legal Involvement
- Sexual Abuse as victim and/or sexually offending behavior
- Neglect/Physical Abuse
- Brief Treatment History
- Past history of Peer Reviews
- Reason for referral to Peer Review

#### 3. Peer Decision

- **[Choose One] Approve** (does meet), **Deny** (does not meet), **Reduce** (partially meets)
- List approved amount & duration
- List date ranges of authorization
- **[Include sentence]** *This decision includes 30 days for transition, appeal and linkage to recommendations below for concurrent reviews.*

#### 4. Reason for Adverse Decision

- A. Does not meet DHHS Clinical Coverage Policy medical necessity guidelines for **entrance/continued stay [choose one]**.
  - Cite portion of clinical coverage policy that is not met – **See Page 3**

**Peer Review Form for Individuals Over the Age of 21, page 2****5. Alternative Treatment Recommendations**

*These alternative treatments are effective and similarly efficacious to the service requested. It is not sufficient to cover a standard, lower cost service instead of the requested service if the lower cost service is not equally effective in this individual case. The most appropriate services and interventions per Peer Review are as follows: [include sentence] **SEE PAGE 3 for possible citations***

**[Check all that apply but also add additional services that are most appropriate according to clinical best practice standards.]**

1. Immediate Psychiatric/Medical evaluation
2. Home and Community Supports
3. Personal Care Services
4. Day Supports
5. Residential Supports
6. Supported Employment
7. Respite
8. Other DD Service (specify) \_\_\_\_\_
9. Non-Waiver service (specify) \_\_\_\_\_
10. Equipment (specify) \_\_\_\_\_
11. Targeted Case Management
12. Refer to DMA for consideration of alternate Medicaid service (specify)
13. Community team meet and update PCP
14. Updated Psychiatric evaluation
15. Updated Medication evaluation
16. Psychological Evaluation
17. NeuroPsychological Evaluation
18. Psychoeducational testing to rule out learning disability
19. OT evaluation to rule out sensory integration disorder
20. Speech and Language evaluation
21. Hearing assessment
22. Team meet with school to address \_\_\_\_\_
23. Safety plan be developed for community, school, home
24. Consider DSS support/involvement
25. Parent skill development
26. Behavioral plan
27. Social skills training, ideally in a group setting
28. Family therapy
29. Individual therapy
30. Referral to outpatient therapy

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**Peer Review Form for Individuals Over the Age of 21, page 3**

31. Referral to ACTT
32. Referral to CST
33. Referral to PSR
34. Referral to SA evaluation/treatment program
35. Referral to Intensive In Home
36. Referral to MST
37. Referral to Day Treatment
38. Referral to CAP-MR/DD services
39. Link with natural supports
40. Sex Offender Risk assessment/SOSE
41. Evaluate community concern/questions related to sexualized behavior
42. Team meeting to include representatives from DJJ/Criminal Justice system
43. Consider out of home placement
44. Therapeutic Foster Care
45. Substance Abuse Services (specify)
46. Residential (specify)
47. VR Referral
48. Other

**6. Required Signatures**

*Clinician Reviewer: Name, Credentials, Date*

*Peer Reviewer: Name, Credentials, Date*

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**Peer Review Form for Individuals Over the Age of 21, page 4****CITATIONS**

**Code of Federal Regulations, Chapter 42 Part 431, Subpart E  
NCGS §108A-25(b) and §108A-54  
North Carolina Administrative Code 10A NCAC 220.0301**

**Outpatient Behavioral Health Services Clinical Coverage Policy #8C**  
(<http://www.ncdhhs.gov/dma/mp/>).

**Enhanced (Community Intervention Services) Behavioral Health Services Clinical Coverage Policy #8A** (<http://www.ncdhhs.gov/dma/mp/>).

**Inpatient Behavioral Health Services Clinical Coverage Policy #8B** (<http://www.ncdhhs.gov/dma/mp/>).

**CAP/MR-DD CAP/MR-DD waiver** (<http://www.ncdhhs.gov/mhddsas/cap-mrdd/>) and **CAP-MR/DD Manual** (<http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm#capmanual/>)

**Targeted Case Management** Medical necessity criteria are defined in the July 2005 Special Bulletin, *Targeted Case Management for Mentally Retarded/Developmentally Disabled (MR/DD) Individuals* (<http://www.ncdhhs.gov/dma/bulletin/>).

**American Society of Addiction Medicine (ASAM) Practice Guidelines**  
(<http://www.asam.org/PracticeGuidelines.html>)

**American Psychiatric Association Practice Guidelines**  
(<http://www.psychiatryonline.com/pracGuide/pracGuideHome.aspx>)

## Attachment J: CAP/MR-DD Quality Assurance Review Letter Template, Instructions, Response Form, and Review Form

### CAP/MR-DD Quality Assurance Review Letter Template

[INSERT VENDOR LETTERHEAD]

Request Date:

To:

Re: Quality Assurance Review

**UR Vendor** has been selected by the North Carolina Division of Medical Assistance (DMA) to conduct a quality assurance review on randomly sampled plans of care/cost summaries for the Community Alternatives Programs for persons with Mental Retardation/Developmental Disabilities (CAP/MR-DD).

The purpose of the review is to validate that the information given to **UR Vendor** is reflected in the medical record documentation, to ensure consistency in the application of authorization criteria and to monitor the quality of the care provided. The Quality Assurance program is part of the federally approved home and community-based services waiver that authorizes North Carolina to operate this 1915(c) waiver.

DMA has randomly selected the consumer listed below for a review of the care provided during the review month.

Consumer:

Medicaid ID:

Review Month:

The enclosed Quality Review Instruction Sheet Outlines what is to be submitted.

**The records are to be mailed to \_\_\_\_\_ by:**

Please mail the documentation to the following address:

**VENDOR ADDRESS**

If you have any questions or require any assistance, please contact **NAME**, CAP/MR-DD Auditor, at **PHONE NUMBER**. Thank you for your cooperation.

Sincerely,

**CAP/MR-DD Quality Assurance Review Instruction Sheet****CAP-MR/DD QUALITY ASSURANCE REVIEW INSTRUCTION SHEET**

The following information **MUST** be submitted to for each case in effect for the review month:

1. The MR-2. For an initial POC, a copy of the EDS (or Murdoch) stamped MR-2. For a CNR, a copy of the MR-2 in effect at the time of the audit.
2. A copy of the Person Centered Plan of Care in effect during the month audited including the cost summary.
3. A copy of all summary revisions approved since the last POC.
4. Copies of documentation of goals to include daily progress notes/service delivery for all waiver services provided for the month under review.
5. Copies of CAP letters approving, denying, or requesting additional information for any initial, CNR, or revisions for cost summaries. Include copies of all authorization letters for each waiver service provided during the month under review.
6. Copies of Targeted Case Manager's service notes for the month under review.

**NOTE:** One monthly face-to-face contact is required, and an in-home contact is required once every 6 months. Please provide documentation for most recent face-to-face and in-home contacts.

7. Complete the enclosed Response Sheet. If services were not provided during the review month as listed on the cost summary, written documentation indicating the particular services, date(s), and the deviation and reason must be submitted. Also, confirm whether the consumer's needs were met and if so, how and by whom.

**NOTE:** A deviation in services includes no service being provided, interruptions in services, a greater or lesser amount of a service, a service provided but not billed for, and a service being provided but not listed on the cost summary in effect for the review month.

8. If a CNR was performed during the review month, complete records (Numbers 1, 2, 3 and 4 above) for both the current POC in effect and next POC in effect must be submitted.

9. If CAP services were terminated before the review month, written confirmation indicating the reason is required. If termination occurred during the review month, it is considered a reviewable case, and all the requested information must be submitted.

**CAP/MR-DD Quality Assurance Review Response Sheet, page 1**

**CAP-MR/DD QUALITY ASSURANCE RESPONSE SHEET**

Consumer's Name: \_\_\_\_\_

Consumer's Medicaid ID Number: \_\_\_\_\_

Review Month/Year: \_\_\_\_\_

LME/Case Management: \_\_\_\_\_

**A deviation includes:**

1. no service provided during the review month;
2. interruptions in the service during review month;
3. a greater or lesser amount of a service;
4. a service provided but not billed for;
5. a service provided but not listed on the cost summary or plan of care in effect for the review month;
6. no case management notes and/or no face-to-face visit during the review month.

• **If there were no deviations in the services authorized during this review month, please check here \_\_\_\_ and sign and date below.**

• **If there were deviations in the services, list all deviations in during the review month in the following chart and sign and date below:**

Name of Service	Start, End Dates of Deviation (ex: 1/1/08-1/15/08)	Identify Deviation and Reason	How Were Consumer's Needs Met?

---

**CAP/MR-DD Quality Assurance Review Response Sheet, page 2**

**Additional comments:**

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

**Case manager's name (printed):**

\_\_\_\_\_

**Case manager's signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Contact telephone:** \_\_\_\_\_

**Contact fax:** \_\_\_\_\_

**Contact e-mail:** \_\_\_\_\_

**CAP/MR-DD Quality Assurance UR Vendor Review Form, page 1**

<b>UR VENDOR REVIEW</b>	
<b>Waiver Service:</b>	<b>Service Type:</b> CAP-MR/DD
<b>Provider:</b>	<b>Audit Month/Year:</b>
<b>SECTION A: AUDIT INFORMATION</b>	
Audit Date:	Auditor:
Service Start Date:	Service End Date:
Section A: Comments:	
<b>SECTION B: PATIENT INFORMATION</b>	
MID:	Date of Birth:
Diagnoses: Axis I: Axis II: Axis III: Axis IV: Axis V:	
Does the diagnosis meet the criteria for CAP-MR/DD services?	
If the diagnosis DOES NOT meet the criteria for CAP-MR/DD services, why not?	
Section B Comments:	
<b>SECTION C: PROVIDER INFORMATION</b>	
Is the provider endorsed by Medicaid to deliver this specific service?	
Does the service documentation reflect purpose of contact, staff intervention and assessment of progress toward goals?	
Does the service documentation relate to the individual's goals as listed on the service plan?	
If there is no documentation related to the individual's goals, is any reason given for the lack of documentation?	
Does the documentation reflect treatment for the duration of the service audit period?	
Is the documentation initialed and signed by the person who delivered the service?	
Section C Comments:	
<b>SECTION D: SERVICE DELIVERY</b>	
Was an authorization covering this date of service in place?	
If an authorization covering this date of services was NOT in place, was a request for authorization submitted prior to this date of service?	
Does the POC or CNR identify the authorized service?	

**CAP/MR-DD Quality Assurance UR Vendor Review Form, page 2**

Does the service audited meet the specific requirements from the CAP-MR/DD Manual, Section 4.6 Services?

Do the units billed match the duration of service?

Section D Comments:

**SECTION E: CNR/POC/MR2 INFORMATION**

Is the POC/CNR/MR2 current with the date of service?

Are the required signatures on the POC/CNR?

Was a POC or CNR update submitted?

If a POC or CNR update was submitted, were the plan goals updated?

If a CNR update was submitted, was the cost summary updated?

Was medical necessity met for the requested service via the identified goals on the POC/CNR and the CAP/CTCM form?

Section E Comments:

**SECTION F: FINAL DISPOSITION**

Audit Referred to DMA and Program Integrity?

Comments”

**Attachment K: Service Authorization Notifications****Notice of Approval of Service Request (DMA 3504), page 1**

[Insert Vendor Letterhead]

**NOTICE OF APPROVAL OF SERVICE REQUEST**

[Insert Date]

[Medical Provider Name]

[Address]

[Recipient Name]

[Recipient Address]

[Recipient MID #]:

Dear [insert name of provider]:

On [insert date] and on behalf of [insert name of recipient], [insert name of physician or other licensed clinician who requested service] requested that Medicaid pay for [insert specific service/procedure requested].

[insert name of service approved, number of units approved, time period of approval, if relevant]

While the request for the above named recipient has been approved, the Medicaid claims payment system will not allow payment of a claim for [insert name of product, procedure, or service] at this time because it is a non-covered [insert product, procedure, or service]. You will be notified concerning when and how the claim should be submitted to receive payment.

Also, please note the following:

1. See the specific clinical coverage policy and Medicaid's Basic Billing Guide for complete details re provision of and payment for services rendered. Clinical coverage policies and the Basic Medicaid Billing Guide can be found at <http://www.dhhs.state.nc.us/dma/prov.htm>.
2. Obtaining prior approval does **not** guarantee payment or ensure recipient eligibility on the date of service. A recipient must be eligible for Medicaid coverage on the date the procedure is performed or the service rendered, and the provider must be an enrolled Medicaid provider for that service and provider type on the day of service.

**Notice of Approval of Service Request (DMA 3504), page 2**

Recipient Name  
MID #

3. Obtaining prior approval does **not** guarantee payment or ensure recipient eligibility on the date of service. A recipient must be eligible for Medicaid coverage on the date the procedure is performed or the service rendered, and the provider must be an enrolled Medicaid provider for that service and provider type on the day of service.
4. **The service must be rendered as specified in this notice**, including service approved, number of units approved, time period of approval, if relevant. See previous page re details of authorization.
5. Effective the date of this notice and if the prior approval is time limited, this EPSDT prior approval authorization is time limited to the first of the following to occur:
  - a. time limit specified by this prior approval **OR**
  - b. 365 days from date of this prior approval.
6. You have up to 365 days from the date the service is rendered to submit the claim for payment. See specific clinical coverage policy and the Basic Medicaid Billing Guide for complete details re provision of and payment for services rendered.

If you have questions concerning this notice of approval, please contact [insert name of contact person] at [insert telephone number]. Thank you for serving the citizens of North Carolina by participating in the Medicaid program.

Sincerely,

[insert contact name and credentials]  
[insert telephone # of contact]

C: Recipient

**Notice of Approval of Service Request (EPSDT) (DMA 3504E), page 1**

[Insert Vendor Letterhead]

**NOTICE OF APPROVAL OF SERVICE REQUEST**

[Insert Date]

[Medical Provider Name]  
[Address]

[Recipient Name]  
[Recipient Address]  
[Recipient MID #]:

Dear [insert name of provider]:

On [insert date] and on behalf of [insert name of recipient], [insert name of physician or other licensed clinician who requested service] requested that Medicaid pay for [insert specific service/procedure requested]. Effective [insert date], Medicaid approved this request under Early and Periodic Screening, Diagnostic, and Testing (EPSDT) as specified below.

[insert name of service approved, number of units approved, time period of approval, if relevant]

EPSDT makes services available to recipients under 21 years of age without many of the restrictions Medicaid imposes for services under a waiver **OR** for adults (recipients over 21 years of age). Specifically, the service limitations on scope, amount, duration, frequency, and other specific criteria described in DMA's clinical coverage policies may be exceeded or may not apply provided documentation shows that the requested service is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. The services must be prescribed by the recipient's physician, therapist, or other licensed practitioner.

While the request for the above named recipient has been approved, the Medicaid claims payment system will not allow payment of a claim for [insert name of product, procedure, or service] at this time because it is a non-covered [insert product, procedure, or service]. You will be notified concerning when and how the claim should be submitted to receive payment.

Also, please note the following:

- 1. This notice of approval is valid only as long as the recipient is under 21 years of age. If the recipient is over 21 years of age and you have not provided the service, although prior approval was granted, please follow DMA's published procedures and submit a new request for prior approval, if prior approval is required.** See the specific clinical coverage policy and Medicaid's Basic Billing Guide for complete details re provision of and payment for services rendered.

Clinical coverage policies and the Basic Medicaid Billing Guide can be found at <http://www.dhhs.state.nc.us/dma/prov.htm>.

DMA 3504  
01/05/06  
REV. 09/09/06

**Notice of Approval of Service Request (EPSDT) (DMA 3504E), page 2**

Recipient Name  
MID #

2. Obtaining prior approval does **not** guarantee payment or ensure recipient eligibility on the date of service. A recipient must be eligible for Medicaid coverage on the date the procedure is performed or the service rendered, and the provider must be an enrolled Medicaid provider for that service and provider type on the day of service.
3. **The service must be rendered as specified in this notice**, including service approved, number of units approved, time period of approval, if relevant. See previous page re details of authorization.
4. Effective the date of this notice and if the prior approval is time limited, this EPSDT prior approval authorization is time limited to the first of the following to occur:
  - a. recipient reaches 21 years of age **OR**
  - b. time limit specified by this prior approval **OR**
  - c. 365 days from date of this prior approval.
5. If the recipient is under 21 years of age and the authorization has expired and if the service, product, or procedure is still desired and is medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by screening, submit a new request for prior approval. See specific clinical coverage policy and the Basic Medicaid Billing Guide for complete details re provision of and payment for services rendered.
6. You have up to 365 days from the date the service is rendered to submit the claim for payment. See specific clinical coverage policy and the Basic Medicaid Billing Guide for complete details re provision of and payment for services rendered.

If you have questions concerning this notice of approval, please contact [insert name of contact person] at [insert telephone number]. Thank you for serving the citizens of North Carolina by participating in the Medicaid program.

Sincerely,

[insert contact name and credentials]

[insert telephone # of contact]

C: Recipient

**Notice of Prior Approval When Requested Time Period for Approval Exceeds Policy Maximum (DMA 1059)**

[Insert Vendor Letterhead]

**NOTICE OF PRIOR APPROVAL WHEN REQUESTED TIME PERIOD  
FOR APPROVAL EXCEEDS POLICY MAXIMUM**

[insert date notice to be mailed]

Provider Name  
Provider Address

Recipient's or Legal Rep's Name  
Address

RE: [insert recipient's name]  
MID: [insert MID #]

Dear Provider:

Your request for [insert service, product, procedure, or description] on behalf of the above named recipient has been approved. Please note that prior approval for this [insert service, product, or procedure or description] has been given for the maximum time allowable according to the Division of Medical Assistance's clinical coverage policy on [insert name of clinical coverage policy], [insert number of clinical coverage policy]. For this [insert service, product, or procedure], the approved time period is from [insert start date] to [insert end date].

If you have questions, please contact me at the number below.

Sincerely,

[insert Name and credentials Title]  
[insert Telephone #]

DMA 1059  
11/22/06  
REV. 09/24/08

**Notice of Receipt of Second Request (DMA-1058)**

[Insert Vendor Letterhead]

**NOTICE OF RECEIPT OF SECOND REQUEST**

Date [Insert]

Recipient Name [Insert]	Provider Name [Insert]
Recipient Address [Insert]	Provider Address [Insert]
Recipient MID #: [Insert]	Provider Telephone Number [Insert]
PA #: [Insert]	

Dear [insert name of recipient or parent/guardian/authorized representative]:

On [insert date of initial request], [insert name of physician, recipient or other person who requested service] asked Medicaid to pay for [insert PA type or name of specific service, product, or procedure requested and time period if relevant]. This request was reviewed, and Medicaid **denied** the request. You were issued a notice on [insert date of notice] that stated Medicaid’s decision and that told you how to appeal if you disagreed with the decision. That notice also told you about the time limits for you to file an appeal if you disagreed with our decision.

A second request for [insert PA type or name of specific product, service, or procedure] was received on [insert date of second request]. The requests have been compared and found to be identical, meaning that the second request did not provide additional information relevant to the coverage criteria found in [insert name of policy and policy number]. Medicaid’s policies are located at <http://www.ncdhhs.gov/dma/mp/index.htm>.

Please refer to the notice we mailed to you on [insert date of initial notice]. As stated above, that notice informed you of your right to appeal and also explained the time limits for filing an appeal. **THIS NOTICE DOES NOT EXTEND THE TIME LIMITS FOR YOU TO FILE AN APPEAL.** All documents regarding the second request have been returned to your provider.

Recipient Name [Insert]  
MID #: [Insert]

If you have questions about this notice, please contact me at the number provided below or call the **CARE-LINE, Information and Referral Services**, toll free at **1-800-662-7030**. Providers should call the **EDS Prior Approval Unit** toll free at **1-800-688-6696 [or insert other appropriate vendor and telephone number]**.

Sincerely,

[Name]  
[Title]  
[Telephone # of contact]

C: Provider



Si necesitas ayuda para leer y entender la carta, por favor contáctese con el 1-800-662-7030. DIGA AL OPERADOR QUE LA NOTIFICACION DMA 1058.



Location: 1985 Umstead Drive • Dorothea Dix Hospital Campus • Raleigh, N.C. 27603  
An Equal Opportunity / Affirmative Action Employer  
[www.ncdhhs.gov/dma](http://www.ncdhhs.gov/dma)

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**Notice of Decision on Initial Request for Medicaid Services (DMA 2001), page 1**

[Insert Vendor Letterhead]

**NOTICE OF DECISION ON INITIAL REQUEST  
FOR MEDICAID SERVICES**

[Insert date to be mailed]

Recipient's or Legal Rep's name  
Address

Provider Name  
Provider Address

RE: [insert recipient name]

MID: [insert MID #]

Dear [insert name of recipient or parent/legal representative/authorized representative]:

The above named provider requested prior approval for [insert specific service/procedure, # of units and time period, if relevant]. After reviewing the documentation submitted by the provider, Medicaid [insert **denied, reduced, or changed**] the request for the above named recipient effective the **date this notice was mailed**. [If approving any other Medicaid service not requested by the provider or changes in the service request submitted by the provider, insert: Medicaid **approved** (insert: service/procedure, # of units and time period, if relevant) effective the **date this notice was mailed**. May insert other effective date as needed]. This letter explains why the decision was made and tells you how to appeal if you disagree.

It is also important to note that you may also be eligible for other Medicaid services. Please check with your physician, other licensed clinician, or provider to determine if [if recommending no services, insert: there are other services that are more appropriate for you or if recommending services, insert: the services listed below are appropriate for you].

- List Medicaid services.
- List Medicaid services.

Medicaid [insert denied, reduced, changed] the request because [insert specific reason].

The decision is based on the authority granted to the North Carolina Department of Health and Human Services and its contractors by the Code of Federal Regulations,

**Si desea apelar esta decisión, debe responder a no más tardar de 30 días a partir de la fecha que esta carta fue enviada. Si necesitas ayuda para leer y entender la carta, por favor contáctese con el 1-800-662-7030. DIGA AL OPERADOR QUE LA NOTIFICACION DMA 2001.**

DMA 2001  
09/08/05  
REV 09/24/08

**Notice of Decision on Initial Request for Medicaid Services (DMA 2001), page 2**

Chapter 42 Part 431, Subpart E, N.C.G.S. §108A-25(b) and §108A-54, as well as the law(s) and policy(ies) specified below.

- [insert NCAC citation, C.F.R., or other applicable law or title of specific medical policy supporting decision]
- United States Code [insert code]
- North Carolina Administrative Code [insert code]
- North Carolina Administrative Code 10A NCAC 22O .0301

Medicaid's clinical coverage policies can be found at

<http://www.ncdhhs.gov/dma/mp/mpindex.htm>.

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION.** If you decide to appeal the decision, you must file for an evidentiary hearing with the Office of Administrative Hearings. **YOU HAVE 30 DAYS FROM THE DATE THIS DECISION LETTER WAS MAILED TO FILE THE REQUEST FOR HEARING.**

To learn more about the hearing process or to speak with a Medicaid clinical policy analyst about this decision, call the Appeals Unit, Division of Medical Assistance at 919-855-4260. You may also call the toll free **CARE-LINE, Information and Referral Services, at 1-800-662-7030** and request that your call be transferred. The enclosed general information sheet also explains the hearing process.

**THE HEARING PROCESS AND FILING THE REQUEST:**

- Hearings are conducted by an administrative law judge with the Office of Administrative Hearings (OAH).
- To file for a hearing, you must submit **a completed hearing request form** (enclosed in this mailing). You can also obtain a hearing request form by calling the Division of Medical Assistance at the number specified above, or you can call the Office of Administrative Hearings at 919-431-3000.
- Mail or fax the completed hearing request form to Clerk, Office of Administrative Hearings **AND** General Counsel, North Carolina Department of Health and Human Services at the addresses or fax numbers on the enclosed hearing request form. **The completed form must be filed within 30 days of the date this decision letter was mailed.** As the mailing date is located on the envelope, **please keep the envelope containing this decision letter.**
- The Office of Administrative Hearings or the Mediation Network of North Carolina will contact you to discuss your case and to offer an opportunity for mediation in an effort to resolve your appeal. If mediation resolves your case, your hearing will be dismissed, and services will be provided as specified by the Mediation Network of North Carolina.
- If you do not accept the offer of mediation or the results of mediation, your case will proceed to hearing. You will be notified by mail of the date, time, and location of your hearing.

2

Recipient Name [insert]

MID # [insert]

DMA 2001

09/08/05

REV 09/24/08

**Notice of Decision on Initial Request for Medicaid Services (DMA 2001), page 3**

- The administrative law judge will make a decision and will send that decision to Medicaid for a final agency decision. You will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision.
- If you do not agree with Medicaid's final agency decision, you may ask for a judicial review in superior court.
- You may represent yourself in the appeal process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for you.

**Free legal aid may be available to assist with your appeal.** Contact your nearest Legal Aid of North Carolina office or call 919-856-2564 or toll-free at 1-866-369-6923 to obtain the telephone number of the office that serves your community.

Sincerely,

[insert contact name and credentials]

[insert telephone # of contact]

Enclosure: Recipient Hearing Request Form, DMA 2003  
(Only the recipient may appeal the decision).

C: Provider  
Appeals Unit, Division of Medical Assistance  
Office of Administrative Hearings

3

Recipient Name [insert]

MID # [insert]

DMA 2001  
09/08/05  
REV 09/24/08

**Notice of Decision on Initial Request for Medicaid Services (DMA 2001), page 4****POSSIBLE EXAMPLES FOR PARAGRAPH #1 SUGGESTED BY VO  
DO NOT INCLUDE WITH NOTICE**

While the scenarios are written for behavioral health services, they should work for services that have similar request patterns. They should also work for services that have no time frames or units by deleting them from the samples. These scenarios in their entirety would be substituted for paragraph #1, page 1.

**Initial Request – Denial – Community Support Services:** Request for 416 units of Community Support from 10/1/08 – 12/30/08. Peer Advisor decision is a straight denial. Letter date is 9/25/08. Suggested paragraph:

The above named provider requested prior authorization for 416 units of Community Support Services from October 1, 2008 – December 30, 2008. After reviewing the documentation submitted by the provider, Medicaid **denied** the request **effective the date this notice was mailed**.

**Initial Request – Reduction – Community Support Services:** Request for 416 units of Community Support from 10/1/08 – 12/30/08. Peer Advisor decision is a partial authorization, a reduction. Letter date is 9/25/08. Suggested paragraph:

The above named provider requested prior authorization for 416 units of Community Support Services from October 1, 2008 – December 30, 2008. After reviewing the documentation submitted by the provider, Medicaid **reduced** the request effective the **date this notice was mailed**. Medicaid has authorized 200 units for the period October 1, 2008 – December 30, 2008.

**Initial Request – Denial - Residential:** Request for 60 days of Residential from 10/1/08 - 11/29/08. Peer Advisor decision is a straight denial. Letter date is 9/25/08. Suggested paragraph:

The above named provider requested prior authorization for 60 days of Residential Services from October 1, 2008 – November 29, 2008. After reviewing the documentation submitted by the provider, Medicaid **denied** the request effective the **date this notice was mailed**.

**Initial Request – Reduction Residential:** Request for 60 days of Residential from 10/1/08 – 11/29/08. Peer Advisor decision is a partial authorization, a reduction. Letter date is 9/25/08. Suggested paragraph:

4

Recipient Name [insert]  
MID # [insert]

DMA 2001  
09/08/05  
REV 09/24/08

**Notice of Decision on Initial Request for Medicaid Services (DMA 2001), page 5**

The above named provider requested prior authorization for 60 days of Residential Services from October 1, 2008 – November 29, 2008. After reviewing the documentation submitted by the provider, Medicaid **reduced** the request effective the **date this notice was mailed**. Medicaid has authorized 30 days for the period October 1, 2008 – October 30, 2008.

**Initial Request – Changed (Different service approved than requested)**: Request for 416 units (8 hrs/wk or 32 units) of Community Support Services from 10/1/08 – 12/30/08. Decision is to authorize Community Support Team at 140 units per week (35 hours) for the period requested. Letter date is 09/1/08. Suggested paragraph:

The above named provider requested prior approval for [insert name of service] from [insert period—October 01–November 29, 2008-if applicable]. After reviewing the documentation submitted by the provider, Medicaid **changed** this request. Medicaid **approved** [insert: service/procedure, # of units and time period, if relevant] effective the **date this notice was mailed**. May insert other effective date as needed].

5

Recipient Name [insert]  
MID # [insert]

DMA 2001  
09/08/05  
REV 09/24/08

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**Notice of Decision on Initial Request for Medicaid Services (EPSDT) (DMA 2001E), page 1**

[Insert Vendor Letterhead]

**NOTICE OF DECISION ON INITIAL REQUEST  
FOR MEDICAID SERVICES**

[insert date notice to be mailed]

Recipient's or Legal Rep's name  
Address

Provider Name  
Provider Address

RE: [insert recipient name]  
MID: [insert MID #]

Dear [insert name of recipient or parent/legal representative/authorized representative]:

The above named provider requested prior approval for [insert specific service/procedure, # of units and time period, if relevant]. After reviewing the documentation submitted by the provider, Medicaid [insert **denied, reduced, or changed**] the request for the above named recipient effective the **date this notice was mailed**. [If approving any other Medicaid service not requested by the provider or changes in the service request submitted by the provider, insert: Medicaid **approved** (insert: service/procedure, # of units and time period, if relevant) effective the **date this notice was mailed**. May insert other effective date as needed]. This letter explains why the decision was made and tells you how to appeal if you disagree.

- It is also important to note that you **may** also be eligible for other Medicaid services. Please check with your physician, other licensed clinician, or provider to determine if there are other services more appropriate for you

As the recipient is under 21 years of age, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) apply. EPSDT makes services available to recipients under 21 years of age without many of the restrictions Medicaid imposes for services under a waiver **OR** for adults (recipients over 21 years of age). Specifically, the service limitations on scope, amount, duration, frequency, and other specific criteria described in DMA's clinical

**Si desea apelar esta decisión, debe responder a no más tardar de 30 días a partir de la fecha que esta carta fue enviada. Si necesitas ayuda para leer y entender la carta, por favor contáctese con el 1-800-662-7030. DIGA AL OPERADOR QUE LA NOTIFICACION DMA 2001E.**

DMA 2001E  
09/08/05  
REV 09/24/08

**Notice of Decision on Initial Request for Medicaid Services (EPSDT) (DMA 2001E), page 2**

coverage policies may be exceeded or may not apply if documentation submitted by the provider shows that all EPSDT criteria are met. The services must be prescribed by the recipient's physician, therapist, or other licensed practitioner.

When a recipient is under 21 years of age, the provider's request for service is evaluated under the applicable Medicaid clinical coverage policies as well as the EPSDT criteria. If the request cannot be approved under the clinical coverage policy criteria, all of the EPSDT criteria must be met to approve the request.

Based on the information submitted by the provider, the recipient does not meet [insert specific policy criteria not met]. As the recipient is under 21 years of age, the request was also evaluated under the EPSDT criteria. Medicaid denied this request because the [insert: for single criterion not met, insert: criterion specified below was or for several criteria not met, insert: criteria specified below were] not met.

- EPSDT services must be coverable services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].
- The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner.
- The requested service must be determined to be medical in nature.
- The service must be safe.
- The service must be effective.
- The service must be generally recognized as an accepted method of medical practice or treatment.
- The service must not be experimental/investigational.

The decision is based on the authority granted to the North Carolina Department of Health and Human Services and its contractors by the Code of Federal Regulations, Chapter 42 Part 431, Subpart E, N.C.G.S. §108A-25(b) and §108A-54, as well as the law(s) and policy(ies) specified below.

- [insert NCAC citation, C.F.R., or other applicable law or title of specific medical policy supporting decision]
- United States Code [insert code]
- United States Code 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]
- North Carolina Administrative Code [insert code]
- North Carolina Administrative Code 10A NCAC 22O .0301

Medicaid's clinical coverage policies and EPSDT policy can be found at the websites listed below.

<http://www.ncdhhs.gov/dma/mp/mpindex.htm>  
<http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

Recipient Name [insert]  
MID # [insert]

DMA 2001E  
09/08/05  
REV 09/24/08

**Notice of Decision on Initial Request for Medicaid Services (EPSDT) (DMA 2001E), page 3**

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION.** If you decide to appeal the decision, you must file for an evidentiary hearing with the Office of Administrative Hearings. **YOU HAVE 30 DAYS FROM THE DATE THIS DECISION LETTER WAS MAILED TO FILE THE APPEAL REQUEST.**

To learn more about the hearing process or to speak with a Medicaid clinical policy analyst about this decision, call the Appeals Unit, Division of Medical Assistance at 919-855-4260. You may also call the toll free **CARE-LINE, Information and Referral Services, at 1-800-662-7030** and request that your call be transferred. The enclosed general information sheet also explains the hearing process.

**THE HEARING PROCESS AND FILING THE REQUEST:**

- Hearings are conducted by an administrative law judge with the Office of Administrative Hearings (OAH).
- To file for a hearing, you must submit **a completed hearing request form** (enclosed in this mailing). You can also obtain a hearing request form by calling the Division of Medical Assistance at the number specified above, or you can call the Office of Administrative Hearings at 919-431-3000.
- Mail or fax the completed request form to Clerk, Office of Administrative Hearings **AND** General Counsel, North Carolina Department of Health and Human Services at the addresses or fax numbers on the enclosed hearing request form. **The completed form must be filed within 30 days of the date this decision letter was mailed.** As the mailing date is located on the envelope, **please keep the envelope containing this decision letter.**
- The Office of Administrative Hearings or the Mediation Network of North Carolina will contact you to discuss your case and to offer an opportunity for mediation in an effort to resolve your appeal. If mediation resolves your case, your hearing will be dismissed, and services will be provided as specified by the Mediation Network of North Carolina.
- If you do not accept the offer of mediation or the results of mediation, your case will proceed to hearing. You will be notified by mail of the date, time, and location of your hearing.
- The administrative law judge will make a decision and will send that decision to Medicaid for a final agency decision. You will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision.
- If you do not agree with Medicaid's final agency decision, you may ask for a judicial review in superior court.
- You may represent yourself in the hearing process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for you.

**Free legal aid may be available to assist with your appeal.** Contact your nearest Legal Aid of North Carolina office or call 919-856-2564 or toll-free at 1-866-369-6923 to obtain the telephone number of the office that serves your community.

Sincerely,

3

Recipient Name [insert]  
MID # [insert]

DMA 2001E  
09/08/05  
REV 09/24/08

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**Notice of Decision on Initial Request for Medicaid Services (EPSDT) (DMA 2001E), page 4**

[insert contact name and credentials]

[insert telephone # of contact]

Enclosure: Recipient Hearing Request Form, DMA 2003  
(Only the recipient may appeal the decision).

C: Provider  
Appeals Unit, Division of Medical Assistance  
Office of Administrative Hearings

Recipient Name [insert]  
MID # [insert]

4

DMA 2001E  
09/08/05  
REV 09/24/08

**Notice of Decision on Initial Request for Medicaid Services (EPSDT) (DMA 2001E), page 5****POSSIBLE EXAMPLES FOR PARAGRAPH #1 SUGGESTED BY VO  
DO NOT INCLUDE WITH NOTICE**

While the scenarios are written for behavioral health services, they should work for services that have similar request patterns. They should also work for services that have no time frames or units by deleting them from the samples. These scenarios in their entirety would be substituted for paragraph #1, page 1.

**Initial Request – Denial – Community Support Services:** Request for 416 units of Community Support from 10/1/08 – 12/30/08. Peer Advisor decision is a straight denial. Letter date is 9/25/08. Suggested paragraph:

The above named provider requested prior authorization for 416 units of Community Support Services from October 1, 2008 – December 30, 2008. After reviewing the documentation submitted by the provider, Medicaid **denied** the request **effective the date this notice was mailed**.

**Initial Request – Reduction – Community Support Services:** Request for 416 units of Community Support from 10/1/08 – 12/30/08. Peer Advisor decision is a partial authorization, a reduction. Letter date is 9/25/08. Suggested paragraph:

The above named provider requested prior authorization for 416 units of Community Support Services from October 1, 2008 – December 30, 2008. After reviewing the documentation submitted by the provider, Medicaid **reduced** the request effective the **date this notice was mailed**. Medicaid has authorized 200 units for the period October 1, 2008 – December 30, 2008.

**Initial Request – Denial - Residential:** Request for 60 days of Residential from 10/1/08 - 11/29/08. Peer Advisor decision is a straight denial. Letter date is 9/25/08. Suggested paragraph:

The above named provider requested prior authorization for 60 days of Residential Services from October 1, 2008 – November 29, 2008. After reviewing the documentation submitted by the provider, Medicaid **denied** the request effective the **date this notice was mailed**.

**Initial Request – Reduction Residential:** Request for 60 days of Residential from 10/1/08 – 11/29/08. Peer Advisor decision is a partial authorization, a reduction. Letter date is 9/25/08. Suggested paragraph:

5

Recipient Name [insert]  
MID # [insert]

DMA 2001E  
09/08/05  
REV 09/24/08

**Notice of Decision on Initial Request for Medicaid Services (EPSDT) (DMA 2001E), page 6**

The above named provider requested prior authorization for 60 days of Residential Services from October 1, 2008 – November 29, 2008. After reviewing the documentation submitted by the provider, Medicaid **reduced** the request effective the **date this notice was mailed**. Medicaid has authorized 30 days for the period October 1, 2008 – October 30, 2008.

**Initial Request – Changed (Different service approved than requested):** Request for 416 units (8 hrs/wk or 32 units) of Community Support Services from 10/1/08 – 12/30/08. Decision is to authorize Community Support Team at 140 units per week (35 hours) for the period requested. Letter date is 09/1/08. Suggested paragraph:

The above named provider requested prior approval for [insert name of service] from [insert period—October 01–November 29, 2008-if applicable]. After reviewing the documentation submitted by the provider, Medicaid **changed** this request. Medicaid **approved** [insert: service/procedure, # of units and time period, if relevant] effective the **date this notice was mailed**. May insert other effective date as needed].

Recipient Name [insert]  
MID # [insert]

DMA 2001E  
09/08/05  
REV 09/24/08

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**Notice of Decision on a Continuing Request for Medicaid Services (DMA 2002), page 1**

[Insert Vendor Letterhead]

**NOTICE OF DECISION ON A CONTINUING REQUEST  
FOR MEDICAID SERVICES**

[insert date to be mailed]

Recipient's or Legal Rep's name  
Address

Provider Name  
Provider Address

RE: [insert recipient name]

MID: [insert MID #]

Dear [insert name of recipient or parent/legal representative/authorized representative]:

The above named provider requested prior approval for (<> units of <service/level of care> for the period <date> through <date> (ex. October 01-30, 2008 or November 01, 2008-January 01, 2009). Insert either option 1 or 2 here].

**Option 1—Reduction or Change in Service Request Submitted by the Provider**

After reviewing the documentation submitted by the provider, Medicaid could not approve the request for the above named recipient. Medicaid **approved** (insert: (<> units of <service/level of care> for the period <date> through <date> (ex. October 01-30, 2008 or November 01, 2008-January 01, 2009). This decision is a [insert: **reduction of or change in**] the prior authorization request submitted by your provider, and it is effective **30 days from the date this notice was mailed**.

**Option 2—Termination of Requested Service**

After reviewing the documentation submitted by the provider, Medicaid could not approve the request for the above named recipient. This decision **terminates** [insert name of service/level of care] effective **30 days from the date this notice was mailed**.

This letter explains why the decision was made and tells you how to appeal if you disagree. It is also important to note that you **may** also be eligible for other Medicaid services. Please check with your physician, other licensed clinician, or provider to determine if [if recommending no services, insert: there are other services that are more appropriate for you or if recommending services, insert: the services listed below are appropriate for you].

- List Medicaid services.

**Si desea apelar esta decisión, debe responder a no más tardar de 30 días a partir de la fecha que esta carta fue enviada. Si necesitas ayuda para leer y entender la carta, por favor contáctese con el 1-800-662-7030. DIGA AL OPERADOR QUE LA NOTIFICACION DMA 2002.**

DMA 2002  
09/08/05  
REV 09/24/08

**Notice of Decision on a Continuing Request for Medicaid Services (DMA 2002), page 2**

- List Medicaid services.

Medicaid [insert terminated, reduced, or changed] the request because [insert specific reason].

The decision is based on the authority granted to the North Carolina Department of Health and Human Services and its contractors by the Code of Federal Regulations, Chapter 42 Part 431, Subpart E, N.C.G.S. §108A-25(b) and §108A-54, as well as the law(s) and policy(ies) specified below.

- [insert NCAC citation, C.F.R., or other applicable law or title of specific medical policy supporting decision]
- United States Code [insert code]
- North Carolina Administrative Code [insert code]
- North Carolina Administrative Code 10A NCAC 22O .0301

Medicaid's clinical coverage policies can be found on its website at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>.

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION.** If you decide to appeal the decision, you must file for an evidentiary hearing with the Office of Administrative Hearings. **YOU HAVE 30 DAYS FROM THE DATE THIS DECISION LETTER WAS MAILED TO FILE THE REQUEST FOR HEARING.**

To learn more about the hearing process or to speak with a Medicaid clinical policy analyst about this decision, call the Appeals Unit, Division of Medical Assistance at 919-855-4260. You may also call the toll free **CARE-LINE, Information and Referral Services, at 1-800-662-7030** and request that your call be transferred. The enclosed general information sheet also explains the hearing process.

**THE HEARING PROCESS AND FILING THE REQUEST:**

- Hearings are conducted by an administrative law judge with the Office of Administrative Hearings (OAH).
- To file for a hearing, you must submit **a completed hearing request form** (enclosed in this mailing). You can also obtain a hearing request form by calling the Division of Medical Assistance at the number specified above, or you can call the Office of Administrative Hearings at 919-431-3000.
- Mail or fax the completed hearing request form to Clerk, Office of Administrative Hearings **AND** General Counsel, North Carolina Department of Health and Human Services at the addresses or fax numbers on the enclosed hearing request form. **The completed form must be filed within 30 days of the date this decision letter was mailed.** As the mailing date is located on the envelope, **please keep the envelope containing this decision letter**.

2

Recipient Name [insert]  
MID # [insert]

DMA 2002  
09/08/05  
REV 09/24/08

**Notice of Decision on a Continuing Request for Medicaid Services (DMA 2002), page 3**

- The Office of Administrative Hearings or the Mediation Network of North Carolina will contact you to discuss your case and to offer an opportunity for mediation in an effort to resolve your appeal. If mediation resolves your case, your hearing will be dismissed, and services will be provided as specified by the Mediation Network of North Carolina.
- If you do not accept the offer of mediation or the results of mediation, your case will proceed to hearing. You will be notified by mail of the date, time, and location of your hearing.
- The administrative law judge will make a decision and will send that decision to Medicaid for a final agency decision. You will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision.
- If you do not agree with Medicaid's final agency decision, you may ask for a judicial review in superior court.
- You may represent yourself in the hearing process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for you.
- If a **continuing** request for services is denied and you submit a request for hearing within **30 days of the date this decision letter was mailed** and as long as you remain otherwise Medicaid eligible, unless you give up this right, you are entitled to receive services during the pendency of the appeal. **This right to receive services applies even if you change providers.** Services will be provided at the same level you were receiving the day before the decision or the level requested by your provider, whichever is less. The services that continue must be based on your current condition and must be provided in accordance with all applicable state and federal statutes and rules and regulations.
- If you lose your appeal, you may be required to pay for the services that continue because of the appeal.

**Free legal aid may be available to assist with your appeal.** Contact your nearest Legal Aid of North Carolina office or call 919-856-2564 or toll-free at 1-866-369-6923 to obtain the telephone number of the office that serves your community.

Sincerely,

[insert contact name and credentials]

[insert telephone # of contact]

Enclosure: Recipient Hearing Request Form, DMA 2003  
(Only the recipient may appeal the decision).

C: Provider  
Office of Administrative Hearings  
Appeals Unit, Division of Medical Assistance

3

Recipient Name [insert]

MID # [insert]

DMA 2002  
09/08/05  
REV 09/24/08

**Notice of Decision on a Continuing Request for Medicaid Services (DMA 2002), page 4****POSSIBLE PARAGRAPH 1 SAMPLES****DO NOT INCLUDE WITH NOTICE**

**Example #1:** The above named provider requested prior authorization for Community Support Services at an intensity of 416 units for a 90 day period. After reviewing the request, Medicaid **reduced** the request effective **30 days from the date this notice was mailed**. Two hundred units are authorized for the period October 15-November 25, 2008 or October 15, 2007-January 14, 2009.

**Example #2:** The above named provider requested prior authorization for Community Support Services at an intensity of 416 units for a 90 day period. After reviewing the request, Medicaid **changed** the request. Community Support Team is authorized at 1,820 units for the period October 01-December 29, 2008. The decision is effective **30 days from the date this notice was mailed**.

**Example #3:** The above named provider requested prior authorization for skilled level of care. After reviewing the request, Medicaid **reduced** the request to intermediate level of care effective **30 days from the date this notice was mailed**.

**Example #4:** The above named provider requested prior authorization for physical therapy at an intensity of 45 units for a 60 day period. After reviewing the request, Medicaid **terminated** the service effective **30 days from the date this notice was mailed**.

**POSSIBLE EXAMPLES FOR PARAGRAPH #1 SUGGESTED BY VO**

While the scenarios are written for behavioral health services, they should work for services that have similar request patterns. They should also work for services that have no time frames or units by deleting them from the samples. These scenarios in their entirety would be substituted for paragraph #1, page 1.

**Concurrent Request – Reduction – Community Support:** Request for 416 units (8 hrs/wk) of Community Support from 10/1/08 – 12/30/08. Peer Advisor decision is to authorize 4 hrs/wk. Letter date is 10/1/08. Total authorized units accommodate 8 hrs/wk for 30 days from letter date, and then 4 hrs/week for the remainder of the authorization period. Suggested paragraph:

4

Recipient Name [insert]  
MID # [insert]

DMA 2002  
09/08/05  
REV 09/24/08

**Notice of Decision on a Continuing Request for Medicaid Services (DMA 2002), page 5**

The above named provider requested prior authorization for 416 units of Community Support Services from October 1, 2008 – December 30, 2008. After reviewing the documentation submitted by the provider, Medicaid **reduced** this request. Medicaid has authorized 277 units for the period October 1, 2008 – December 30, 2008. **This authorization includes units at the lesser of the previous or requested rate for the first 30 days, with the reduction applied to the remaining days of the authorization period.** The decision is effective **30 days from the date this notice was mailed.**

**Concurrent Request – Reduction - Residential:** Request for 60 days of Residential services from 10/1/08 – 11/29/08. Peer Advisor decision is to deny ongoing Residential services. Letter date is 10/1/08.

The above named provider requested prior authorization for 60 days of Residential Services from October 1, 2008 – November 29, 2008. After reviewing the documentation submitted by the provider, Medicaid **reduced** this request. Medicaid has authorized 30 days for the period October 1, 2008 – October 30, 2008. The decision is effective **30 days from the date this notice was mailed.**

**Concurrent/Continuing Request – Changed (Different service approved than requested)**

Request for 416 units (8 hrs/wk or 32 units) of Community Support from 10/1/08 – 12/30/08. Decision is to authorize Community Support Team at 140 units per week (35 hours) for the period requested. Letter date is 09/1/08. Suggested paragraph:

The above named provider requested prior approval for [insert name of service] from [insert period—October 01–November 29, 2008-if applicable]. After reviewing the documentation submitted by the provider, Medicaid **changed** this request. Medicaid **approved** [insert: service/procedure, # of units and time period, if relevant] effective **30 days from the date this notice was mailed.**

**Concurrent/Continuing Request - Terminated**

Request for 416 units of Community Support Services is requested from 10/1/08 – 12/30/08. Decision is a straight termination. Letter date is 09/01/08. Suggested paragraph:

The above named provider requested prior approval for [insert #] units of [insert name of service] from [insert time period—i.e., October 1-December 30, 2008 or November 01, 2008-January 01, 2009]. After reviewing the documentation submitted by the provider, Medicaid **terminated** the service. The decision is effective **30 days from the date this notice was mailed.**

5

Recipient Name [insert]  
MID # [insert]

DMA 2002  
09/08/05  
REV 09/24/08

**Notice of Decision on a Continuing Request for Medicaid Services (EPSDT) (DMA 2002E),  
page 1**

[Insert Vendor Letterhead]

**NOTICE OF DECISION ON A CONTINUING REQUEST  
FOR MEDICAID SERVICES**

[insert date notice to be mailed]

Recipient's or Legal Rep's name  
Address

Provider Name  
Provider Address

RE: [insert recipient name]

MID: [insert MID #]

Dear [insert name of recipient or parent/legal representative/authorized representative]:

The above named provider requested prior approval for (< units of <service/level of care> for the period <date> through <date> (ex. October 01-30, 2008 or November 01, 2008-January 01, 2009). Insert either option 1 or 2 here.]

**Option 1—Reduction or Change in Service Request Submitted by the Provider**

After reviewing the documentation submitted by the provider, Medicaid could not approve the request for the above named recipient. Medicaid **approved** (insert: (< units of <service/level of care> for the period <date> through <date> (ex. October 01-30, 2008 or November 01, 2008-January 01, 2009). The decision is a [insert: **reduction** of or **change in**] the prior authorization request submitted by your provider, and it is effective **30 days from the date this notice was mailed.**

**Option 2—Termination of Requested Service**

**Si desea apelar esta decisión, debe responder a no más tardar de 30 días a partir de la fecha que esta carta fue enviada. Si necesitas ayuda para leer y entender la carta, por favor contáctese con el 1-800-662-7030. DIGA AL OPERADOR QUE LA NOTIFICACION DMA 2002E.**

DMA 2002E  
09/08/05  
REV 09/24/08

**Notice of Decision on a Continuing Request for Medicaid Services (EPSDT) (DMA 2002E),  
page 2**

After reviewing the documentation submitted by the provider, Medicaid could not approve the request for the above named recipient. The decision **terminates** [insert name of service/level of care] effective **30 days from the date this notice was mailed**.

This letter explains why the decision was made and tells you how to appeal if you disagree. It is also important to note that you **may** also be eligible for other Medicaid services. Please check with your physician, other licensed clinician, or provider to determine if [if recommending no services, insert: there are other services that are more appropriate for you or if recommending services, insert: the services listed below are appropriate for you].

- List Medicaid services
- List Medicaid services

As the recipient is under 21 years of age, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) apply. EPSDT makes services available to recipients under 21 years of age without many of the restrictions Medicaid imposes for services under a waiver **OR** for adults (recipients over 21 years of age). Specifically, the service limitations on scope, amount, duration, frequency, and other specific criteria described in DMA's clinical coverage policies may be exceeded or may not apply if documentation submitted by the provider shows that all EPSDT criteria are met. The services must be prescribed by the recipient's physician, therapist, or other licensed practitioner.

When a recipient is under 21 years of age, the provider's request for service is evaluated under the applicable Medicaid clinical coverage policies as well as the EPSDT criteria. If the request cannot be approved under the clinical coverage policy criteria, all of the EPSDT criteria must be met to approve the request.

Based on the information submitted by the provider, the recipient does not meet [insert specific policy criteria not met]. As the recipient is under 21 years of age, the request was also evaluated under the EPSDT criteria. Medicaid denied this request because the [insert: for single criterion not met, insert: criterion specified below was or for several criteria not met, insert: criteria specified below were] not met.

- EPSDT services must be coverable services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].
- The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner.
- The requested service must be determined to be medical in nature.
- The service must be safe.
- The service must be effective.
- The service must be generally recognized as an accepted method of medical practice or treatment.

2

Recipient Name [insert]  
MID # [insert]

DMA 2002E  
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**Notice of Decision on a Continuing Request for Medicaid Services (EPSDT) (DMA 2002E), page 3**

- The service must not be experimental/investigational.

The decision is based on the authority granted to the North Carolina Department of Health and Human Services and its contractors by the Code of Federal Regulations, Chapter 42 Part 431, Subpart E, N.C.G.S. §108A-25(b) and §108A-54, as well as the law(s) and policy(ies) specified below.

- [insert NCAC citation, C.F.R., or other applicable law or title of specific medical policy supporting decision]
- United States Code 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]
- United States Code [insert code]
- North Carolina Administrative Code [insert code]
- North Carolina Administrative Code 10A NCAC 22O .0301

Medicaid's clinical coverage policies and EPSDT policy can be found at the websites listed below.

<http://www.ncdhhs.gov/dma/mp/mpindex.htm>  
<http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION.** If you decide to appeal the decision, you must file for an evidentiary hearing with the Office of Administrative Hearings. **YOU HAVE 30 DAYS FROM THE DATE THIS DECISION LETTER WAS MAILED TO FILE THE REQUEST FOR HEARING.**

To learn more about the hearing process or to speak with a Medicaid clinical policy analyst about this decision, call the Appeals Unit, Division of Medical Assistance at 919-855-4260. You may also call the toll free **CARE-LINE, Information and Referral Services, at 1-800-662-7030** and request that your call be transferred. The enclosed general information sheet also explains the hearing process.

**THE HEARING PROCESS AND FILING THE REQUEST:**

- Hearings are conducted by an administrative law judge with the Office of Administrative Hearings (OAH).
- To file for a hearing, you must submit **a completed hearing request form** (enclosed in this mailing). You can also obtain a hearing request form by calling the Division of Medical Assistance at the number specified above, or you can call the Office of Administrative Hearings at 919-431-3000.
- Mail or fax the completed hearing request form to Clerk, Office of Administrative Hearings **AND** General Counsel, North Carolina Department of Health and Human Services at the addresses or fax numbers on the enclosed hearing request form. **The completed form must be filed within 30 days of the date this decision letter was mailed.** As the mailing date is located on the envelope, **please keep the envelope containing this decision letter.**

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Recipient Name [insert]  
MID # [insert]

DMA 2002E  
09/08/05  
REV 09/24/08

**Notice of Decision on a Continuing Request for Medicaid Services (EPSDT) (DMA 2002E),  
page 4**

- The Office of Administrative Hearings or the Mediation Network of North Carolina will contact you to discuss your case and to offer an opportunity for mediation in an effort to resolve your appeal. If mediation resolves your case, your hearing will be dismissed, and services will be provided as specified by the Mediation Network of North Carolina.
- If you do not accept the offer of mediation or the results of mediation, your case will proceed to hearing. You will be notified by mail of the date, time, and location of your hearing.
- The administrative law judge will make a decision and will send that decision to Medicaid for a final agency decision. You will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision.
- If you do not agree with Medicaid's final agency decision, you may ask for a judicial review in superior court.
- You may represent yourself in the hearing process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for you.
- If a **continuing** request for services is denied and you submit a request for hearing within **30 days of the date this decision letter was mailed** and as long as you remain otherwise Medicaid eligible, unless you give up this right, you are entitled to receive services during the pendency of the appeal. **This right to receive services applies even if you change providers.** Services will be provided at the same level you were receiving the day before the decision or the level requested by your provider, whichever is less. The services that continue must be based on your current condition and must be provided in accordance with all applicable state and federal statutes and rules and regulations.
- If you lose your appeal, you may be required to pay for the services that continue because of the appeal.

**Free legal aid may be available to assist with your appeal.** Contact your nearest Legal Aid of North Carolina office or call 1-919-856-2564 or toll-free at 1-866-369-6923 to obtain the telephone number of the office that serves your community.

Sincerely,

[insert contact name and credentials]

919- [insert telephone # of contact]

Enclosure: Recipient Hearing Request Form, DMA 2003  
(Only the recipient may appeal the decision).

C: Provider  
Appeals Unit, Division of Medical Assistance  
Office of Administrative Hearings

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Recipient Name [insert]  
MID # [insert]

DMA 2002E  
09/08/05  
REV 09/24/08

**Notice of Decision on a Continuing Request for Medicaid Services (EPSDT) (DMA 2002E),  
page 5**

**POSSIBLE PARAGRAPH 1 SAMPLES**

**DO NOT INCLUDE WITH NOTICE**

**Example #1:** The above named provider requested prior authorization for Community Support Services at an intensity of 416 units for a 90 day period. After reviewing the request, Medicaid **reduced** the request effective **30 days from the date this notice was mailed**. Two hundred units are authorized for the period October 15-November 25, 2008 or October 15, 2007-January 14, 2009.

**Example #2:** The above named provider requested prior authorization for Community Support Services at an intensity of 416 units for a 90 day period. After reviewing the request, Medicaid **changed** the request. Community Support Team is authorized at 1,820 units for the period October 01-December 29, 2008. The decision is effective **30 days from the date this notice was mailed**.

**Example #3:** The above named provider requested prior authorization for skilled level of care. After reviewing the request, Medicaid **reduced** the request to intermediate level of care effective **30 days from the date this notice was mailed**.

**Example #4:** The above named provider requested prior authorization for physical therapy at an intensity of 45 units for a 60 day period. After reviewing the request, Medicaid **terminated** the service effective **30 days from the date this notice was mailed**.

**POSSIBLE EXAMPLES FOR PARAGRAPH #1 SUGGESTED BY VO**

While the scenarios are written for behavioral health services, they should work for services that have similar request patterns. They should also work for services that have no time frames or units by deleting them from the samples. These scenarios in their entirety would be substituted for paragraph #1, page 1.

**Concurrent Request – Reduction – Community Support:** Request for 416 units (8 hrs/wk) of Community Support from 10/1/08 – 12/30/08. Peer Advisor decision is to

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Recipient Name [insert]  
MID # [insert]

DMA 2002E  
09/08/05  
REV 09/24/08

**Notice of Decision on a Continuing Request for Medicaid Services (EPSDT) (DMA 2002E), page 6**

authorize 4 hrs/wk. Letter date is 10/1/08. Total authorized units accommodate 8 hrs/wk for 30 days from letter date, and then 4 hrs/week for the remainder of the authorization period. Suggested paragraph:

The above named provider requested prior authorization for 416 units of Community Support Services from October 1, 2008 – December 30, 2008. After reviewing the documentation submitted by the provider, Medicaid **reduced** this request. Medicaid has authorized 277 units for the period October 1, 2008 – December 30, 2008. **This authorization includes units at the lesser of the previous or requested rate for the first 30 days, with the reduction applied to the remaining days of the authorization period.** The decision is effective **30 days from the date this notice was mailed.**

**Concurrent Request – Reduction - Residential:** Request for 60 days of Residential services from 10/1/08 – 11/29/08. Peer Advisor decision is to deny ongoing Residential services. Letter date is 10/1/08.

The above named provider requested prior authorization for 60 days of Residential Services from October 1, 2008 – November 29, 2008. After reviewing the documentation submitted by the provider, Medicaid **reduced** this request. Medicaid has authorized 30 days for the period October 1, 2008 – October 30, 2008. The decision is effective **30 days from the date this notice was mailed.**

**Concurrent/Continuing Request – Changed (Different service approved than requested)**

Request for 416 units (8 hrs/wk or 32 units) of Community Support from 10/1/08 – 12/30/08. Decision is to authorize Community Support Team at 140 units per week (35 hours) for the period requested. Letter date is 09/1/08. Suggested paragraph:

The above named provider requested prior approval for [insert name of service] from [insert period—October 01–November 29, 2008-if applicable]. After reviewing the documentation submitted by the provider, Medicaid **changed** this request. Medicaid **approved** [insert: service/procedure, # of units and time period, if relevant] effective **30 days from the date this notice was mailed.**

**Concurrent/Continuing Request - Terminated**

Request for 416 units of Community Support Services is requested from 10/1/08 – 12/30/08. Decision is a straight termination. Letter date is 09/01/08. Suggested paragraph:

The above named provider requested prior approval for [insert #] units of [insert name of service] from [insert time period—i.e., October 1-December 30, 2008 or November 01,

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Recipient Name [insert]  
MID # [insert]

DMA 2002E  
09/08/05  
REV 09/24/08

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**Notice of Decision on a Continuing Request for Medicaid Services (EPSDT) (DMA 2002E),  
page 7**

**2008-January 01, 2009].** After reviewing the documentation submitted by the provider, Medicaid **terminated** the service. The decision is effective **30 days from the date this notice was mailed.**

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**Recipient Name [insert]**  
**MID # [insert]**

**DMA 2002E**  
**09/08/05**  
**REV 09/24/08**

**Notice of Termination Of Community Alternatives Program For Persons With Mental Retardation and Developmental Disabilities (CAP-MRDD) Services (DMA-2002CAP), page 1**

[Insert Vendor Letterhead]

**NOTICE OF TERMINATION OF COMMUNITY ALTERNATIVES PROGRAM FOR PERSONS WITH MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES (CAP-MRDD) SERVICES**

[Insert Date]

[Recipient/Legal Representative/Guardian's Name] [Medical Provider Name]  
[Recipient Address] [Address]

RE: [Insert Recipient's Name]  
MID #: [Insert last four digits and alpha of MID #]

Dear [insert name of recipient or parent/guardian/authorized representative]:

Medicaid will no longer pay for Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP-MRDD) waiver services for the above named recipient. CAP-MRDD waiver participation is **terminated 30 days from the date this notice was mailed**. This notice explains why this decision was made and tells you how to appeal if you disagree.

It is also important to note that you may also be eligible for other Medicaid services. Please check with your physician, other licensed clinician, or provider to determine if [if recommending no services, insert: there are other services that are more appropriate for you or if recommending services, insert: the services listed below are appropriate for you].

- List Medicaid services.
- List Medicaid services.

Medicaid terminated coverage for CAP-MRDD because a review of the recipient's medical records revealed that [he/she] has not utilized CAP-MRDD waiver services since [insert date] for a period of [insert number of days] days. The waiver requires services to be utilized at least monthly for an individual to participate in this waiver program. The CAP-MRDD Waiver Manual specifically states, "For an individual to be considered to

require the level of care specified for the waiver, it must be determined that a person requires at least one waiver service, and requires the provision of waiver services at least

**Si desea apelar esta decisión, debe responder a no más tardar de 30 días a partir de la fecha que esta carta fue enviada. Si necesitas ayuda para leer y entender la carta, por favor contáctese con el 1-800-662-7030. DIGA AL OPERADOR QUE LA NOTIFICACION DMA 2002.**

DMA 2002-CAP-MRDD Utilization  
07/03/08  
REV 09/24/08

**Notice of Termination Of Community Alternatives Program For Persons With Mental Retardation and Developmental Disabilities (CAP-MRDD) Services (DMA-2002CAP), page 2**

monthly, or if less frequently, requires monthly monitoring to assure health and safety. Individuals may not be enrolled in the waiver for the sole purpose of enabling them to obtain Medicaid eligibility and must receive at least monitoring monthly through case management to insure health and safety.”

The decision is based on the authority granted to the North Carolina Department of Health and Human Services and its contractors by the Code of Federal Regulations, Chapter 42 Part 431, Subpart E, N.C.G.S. §108A-25(b) and §108A-54, as well as the law(s) and policy(ies) specified below.

- CAP-MRDD Waiver Manual
- North Carolina Administrative Code 10A NCAC 22O .0301

Medicaid’s clinical coverage policies and the CAP-MRDD Manual can be found at the websites specified below, respectively.

- <http://www.ncdhhs.gov/dma/mp/mpindex.htm>
- <http://www.ncdhhs.gov/mhddsas/cap-mrdd/capmanual1-18-06.pdf>

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION.** If you decide to appeal the decision, you must file for an evidentiary hearing with the Office of Administrative Hearings. **YOU HAVE 30 DAYS FROM THE DATE THIS DECISION LETTER WAS MAILED TO FILE THE REQUEST FOR HEARING.**

To learn more about the hearing process or to speak with a Medicaid clinical policy analyst about this decision, call the Appeals Unit, Division of Medical Assistance at 919-855-4260. You may also call the toll free **CARE-LINE, Information and Referral Services, at 1-800-662-7030** and request that your call be transferred. The enclosed general information sheet also explains the hearing process.

**THE HEARING PROCESS AND FILING THE REQUEST:**

- Hearings are conducted by an administrative law judge with the Office of Administrative Hearings (OAH).
- To file for a hearing, you must submit **a completed hearing request form** (enclosed in this mailing). You can also obtain a hearing request form by calling the Division of Medical Assistance at the number specified above, or you can call the Office of Administrative Hearings at 919-431-3000.
- Mail or fax the completed hearing request form to Clerk, Office of Administrative Hearings AND General Counsel, North Carolina Department of Health and Human Services at the addresses or fax numbers on the enclosed hearing request form. **The completed form must be filed within 30 days of the date this decision letter was mailed.** As the mailing date is located on the envelope, **please keep the envelope containing this decision letter.**

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DMA 2002-CAP-MRDD Utilization  
07/03/08  
REV 09/24/08

Recipient’s Name  
MID #: [insert last four digits and alpha]

**Notice of Termination Of Community Alternatives Program For Persons With Mental Retardation and Developmental Disabilities (CAP-MRDD) Services (DMA-2002CAP), page 3**

- The Office of Administrative Hearings or the Mediation Network of North Carolina will contact you to discuss your case and to offer an opportunity for mediation in an effort to resolve your appeal. If mediation resolves your case, your hearing will be dismissed, and services will be provided as specified by the Mediation Network of North Carolina.
- If you do not accept the offer of mediation or the results of mediation, your case will proceed to hearing. You will be notified by mail of the date, time, and location of your hearing.
- The administrative law judge will make a decision and will send that decision to Medicaid for a final agency decision. You will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision.
- If you do not agree with Medicaid's final agency decision, you may ask for a judicial review in superior court.
- You may represent yourself in the hearing process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for you.
- If a **continuing** request for services is denied and you submit a request for hearing **within 30 days of the date this decision letter was mailed** and as long as you remain otherwise Medicaid eligible, unless you give up this right, you are entitled to receive services during the pendency of the appeal. **This right to receive services applies even if you change providers.** Services will be provided at the same level you were receiving the day before the decision or the level requested by your provider, whichever is less. The services that continue must be based on your current condition and must be provided in accordance with all applicable state and federal statutes and rules and regulations.
- If you lose your appeal, you may be required to pay for the services that continue because of the appeal.

**Free legal aid may be available to assist with your appeal.** Contact your nearest Legal Aid of North Carolina office or call 919-856-2564 or toll-free at 1-866-369-6923 to obtain the telephone number of the office that serves your community.

Sincerely,

[insert contact name and credentials]

919- [insert telephone # of contact]

Enclosure: Recipient Hearing Request Form, DMA 2003  
(Only the recipient may appeal the decision).

C: Provider  
Appeals Unit, Division of Medical Assistance  
Office of Administrative Hearings

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DMA 2002-CAP-MRDD Utilization  
07/03/08  
REV 09/24/08

Recipient's Name

MID #: [insert last four digits and alpha]

**Notice of Return Request to Provider (DMA 3503)**

[Insert Vendor Letterhead]

**NOTICE OF RETURN REQUEST TO PROVIDER**

[insert date notice to be mailed]

Provider Name  
Provider Address

Recipient's or Legal Rep's Name  
Address

RE: [insert recipient name if known and delete RE if unknown]

MID: [insert MID # if known and delete MID if unknown]

Dear [insert provider name]:

Medicaid received your correspondence dated [insert date of correspondence] in which you requested prior authorization of a Medicaid service. Your request cannot be processed because it did not identify [insert all applicable: the recipient's name, address, Medicaid identification (MID) number or date of birth, provider contact information, date of request, or the procedure, service, or product being requested].

To initiate a prior approval request, please refer to the Basic Medicaid Billing Guide. The Guide explains how to request prior approval. The publication is located on the DMA website at <http://www.ncdhhs.gov/dma/medbillcaguide.htm>.

Recipient appeal rights are not implicated as no action could be taken on this request. For your convenience, your correspondence is enclosed in this mailing.

Please contact me at the telephone indicated below if you have questions.

Sincerely,

[insert name and credentials]  
[insert title]  
[insert telephone number]

DMA 3503  
09/08/05  
REV. 09/24/08

**Notice of Return Request to Provider (DMA 3503MH)****[Insert Vendor Letterhead]****NOTICE OF RETURN REQUEST TO PROVIDER**

[insert date notice to be mailed]

Provider Name  
Provider AddressRecipient's or Legal Rep's Name  
Address

RE: [insert recipient name if known and delete RE if unknown]

MID: [insert MID # if known and delete MID if unknown]

Dear [insert provider name]:

Medicaid received your correspondence dated [insert date of correspondence] in which you requested prior authorization of a Medicaid service. Your request cannot be processed because [insert only one of the following]:

1. it did not identify [insert all applicable: the recipient's name, address, Medicaid identification (MID) number or date of birth, provider contact information, signatures, date of request, or the procedure, service, or product being requested] OR
2. it did not include the required service order checkboxes which designate whether or not the clinician completed a face-to-face interview and reviewed the assessment. OR
3. it did not include all required elements of the PCP OR
4. another provider is currently authorized to provide this service, and two providers cannot be authorized at the same time OR
5. the recipient is not Medicaid eligible for the date of the service requested; OR
6. The CAP-MR/DD request exceeds the benefit limit of the approved tier of service

To initiate a prior approval request, please refer to the Basic Medicaid Billing Guide. The Guide explains how to request prior approval. The publication is located on the DMA website at <http://www.ncdhhs.gov/dma/basicmed/>.

Recipient appeal rights are not implicated as no action could be taken on this request. For your convenience, your correspondence is enclosed in this mailing.

Please contact me at the telephone number indicated below if you have questions.

Sincerely,

[insert name and credentials]

[insert title]

919-[insert telephone number]

DMA 3503MH  
09/08/05  
REV. 09/24/08  
REV. 03/20/09

**Notice of Request for Additional Information (DMA 3501), page 1**

[Insert Vendor Letterhead]

**NOTICE OF REQUEST FOR ADDITIONAL INFORMATION**

[insert date to be mailed]

Provider Name  
Provider Address

RE: [insert recipient name]  
MID: [insert MID #]

Dear [insert provider name]:

The Division of Medical Assistance (DMA) has received a request for [insert service, product, or procedure requested] on behalf of the recipient referenced above. As a part of the review process, it is necessary to review documentation related to the recipient's condition.

The Division of Medical Assistance and its contractual agents are authorized access to patient records by Federal Statute Social Security Act 1902 (a) (27) and Federal Regulation 42 CFR 431.107 for purposes directly related to the administration of the Medicaid program, and no special permission is required. Additionally, for health oversight activities authorized by law, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule provides that protected health information (PHI) may be used and disclosed without the authorization of the patient. The Privacy Rule can be found at 45 CFR Part 164.502 and .508. It should be noted that upon acceptance of Medicaid eligibility, recipients grant the state Medicaid agency, the Division of Medical Assistance, the right to access medical records.

North Carolina Medicaid requires the provider of services to keep any records necessary to disclose the extent of services furnished and upon request, furnish to the Medicaid agency and its authorized representatives any and all information contained in medical records.

**Please send copies of the medical information specified below that document the condition of the recipient related to the request for [insert name of service, product or procedure requested or denied].**

List the records needed. (The HIPAA Privacy Rule requires that only the amount of information that is needed to accomplish the purpose of the request be submitted. Only request the complete medical record if it is really needed, otherwise specify the specific documents/information that is required to complete the review).

No later than **15 business days from the date of this notice**, the required information specified above must either be submitted or contact must be made with the person indicated below to

Recipient [insert name]  
MID #: [insert number]

DMA 3501  
10/05  
REV 09/24/08

**Notice of Request for Additional Information (DMA 3501), page 2**

provide a reasonable date that the additional information can be provided. Failure to respond to this notice within the required timeframe shall result in a denial of the request. Mail or fax copies of the above referenced information to:

[insert staff name]  
LME Name  
LME Address  
City, NC Zip  
Fax number: [insert number]

Please contact me at the telephone number specified below if you have any questions concerning this request.

Sincerely,

[insert name and credentials]  
[insert title]  
[insert telephone number]

Recipient [insert name]  
MID #: [insert number]

2

DMA 3501  
10/05  
REV 09/24/08

**Notice of Request for Additional Information (EPSDT) (DMA 3501E), page 1**

[Insert Vendor Letterhead]

**NOTICE OF REQUEST FOR ADDITIONAL INFORMATION**

[insert date to be mailed]

Provider Name  
Provider Address

RE: [insert recipient name]  
MID: [insert MID #]

Dear [insert provider name]:

The Division of Medical Assistance (DMA) has received a request for a [insert service, product, or procedure requested] on behalf of the recipient referenced above. As a part of the review process, it is necessary to review documentation related to the recipient's condition.

The Division of Medical Assistance and its contractual agents are authorized access to patient records by Federal Statute Social Security Act 1902 (a) (27) and Federal Regulation 42 CFR 431.107 for purposes directly related to the administration of the Medicaid program, and no special permission is required. Additionally, for health oversight activities authorized by law, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule provides that protected health information (PHI) may be used and disclosed without the authorization of the patient. The Privacy Rule can be found at 45 CFR Part 164.502 and .508. It should be noted that upon acceptance of Medicaid eligibility, recipients grant the state Medicaid agency, the Division of Medical Assistance, the right to access medical records.

North Carolina Medicaid requires the provider of services to keep any records necessary to disclose the extent of services furnished and upon request, furnish to the Medicaid agency and its authorized representatives any and all information contained in medical records.

**Please send copies of the medical information specified below that document the condition of the recipient related to the request for [insert name of service, product or procedure requested or denied].**

List the records needed. (The HIPAA Privacy Rule requires that only the amount of information that is needed to accomplish the purpose of the request be submitted. Only request the complete medical record if it is really needed, otherwise specify the specific documents/information that is required to complete the review).

[Insert next three paragraphs if EPSDT information is needed. If not needed, delete.]

As the recipient is under 21 years of age, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) apply. EPSDT makes services available to recipients under 21 years of age without many of the restrictions Medicaid imposes for services under a waiver **OR** for adults (recipients over 21 years of age). Specifically, the service limitations on scope, amount, duration, frequency, and other specific criteria described in DMA's clinical coverage policies may be exceeded or may not apply if documentation submitted by the provider shows that all

DMA 3501E  
10/05  
REV 09/24/08

**Notice of Request for Additional Information (EPSDT) (DMA 3501E), page 2**

EPSDT criteria are met. The services must be prescribed by the recipient's physician, therapist, or other licensed practitioner.

When a recipient is under 21 years of age, the provider's request for service is evaluated under the applicable Medicaid clinical coverage policies as well as the EPSDT criteria if all clinical coverage policy criteria are not met. To expedite this review, please provide information about the criteria specified below.

[Insert all that apply or delete if not requesting EPSDT information. Double space between paragraph before and after EPSDT criteria.]

- EPSDT services must be coverable services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].
- The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner.
- The requested service must be determined to be medical in nature.
- The service must be safe.
- The service must be effective.
- The service must be generally recognized as an accepted method of medical practice or treatment.
- The service must not be experimental/investigational.

No later than **15 business days from the date of this notice**, the required information specified above must either be submitted or contact must be made with the person indicated below to provide a reasonable date that the additional information can be provided. Failure to respond to this notice within the required timeframe shall result in a denial of the request. Mail or fax copies of the above referenced information to:

[insert staff name]  
LME Name  
LME Address  
City, NC Zip  
Fax number: [insert number]

Please contact me at the telephone number specified below if you have any questions concerning this request.

Sincerely,

[insert name and credentials]  
[insert title]  
[insert telephone number]

Recipient [insert name]  
MID #: [insert number]

2

DMA 3501E  
10/05  
REV 09/24/08

**Notice of Denial of Service Request – Additional Information Previously Requested and Not Received (DMA 2001A), page 1**

[Insert Vendor Letterhead]

**NOTICE OF DENIAL OF SERVICE REQUEST  
Additional Information Previously Requested and Not Received**

[insert date to be mailed]

Recipient's or Legal Rep's Name  
Address

Provider Name  
Provider Address

RE: [insert recipient name]

MID: [insert MID #]

Dear [insert name of recipient or parent/guardian/authorized representative]:

On [insert date], [insert name of physician, recipient or other person who requested service] asked Medicaid to authorize a prior approval request for [insert specific service/procedure requested and time period if relevant]. Medicaid **denied** the request for the above named recipient effective [if an initial request, insert: **the date this letter was mailed** or if currently receiving services, insert: **30 days from the date this letter was mailed**]. This letter explains why the request was denied and tells you how to appeal this decision if you disagree.

Medicaid denied the request because medical necessity could not be validated. Specifically, Medicaid sent your provider a letter dated [insert date of notice for additional information—October 01, 2008], requesting additional information in an effort to determine if Medicaid could authorize the prior approval request as indicated above. This information was due [insert due date for additional information], and, to date, it has not been received, and the provider did not request an extension of time to submit the additional information. The law or policy the denial is based on is 10A NCAC 22O .0301. The North Carolina Administrative Code can be found at <http://reports.oah.state.nc.us/ncac.asp>.

While you have the right to appeal this decision, the provider may submit a new request at any time along with the additional information requested in the letter dated [insert date of notice for additional information] to the address specified below.

[insert name and credentials]

LME Name

Address

City, NC Zip

**Si desea apelar esta decisión, debe responder a no más tardar de 30 días a partir de la fecha que esta carta fue enviada. Si necesitas ayuda para leer y entender la carta, por favor contáctese con el 1-800-662-7030. DIGA AL OPERADOR QUE LA NOTIFICACION DMA 2001A.**

DMA 2001A  
09/08/05  
REV 09/24/08

**Notice of Denial of Service Request – Additional Information Previously Requested and Not Received (DMA 2001A), page 2**

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION.** If you decide to appeal the decision, you must file for an evidentiary hearing with the Office of Administrative Hearings. **YOU HAVE 30 DAYS FROM THE DATE THIS DECISION LETTER WAS MAILED TO FILE THE APPEAL REQUEST.**

To learn more about the hearing process or to speak with a Medicaid clinical policy analyst about this decision, call the Appeals Unit, Division of Medical Assistance at 919-855-4260. You may also call the toll free **CARE-LINE, Information and Referral Services, at 1-800-662-7030** and request that your call be transferred. The enclosed general information sheet also explains the hearing process.

**THE HEARING PROCESS AND FILING THE REQUEST:**

- Hearings are conducted by an administrative law judge with the Office of Administrative Hearings (OAH).
- To file for a hearing, you must submit **a completed hearing request form** (enclosed in this mailing). You can also obtain a hearing request form by calling the Division of Medical Assistance at the number specified above, or you can call the Office of Administrative Hearings at 919-431-3000.
- Mail or fax the completed request form to Clerk, Office of Administrative Hearings **AND** General Counsel, North Carolina Department of Health and Human Services at the addresses or fax numbers on the enclosed hearing request form. **The completed form must be filed within 30 days of the date this decision letter was mailed.** As the mailing date is located on the envelope, **please keep the envelope containing this decision letter**.
- The Office of Administrative Hearings or the Mediation Network of North Carolina will contact you to discuss your case and to offer an opportunity for mediation in an effort to resolve your appeal. If mediation resolves your case, your hearing will be dismissed, and services will be provided as specified by the Mediation Network of North Carolina.
- If you do not accept the offer of mediation or the results of mediation, your case will proceed to hearing. You will be notified by mail of the date, time, and location of your hearing.
- The administrative law judge will make a decision and will send that decision to Medicaid for a final agency decision. You will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision.
- If you do not agree with Medicaid's final agency decision, you may ask for a judicial review in superior court.
- You may represent yourself in the hearing process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for you.
- **Insert only if receiving services: If a continuing request for services is denied and you submit a request for hearing within 30 days of the date this decision letter was mailed and as long as you remain otherwise Medicaid eligible, unless you give up this right, you are entitled to receive services during the pendency of the appeal. **This right to receive services applies even if you change providers.** Services will be**

2

Recipient Name [insert]

MID # [insert]

DMA 2001A  
09/08/05  
REV 09/24/08

**Notice of Denial of Service Request – Additional Information Previously Requested and Not Received (DMA 2001A), page 3**

provided at the same level you were receiving the day before the decision or the level requested by your provider, whichever is less. The services that continue must be based on your current condition and must be provided in accordance with all applicable state and federal statutes and rules and regulations.

- Insert only if receiving services: If you lose your appeal, you may be required to pay for the services that continue because of the appeal.

**Free legal aid may be available to assist with your appeal.** Contact your nearest Legal Aid of North Carolina office or call 919-856-2564 or toll-free at 1-866-369-6923 to obtain the telephone number of the office that serves your community.

Sincerely,

[insert contact name and credentials]

[insert telephone # of contact]

Enclosure: Recipient Hearing Request Form, DMA 2003  
(Only the recipient may appeal the decision).

C: Provider  
Office of Administrative Hearings  
Appeals Unit, Division of Medical Assistance

3

Recipient Name [insert]

MID # [insert]

DMA 2001A  
09/08/05  
REV 09/24/08

# Attachment L: Recipient Hearing Request Form and Medicaid Fair Hearing Timeline

## General Information About the Hearing Process

*FOR YOUR INFORMATION ONLY  
DO NOT SEND THIS PAGE WITH A COMPLETED HEARING REQUEST FORM.*

### GENERAL INFORMATION ABOUT THE HEARING PROCESS

**UNDERSTANDING THE APPEAL PROCESS:** If you choose to appeal, you may represent yourself during the appeal process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for you. Your case will begin as soon as the completed recipient hearing request form that you were sent in this mailing is **received and filed** with the Office of Administrative Hearings (OAH) AND the Department of Health and Human Services (DHHS). You will be contacted by the Office of Administrative Hearings or the Mediation Network of North Carolina to discuss your case and to be offered an opportunity for mediation in an effort to resolve your appeal. If mediation resolves your case, your hearing will be dismissed, and services will be provided as specified by the Mediation Network of North Carolina. If you do not accept the offer of mediation or the results of mediation, your case will proceed to hearing and will be heard by an administrative law judge with the Office of Administrative Hearings. You will be notified by mail of the date, time, and location of your hearing. The administrative law judge will make a decision and will send that decision to Medicaid for a final agency decision. You will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision. If you do not agree with Medicaid's final agency decision, you may ask for a judicial review in superior court. The hearing process must be completed within 90 days of receipt of your completed Recipient Hearing Request Form. For more information about the hearing process, visit the websites indicated below.

- **Adults:** <http://www.ncdhhs.gov/dma/medicaid/abd.pdf>
- **Children:** <http://www.ncdhhs.gov/dma/medicaid/famchld.pdf>

**SERVICES DURING THE APPEAL PROCESS:** If a **continuing** request for services is denied and you submit a request for hearing within **30 days of the date the notice was mailed** and as long as you remain otherwise Medicaid eligible, unless you give up this right, you are entitled to receive services during the pendency of the appeal. **This right to receive services applies even if you change providers.** The service will be provided at the same level you were receiving the day before the decision or the level requested by your provider, whichever is less. The services that continue must be based on your current condition and must be provided in accordance with all applicable state and federal statutes and rules and regulations. If you lose your appeal, you may be required to pay for the services that continue because of the appeal.

**FILING A RECIPIENT HEARING REQUEST FORM WITH OAH AND DHHS:** Complete the enclosed Recipient Hearing Request Form if you decide to appeal Medicaid's decision to deny, terminate, reduce (change), or suspend the services requested by your provider. Hearing requests must be served on **BOTH** OAH and DHHS. The request must be filed by mail or fax within **30 days of the date the notice was mailed**. The mailing addresses and telephone and fax numbers for OAH and DHHS appear below.

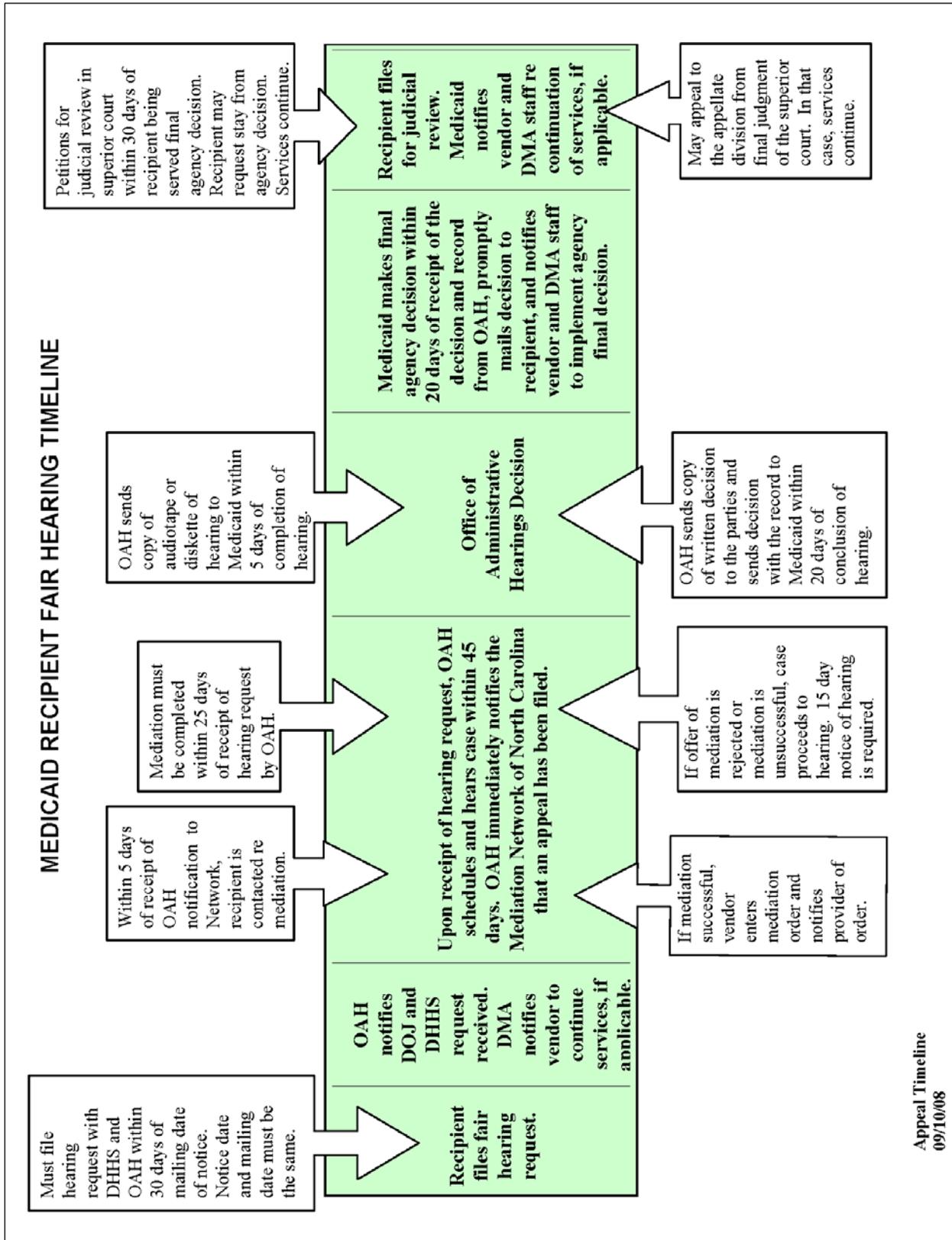
For questions concerning the decision Medicaid made about your provider's request for service, please contact Medicaid. Should you have questions about the appeal process, please contact OAH. You may also contact the Appeals Unit, Division of Medical Assistance (Medicaid) if you have questions.

AGENCY	MAILING ADDRESS	OFFICE NUMBER	FAX NUMBER
Office of Administrative Hearings (OAH)	Clerk 6714 Mail Service Center Raleigh, NC 27699-6714	919-431-3000	Clerk 919-431-3100
NC Department of Health and Human Services (DHHS)	General Counsel 2001 Mail Service Center Raleigh NC 27699-2001	919-733-4534	General Counsel 919-715-4645
Division of Medical Assistance (Medicaid)	Appeals Unit Clinical Policy and Programs 2501 Mail Service Center Raleigh NC 27699-2501	919-855-4260 Toll-free: 1-800-662-7030 Ask for your call to be transferred to the DMA Appeals Unit, Clinical Policy and Programs.	Appeals Unit 919-733-2796

DMA 2003  
09/08/05  
REV 09/24/08



**Medicaid Recipient Fair Hearing Timeline**



## Attachment M: Due Process Work Flow

### Administrative Denials Due to Invalid Requests – Child and Adult

<b>ADMINISTRATIVE DENIALS DUE TO INVALID REQUESTS - CHILD &amp; ADULT</b>					
	<b>UNABLE TO PROCESS</b>	<b>UNABLE TO PROCESS</b>	<b>UNABLE TO PROCESS</b>	<b>UNABLE TO PROCESS WITH APPEAL RIGHTS</b>	<b>UNABLE TO PROCESS WITH APPEAL RIGHTS</b>
<b>Identifying Information</b>	No MID, DOB Wrong County of Eligibility No Name/Address No Procedure Code/Service No Start Date of Request No Provider Information <i>Duplicate Request</i>	All Identifying Information Present	All Identifying Information Present	All Identifying Information Present	Not Medicaid Eligible
<b>Forms</b>	No ITR, ORF, CTCM No PCP (when applicable)	ITR, ORF, CTCM unsigned PCP unsigned – recipient, service order, checkboxes for MH/SA	Signatures exceed 1 year Signatures exceed relevant Goal review time period Missing or blank PCP pages for: Action Plan/Goals p.2 of Crisis Plan Observation & Assessment	Request exceeds CAP tier limitations: Exceeds \$135,000 for CAP-CM Indicator Exceeds \$17,500 for CAP-C2 Indicator	
<b>Reviewer</b>	Adm staff	Adm staff	Adm staff	Adm staff	Adm staff
<b>Decision</b>	Unable to Process	Unable to Process	Unable to Process	Unable to Process	Unable to Process with Appeal Rights
<b>Outcome</b>	Return to Sender	Return to Sender	Return to Sender	Return to Sender	Return to Sender

**Clinical Denials/Reductions – Child and Adult**

<b>CLINICAL DENIALS/REDUCTIONS – CHILD &amp; ADULT</b>				
<b>Reviewer</b>	<b>Clinician</b>	<b>Clinician</b>	<b>Clinician</b>	<b>Clinician</b>
<b>Forms</b>	Signatures are present, but Service Request form is missing information  PCP Signatures are present and PCP has information on required pages  Clinician unable to make <u>any</u> decision based upon materials submitted (yes, no or reduced)	If an alternative service is being discussed or a different amount of the same service, must pend while the provider seeks recipient agreement. The amount of authorized service may be different than the requested service listed on the PCP. If a new service will require a new PCP service order and signatures.	Requested Service Exceeds maximum policy guidelines for <b>duration</b> e.g. RCC for 1 year, ACTT for 1 year, CS for 6 months, SA Res Tx for 60 days	Requested Service Exceeds maximum policy guidelines for <b>amount or combination of services</b> e.g. 96 units per day of Facility Based Crisis, 4 hours per month of CS while also receiving ACTT
<b>Decision</b>	Ask for More Information	Start Date of Authorization: If <b>amount changed</b> , use date of receipt of request as start date and can accept verbal statement from provider that the recipient or guardian agrees.	Reduce the request to allowable maximum duration if medically necessary	Adult - Reduce the request to allowable maximum if medically necessary <b>OR</b> Child – Evaluate under EPSDT
<b>Outcome</b>	Pend – after 15 days if no response, Deny	Evaluate request – If a denial or reduction of requested amount, then send to Peer Review  NOTE: If issue a proportionate <b>amount</b> to that requested, must give appeal rights	Authorize maximum duration – no Appeal Rights <b>OR</b> Authorize less than maximum duration – goes to Peer Review & gets Appeal Rights	Adult - Authorize maximum – no Appeal Rights <b>OR</b> Adult - Authorize less than maximum – goes to Peer Review & gets Appeal Rights <b>OR</b> Child – Authorize less than amount requested – goes to peer review & gets appeal rights
<b>Appeal</b>	Adm may issue denial with appeal rights	Clinical Denial with Appeal	Clinical Denial with & without Appeal	Clinical Denial with & without Appeal

## Attachment N: HIPAA Breach Report

### HIPAA BREACH REPORT

#### INSTRUCTIONS

NOTE: This is an administrative report; DO NOT include in any agency designated record set(s), including client health records.

#### SECTION I – GENERAL INFORMATION

<b>Name of Staff Member Reporting Incident</b>	
<b>Telephone Number</b>	( ) - - x                      Email Address
<b>LME Entity</b>	
<b>Unit/Section</b>	
<b>Supervisor</b>	

#### SECTION II – PRIVACY INCIDENT INFORMATION

<b>Date of Incident</b>	<b>Time of Incident</b>	<b>Location of Incident</b>
<b>Description of Incident</b> (Include the names of those involved in the privacy incident.)		
<b>Incident also reported to</b>		

Signature/Title: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Staff member reporting privacy incident)

<b>Supervisor Comments</b>
----------------------------

Signature/Title: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Supervisor of staff member reporting privacy incident)

## Attachment O: LME PA Authorization Inbound/Outbound File Layout

### LME PA Authorization Inbound/Outbound File Layout, page 1

Item #	EDS Data Element Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position	Definition	NEW Edit Criteria
1	SUBMITTAL-ID	A1 = Durham A2 = Eastpointe A3 = Mecklenburg A4 = Western Highlands VO = ValueOptions	A/N	2		Required	1	2	Field that uniquely identifies the inbound PA file	Required - Value Must be A1, A2, A3 A4 or VO <b>ER Code = A</b>
2	SERVICE TYPE	I = Inpatient (Includes OOS) M = Independent MH O = Outpatient P = PRTF (Includes OOS) R = Residential Child Care (Includes OOS) H = High Risk E = Enhanced Services C = CAP (N/A for VO) T = Targeted Case Mgmt. (N/A for VO)	A/N	1		Required must be one of the following: 'I', 'M', 'O', 'P', 'R', 'H', 'E', 'C' or 'T'	3	3	Category of service that has been prior authorized.  You must ensure that the combination sent in fields 2 service type and 19-procedure code is a valid combination according to Appendix G of the DABD.	Required - Valid Values are: I, M, O, P, R, H, E, C, and T <b>ER Code = B</b>  Other Edits related to Service Type:  If 'I', PCODE MUST BE 'RC100' <b>ER Code = Z</b>  If 'P', PCODE MUST BE 'RC911' <b>ER Code = Z</b>  If 'E', PCODE MUST BE 'H0040' 'H2011' 'H2022' 'H2033' 'T1023' 'H0015' 'H2035' 'H0013' 'H0014' 'H0010' 'H2036' 'H0035' 'S9484' 'H2017' 'H0020' 'H0036' 'H2015' 'H0012' 'H2012' <b>ER Code = Z</b>

LME PA Authorization Inbound/Outbound File Layout, page 2

Item #	EDS Data Element Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position	Definition	NEW Edit Criteria
										If 'T' PCODE MUST BE 'T1017'. ER Code = Z  If 'O' or 'M', PCODE MUST BE '90801'-'90802' '90804' THRU '90809' '90810' THRU '90819' '90821' THRU '90824' '90826' THRU '90829' '90845' THRU '90847' '90849'-'90853' '90857'-'96101' '96110'-'96111' '96116'-'96118' 'H0001'-'H0004' 'H0005' 'H0031'. ER Code = Z  If 'C' PCODE MUST BE 'H0045' 'H2011' 'H2015' 'H2016' 'H2019' 'H2023' 'H2025'-'S5102' 'S6110'-'S6125' 'S5150'-'S5161' 'S5165'-'T1005' 'T1019'-'T1999'

**LME PA Authorization Inbound/Outbound File Layout, page 3**

Item #	EDS Data Element Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position	Definition	NEW Edit Criteria
3	SUB-SEC-CODE	Submittal Security Code	A/N	4	LMA1 LMA2 LMA3 LMA4 VOI	Required	4	7	Unique identifier for each LME that identifies the PA stored on the PA master file	'T2001' 'T2014' 'T2016' 'T2020' 'T2021' 'T2025' 'T2028' 'T2033' 'T2039' 'V5336' ER Code = Z  Required If blank ER Code = C  If not consistent with Submittal-Id ER Code = C  If not consistent with source of file ER Code = C
4	STATE-CODE	State Code	A/N	2	'NC'	Required	8	9	North Carolina	Required If NOT a valid state code equal to one of the 50 states: ER Code = D
5	MID	Medicaid Identification Number	A/N	10		Required	10	19	Medicaid identification number  The number must be on the eligibility file. The county must be within the LMEs catchment area.	If MID not found on Eligibility File ER Code = E  If county of eligibility for this MID outside catchment area ER Code = 1
6	RECIPIENT-LNAME	Recipient's Last Name	A	20		Required	20	39	Recipient's last name	If first 15 characters of

**LME PA Authorization Inbound/Outbound File Layout, page 4**

Item #	EDS Data Element Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position	Definition	NEW Edit Criteria
7	RECIPIENT-FNAME	Recipient's First Name	A	9		Required	40	48	The name must match what is found on the eligibility file.  Recipient's first name  The name must match what is found on the eligibility file.	RECIPIENT-LNAME not equal the first 15 characters of Recipient Last Name found on the Eligibility File <b>ER Code = F</b>  If all 9 characters of RECIPIENT-FNAME not equal the first 9 characters of Recipient First Name found on the Eligibility File <b>ER Code = G</b>
8	RECIPIENT-DOB	Recipient's Date of Birth	N	8	MMDDCCYY	Required	49	56	Recipient's date of birth  The date of birth must match what is found on the eligibility file.	If RECIPIENT-DOB not equal Recipient Date of Birth found on the Eligibility File <b>ER Code = H</b>
9	START-DATE	PA Starting Date	N	8	MMDDCCYY	Required	57	64	Start date of the PA authorization  The start date must never be changed.	Required - If invalid (Month > 12, etc.) <b>ER Code = I</b>
10	END-DATE	PA Ending Date	N	8	MMDDCCYY	Required Note: This is new for VO	65	72	End date of the PA authorization	Required If > zeros & invalid (Month > 12, etc.)

**LME PA Authorization Inbound/Outbound File Layout, page 5**

Item #	EDS Data Element Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position	Definition	NEW Edit Criteria
11	UNITS-APPROVED	Number of Units Approved	N	4		Required If denial, units must be zero  Note: This is new for VO	73	76	This date cannot be more than 12 months from the start date.  Number of units approved	<b>ER Code = J</b>  If start date >= (start date + 12 months) <b>ER Code = J</b>  Required If REC-TYPE = ADD or CHANGE and PA-STATUS = APPROVED UNITS-APPROVED must be > 0 Void or Denied PAs must have 0 units. <b>ER Code = K</b>
12	PA-NUMBER Example: 00A1090470001	PA Number <b>For LMEs</b> the format is, Pos 1-2 = "00" Pos 3-4 = Submittal Id Pos 5-6 = YY Pos 7-9 = Julian day of year Pos 10-13 = Daily sequence number that begins at 1 each day <b>For VO:</b> no change in format	A/N	13		Required – Must be unique for each LME	77	89	Unique number assigned by the LME to the PA authorization	Required If PA-NUMBER = SPACES <b>ER Code = L</b>
13	ADMISSION-DATE	Date of Recipient admission	N	8	MMDD CCYY	Optional for all services except Inpatient (I), PRTE (P)	90	97	Date admitted to facility	Required if (SERVICE-TYPE = I, P or H) and (REC-TYPE = ADD or

**LME PA Authorization Inbound/Outbound File Layout, page 6**

Item #	EDS Data Element Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position	Definition	NEW Edit Criteria
14	PROVIDER	Provider Number When Criterion 5 (H) the provider would be the LME	A/N	13		and Criterion 5 (H). Note: This is new for VO	98	110	Identifies the provider authorized to perform the service(s)  This number must be found on the provider file and the provider must be active.	CHANGE) -ER Code = M  If Admission Date is present it must be a valid date ER Code = M Required – if Provider Number is Missing ER Code = N  If present, Provider Number must be valid ER Code = O
15	REFER-PROVIDER	Provider Number which referred Recipient  When Criterion 5 (service type H) provider number is the hospital provider number.	A/N	13		Required for High Risk only	111	123	Provider number of hospital where recipient is located	Required - for High Risk Service Type ER Code = W  If present, REFER-PROVIDER number must be valid ER Code = P  If present, REFER-PROVIDER number TYPE/SPECIALTY must be

LME PA Authorization Inbound/Outbound File Layout, page 7

Item #	EDS Data Element Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position	Definition	NEW Edit Criteria
16	DIAG-CODE1	Diagnosis Code 1	A/N	5		Required for all except CAP and TCM (CAP and TCM N/A for VO) Note: Will impact VO	124	128	Diagnosis submitted by the provider  This field must contain a valid diagnosis code.	valid ER Code = Y  Must be present and on Diagnosis Master File ER Code = Q
17	DIAG-CODE2	Diagnosis Code 2	A/N	5		Optional Note: Will impact VO	129	133		Must be numeric ER Code = R
18	DIAG-CODE3	Diagnosis Code 3	A/N	5		Optional Note: Will impact VO	134	138		Must be numeric ER Code = S
19	PROCEDURE-CODE	Procedure Code	A/N	5		Required	139	143	Service that was authorized  You must ensure that the combination sent in fields 2 service type and 19-procedure code is a valid combination according to Appendix G of the DABD	Required - for all PA-STATUS  If PCODE equals spaces "90899" 'H0019' 'H2020' 'H0046' 'S5145' ER Code = T  If PCODE not found on Pcode File ER Code = T  If Service-Type is High Risk PCODE must equal 'Y2343' ER Code = X
20	REC-TYPE	A = add new PA record C = change existing	A/N	1	'A', 'C'	Required	144	144	Identifies the type record being	Required -if not 'A' or 'C' ER Code = U

**LME PA Authorization Inbound/Outbound File Layout, page 8**

Item #	EDS Data Element Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position	Definition	NEW Edit Criteria
		PA record							submitted by the LME	If REC-TYPE = 'A' and PA Number/MID was previously submitted as an ADD <b>ER Code = U</b>  If REC-TYPE = 'C' and PA Number/MID was <u>not</u> previously submitted as an ADD <b>ER Code = U</b>  If 'C' PA start date is not allowed to change. ER Code = U
21	PA-STATUS	A = Approved D = Clinical Denial V = Void	A/N	1	'A', 'D' or 'V'	Required	145	145	Decision made on PA requests  VOIDS – information needs to match the 'ADD' record exactly. The record type is 'CHANGE'. Further defines the procedure code	Required – if not 'A' or 'D' or 'V' <b>ER Code = V</b>
22	MOD CODE	SERVICE MODIFIER CODE	A	2		Optional	146	147		Optional If present(non Blank):

LME PA Authorization Inbound/Outbound File Layout, page 9

Item #	EDS Data Element Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position	Definition	NEW Edit Criteria
										<p>MODIFIER must equal:                      'GT' 'HA' 'HB' 'HI' 'HN' 'HO' 'HP' 'HQ' 'HR' 'HS' 'HT' 'TD' 'TE'                      ER Code = T</p> <p>PCODE &amp; MOD combination must equal:                      'H0036HA' 'H0036HB' 'H0036HQ' 'H2015HT' 'H0012HB' 'H2012HA' 'T1017HI' 'H0004HQ' 'H0004HR' 'H0004HS' '90801GT' '90804GT' '90805GT' '90806GT' '90807GT' '90808GT' '90809GT'.                      ER Code = T</p> <p>IF PCODE equals                      H0036' 'H2015' 'H0012' 'H2012' 'T1017'                      A valid Modifier must be present                      ER Code = T</p>

LME PA Authorization Inbound/Outbound File Layout, page 10

Item #	EDS Data Element Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position	Definition	NEW Edit Criteria
23	FILLER	Reserved space. For VO, this area will be the 74 byte filler and the 24 byte error code table. For LMEs, this area will be not used.	A	98	None	n/a	148	245	Initialize to spaces	
24	ORIG-UNITS	Original Units	N	4		Required for Approved or Denied PA's	246	249		ER Code = 6
25	READMIT-IND	Readmit to same or different facility at same level of care Indicator	A	1	'A' – Readmitted to the same facility within 30 Days 'B' – Readmitted to same facility within 90 days 'C' – Admitted to a different facility at the same level of care within 30 days. 'D' –	Valid only for Inpatient (I), PRTE (P) and Criterion 5 (H)	250	250	Identifies whether a recipient is returning to the same or different facility at the same level of care within 30 or 90 days.	If SERVICE- TYPE IS I, P or H, READMIT-IND must equal space, A, B, C or D ER Code = 4

LME PA Authorization Inbound/Outbound File Layout, page 11

Item #	EDS Data Element Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position	Definition	NEW Edit Criteria
26	EPSDT-IND	EPSDT PA	A	1	Admitted to a different facility at the same level of care within 90 days. Y = EPSDT	Optional	251	251	Indicates whether the recipient is receiving services under EPSDT	'Y' or spaces ER Code = 2
27	REFERRAL-IND	Referred to	A	1	'P' = Peer Review	Optional	252	252	Indicator showing whether a PA authorization was reviewed by Peer Review.  This indicator applies to both approvals and denials.	'P' or spaces ER Code = 3
28	REDUCED-IND	Reduced by indicator	A	1	'P' = Reduced by Peer Review 'C' = Reduced by Clinician	Optional Only applies to Approved status	253	253	Indicates whether services were reduced and if so was it by peer review or a clinician with provider agreement	'P', 'C' or spaces ER Code = 5

LME PA Authorization Inbound/Outbound File Layout, page 12

Item #	EDS Data Element Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position	Definition	NEW Edit Criteria
29	DENIED-IND	Denied Indicator	A	1	n With Peer Agreement 'P' = Peer Administrative	Required for Denied PA's	254	254	Indicates whether a denial was a clinical or administrative denial.	Must be space, P or A ER Code = 8
30	NUM-DAYS	Number of Days to completion	N	3		Required for Approved or Denied PA's	255	257	Number of business days from receipt of service request until the authorization is approved or denied, excluding days returned for lack of information. If authorized on date of receipt, the number of days is zero	Must be numeric when status is = to D or A ER Code = A1
31	MOS-IND	Maintenance of Service Indicator	A	1	'Y' – MOS PA	Optional	258	258	Indicates if any units are due to Maintenance of Service	If not space or Y ER Code = A3
32	MOS-UNITS	Of the number of units on this PA, how much are MOS units	N	4	9999	Required if MOS-IND = 'Y'	259	262	Provides the number of units that are Maintenance	If not 0 or greater ER Code = A3

LME PA Authorization Inbound/Outbound File Layout, page 13

Item #	EDS Data Element Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position	Definition	NEW Edit Criteria
33	CON-IND	Certificate of Need (CON)	A	1	'Y' – Certificate of Need	Optional	263	263	of Service A CON must be submitted for all initial requests to free-standing psychiatric hospitals and all PRTFs for under age 21.	If not space or Y ER Code = A4
34	RETRO-IND	Retroactive Reviews	A	1	'Y' – Retro Active Review	Optional	264	264	Indicates whether the service request is for retroactive eligibility months	Must be space or Y ER Code = A5
35	TRANSMIT-DATE	Date PA file sent to EDS	N	8	CCYYMMDD	Required for Approved or Denied PA's	265	272		If date invalid or missing ER Code = A6
36	TRANSMIT-REC-COUNT	Count of records transmitted to EDS. This field is sent as the first record in a Transmitted file with all other fields initialized except for the SUBMITTAL-ID	N	7		Required	273	279		If missing or invalid ER Code = A2 (Missing or invalid record count in transmission)
37	FILLER	FILLER	A/N	50		N/A	280	329		
38	REC-ERROR-TABLE	Error Table Indicators – Not used on Inbound Transmissions This error code table is only used by LMEs	A/N	94		N/A	330	423		

## Attachment P: PA Authorization Error Codes

### PA Authorization Error Codes, page 1

Error Number	Error Code	Reason
1	' '	Exact duplicate record in transmission. (The error code will be a space.)
2	A	The submittal Id is invalid.
3	B	The Service Type Id is not 'I' for Inpatient 'M' for Independent Mental Health 'O' for Outpatient 'P' for PRTF 'R' for Residential Child Care 'H' for High Risk 'E' for Enhanced Services 'C' for CAP (N/A for VO) 'T' for Targeted Case Management (N/A for VO)
4	C	Submittal Security Code is missing or invalid.
5	D	State Code is missing or invalid
6	E	Medicaid Identification not eligible for Medicaid
7	F	First 15 characters of the Last Name of Recipient does not match the eligibility file
8	G	First 9 characters of the First Name of Recipient does not match the eligibility file
9	H	Recipient's Date of Birth does not match the eligibility file
10	I	PA Starting Date is not a valid date
11	J	The PA Ending Date is missing, invalid, or greater than 1 year from the start date.
12	K	Approved units are invalid.
13	L	No PA Number present
14	M	The Admission Date is invalid or missing.
15	N	Provider Number is missing
16	O	Provider Number is not on file
17	P	The Referring Provider Number is not on file.
18	Q	1 <sup>st</sup> Diagnosis Code is missing or invalid.
19	R	The 2 <sup>ND</sup> Diagnosis Code is invalid.
20	S	The 3 <sup>rd</sup> Diagnosis Code is invalid.
21	T	The Procedure Code or Modifier is missing or invalid.
22	U	Record Type is not 'A' for add or 'C' for change. Record type is 'A' but record already exists in PA Master. Record type is 'C' but record NOT present in PA Master. or It is present but does not match the PA Start date PA start date not allowed to change.
23	V	PA Status is not 'A' for approval, 'D' for denial or 'V' for Void
24	W	Hospital Provider Number (Referring Provider Field) is missing for High Risk Service Type
25	Y	Referring Provider Type Invalid for High Risk Service Type
26	X	Procedure Code invalid / missing for High Risk Service Type

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**PA Authorization Error Codes, page 2**

<b>Error Number</b>	<b>Error Code</b>	<b>Reason</b>
27	Z	Service Type ID, Procedure Code / Modifier combination is invalid
28	1	Outside Catchment Area
29	2	Invalid EPSDT Indicator or EPSDT Indicator is valid, but Recipient not under 21
30	3	Referral Indicator Invalid
31	4	Readmit Indicator Invalid
32	5	Reduced By Indicator Invalid or Reduced by indicator is set on a record that does not have an approved status
33	6	Original units not present for approved or denied PA
34	8	Denied By Indicator not present or invalid for denied PA
35	9	Duplicate Record In Transmission – The following combination of fields (MID, PROVIDER, SERVICE TYPE, PROCEDURE CODE, and START DATE) occurs multiple times in transmitted file.
36	A1	Number of days is missing or invalid.
37	A2	Missing or invalid control record count
38	A3	Invalid MOS Indicator or MOS Units is required when MOS-IND = 'Y' or MOS units > 0, but MOS-IND not = 'Y'
39	A4	Certificate of Need (CON) indicator is invalid.
40	A5	Retroactive Indicator invalid
41	A6	Transmit Date is required for Approved or Denied PA
42 - 48	7, A7 – B3	Reserved for future use

## Attachment Q: Weekly Summary Inbound/Outbound File Layout

### Weekly Summary Inbound/Outbound File Layout, page 1

Item #	EDS Data Element/Structure	Field Description	Data Type	Field Length	Edit Format (\$zz99.99)	Data Required /Optional	Starting Position	Ending Position
1	SUBMITTAL-ID	A1 = Durham A2 = Eastpointe A3 = Mecklenburg A4 = Western Highlands	A/N	2		Required	1	2
2	SERVICE TYPE	X = Summary Data	A/N	1		Required – must be 'X'	3	3
3	SUB-SEC-CODE	Submittal Security Code	A/N	4	LMA1 LMA2 LMA3 LMA4	Required	4	7
4	STATE-CODE	State Code	A/N	2	'NC'	Required	8	9
5	WE-DATE	Week Ending Date <i>Thursday 11 am</i>	N	8	MMDDCCYY	Required	10	17
6	TOT-DIS-30	Total Discharges in this week where the recipient was inpatient status between 1-30 days. Only affects Inpatient Discharges (Service Type I)	N	7	9999999	Optional	18	24
7	TOT-DIS-90	Total Discharges in this week where the recipient was inpatient status between 31-90 days. Only affects Inpatient Discharges (Service Type I)	N	7	9999999	Optional	25	31
8	TOT-CALLS	Total Calls	N	7	9999999	Required	32	38
9	AVG-ANS-SPEED	Average Speed of answer in seconds	N	7	9999999	Required	39	45
10	ABAN-RATE	Abandonment rate	N	4	99V99	Required	46	49
11	RET-PA-TABLE occurs 100 times	Unable To Process returns by provider number	A/N	1800		Optional	50	1849

Weekly Summary Inbound/Outbound File Layout, page 2

Item #	EDS Data Element/Structure	Field Description	Data Type	Field Length	Edit Format (\$zz99.99)	Data Required /Optional	Starting Position	Ending Position
11a	RET-PA-PROV- NUM	Provider Number	A/N	13				
11b	RET-PA-PROV- COUNT	Return Count	N	5	99999			
12	IN-PROCESS- PA-CNT-INPT	Inpatient in process count. See revised Appendix G in the Tech Design for associated procedure codes	N	5	99999	Optional	1850	1854
13	IN-PROCESS- PA-CNT-PRTF	PRTF in process count.	N	5	99999	Optional	1855	1859
14	IN-PROCESS- PA-CNT-RES	Residential Levels I-IV in process count. See revised Appendix G in the Tech Design for associated procedure codes	N	5	99999	Optional	1860	1864
15	IN-PROCESS- PA-CNT-OSSAD	Outpatient, SAIOP, SACOT, Amb. Detox, Mobile Crisis, or Opiod in process count. See revised Appendix G in the Tech Design for associated procedure codes	N	5	99999	Optional	1865	1869
16	IN-PROCESS- PA-CNT-TCM	DD/Targeted Case Management in process count. (T1017 HI)	N	5	99999	Optional	1870	1874
17	IN-PROCESS- PA-CNT-CAP	DD/CAP Services in process count. See revised Appendix G in the Tech Design for associated procedure codes	N	5	99999	Optional	1875	1879
18	IN-PROCESS- PA-CNT-EPSTD	EPSTD in process count.	N	5	99999	Optional	1880	1884
19	IN-PROCESS- PA-CNT-CS	Community Support in process count. See revised Appendix G in the Tech Design for associated procedure codes	N	5	99999	Optional	1885	1889
20	IN-PROCESS- PA-CNT-OTHER	All Other Enhanced Services in process count. See revised Appendix G in the Tech Design for associated	N	5	99999	Optional	1890	1894

Weekly Summary Inbound/Outbound File Layout, page 3

Item #	EDS Data Element/Structure	Field Description	Data Type	Field Length	Edit Format (\$zz99.99)	Data Required /Optional	Starting Position	Ending Position
		procedure codes						
<b>Fields below this are supplied by EDS on outbound files only</b>								
21	FILLER	Future use	A/N	42		N/A	1895	1936
22	REC-ERROR-TABLE	Error Table Indicators - Not used on Inbound Transmissions	A/N	26		N/A	1937	1965

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**Attachment R: Weekly Summary Error Codes**

<b>Error Number</b>	<b>Error Code</b>	<b>Reason</b>
1	A	The submittal Id is invalid
2	B	Service Type is missing or invalid
3	C	Submittal Security Code is missing or invalid
4	D	State Code is missing or invalid
5	E	Week Ending Date is missing or invalid
6	F	Total Calls are missing or invalid.
7	G	Average Answer Speed required for Summary Data Service Type
8	H	Abandonment rate is missing or invalid.
9	I	Provider number or Return count is missing or invalid.
10	J	Total In Process Count must be greater than zero
11 - 26	K Thru Z	Reserved for additional Summary file edits

## Attachment S: Quality of Care Incident Report

### Quality of Care Incident Report Form

\_\_\_\_\_ (Vendor)  
**Medicaid Program Incidents - Quarterly Update**  
 Reported to DMA between \_\_\_\_\_ to \_\_\_\_\_

Provider	MID	Patient Last	Patient First	Treatment	Incident Code	Date Reported to LME
<i>Medicaid Members</i>						

### Quality of Care Incident Report Codes

*Medicaid Program Incidents  
 Incident Code Table*

<i>Code</i>	<i>Incident</i>
1	Adverse Reaction to Treatment
2	Damage to Property
3	Elopement
4	Human Rights Violation
5	Injury
6	Medication or treatment error
7	Other
8	Self-inflicted harm
9	Sexual Behavior
10	Unanticipated Death
11	Violent or assaultive behavior (non-lethal)

# Attachment T: Invoice Report Format

## Invoice Report Format, page 1

<b>LME Monthly Invoice Reconciliation</b>			
PERIOD ENDING: 99/99/9999	MONTHLY INVOICE	RUN DATE: 99/99/9999	
LEVEL OF CARE	REVIEWS	RATE	AMOUNT
Hospital Inpatient Reviews			
CON review by facility (initial)	9999999	9999.99	9999999.99
No CON required (initial or concurrent)	9999999	9999.99	9999999.99
Retroactive Reviews	9999999	9999.99	9999999.99
PRTF Reviews			
Total reviews	9999999	9999.99	9999999.99
Retroactive Reviews	9999999	9999.99	9999999.99
Residential SVC II-IV Reviews			
Total reviews	9999999	9999.99	9999999.99
Retroactive Reviews	9999999	9999.99	9999999.99
Outpatient Reviews			
Total reviews	9999999	9999.99	9999999.99
SAIOP			
Total reviews	9999999	9999.99	9999999.99
Criterion 5 reviews			
Total reviews	9999999	9999.99	9999999.99
Community Supports (child [group], adult [group], & team)			
Total reviews	9999999	9999.99	9999999.99
Intensive in-home Multi systemic therapies (MST)			
Total in-home	9999999	9999.99	9999999.99
Total MST	9999999	9999.99	9999999.99
Opioid treatment			
Total reviews	9999999	9999.99	9999999.99
Partial hospital			
Total reviews	9999999	9999.99	9999999.99
Out of state placement (Inpatient, PRTF, & Residential)			
Total reviews	9999999	9999.99	9999999.99
Psychosocial rehab			
Total reviews	9999999	9999.99	9999999.99
Day treatment for child-adolescents			
Total reviews	9999999	9999.99	9999999.99
ACTT			
Total reviews	9999999	9999.99	9999999.99

**Comment [AP1]:** RC100

**Comment [AP2]:** Certificate of Need Indicator = Y for RC100

**Comment [AP3]:** Certificate of Need Indicator = spaces for RC100

**Comment [AP4]:** Retroactive Indicator = Y for RC100

**Comment [AP5]:** RC911

**Comment [AP6]:** Retroactive Indicator is Y for RC911

**Comment [AP7]:** Y2362  
Y2363  
Y2348  
Y2349  
Y2360  
Y2361

**Comment [AP8]:** Retroactive Indicator is Y for Y2362  
Y2363  
Y2348  
Y2349  
Y2360  
Y2361

**Comment [AP9]:** Services identified under service type O and M

**Comment [AP10]:** H0015

**Comment [AP11]:** Y2343

**Comment [AP12]:** H0036 HA and H0036 HQ under 21  
  
H0036 HB and H0036 HQ age 21 and over  
  
H2015 modifier HT

**Comment [AP13]:** H2022  
H2033

**Comment [AP14]:** H0020

**Comment [AP15]:** H0035

**Comment [AP16]:** Providers with a county code of 102 given prior authorization for service types I, P, and R

**Comment [AP17]:** H2017

**Comment [AP18]:** H2012 HA

**Comment [AP19]:** H0040

Invoice Report Format, page 2

REPORT: HMKR9102 AREA MENTAL HEALTH PAGE: 99999  
 PERIOD ENDING: 99/99/9999 MONTHLY INVOICE RECONCILIATION REPORT RUN DATE:  
 99/99/9999

LME01 - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

LEVEL OF CARE	REVIEWS	RATE	AMOUNT
SA Comprehensive Outpatient TX Prog			
Total reviews	9999999	9999.99	9999999.99
Facility-based crisis			
Total reviews	9999999	9999.99	9999999.99
Ambulatory Detox			
Total reviews	9999999	9999.99	9999999.99
Targeted case management (non CAP)			
Total reviews	9999999	9999.99	9999999.99
Plan of care review/auth scvs CAP			
Total reviews	9999999	9999.99	9999999.99
Continued need review (CNR) CAP			
Total reviews	9999999	9999.99	9999999.99
Single service, out of cycle (discrete) CAP			
Total reviews	9999999	9999.99	9999999.99
EPSDT reviews			
Total reviews	9999999	9999.99	9999999.99
Mobile crisis SVCS			
Total reviews	9999999	9999.99	9999999.99
Non Hospital Medical detox			
Total reviews	9999999	9999.99	9999999.99
Substance Abuse, non medically monitored			
Total reviews	9999999	9999.99	9999999.99
Substance Abuse, Medically monitored			
Total reviews	9999999	9999.99	9999999.99
Diagnostic Assessment			
Total reviews	9999999	9999.99	9999999.99
Court Proceedings			
Total mediations and hearings	9999999	9999.99	9999999.99
QA Reviews			
Total reviews	9999999	9999.99	9999999.99
Special Team Reviews			
Total reviews	9999999	9999.99	9999999.99
<b>Grand Total</b>	<b>99999999</b>		<b>99999999.99</b>

- Comment [AP20]: H2035
- Comment [AP21]: S9484 S9484 HA
- Comment [AP22]: H0014
- Comment [AP23]: T1017 HI
- Comment [AP24]: Count
- Comment [AP25]: Count
- Comment [AP26]: Count
- Comment [AP27]: Prior approval records with the EPSDT indicator set to Y for recipients under the age of 21.
- Comment [AP28]: H2011
- Comment [AP29]: H0010
- Comment [AP30]: H0012 HB
- Comment [AP31]: H0013
- Comment [AP32]: This will be zero. This service currently does not require prior authorization according to DMA policy. This could change at some point in the future. (FYI, the procedure code is T1023)
- Comment [AP33]: This will be zero. This service currently does not require prior authorization according to DMA policy. This could change at some point in the future. (FYI, the procedure code is T1023)

**Attachment U: Invoice Rates**

**Invoice Rates, page 1**

LINE NO.	DESCRIPTIONS	REVIEWS AND HOURS	RATE	AMOUNT
	<b>Hospital Inpatient Reviews</b>			
	CON review by Facility (initial)		\$44.67	\$0.00
	No CON Required (initial or concurrent)		\$49.78	\$0.00
	Retroactive Reviews		\$70.59	\$0.00
	<b>PRTF Reviews</b>			
	Total Reviews		\$34.78	\$0.00
	Retroactive Reviews		\$88.32	\$0.00
	<b>Residential Svcs II-IV Reviews</b>			
	Total Reviews		\$64.79	\$0.00
	Retroactive Reviews		\$88.32	\$0.00
	<b>Outpatient Reviews</b>			
	Total Reviews		\$34.78	\$0.00
	<b>SAIOP</b>			
	Total Reviews		\$32.39	\$0.00
	<b>Criterion 5 Reviews</b>			
	Criterion 5		\$126.18	\$0.00
	<b>Community Supports (Child, Adult&amp; Team)</b>			
	Total Reviews		\$37.85	\$0.00
	<b>Intensive InHome, MST</b>			
	Intensive InHome Reviews		\$52.86	\$0.00
	MST Reviews		\$52.86	\$0.00
	<b>Opiod Treatment</b>			
	Total Reviews		\$22.51	\$0.00
	<b>Partial Hospital</b>			
	Total Reviews		\$32.39	\$0.00
	<b>OutofState Placements</b>			
	OutofState Placements		\$321.27	\$0.00
	<b>Psychosocial Rehab</b>			
	Total Reviews		\$37.51	\$0.00
	<b>Day Treatment for Children-Adolescents</b>			
	Total Reviews		\$42.48	\$0.00
	<b>ACTT</b>			
	Total Reviews		\$37.51	\$0.00
	<b>Diagnostic Assessments</b>			
	Total Reviews		\$17.39	\$0.00
	<b>SA Comprehensive Outpatient Tx Prog</b>			
	SA Comprehensive Outpatient Tx Prog (Admin)		\$22.51	\$0.00

**Invoice Rates, page 2**

LINE NO.	DESCRIPTIONS	REVIEWS AND HOURS	RATE	AMOUNT
	<b>Facility-Based Crisis</b>			
	Total Reviews		\$55.24	\$0.00
	<b>Ambulatory Detox (Non-Res)</b>			
	Admission Reviews		\$49.78	\$0.00
	<b>Substance Abuse, Medically Monitored</b>			
	Total Reviews		\$49.78	\$0.00
	<b>Substn Abuse, Non-Medically Monitored (Res)</b>			
	Total Reviews		\$49.78	\$0.00
	<b>Quality Assurance Reviews</b>			
	Total Reviews		\$151.41	\$0.00
	<b>Hearings</b>			
	Reconsideration Hearings		\$232.92	\$0.00
	<b>Special Team Reviews</b>			
	Special Team Reviews		\$629.64	\$0.00
	<b>Targeted Case ManagementCAP</b>			
	Targeted Case Mgmt Non-CAP		\$155.07	\$0.00
	<b>Initial PlanofCare Review/AuthorizationScvsCAP</b>			
	PlanofCare Review/AuthorizationScvsCAP		\$354.05	\$0.00
	<b>Continuous Need Review CAP</b>			
	CNR/ServcAuthCAP		\$292.87	\$0.00
	<b>Discrete/Single Service, CAP</b>			
	Discreet Service CAP review		\$86.15	\$0.00
	<b>EPSDT Reviews</b>			
	EPSDT Reviews		\$139.00	\$0.00
	<b>Mobile Crisis Svcs</b>			
	Total Reviews		\$52.08	\$0.00
	<b>Non-Hospital Medical Detox</b>			
	Total Reviews		\$55.24	\$0.00
	<b>TOTAL INVOICED AMOUNT</b>			\$0.00