

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

1985 Umstead Drive • 2501 Mail Service Center • Raleigh, N.C. 27699-2501

Dear Interested NC Resident:

In an effort to provide information about the Family and Children's Health Care Coverage programs, we developed this handbook, **A Consumer's Guide to North Carolina Health Care Coverage Programs for Families and Children**. This handbook gives an overview of the programs, eligibility requirements, and covered services.

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

If you have questions regarding Medicaid Programs for Adults, there is another handbook, **A Consumer's Guide to North Carolina Medicaid Health Care Coverage for the Aged, Blind and Disabled**. There is also a handbook for residents who are on Medicare, **A Consumer's Guide to Medicare Savings Programs within North Carolina Medicaid**. To receive these handbooks, you may contact your local DSS or the DHHS Customer Service Center that is referenced in this handbook and ask to speak to a representative in the Recipient and Provider Services Section, Medicaid Eligibility Unit. The handbooks may also be viewed on or downloaded from the internet at www.dhhs.state.nc.us/dma/consinfo.htm.

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

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North Carolina Health Care Coverage Programs for Families and Children



Welcome to “A Consumer’s Guide to North Carolina Health Care Coverage Programs for Families and Children.” This information will help you understand what programs and services are available and what they cover.

This Consumer’s Guide contains information about Medicaid and the North Carolina Health Choice Program and coverage.

This handbook is also for:

- Individuals or couples who have children living with them
- Individuals or couples expecting a child
- Health care providers
- Others seeking information about available North Carolina Health Care Coverage programs
- Medicaid and NC Health Choice for Children (NCHC) recipients

THIS HANDBOOK IS ONLY A SUMMARY.

Please read this handbook carefully so that you will understand the benefits. To get more information or find out if you qualify for a North Carolina Health Care Coverage Program call your local department of social services (DSS). The phone number will be in your local phone book. Look under the County Government section. If you still cannot find it, call the DHHS Customer Service Center at 1-800-662-7030. Hearing impaired callers may call the TTY dedicated line at 877 452-2514. DHHS Customer Service Center is available Monday through Friday 8 a.m. to 5 p.m. except for state holidays. A bilingual information and referral specialist is available to translate for persons with limited English proficiency.

Visit our website at:
<http://www.ncdhhs.gov/dma/>
For additional information

Terms and Definitions

Community Alternatives Programs (CAP)	Programs that help people who need long term care stay in their own homes. CAP provides both medical and non-medical services to prevent or delay care in a facility.
Case Management	A service that identifies, assesses, and finds resources that are needed to help recipients who have ongoing medical problems or other challenges.
Child	<p>For Medicaid: A person under the age of 21 who lives in your household.</p> <p>For NC Health Choice for Children: A person age 6 through 18 who lives in your home.</p>
Community Care of North Carolina/ Carolina ACCESS (CCNC/CA)	North Carolina’s Medicaid managed care program. It provides you with a medical home and a primary care provider (PCP) who will coordinate your medical care.
Co-payment (or co-pay)	Part of the charge for a covered service that a recipient may have to pay.
Coverage Category	The type of North Carolina Health Care Coverage Program that you have with the package of medical services that are covered.
Covered Services	Medical, mental health, dental, preventive, or treatment needs for which Medicaid and NC Health Choice for Children pays.
Deductible (or spenddown)	<p>A deductible is an amount of medical bills a recipient will have to be responsible for paying before they can get Medicaid.</p> <p>A deductible is usually required for people whose income is above certain dollar eligibility limits.</p>

Terms and Definitions

<p>Department of Social Services (DSS)</p>	<p>Under state law, county departments of social services (DSS) are responsible for determining the eligibility for the North Carolina Health Care Coverage Programs, including Medicaid and NC Health Choice for Children. The phone number will be in your local phone book. Look under the county governmental section, call the DHHS Customer Service Center, 1-800-662-7030 or go to http://www.ncdhhs.gov/DSS/local/index.htm to locate.</p>
<p>Division of Medical Assistance (DMA)</p>	<p>The NC state agency responsible for administration of the North Carolina Medicaid and NC Health Choice for Children Programs.</p>
<p>Family Planning Medicaid</p>	<p>A program that provides family planning services for non-sterilized men and women, with income at or below 185% of the federal poverty level.</p>
<p>Health Check/EPSTD (Early and Periodic Screening, Diagnosis, and Treatment)</p>	<p>A Medicaid program only for children in North Carolina. Health Check/EPSTD covers medical and dental services for children between the ages of 0-21. Sick visits and well visits (check-ups) are covered as well as medically necessary services ordered by a doctor.</p>
<p>In Home Care (IHC)</p>	<p>Provides person-to- person hands on assistance with common activities of daily living, such as bathing, toileting, and taking and recording of vital signs, delivered by a paraprofessional aide in the recipient's home. Two programs are available: IHC for Adults (IHCA) age 21 and over and IHC for Children (IHCC) under age 21.</p>
<p>Low Income Subsidy (LIS)</p>	<p>A Medicare subsidy benefit that provides assistance with paying the premium of the Medicare Part D, prescription drug plan, for individuals with income less than 150% of the federal poverty level. Eligibility for this subsidy is based on income and resources. Subsidy amount may vary depending on income.</p>
<p>Managed Care</p>	<p>A primary care network that uses a variety of techniques intended to improve the quality of care for individuals, and reduce the cost of providing health benefits.</p>

Terms and Definitions

Medicaid	A health care coverage program for low-income individuals and families who cannot afford health care costs. Medicaid serves low-income parents, children, seniors, and people with disabilities.
Medical Home	The primary care provider where you go for help when you need health care.
Medicare Part D	A voluntary prescription drug program through Medicare that provides all Medicare beneficiaries with prescription drug assistance. Medicare beneficiaries must also enroll in a prescription drug plan (PDP) to have prescription coverage. Medicaid recipients who receive Medicare receive prescription drug coverage through Part D.
NC Health Choice for Children (NCHC)	Health care coverage for children ages 6 through 18 with family income from 101% - 200% of the federal poverty level. Children cannot be eligible for Medicaid or be covered by comprehensive private health insurance.
Non-covered Services	Certain medical, mental health, dental, preventive, long-term care, or other services for which Medicaid or NC Health Choice for Children does not pay.
Pregnancy Medical Home	A group of prenatal care providers who agree to provide a higher standard of care to Medicaid pregnant women to help the mothers and their babies be as healthy as possible.
Premium	The amount of money paid for health insurance coverage for a specific period of time.
Prescription Drug	A drug that can only be bought with a doctor's written order. Medicaid and NC Health Choice for Children do not cover drugs that are experimental. The U.S. Food and Drug Administration (FDA) must approve the drug. Medicaid will only cover prescription drugs for Medicare beneficiaries under certain circumstances.
Primary Care Physician (PCP)	A Community Care of North Carolina/Carolina ACCESS (CCNC/CA) enrolled medical provider who either provides or arranges medical services to meet the patient's health care needs.

Terms and Definitions

Prior Approval	A request made by the treating licensed healthcare professional, to be sure that a service meets the definition of medically necessary prior to providing the service.
Program Limits	<p>Income limit: the highest amount of countable monthly income a recipient can receive and still qualify for Medicaid or NC Health Choice for Children as determined by federal regulations.</p> <p>Coverage limits: how many times and how often Medicaid or NC Health Choice for Children will pay for a covered service, or when only certain kinds of doctors or medical professionals can give the care.</p> <p>Resource limits: the highest amount of countable resources or assets a recipient can have and still qualify for Medicaid. (Example: cash, money in a bank account, life insurance, stocks, bonds, trust funds).</p>

What are the North Carolina Health Care Coverage Programs for Families and Children?

◆ **North Carolina Health Choice for Children (NCHC):**

NC Health Choice for Children (NCHC) is a health care coverage program funded by the federal and state governments. A child may be eligible if the child:

- lives in the state of North Carolina,
- is age **6 through 18**,
- **has no comprehensive private health insurance and**
- does not qualify for Medicaid, Medicare, or other federal government sponsored health insurance, such as TRICARE, CHAMPVA.

A child may be eligible depending on the family's income. NC Health Choice for Children may be stopped or suspended at any time if federal or state money is no longer available. NC Health Choice for Children is not an entitlement program. A program enrollment fee may be required. For more information on NC Health Choice for Children, visit the website at <http://www.ncdhhs.gov/dma/healthchoice/index.htm>.

Legal information and requirements for the NC Health Choice for Children program are in Chapter 108A of the North Carolina General Statutes. See: <http://www.ncga.state.nc.us/gascripts/Statutes/StatutesTOC.pl>.

- ◆ **Medicaid:** Medicaid is a health care coverage program for low income individuals and families who cannot afford health care costs. Medicaid serves low-income parents, children, seniors, and people with disabilities. Medicaid is governed by federal and state laws.

There are several eligibility programs within Medicaid. Below are the most common programs.

- **Medicaid for Families with Dependent Children (MAF)**—Health Care coverage for single parents or couples with children under age 19 in their household or for children ages 19 and 20.
- **Medicaid for Infants and Children (MIC)**—Medical coverage for children under the age of 19.
- **Medicaid for Pregnant Women (MPW)**—Medical coverage for pregnant women.
- **Work First Family Assistance (WFFA)** — A cash payment program for families with children (also known as TANF). If eligible for WFFA, Medicaid is included.
- **Family Planning Medicaid (FPW)**—Medical coverage for family planning services only.

Other programs that are offered under the **Medicaid** program are for individuals who are aged, blind or disabled with low income who cannot afford health care costs.

These programs include:

- **Medicaid for the Aged, Blind or Disabled (MAABD)** - Medical coverage for individuals who are age 65 or older, blind, or disabled. Eligibility for these programs is based on the family's monthly income and the amount of resources the family owns.
- **Community Alternatives Programs (CAP)** – CAP participants must meet all Medicaid eligibility requirements. These programs provide home and community based services for persons who are at risk of being institutionalized, but for whom care can be provided cost-effectively and safely in the community. CAP categories are:
 - **Community Alternatives Program for Persons with Intellectual and Developmental Disabilities (CAP-I/DD)**
 - **Community Alternatives Program for Children (CAP-C)**
 - **Community Alternatives Program for Disabled Adults (CAP/DA)**
 - **CAP/Choice.**
- **Money Follows the Person (MFP)** - A project that assists Medicaid-eligible North Carolinians who live in inpatient facilities, but would be able to live in a private living arrangement, or to move into their own homes and communities with supports.
- **Program for All-Inclusive Care for the Elderly (PACE)** – A managed care program that allows elderly Medicaid-eligible individuals who need nursing facility care to live in a private living arrangement and as independently as possible. All the participant's medical needs are met by the services of the PACE agency.

Contact your local county DSS for more information about these programs or visit our website at <http://www.ncdhhs.gov/dma/>

What You Can Expect From North Carolina Health Care Coverage Programs:

- Individuals will receive a NC Health Care Coverage Identification Card.
- There are co-payments for some services.
- North Carolina Health Care Coverage programs have several different types of coverage for people with different needs. For instance, pregnant women have a special package of benefits all their own under Medicaid. NC Health Choice for Children does not cover pregnancy related services.
- You cannot be rejected because of a health condition you already have. Instead, North Carolina Health Care Coverage program eligibility is based on your family's finances. You do not have to have a medical need when application is made.
- Provides you with a medical home with a primary care physician. The medical home will help you receive the services you need.

Applying for North Carolina Health Care Coverage Programs

As with any health coverage, you will need to fill out an application. The same application is used for both Medicaid and NC Health Choice for Children. You may download an application from the DMA website at <http://www.ncdhhs.gov/dma/medicaid/apply.htm>. You may also visit the website <http://www.ncdhhs.gov/DSS/local/index.htm> for information regarding your local department of social services. You may also call directory assistance or find the telephone number for your local department of social services in the county government section of your phone book. These pages are usually blue. A caseworker at the local DSS will give you an application and if needed assist you in completing it. The caseworker will also review the information you provide and evaluate you and your family for the most appropriate program. You may ask to have an application mailed to you if you prefer.

Information you provide to the county department of social services, to establish your eligibility for Medicaid and NC Health Choice for Children, may be checked by a State or Federal reviewer. You must cooperate with the reviewer's investigation. **If a child is not eligible for Medicaid, he or she will be evaluated for NC Health Choice for Children eligibility. You do not need to fill out a separate application.**

You will need to provide items to prove you qualify for a North Carolina Health Care Coverage Program. If possible, have everything on this checklist when you go to apply. If you cannot get all of these items, please apply anyway. You may provide information after you apply, and the caseworker can help if you need assistance.

- **A copy of all pay stubs for last month.**
- **Your social security card or proof that you have applied for one for yourself or anyone you are applying for.**
- **Copies of all medical or life insurance policies you have for yourself and the members of your family who want North Carolina Health Care Coverage Program assistance.**
- **A list of all cars, trucks, motorcycles, or other vehicles you or anyone in your household own.**
- **Most recent financial statements from financial institutions (such as bank statements).**
- **Current financial statements from other sources of family income, such as social security, retirement benefits or pensions, veteran benefits, SSI, child support, or other sources.**
- **For applicants who are not citizens, but have specific lawfully residing immigration status, proof of the immigration status is required.**
- **Proof of pregnancy (doctor's statement or note from other health professional indicating due date) if you are applying for Medicaid for Pregnant Women (MPW).**

While the local DSS caseworker is determining your eligibility, you may be asked to give them more information. Once you have given them all the information they have asked for, you will receive a notice in the mail that will tell you whether or not you can receive Medicaid or NC Health Choice for Children. If you are told you do not qualify, this notice will also give you information regarding your right to appeal the decision made by the agency. If you knowingly provide false information or if you withhold information, you may be prosecuted by law enforcement and/or made to repay any medical bills that were paid incorrectly.

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

INCOME LIMITS

(Effective April 1, 2012)

The amounts listed below may change every April

To obtain updated income limits, visit our website at <http://www.ncdhhs.gov/dma/>

Medicaid and NC Health Choice for Children are health care coverage programs for low income families that cannot afford health care costs. Eligibility is determined based on the family's income. This means that income after allowable deductions is compared to an income level for number of persons in the family. This chart shows highest monthly income amounts allowed.

Number in family	Pregnant women & Family planning	Medicaid for children under age 6 and NC Health Choice for Children (children 6-18)	Medicaid for Children age 6-18	Families with children under age 19. Individuals age 19 & 20
1	\$ 1,723	\$ 1,862	\$ 931	\$ 362
2*	\$ 2,333	\$ 2,522	\$ 1,261	\$ 472
3	\$ 2,944	\$ 3,182	\$ 1,591	\$ 544
4	\$ 3,554	\$ 3,842	\$ 1,921	\$ 594
5	\$ 4,165	\$ 4,502	\$ 2,251	\$ 648
6	\$ 4,775	\$ 5,162	\$ 2,581	\$ 698
7	\$ 5,386	\$ 5,822	\$ 2,911	\$ 746
8	\$ 5,996	\$ 6,482	\$ 3,241	\$ 772

*Pregnant woman counts as family of 2

If your income is more than one of the amounts listed above, you may still qualify if you have medical bills or if you expect that you will need medical treatment in the near future. However, you may have to meet a deductible before you can receive Medicaid

IT IS IMPORTANT TO LET YOUR DSS WORKER KNOW WITHIN 10 DAYS IF ANY CHANGES OCCUR IN YOUR SITUATION:

Some changes that need to be reported are:

- Change in income for you, your family and anyone getting Medicaid or NC Health Choice for Children (This includes parents of children getting Medicaid or NC Health Choice for Children).
- Change in the amount of child support or alimony that you pay or receive.
- Change in the amount of childcare you pay.
- If anyone who receives Medicaid or NC Health Choice for Children starts getting private health insurance.
- Change in health insurance coverage for anyone currently receiving Medicaid or NC Health Choice for Children.
- Change in your home or mailing address.
- If anyone moved into or out of your home.
- You start or stop receiving unemployment, workers' compensation, disability, social security, VA, and/or any other income.
- Change in your primary care physician.

Medicaid Fraud/Abuse Costs You!

Thinking Medicaid fraud and abuse “don’t hurt anyone” is just wrong! Every dollar wasted or stolen is a dollar that could have been spent on health care for someone who needs it and who follows the rules. And those dollars add up – tens of millions in North Carolina each year.

How you can save Medicaid dollars:

- ✓ *Keep all paperwork together*
- ✓ *Do not share medical records or your Medicaid number with anyone except your doctor, hospital, pharmacist, or other health care provider.*
- ✓ *Never sign a blank form.*
- ✓ *Do not allow anyone to use your Medicaid card.*

REMEMBER: Use of the North Carolina Health Care Coverage ID card or ID Number by anyone not listed on the North Carolina Health Care Coverage ID card is fraud and punishable by a fine, imprisonment, or both.

Be alert for:

- ✓ *Services promised but never given*
- ✓ *Unnecessary tests or procedures*
- ✓ *Repeat billing for the same procedure*
- ✓ *Statements that don’t match your actual health or medical condition*

Report Medicaid recipients who:

- ✓ *Lie about eligibility*
- ✓ *Lie about medical conditions*
- ✓ *Forge prescriptions*
- ✓ *Sell prescription drugs*
- ✓ *Loan Medicaid cards to others*

Whether you’re a Medicaid provider, recipient, or simply a taxpayer, fraud and abuse cost YOU! If you know or suspect someone has gained Medicaid benefits improperly, report it by:

1. Calling the state Division of Medical Assistance at 1-877-DMA-TIP1 (1-877-362-8471),
2. Reporting online at www.ncdhhs.gov/dma/fraud/reportfraudform.htm, or
3. Contacting the DHHS Customer Service Center at 1-800-662-7030

Don’t feel guilty about reporting someone who steals health care from those who need and deserve it!

If you qualify for a North Carolina Health Care Coverage Program, you will get an Identification (ID) card

- Your caseworker will mail you a notice to tell you if your application was approved.
- You will receive a gray colored identification card in the mail (See examples on the following pages.)
- You will only receive one ID card per year, so please take special care of your ID card.
- Review the information on the ID card to make sure it is correct. **If the information on the ID card is incorrect, contact your caseworker immediately.**
- Sign the ID card and present the signed ID card along with picture identification to each medical provider. Failure to present this ID card or identification to a medical provider could result in the provider refusing to provide service or they may bill you!
- Contact the Community Care of North Carolina/Carolina ACCESS (CCNC/CA) Medical Home primary care provider (PCP) on the ID card to make an appointment to get a medical history established.
- You must see your PCP for most health care services; otherwise, you may be responsible for paying the bill.
- If you need to change the PCP listed on your ID card, call your caseworker at your local county department of social services.
- Do not allow anyone else to use your ID card.
- Keep your ID card with you at all times.
- Before you receive services, make sure that the provider accepts the North Carolina Health Care Coverage Program you are eligible to receive (Medicaid or NC Health Choice for Children).
- Only go to the emergency room when you have a life threatening problem; otherwise, call your PCP before going. If you need medical advice after the office closes, call the PCP's after-hours number on your ID card.
- If you lose your ID card, notify the county DSS immediately. They can request a replacement ID card be sent to you at no charge.

ALWAYS TAKE YOUR NORTH CAROLINA HEALTH CARE COVERAGE PROGRAM ID CARD WITH YOU

Always show your Health Care Coverage ID card when you go to a doctor, clinic, hospital or other health care professional for medical care or to the drug store when you get a prescription drug. If you do not show your ID card, the person treating you may not know that you are covered under a **North Carolina Health Care Coverage program**. You may then be charged for the full cost of the service or a prescription drug.

Use of the North Carolina Health Care Coverage ID card or ID Number by anyone not listed on the North Carolina Health Care Coverage ID card is fraud and punishable by a fine, imprisonment, or both. For questions about your North Carolina Health Care Coverage program or to report fraud, waste or program abuse, please contact DHHS Customer Service Center at 1-800-662-7030.

The North Carolina Health Choice for Children (NCHC) Identification (ID) Card:

Front of ID Card (Sample)

NORTH CAROLINA HEALTH CHOICE FOR CHILDREN		FOLD HERE		N.C. DEPT. OF HEALTH AND HUMAN SERVICES
COPAYS: Office/Outpatient: \$000.00 Pharmacy: \$0/00/\$0.00/\$0.00			RECIPIENT I.D.	DIVISION OF MEDICAL ASSISTANCE
Non-Emergency ER :\$000.00			### ##-###-M	RECIPIENT NAME
				JOHNJOHNJOHN A. DOEDOEDOEDOEDOE
CLIENT NAME			BIRTH DATE MM/DD/YYYY	ISSUE DATE MM/DD/YYYY
ADDRESS 1			PCP NAME	
ADDRESS 2			ADDRESS 1	
ADDRESS 3			ADDRESS 2	
ADDRESS 4			ADDRESS 3	
ADDRESS 5			ADDRESS 4	
Recipient Signature _____		ADDRESS 5		
(Not valid unless signed)		PHONE NUMBERS		
USE OF THIS CARD BY ANYONE NOT LISTED ON THE CARD IS FRAUD AND IS PUNISHABLE BY A FINE, IMPRISONMENT OR BOTH		For questions about your Health Choice coverage and/or to report Health Choice fraud, waste or program abuse, please contact DHHS Customer Service at 1-800-662-7030.		

The front of the NC Health Choice for Children ID card has the NC Health Choice for Children logo and important information such as the child's:

- Name
- Date of Birth
- NC Health Choice for Children ID Number
- Date the ID card was issued
- Medical Home (Primary care provider)
- Medical Home Telephone number and after-hours contact
- Co-pay information

You will receive one (1) ID card in the mail for each child enrolled in NC Health Choice for Children. If more than one child is covered, please make sure you present the correct ID card for each child.

The ID card is not proof of NC Health Choice for Children eligibility. It is mandatory that all recipients be enrolled with the medical home of a Primary Care Physician (PCP). The ID card lists the name, address and telephone numbers of your PCP.

Use of the ID card by anyone not listed on the ID card is fraud and is punishable by a fine, imprisonment or both.

Back of ID Card (Sample)

<u>NOTICE TO PROVIDERS</u>		FOLD HERE	<u>Prior Approval:</u> Some NC Health Choice services must be approved in advance. Refer to the Basic Medicaid Billing Guide for prior approval requirements. Changes are published the first of each month in Medicaid Provider bulletins.
The NC Health Choice Identification card is not proof of Health Choice eligibility. It is the responsibility of the medical provider to verify identity of the individual, the NC Health Choice covered services, medical home, primary care physician with whom the recipient is enrolled, and to obtain authorization from the primary care physician as required. Refer to the Basic Medicaid Billing Guide at http://www.ncdhhs.gov/dma/basicmed for information on how to verify eligibility of NC Health Choice covered services and to obtain authorization.			<u>http://www.ncdhhs.gov/dma/bulletin/</u>
Eligible Provider: As of October 1, 2011, a provider must be a Medicaid Enrolled Provider in order to be paid for services rendered to NC Health Choice recipients. If not enrolled, go to http://www.nctracks.nc.gov to find enrollment information and forms.			Out of state providers must obtain approval prior to delivering NC Health Choice services unless there is a medical emergency.
			<u>Claim Filing:</u> NC health choice recipients must be uninsured at the time of eligibility. Payment is full payment even if charges exceed the payment. Refer to the Basic Medicaid Billing Guide for additional information regarding claim filing.

The back of the NC Health Choice for Children ID card also has important information. Before receiving a service from a provider, ask if they are a Medicaid-enrolled provider. If they are not, you will be required to pay for their service. Some services, like out-of-state services, require prior approval. The doctor is responsible for asking for prior approval.

The North Carolina Medicaid Identification (ID) Card:

Front of Card: (Sample)

ANNUAL MEDICAID IDENTIFICATION CARD

CASEHEAD NAME
CASEHEAD ADDRESS LINE 1
CASEHEAD ADDRESS LINE 2
CASEHEAD ADDRESS LINE 3
CASEHEAD ADDRESS LINE 4
CASEHEAD ADDRESS LINE 5

Recipient Signature _____
(Not valid unless signed)

USE OF THIS CARD BY ANYONE NOT LISTED ON THE CARD IS FRAUD AND IS PUNISHABLE BY A FINE, IMPRISONMENT OR BOTH

**N.C. DEPT. OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE**

RECIPIENT I.D. RECIPIENT NAME
000_00_0000_N JONNXXXXX Q. PUBLIC

ISSUE DATE JULY 1, 2009

PRIMARY CARE PROVIDER NAME
PRIMARY CARE PROVIDER ADDRESS LINE 1
PRIMARY CARE PROVIDER ADDRESS LINE 2
PRIMARY CARE PHONE NO. AND AFTER HOURS NO.

For questions about your Medicaid coverage and/or to report Medicaid fraud, waste or program abuse, please contact DHHS Customer Service Center at 1-800-662-7030.

FOLD HERE

The front of the Medicaid ID card has important information such as the person's:

- Name
- Date of Birth
- Medicaid ID Number
- Date the ID card was issued
- Medical Home (Primary care physician)
- Medical Home Telephone number and after-hours contact

You will receive one (1) ID card in the mail for each recipient enrolled in Medicaid. If more than one child is covered, please make sure you present the correct ID card for each person.

The ID card is not proof of Medicaid eligibility. If the recipient is enrolled with the medical home of a Primary Care Physician (PCP), the ID card lists the name, address and telephone numbers of your PCP.

Use of the ID card by anyone not listed on the ID card is fraud and is punishable by a fine, imprisonment or both.

Back of ID Card: (Sample)

NOTICE TO PROVIDERS

The Medicaid Identification card is not proof of Medicaid eligibility. It is the responsibility of the medical provider to verify the identity of the individual, if the individual is eligible for Medicaid covered services, and the primary care physician with whom the recipient is enrolled. The Automated Voice Response (AVR) system (800-723-4337) allows enrolled providers to readily access detailed information on Medicaid eligibility using a touch-tone telephone.

Eligible Provider: A provider must be enrolled in the NC Medicaid program to be paid for services rendered to NC Medicaid recipients. If not enrolled, go to www.netracks.nc.gov to find enrollment information and forms or call the CSC Enrollment Verification and Credentialing (EVC) Center at 1-866-844-1113.

Prior Approval: Some Medicaid services must be approved in advance. Refer to the Basic Medicaid Billing Guide at <http://www.ncdhhs.gov/dma/basicmed/index.htm> for prior approval requirements. Changes are published the first of each month in Medicaid Provider bulletins <http://www.ncdhhs.gov/dma/bulletin/index.htm>

Out of state providers must obtain approval prior to delivering Medicaid services unless there is a medical emergency. In cases of medical emergency, out of state providers must notify North Carolina Medicaid within 72 hours.

Claim Filing: Bill other insurance first; Medicaid is last payor. Medicaid payment is full payment even if charges exceed the payment. Refer to the Medicaid Billing Guide for additional information regarding claim filing.

FOLD HERE

Cut Along Dotted Lines

The back of the Medicaid ID card also has important information. Before receiving services from providers, ask if they are Medicaid-enrolled providers. If they are not, you will be required to pay for their service. Some services, like out-of-state services, require prior approval. The doctor is responsible for asking for prior approval. If you have other insurance, please inform your provider, as Medicaid is the last to pay and other insurance needs to be filed first.

Community Care of North Carolina/Carolina ACCESS (CCNC/CA)

Community Care of North Carolina/Carolina ACCESS (CCNC/CA) is North Carolina's Medicaid managed care program. It provides you with a Medical home and a primary care physician (PCP) who will coordinate your medical care. Most Medicaid and NC Health Choice for Children recipients are required to participate in CCNC/CA.

As a Community Care of North Carolina/Carolina ACCESS (CCNC/CA) member, you are eligible for all the services that Medicaid or NC Health Choice for Children covers. Being a member also has the following advantages:

- You can choose a medical home with a primary care doctor. A medical home can be chosen for each family member. Your local county department of social services (DSS) office has a complete list of participating primary care doctors. If you do not choose a medical home, you may be automatically assigned to one.
- The name, address, and phone number of your primary care doctor is on your ID card. If you have never had a visit with your primary care doctor, call and make an appointment **IMMEDIATELY** after you get your ID card.
- You can call your primary care doctor 24 hours a day, 7 days a week for medical advice. Check your ID card for your doctor's daytime and after-hours phone numbers.
- You may have a care manager who can help you understand and manage your health care. A care manager can show you how to stay healthy. Ask your doctor for more information about obtaining a care manager and how a care manager can help you.
- You receive regular sick care and well care at your medical home. These services include:
 - Yearly physical check-ups
 - Immunizations
 - Pap smears and
 - Prescriptions for medicines when necessary

Your primary care doctor will make referrals to other doctors if you need special care not provided in your primary care doctor's office.

What the North Carolina Health Care Coverage Programs for Families and Children Will Pay For

It is always a good idea to ask your doctor or pharmacist whether the specific service or item you need is covered by North Carolina Health Care Coverage programs. There are some limits to these services and some may require you or your doctor to get permission from Medicaid or NC Health Choice for Children first (this is called prior approval). Generally, Medicaid and NC Health Choice for Children cover the following:

- Doctor Bills
- Hospital Bills
- Prescription drugs (Excluding prescriptions for Medicare beneficiaries)
- Vision Care
- Dental Care
- Medical Equipment, and Other Home Health Services
- Mental Health Care
- Most medically necessary services for children under age 21
- Hospice care
- Family planning services (contraceptives only for NC Health Choice for Children)

Annual Professional Services Visit Limit

Under Medicaid, you are usually allowed a total of 22 professional service visits per year (July 1 through June 30). If your provider anticipates additional care is needed for a specific condition, the provider may request an exception to the annual Professional Services visit limit. The exception must be requested before you receive the service.

Some Recipients Are Not Subject to the Annual Professional Service Visit Limitation

These recipients include:

- Recipients under the age of 21
- Recipients enrolled in a Community Alternatives Program (CAP)
- Pregnant recipients who are receiving prenatal and pregnancy-related services
- Residents of nursing facilities or an ICF-MR
- Recipients who have one of the following:
 1. End Stage lung disease
 2. End stage renal disease
 3. Chemotherapy and radiation therapy for cancer
 4. Acute sickle cell disease
 5. Unstable diabetes (does not apply to diabetic recipient whose condition is controlled by oral medications, diet or insulin.)
 6. Hemophilia or other blood clotting disorders
 7. Any life threatening illness or terminal stage of any illness (as supported by a doctor's documentation).

Additional information regarding the annual professional services visit limitations can be found online at <http://www.ncdhhs.gov/dma/provider/AnnualVisitLimit.htm>.

Provider types that are included in the professional services visit limit are:

- Physicians (except for physicians enrolled in N.C. Medicaid with a specialty of oncology, radiology, or nuclear medicine)
- Nurse practitioners
- Nurse midwives
- Health departments
- Rural health clinics
- Federally qualified health centers

Medicaid will also cover up to 8 visits to a chiropractor, optometrist, or a podiatrist. (This means a total of 8 visits – for example, 2 visits to the podiatrist and 6 visits to the chiropractor.)

However, some services do not count toward the 22 annual professional services visit limits.

These services include:

- In-Home Care services
- Inpatient hospital services
- Dental services
- Mental health services requiring prior approval
- Services covered by both Medicare and Medicaid
- Physical, Occupational and Speech therapy
- Health Check Examinations

Monthly Prescription Limit

Anyone **21 years of age** and older can only receive up to eight (8) prescriptions per month. (**Medicare recipients, see *NOTE below**) Recipients under the age of 21 or residents of Intermediate Care Facility /Intellectual and Developmental Disability center are not limited.

At the discretion of the pharmacist, the monthly prescription limit may be increased to three (3) additional prescriptions. Unsafe, ineffective or experimental/investigational drugs are not covered.

Medicaid recipients needing more than eleven (11) prescriptions per month are limited to using one pharmacy each month and are enrolled in a Recipient Opt-In Program. Recipients must *elect* to participate in the opt-in program to receive more than 11 prescriptions per month; however, written consent is not required.

Medicaid recipients who overuse certain pain medications or antidepressants will be limited to one prescriber and one pharmacy in order to obtain these prescription drugs. These recipients are identified under the Recipient Management Lock-in Program and will be notified by mail.

Recipients under 21 years of age, recipients in a nursing facility, or recipients in an Intermediate Care facility/ Intellectual and Developmental Disability center are not limited to using one pharmacy each month.

*** NOTE:** Medicaid does not cover prescription drugs for Medicare beneficiaries. Medicare recipients have prescription drug coverage through Medicare Part D, unless they have coverage through a private insurance company. Drugs excluded by Medicare may be covered under Medicaid in certain circumstances.

Co-payments

Medicaid and NC Health Choice for Children recipients may be required to pay a co-payment. This means that you may have to pay the first few dollars of a charge when you go to the doctor's office, outpatient therapist for counseling, hospital for outpatient care, emergency room, or pharmacy. You must pay any required co-pays directly to the doctor, pharmacy, or hospital when the service is provided.

If a **Medicaid** recipient is not able to pay the co-payment, **a provider cannot refuse treatment**, however the patient is still responsible for the co-payment. Providers may open an account for the patient and collect the amount owed as co-payments at a later date.

If a **NC Health Choice for Children** recipient is not able to pay the co-payment, **a provider may** permit the patient to be billed for the co-payment after the service is provided, or refuse treatment to the patient.

Providers may **not** charge co-payments for the following services:

- Ambulance services
- Auditory implant external parts and accessories
- Diagnostic X-ray
- Durable Medical Equipment (DME)
- Family planning services
- Federally Qualified Health Center (FQHC) core services
- Health Check (EPSDT)-related services
- Hearing aid services
- HIV case management
- Home health services
- Home infusion therapy
- Hospice services
- Hospital emergency department services, including physician services delivered in the emergency department
- Hospital inpatient services (inpatient physician services may be charged a co-pay)
- Laboratory services performed in the hospital
- Optical supplies and services (Medicaid)
- Non-hospital dialysis facility services
- In-Home Care for Children and Adults
- Private Duty Nursing (PDN) services
- Rural Health Clinic (RHC) core services
- Services covered by both Medicare and Medicaid
- Services in state-owned psychiatric hospitals
- Services provided to CAP participants
- Services provided to residents of nursing facilities, ICF-MRs, and psychiatric hospitals
- Services related to pregnancy
- Services to individuals under the age of 21

Services that **DO** require co-payments include the following:

- Doctor
- Dentist (only one co-pay for services requiring more than one visit)
- Generic prescriptions
- Brand name prescriptions
- Chiropractic care

- Podiatrist
- Optometrist
- Outpatient visits
- Ophthalmologist
- Optical Services (NC Health Choice for Children)
- Clinic and outpatient services, including local health department visits and outpatient behavioral health services
- Non-emergency visits to a hospital emergency room

If a provider visits you while you are an inpatient in a hospital, you may have to pay a co-payment.

Below is a list of the co-payments required for the North Carolina Health Care Coverage Programs. For NC Health Choice for Children (NCHC) recipients, the total co-payment amount in a 12 month certification period may not exceed 5% of the family's income for that 12 month period. NOTE: These are the current co-payment amounts upon this printing and are subject to change.

Services	Medicaid co-payments	NC Health Choice for Children (NCHC) co-payments (Appropriate Co-payments are listed on your child's ID card)		
		Recipients under 150% of Federal Poverty Level (FPL)		Recipients over 150% of FPL (Enrollment fee \$50.00 per child, maximum \$100.00 per family)
Professional visits (provider and outpatient hospital)	\$3.00 per professional service visits \$2.00 Chiropractic	\$0.00 per professional service visit		\$5.00 per professional service visit (excludes well-child visits and age-appropriate immunizations)
Prescription Drug	\$3.00	Generic	\$1.00	\$1.00
		Brand without generic available	\$1.00	\$1.00
		Brand with generic available	\$3.00	\$10.00
Covered Over-the-Counter Medication	\$3.00	\$1.00		\$1.00
Non-Emergency ER Visit	\$0.00	\$10.00		\$25.00

*For all members of federally recognized Native American tribes and Alaska Natives, there is no cost sharing or enrollment fee imposed. A \$0 co-payment is printed on each qualified recipient's health insurance card.

If a Medicaid or a North Carolina Health Choice (NCHC) for Children medical claim is denied

If you receive a bill for a service that Medicaid or NC Health Choice for Children covers after you were told you qualified for Medicaid or NC Health Choice for Children, and your doctor agreed to accept Medicaid or NC Health Choice for Children as payment, you may not be responsible for the bill.

You have the right to a “reconsideration review” if Medicaid or NC Health Choice for Children denies payment of a bill. If you want a reconsideration review, you have to ask for it no later than 60 days after the first bill.

Send a copy of the bill to:
Claims Analysis
N.C. Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501

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

1. The reason you are requesting the review.
2. Your Medicaid or NC Health Choice for Children identification number.

Your review will take place within 20 days after Claims Analysis gets your letter. They will send you their decision in writing. You may contact the DMA Claims Unit by calling the DHHS Customer Service Center at 1-800-662-7030.

Estate Recovery

(Estate recovery does not apply to NC Health Choice for Children)

Estate Recovery means a claim is filed against the estate of a deceased recipient to recover Medicaid dollars paid on behalf of the individual. It is important to understand that estate recovery does not include placing a lien on the property. Recovery is not initiated until the recipient’s death. In some situations, recovery is waived. The DMA Third Party Recovery Section (TPR) is responsible for collection activities after a claim is filed against the estate. TPR works directly with the representative/administrator of the estate to ensure claims against an estate are paid to the extent the assets are available and in accordance with the order of payment in state law.

The estates of Medicaid recipients may be subject to estate recovery if the recipient applied or re-applied on or after October 1, 1994, and

- is under age 55 and an inpatient in a nursing facility, intermediate care facility for the intellectually developmentally disabled, or other medical institution, and cannot reasonably be discharged to return home,
- or is 55 years of age or older and is living in medical facility and receiving medical care services, or home and community-based services, or In Home Care Services (IHC).

In Home Care Services (IHC) claims for SA recipients ages 55 and over are subject to Medicaid Estate Recovery.

The following pages contain information on some programs that a person receiving assistance through the North Carolina Health Care Coverage Programs for Families and Children may be eligible for.



NC HIPP reimburses its members for the cost of a health insurance policy that covers the policyholder and their dependants that are Medicaid beneficiaries. In some cases, NC HIPP will even reimburse the cost of a family policy that includes coverage for those that are not Medicaid members. In addition, NC HIPP eliminates out-of-pocket medical expenses for eligible Medicaid members. With NC HIPP, Medicaid members keep their Medicaid coverage as well as receive benefits of other insurance.

You may enroll in NC HIPP at any time during the year. To qualify, there must be at least one family member receiving Medicaid coverage, and there also must be a qualified family member that has access to health insurance provided by an employer or COBRA.

Not currently insured through your job or COBRA? A HIPP representative may be able to help you understand the types of health insurance policies your employer may offer that could qualify you for the HIPP program. If you have questions about the program, or need help completing the NC HIPP application, contact NC HIPP at their toll free number 1.855.My.NCHIPP (1.855.696.2447), Monday through Friday between 9am-6pm.

Submit an application:

- On the NC HIPP website: www.MyNCHIPP.com,
- By fax: 1-855-888-3333, Or
- By mail: NC HIPP Program, 4441 Six Forks Rd # 106-227, Raleigh, North Carolina 27609

Did you know...

By providing premium reimbursements to Medicaid members, NC HIPP helps save state and taxpayer money. You can help these efforts by applying to the NC HIPP program today. Learn more about NC HIPP by visiting our website at www.MyNCHIPP.com.

Life Line/Link-Up Discount Telephone Service

Link-Up provides a 50% discount, up to \$30, off the cost of having a telephone installed. Lifeline provides up to \$13.50 off the monthly cost of local telephone service. Medicaid recipients are eligible for Lifeline/Link-Up benefits.

Contact a telephone company of your choice. Request a LIFELINE/LINK-UP SELF-CERTIFICATION FORM. Complete the SELF-CERTIFICATION FORM and return it to the telephone company, and make an application for local telephone service. If you are eligible for Lifeline/Link-Up benefits, you will receive the installation discount and the monthly local service discount.

Note: If your telephone service has been disconnected for unpaid bills, you may still be able to obtain local telephone service and these discounts. Ask your telephone company for details.

Attorney General Roy Cooper, Chair of the Lifeline/Link-Up Task Force, urges you to contact your local telephone company to learn more about these discounts.

HEALTH CHECK/EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

COMPLETE CHECK-UPS AND TREATMENT FOR CHILDREN RECEIVING MEDICAID

(NC Health Choice for Children (NCHC) recipients are not covered for EPSDT services)

Definition: Health Check is the N.C. Medicaid program that means Early and Periodic Screening, Diagnosis, and Treatment. EPSDT services are covered free of charge. These services are required to be offered by federal law for children EPSDT covers:

- Regular medical check-ups. Check-ups prevent illness and find problems early.
- Dental services. Your child should go to the dentist every six months.
- Mental health services, if medically necessary.
- Rehabilitative services for children with disabilities, such as In-home nursing care with a licensed nurse or nurse aide, therapy, and medical equipment.
- Any other medically necessary treatment needed to reduce your child's illness, improve or maintain his/her condition, or restore his/her functioning as long as all EPSDT criteria are met and the service is covered at 1905(a) of the Social Security Act

Who Qualifies: Medicaid recipients are eligible from birth through age 20.

How Often Will My Child Be Seen: With Health Check, your child should have regular screenings (medical exams) as follows:

Within 1 st month
2 months
4 months
6 months
9 or 15 months
12 months
18 months

For children ages 2 through 20, annual visits are recommended

The EPSDT medical screening exam should include:

- a health history and physical exam;
- measurement of height and weight;
- developmental level and mental health assessment;
- immunizations (shots);
- other tests, including tuberculosis and lead poisoning; and
- health education.

What Treatment Services Will EPSDT Pay For: EPSDT covers medically necessary treatments a child needs to ameliorate or improve their condition and to stay as healthy as possible. This includes some services that Medicaid does not provide for adults. The treatment services for each child will be determined by the child's individual needs. To be covered by Medicaid, many EPSDT services must be prescribed by your child's doctor or another licensed clinician. Prior approval from the N.C. Medicaid agency, the Division of Medical Assistance, or its vendors may be needed for some treatment services. Your child's provider will know whether the service requires prior approval. EPSDT can cover services that your child needs to correct a health problem, to improve the problem, to prevent it from getting worse, or to help the child live with the problem. Even if the service, including requests for specialized treatments, will not cure your child's condition, the service must be covered if the service is coverable at 1905(a) of the Social Security Act and all EPSDT criteria are met including medical necessity to improve your child's symptoms or maintain functioning. If your child has a Medicaid card, and your child's doctor or other clinician says your child needs treatment, there is:

- no Medicaid imposed waiting list for EPSDT services
- no upper limit on the total cost of treatment*
- no upper limit on the number of hours necessary health care services are provided*
- no limit on the number of visits to a doctor or therapist
- no requirement that the service or equipment your child needs has to be on Medicaid's usual list of covered services
- no co-payment or other cost to you
- coverage for services that are never covered for adults, and
- coverage for services not listed in the N.C. Medicaid State Plan.

*If your child is enrolled in a Community Alternatives Program (CAP), services are provided in accordance with the waiver requirements. EPSDT only applies to waiver services if the service is both a waiver service and an EPSDT service. An EPSDT service is a service coverable at 1905(a) of the Social Security Act.

Following is a list of some of the services that can be covered by EPSDT if needed to correct or ameliorate a child's health problem

- Inpatient and outpatient hospital services
- Laboratory and x-ray services
- Family planning (birth control), including sexually transmitted disease screening
- Physician services (including pediatricians and pediatric specialists)
- Routine eye exams and eyeglasses
- Hearing testing and hearing aid(s)
- Home health care services
- Therapy services—physical, occupational, and speech/language
- Private duty nursing services
- Clinic services (including rural health clinics)
- Prescribed and over-the-counter drugs
- Dental care, including preventive and restorative care
- Durable medical equipment, including wheelchairs and assistive devices
- Case management
- Medical or remedial services recommended for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level (rehabilitation)
- Intermediate care facilities for the mentally retarded
- Maternity care
- Respiratory care
- In-Home Care for Children (assistance with feeding, bathing, dressing grooming)
- Substance abuse services
- Transportation services

For a complete listing of Medicaid/EPSDT services and their definitions, please visit
http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr440_06.html.

For more information about EPSDT Treatment Services, visit:
<http://www.ncdhhs.gov/dma/provider/epsdthealthcheck.htm> or
<http://www.ncdhhs.gov/dma/medicaid/healthcheck.htm>

“Be Smart” Family Planning (FPW)

(NC Health Choice for Children recipients do not qualify for FPW)

The “Be Smart” Family Planning is a Medicaid program for men and women to receive family planning services.

Who Qualifies?

- Women age 19 through 55
- Men age 19 through 60
- US citizens or documented immigrants
- NC residents who:
 - Have income below 185% of the federal poverty level
 - Are not incarcerated, pregnant or permanently sterilized

What Medicaid Will Pay For: “Be Smart” Family Planning Medicaid pays for one family planning annual exam and six follow-up family planning exams during the year. You may also choose an approved method of birth control.

A “family planning service” is:

- Annual physical exam (includes one pap test and some other limited labs, STD testing and treatment, and HIV testing)
- Follow-up family planning visits
- Pregnancy testing and counseling
- Referrals
- Birth control methods(Medicaid-covered and FDA-approved)

Birth control methods* include:

- Birth control pills
- Depo shots
- Contraceptive implants
- Diaphragm fitting
- Emergency contraception
- Intrauterine device (IUD)
- Natural family planning
- The patch
- The ring
- Male and female sterilizations

* NOTE: For a complete list of covered services, please consult with your health care provider or visit www.ncdhhs.gov/dma/medicaid/familyplanning.htm.

There is no co-payment for Family Planning Medicaid visits or prescriptions, and you are not required to participate in Community Care of North Carolina/Carolina ACCESS (CCNC/CA). Check with your health care provider or pharmacist before receiving services

For more information on “Be Smart” Family Planning Medicaid

Visit our website at:

www.ncdhhs.gov/dma/medicaid/familyplanning.htm

Or

Call the DHHS Customer Service Center at 1-800-662-7030. Hearing impaired callers may call the TTY dedicated line at 877 452-2514. DHHS Customer Service Center is available Monday through Friday 8 a.m. to 5 p.m. except for state holidays. A bilingual information and referral specialist is available to translate for persons with limited English proficiency.

Medicaid for Pregnant Women (MPW)

Definition: Women can receive coverage for pregnancy related services. Female recipients of all ages with MPW coverage are eligible for pregnancy-related prenatal, labor and delivery, and postpartum care as well as services for conditions that in the judgment of their physician may complicate the pregnancy. The eligibility period ends on the last day of the month in which the 60th postpartum day occurs.

Who Qualifies: Pregnant women who meet the income guidelines (See page 8). You may also apply for this coverage after you deliver. Women who have experienced a recent pregnancy loss may also apply. There is no resource or assets test.

*Prenatal care and childbirth are not covered benefits under the NC Health Choice for Children Program. If a NC Health Choice for Children recipient becomes pregnant, please notify the local DSS. A caseworker will evaluate the NC Health Choice for Children recipient for MPW coverage.

What Medicaid Will Pay For under the MPW Program:

- Prenatal care, delivery, and 60 days of postpartum care
- Services to treat medical conditions that may complicate the pregnancy including: doctor visits, laboratory tests, diagnostics, prescription drugs, etc.
- Childbirth classes
- Family planning services
- Baby Love services (see below)
- Some services require prior approval

Baby Love Program

Definition: The Baby Love Program provides maternal support services to eligible women during and after pregnancy (up to 90 days after). The program also provides intervention as early in pregnancy as possible to increase the chances of having a healthy baby.

Baby Love services include:

- Childbirth education classes
- Health and behavioral intervention
- Maternal skilled nurse home visit
- Home visit for postnatal assessment and follow-up care
- Home visit for newborn care and assessment

Baby Love Program providers are located in all 100 North Carolina counties.

**For More Information on the Baby Love Program
Contact your nearest health department**

<http://www.ncalhd.org/county.htm>



The Pregnancy Medical Home (PMH) Program enrolls prenatal care providers who agree to serve women who receive **Medicaid**, throughout their pregnancies. These providers have agreed to higher standards of care to help mothers and babies be as healthy as possible.

With a Pregnancy Medical Home, a woman and her child receive:

- Access to prenatal care.
- A stable relationship with one health care provider for your entire pregnancy.
- A pregnancy care manager to work with you, if your pregnancy is *high risk*.
- 24-hour telephone access to a health care professional for questions or concerns.
- Referrals to other programs such as Medicaid, WIC, family planning and other local resources as needed.

When you have your first visit with your PMH provider, he/she will help decide if you have any risk factors. If you have any risk factors, you will be referred to a pregnancy care manager.

You may be high risk if you:

- Have ever had a premature baby (baby born before 37 weeks).
- Are pregnant with twins, triplets, etc.
- Have diabetes, high blood pressure, HIV, sickle cell, asthma, seizure disorder, mental illness, or other conditions, which can affect your pregnancy.
- Are in an unsafe living environment (homeless, unstable housing, family violence, sexual abuse, community violence).
- Use drugs or alcohol while you are pregnant.
- Smoke or use tobacco products while you are pregnant.

A Pregnancy Care Manager will help you identify your needs, make a plan to address them and work closely with you and your doctor to understand your needs. They can help arrange transportation to medical appointments and help you manage any medicines that you might have. They work hand in hand with you to help you have a healthy baby.

If you currently receive Medicaid, you should report to your case worker that you are pregnant. At that time, your Medicaid caseworker can tell you who the PMH providers are in your area. If you do not receive Medicaid, you may be eligible while you are pregnant. Contact your local county department of social services for information on applying for Medicaid and on the PMH providers in your area. Your local health department can also tell you who the PMH providers are in your area. You are free to choose any prenatal care provider.

Home Health Services

Home Health Services include medically necessary skilled nursing services, specialized therapies (physical therapy, speech-language pathology and occupational therapy), home health aide services, and medical supplies provided to recipients who reside in private residences. Medical supplies may be provided to a recipient even when no home health services are needed.

Skilled nursing, specialized therapies and medical supplies can also be provided if the recipient resides in an adult care home (such as a rest home or family care home). Recipients residing in an adult care home are only eligible to receive skilled nursing, skilled therapy services, and medical supplies. Home health aide services cannot be provided in this setting because the personal care and incidental tasks are performed by the staff of the adult care home.

The home health agency must be able to provide the services safely and effectively in the recipient's home in accordance with all applicable state and federal rules, regulations, and agency policy and procedures. All services must be ordered by a physician and rendered according to an authorized plan of care. Skilled nursing and/or in-home health aide services may be provided up to 7 days per week but cannot exceed eight hours per day and 34 hours per week.

**North Carolina Division of Medical Assistance (DMA)
NOTICE OF PRIVACY PRACTICES**

**Original Effective Date: April 14, 2003
Revised Effective Date: 03/15/2012**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

PLEASE REVIEW IT CAREFULLY.

(Copies may be requested from the DMA Privacy Official listed at the end of this notice.)

YOUR PRIVACY RIGHTS, OUR RESPONSIBILITIES

The North Carolina Division of Medical Assistance (DMA) administers both the NC Medicaid and NC Health Choice health plans. Though these health plans have different eligibility requirements, the processes for the two health plans are being integrated as much as possible. This Notice of Privacy Practices applies to the Division of Medical Assistance and also applies to the use and disclosure of recipient data for individuals in both of these health plans. DMA, which collects and maintains health information about you, is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to this protected health information. This *Notice* describes how DMA may use and share your protected health information and explains your privacy rights. DMA is required to abide by the terms of the notice currently in effect. DMA does, however, reserve the right to change its privacy practices and the terms of this *Notice* and to make new notice provisions effective for all health information that it maintains. Notice of the revision will be sent to you with the internet address of where to find the new *Notice* and instructions about how to receive a paper copy. DMA will not change its privacy practices before you are sent a notice of the revision, unless the change is required by law.

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

If at any time you have questions or concerns about the information in this *Notice* or about our agency's privacy policies, procedures or practices, you may contact the DMA Privacy Official. (See Contact Information at the end of this notice).

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

DMA performs some functions through contracts with other agencies such as your county department of social services and through private contractors and business associates that process your health care provider claims. When services are contracted, DMA must share enough information about you with its contractors and business associates so that the private contractors and business associates can perform the job that DMA has asked them to do.

To protect your protected health information further, DMA will only disclose your protected health information after making sure in writing that its contractors or business associates will safeguard your information the same way that DMA does. They agree to use your information appropriately and are required by law to do so. DMA may use or disclose your protected health information to provide services to you **FOR:**

Payment: DMA may use or disclose your protected health information for payment or payment-related functions. **(EXAMPLE 1: In order for your health care provider's claim to be paid, the contractors and business associates who process claims for payment must have enough health information about you to verify and pay for the services you received. EXAMPLE 2: To determine if your treatment is medically**

necessary and is covered under NC Medicaid or NC Health Choice, DMA may disclose your protected health information to other health care professionals).

Treatment: Information about your health and the services you have received may also be disclosed to your doctor to help in coordinating your care and treating you. **(EXAMPLE: DMA may provide a list of what medicines you have received to physicians, so they can consider these when prescribing additional medications).**

Health Care Operations: DMA may use or disclose your protected health information to perform a variety of business activities that we call health care operations. These operations ensure that you receive quality care; that NC Medicaid and NC Health Choice are administered effectively; that charges are appropriate for the services that you received; and that your health care providers are paid promptly. **(EXAMPLE: We may contract with a private company to review the care and services our clients have received to ensure that a doctor or other health service agency provided quality care to you).** Other “operations” that may require your protected health information to be shared include functions to:

- Review and evaluate the skills, qualifications and performance of health care providers who are taking care of you;
- Improve the quality of your care through processes such as identifying groups of individuals with special needs;
- Provide training programs for students, trainees, professional and non-professional staff to allow them to use, under supervision, the skills they have learned;
- Provide information to certifying and licensing agencies so that staff may fulfill professional requirements;
- Plan DMA’s future operations;
- Enhance investigations conducted by administration whenever a staff member within DMA files a grievance or protests a particular issue;
- Provide information to other health plans and federal agencies to determine if you are enrolled as their member or covered by them;
- Participate in mediations, hearings, appeals, or reviews regarding NC Medicaid or NC Health Choice services;
- Comply with state or federal laws or regulations; and
- Administer the NC Medicaid and NC Health Choice health plans.

Other Circumstances: In these circumstances, DMA is permitted or required to use or disclose protected health information without your written authorization.

- When required by law;
- For public health activities (i.e., disclose health information to public health authorities to report a communicable disease outbreak);
- Regarding abuse, neglect or domestic violence victims;
- For health oversight activities conducted by state or federal agencies;
- For law enforcement purposes unless otherwise prohibited by state or federal law;
- For judicial and administrative proceedings such as court orders to appear in court;
- Related to the donation of organ(s), eye(s) or tissue;
- To avert a serious threat to the health or safety of a person or the public;
- Related to specialized government activities such as national security;
- For Worker’s Compensation matters;
- Cooperate with other government agencies and outside organizations that conduct health oversight activities for the purposes allowed under federal law;
- Comply with court orders, subpoenas, administrative orders, and lawsuits related to the administration of NC Medicaid or NC Health Choice;
- Provide information for research purposes with Institutional Review Board approval as needed.

More Stringent Laws

DMA will evaluate whether your protected health information is governed by more stringent laws or regulations prior to our use or disclosure. There are other more stringent laws and rules, such as the federal substance abuse confidentiality regulations, the NC mental health confidentiality statute(s), the NC public health confidentiality provisions, and state minor consent statute(s), governing *status* (i.e., emancipation, marital status, etc.) or *type of treatment* (abortion, sexually-transmitted disease, birth control, etc.), that may affect how we handle your information.

Contacting You

DMA will contact you personally to keep you informed, such as by providing appointment reminders or other treatment opportunities when necessary or available under certain selected public agency benefit programs.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

NC Medicaid and NC Health Choice recipients have certain rights regarding their protected health information. Unless otherwise noted, please contact DMA staff or the DMA Privacy Official to request the following actions:

YOU HAVE THE RIGHT TO:

- **Receive a copy of this Notice:** You have a right to a paper copy of this notice upon request. You may also obtain a copy of this *Notice* by accessing DMA's web site at:
<http://www.dhhs.state.nc.us/dma/medicaid/rights.htm> (Click the link under "Privacy") or
<http://www.ncdhhs.gov/dma/healthchoice/revrequest.htm> (Click Notice of Privacy Practices "Quick Link" on the left)
- **Request confidential communications:** You have a right to request that DMA communicate with you in a certain way or at a certain location, such as by calling you at work rather than at home.
- **Inspect and copy:** You have a right to request in writing to see your records and obtain a copy within 30 days at a reasonable fee. There are some exceptions to this right such as impending court actions. If this right is denied, you will be notified in writing of the reason for the denial and your right to request review of the denial.
- **Request amendment:** You have a right to request in writing that portions of your DMA records be corrected when you feel information is incorrect or incomplete. We may deny your request if the information was not created by DMA or if we believe the information is accurate. You may then file a statement of disagreement that will be included in any future disclosures if you request these records.
- **An accounting of disclosures:** You have the right to request in writing and receive a written list of certain disclosures of your protected health information made after April 14, 2003. Exceptions from this list include those disclosures regarding treatment, payment or other health care operations or disclosures allowed by certain laws, or disclosures authorized by you.
- **Request restrictions on uses and disclosures of your protected health information:** You have a right to request restrictions on the information DMA uses or discloses about you. DMA is not required to agree to your requested restriction, but it will consider your request and the possibility of accommodating it.
- **File a Complaint:** If you feel we have violated your privacy rights, you may contact the DMA Privacy Official (see contact information below) or the agency listed below. If you file a complaint, we will not take any adverse action against you, change your treatment, or deny treatment to you.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION THAT REQUIRES YOUR AUTHORIZATION

- DMA will not use, communicate or disclose your protected health information without your authorization except as allowed in the circumstances mentioned above. Other uses and disclosures will be made only with your written authorization. You may cancel such authorization by notifying DMA's Privacy Official as provided by CFR 164.508(b) (5). You will be asked to sign and date the Authorization Revocation section of your original authorization. Your authorization will then be considered invalid at that point in time; however, any actions that were taken on the authorization prior to the time you cancelled your authorization will be legal and binding.
- Generally, an individual deemed a "personal representative" of yours may authorize disclosures on your behalf until such time as you reach the age of 18. At the age of 18, only you can manage your health benefits unless you authorize a personal representative to act on your behalf. However, if you have consented to treatment for services regarding the prevention, diagnosis and treatment of certain illnesses including: venereal disease and other diseases that must be reported to the State, pregnancy, abuse of controlled substances or alcohol, or emotional disturbance, you may have the right to authorize disclosure of your health information, even if you are a minor.
- In order to obtain information from school districts to pay for your health related services, we need your authorization. By you or your personal representative signing the DMA application, you give your authorization for the school district that provides DMA-covered services to you or your child(ren) to release to DMA information from your or your child(ren)'s educational records in order for DMA to make payments for the services. The information that will be released each time payment is made may include your or your child(ren)'s name, date of birth, and the type and amount of services that were provided. Your authorization is voluntary and may be withdrawn at any time by contacting the school district. Even if you withdraw your authorization, the school district will continue providing services to you or your child(ren) at no cost to you.

COMPLAINT ADDRESSES

NC Department of Health and Human Services

DMA Privacy Official
2501 Mail Service Center
Raleigh, NC 27699-2501
Voice Phone: 1-888-245-0179 (Toll Free)
(919) 855-4100 (Raleigh local area)

Secretary, US Department of Health & Human Services

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

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

CONTACT FOR FURTHER INFORMATION

DMA Privacy Official
2501 Mail Service Center
Raleigh, NC 27699-2501
Voice Phone: 1-888-245-0179 (Toll Free)
(919) 855-4100 (Raleigh local area)

Behavioral Health and Substance Abuse Treatment Services

Children (under age 21) must be referred for these services by either:

- ▼ Your child's primary doctor, or
- ▼ Your local management entity (LME), or
- ▼ A psychiatrist who takes Medicaid.

Anyone age 21 or older does not need a referral.

HEALTH CHECK (EPSDT) MEDICAID RECIPIENTS UNDER AGE 21 MAY RECEIVE ADDITIONAL ANNUAL PROFESSIONAL SERVICES VISITS AND SERVICES

COVERED SERVICES

The following pages contain information on covered and non-covered Medicaid and NC Health Choice for Children services. **This list does change**, so for accurate information, ask your medical or health care provider, dentist or pharmacist if the service is covered **before having a procedure done**. You may also call the DHHS Customer Service Center at 1-800-662-7030. Hearing impaired callers may call the TTY dedicated line at 877 452-2514. The DHHS Customer Service Center is available Monday through Friday 8 a.m. to 5 p.m. except for state holidays. A bilingual information and referral specialist is available to translate for Spanish-speaking callers and limited-English- speakers.

You may also access information on **covered services** by looking at Medicaid and NC Health Choice for Children clinical coverage policies at <http://www.ncdhs.gov/dma/provider/library.htm>.

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WHEN YOU RECEIVE:	MEDICAID and NC HEALTH CHOICE FOR CHILDREN COVERS THE FOLLOWING SERVICES NOTE: NC Health Choice for Children only covers children age 6-18.	RESTRICTIONS	MEDICAID and NC HEALTH CHOICE FOR CHILDREN DOES NOT COVER: **Incomplete list. Talk with your provider before having a procedure done. **
Adult Health Screening Services	Covers annual physical exams, lab tests, and counseling and intervention for persons over 21 to prevent illness.	If in Community Care of North Carolina/Carolina ACCESS, service must be provided by PCP. Covers only one screening per calendar year.	Does not apply to NC Health Choice for Children
Anesthesia Services	Covered if medically necessary and provided by an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA)		
Case Management for people with Intellectual and Developmental Disabilities <ul style="list-style-type: none"> • Assessment • Coordination and Referral • Monitoring 	Covered for adults and children who have intellectual or developmental disability and who require coordination of services. Client's strengths, weaknesses, and services needed must be assessed. Then a service plan is developed. Must need assistance with two or more conditions (i.e., medical, social, vocational). Resources are identified and coordinated, and the patient is then referred. Patient is monitored to ensure services are received and adequate for his or her needs.		

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<p>Case Management (Targeted) for people with mental illness and substance abuse</p> <ul style="list-style-type: none"> • Assessment • Coordination and Referral • Monitoring 	<p>Covered for adults with mental illness and/or substance abuse and for children with emotional disturbance, mental illness, and/or substance abuse issues.</p> <p>Client's strengths, weaknesses, and services needed must be assessed. Then a service plan is developed. Must need assistance with two or more conditions (i.e., medical, social, vocational).</p> <p>Resources are identified and coordinated, and the patient is then referred.</p> <p>Patient is monitored to ensure services are received and adequate for his or her needs.</p> <ul style="list-style-type: none"> • Manual manipulation of the spine to correct a spinal injury or degeneration. • X-rays (dated within six months) to document the condition for which manual manipulation of the spine is appropriate. 	<p>The recipient cannot be receiving waiver services or live in a Medicaid covered facility or institution</p>	
<p>Chiropractic Services</p>	<p>All services have the same coverage and restrictions as the same services given in a non-clinic setting.</p> <p>Multiple diagnostic visits on the same date of service count as one visit.</p>	<p>Visits are counted toward the annual Professional Services visit limit. Not applicable to children under age 21.</p> <p>This is an optional professional services visit.</p> <p>Prior approval is required for MPW eligible pregnant women.</p> <p>Outpatient clinic visits count toward the annual Professional Services visit limit and/or the optional annual Professional Services visits.</p> <p>Not applicable to children under age 21.</p>	<ul style="list-style-type: none"> • Nutritional Supplements • Physical therapy • Diagnostic or therapeutic service
<p>Clinic Services (Includes services received in certified rural health clinics, federally qualified health centers and local health departments.)</p>			

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<p>Dental Services</p> <p>Does not count toward the annual Professional Services visit limit.</p> <p>Routine services do not require Community Care of North Carolina/Carolina ACCESS PCP referral.</p> <ul style="list-style-type: none"> Routine services include exams, cleanings and fluoride treatments, restorations, sealants, x-rays, and extractions. 2 routine dental check-ups per year. Full mouth and panoramic x-rays once every five years. Fluoride treatment two times a year for children under 21 years of age. Sealants are limited to primary molars for children under age 8 and permanent first and second molars for recipients under age 16. Stainless steel crowns for baby teeth and permanent premolars and first and second molars up to age 21. Stainless steel space maintainer for baby tooth that is removed prematurely or to replace a permanent first molar, up to age 21. Endodontic (root canal) treatment for anterior (front) teeth. Endodontic (root canal) treatment for posterior (back) teeth, for recipients under age 21. 	<p>Services needing prior approval with restrictions include: (incomplete list)</p> <ul style="list-style-type: none"> Complex oral surgeries. (some surgeries may not be covered under NC Health Choice for Children) One full mouth scaling and root planing every 2 years. Periodontal surgery for recipients with gum disease complicated by an underlying medical condition. Complete dentures once every 10 years and acrylic partial dentures once every 8 years. Relining of dentures 6 months after delivery and then no more than once every 5 years. (not covered under NC Health Choice for Children) Orthodontic services for children under age 21 with severe alignment problems. NC Health Choice for Children limits orthodontic coverage for severe malocclusions caused by craniofacial anomalies like cleft lip and/or palate and other syndromic conditions for children ages 6-18. 	<ul style="list-style-type: none"> Fixed bridgework. Experimental procedures. Prescription drugs the dentist gives you while you're in his office. Implants or transplants. Gold or porcelain restorations or crowns. Temporary dentures. Space maintainers that are removable and retainers for braces that are not included in the orthodontic package. Removal of braces when Medicaid did not pay to have them put on. Cosmetic Procedures (bleaching, whitening, bonding, veneers). TMJ splints, night guards and mouthpieces. Upper and lower cast metal partial dentures. 	

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<p align="center">WHEN YOU RECEIVE:</p>	<p align="center">MEDICAID and NC HEALTH CHOICE FOR CHILDREN COVERS THE FOLLOWING SERVICES:</p> <p align="center">NOTE: NC Health Choice for Children only covers children age 6-18.</p>	<p align="center">RESTRICTIONS</p>	<p align="center">MEDICAID and NC HEALTH CHOICE FOR CHILDREN DOES NOT COVER:</p> <p align="center">**Incomplete list. Talk with your provider before having a procedure done. **</p>
<p>Dialysis Services</p>	<p>Covered if provider is either a Medicaid-enrolled provider or independently enrolled.</p> <p>Medical necessity for the use of these items within your home must be documented by your physician.</p> <ul style="list-style-type: none"> • Wheelchairs, walkers, canes, hospital beds, and other medically necessary equipment which is on the Medicaid list. ** • Prosthetics (artificial limbs) or orthotic braces for children under 21 which is on the Medicaid list. • Oxygen and oxygen equipment when medical necessity is documented by your physician. • Medicaid will pay for service/repair of patient-owned DME. <p>*The complete medical list for DME services can be found at http://www.ncdhhs.gov/dma/mp/dmepdf.pdf</p>	<p>Prior approval is required for all durable medical equipment.</p> <p>NOTE: You must go to a durable medical equipment supplier to obtain diabetic supplies</p>	<p>Items not required for function within your home.</p> <p>Items you use for your convenience.</p> <ul style="list-style-type: none"> • Lift chairs • 3-wheeled scooters • Blood pressure cuffs • Mattress covers, pillow covers • Air purifier for allergy sufferers • Vaporizers, humidifiers • Medic alert bracelets <p>Equipment for someone in a nursing facility. (This should be covered in your per diem rate for the nursing home.)</p> <p>Sterile pads are not DME product. (Recipients must go through a Medicare certified home health agency to get sterile pads.)</p>
<p>Durable Medical Equipment (DME)</p>			

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<p>Family Planning Services</p> <ul style="list-style-type: none"> Basic Services Birth Control Sterilization Hysterectomy Abortion 	<p>Family planning services do not require Community Care of North Carolina/Carolina ACCESS PCP referral.</p> <p>Covers consultation, examination, and treatment by a physician, nurse midwife, or nurse practitioner.</p> <p>Covers lab exams and tests</p> <p>Covers pills, IUD, Inplantable contraceptive devices that are Medicaid approved, Depoprovera and Ortho Evra.</p> <p>Includes tubal ligation and vasectomy. Covered only if patient is mentally competent and over 21.</p> <p>Claim must be accompanied by a completed Medicaid consent form signed at least 30 days before the surgery.</p> <p>Covered only if medically necessary. Claim must be accompanied by signed statement of the patient.</p> <p>Covered only in cases of endangerment to the mother's life, and when the pregnancy resulted from incest or rape.</p>	<p>For premature delivery, consent form must be signed at least 30 days before expected date of delivery and at least 72 hours before surgery.</p> <p>For abdominal surgery, consent form must be signed at least 72 hours before surgery.</p> <p>Exceptions are emergency abdominal surgery and premature delivery.</p> <p>Claim must be accompanied by an abortion statement signed by the physician.</p>	<p>Diaphragms and fertility treatments are not covered.</p> <p>NC Health Choice for Children does not cover: contraceptives that can be purchased without a prescription or do not require the services of a physician for fitting or insertion.</p> <p>Medicaid does not cover sterilization reversals.</p> <p>NC Health Choice for Children does not cover sterilizations or sterilization reversals.</p> <p>Hysterectomy for sterilization not covered.</p>

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<p>Health Services Provided in Public School or Head Start</p>	<p>These services do not require Community Care of North Carolina/Carolina ACCESS PCP referral.</p> <ul style="list-style-type: none"> • Audiology services • Speech/language services • Occupational therapy • Physical therapy • Nursing services • Psychological/ counseling services 	<p>Must be ordered by physician.</p> <p>Limited to recipients age 3-20 (age 6-18 for NC Health Choice for Children) in public schools applying for or who receive special education. Services must appear in the Individualized Education Plan (IEP).</p> <p>Service must be given in the setting identified in the IEP.</p> <p>One assessment service per service type is allowed in a six month period.</p> <p>Visits are counted toward the annual Professional Services visit limit. Not applicable to children under age 21.</p>	<p>IEP services billed by the schools are not covered under NC Health Choice For Children.</p> <p>Respiratory therapy services are not covered under NC Health Choice For Children.</p>
<p>Hearing Aid Services</p>	<ul style="list-style-type: none"> • Hearing aids are covered for recipients under age 21 • Initial care kit. (one per lifetime) • Custom ear molds. • Cords, garments, harnesses and other accessories • Medically necessary FM system for children • Batteries. • Dispensing fees • Repairs 	<p>Coverage is only for individuals under age 21. (age 6-18 for NC Health Choice for Children)</p> <p>Prior approval required for all services except batteries.</p>	<ul style="list-style-type: none"> • Battery chargers or testers. • Adapters for telephones, television, or radios. • Shipping/handling fees, postage, or insurance. • Loss, damage insurance or theft insurance. • In-the-ear aids for cosmetic purposes.

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<p>Home Health Services</p> <p>Does not count toward the annual Professional Services visit limit.</p> <p>Covers the following services when they are medically necessary to help restore, rehabilitate, or maintain a patient in the home according to Medicaid guidelines and provided by a Medicare certified home health agency:</p> <ul style="list-style-type: none"> • Skilled nursing visits • Physical therapy • Speech and language pathology • Occupational therapy services • Home health aide services, when supervised by a registered nurse • Medical supplies included on Medicaid's list of approved supplies. 	<p>A Home Health service must be needed by a patient for care in the patient's home, which must be either a private residence or the adult care home where the patient resides.</p> <p>Prior approval is required for MPW eligible pregnant women.</p>	<p>Home health aide services to a patient in an Adult Care Home.</p> <p>Home Health Services to a Medicare or Medicaid Hospice patient related to the terminal illness.</p>	

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<p>Home Infusion Therapy (HIT)</p> <p>Does not count toward the annual Professional Services visit limit.</p> <p>Covers the following self-administered infusion therapies in a patient's home when the therapy is medically necessary:</p> <ul style="list-style-type: none"> • Total Parenteral Nutrition • Enteral Nutrition • Chemotherapy for cancer treatment • Antibiotic therapy (intravenous) • Pain management therapy • Medicines that attempt to stop labor • Nutrition therapy coverage includes the equipment, supplies, and formulas/solutions <p>HIT is for patients who live in a private residence or an adult care home (like a rest home or family care home). "Self-administered" means that a patient and/or an unpaid caregiver is capable, able and willing to administer a therapy following appropriate teaching and with adequate monitoring.</p>	<p>Prior approval is required for MPW eligible pregnant women.</p> <p>If the therapy cannot be self-administered, the care may be available under Home Health Services.</p> <p>Must be ordered by the physician who is actively treating the recipient for whom the referral is made.</p> <p>Drug therapies include the equipment, supplies, nursing services, and pharmacy services needed for the administration of the drug. The package does not pay for the drug. It must be billed through Medicaid Drug Program.</p>	<p>Medicare and Medicaid Hospice patients may not receive HIT services related to the terminal illness.</p>	

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

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<p>Hospital Services: Inpatient</p>	<p>Doctor's visits while in the hospital may count toward the annual Professional Services visit limit. Not applicable to children under age 21</p> <p>These services do require Community Care of North Carolina/Carolina ACCESS PCP referral.</p> <p>Some restrictions apply to family planning services</p>	<p>Non-covered services (incomplete list)</p> <ul style="list-style-type: none"> • Private rooms when they are not necessary • Telephone bill • Use of television • Private duty nurses or sitters • Take home supplies • The day you are discharged • Any bills for being discharged late because it was more convenient • Test or surgery that is experimental 	<p>Supplies or equipment that you take home, unless it is a very small quantity of a supply drug you need to use until you can get a continuing supply elsewhere.</p> <p>Biofeedback</p> <p>Experimental drugs or procedures</p> <p>Routine physicals</p> <p>Brain pacemaker</p> <p>Telephonic pacemaker monitoring</p>
<p>Room and board</p> <p>Other medical services</p>	<p>Semiprivate room covered, except when private room is medically necessary or all that is available.</p> <p>Regular nursing services.</p> <ul style="list-style-type: none"> • Any hospital facilities you use • Medical social services • Drugs and blood tests that you have or use while in the hospital • Supplies, appliances, or equipment that is used for your care while in the hospital • Medically necessary services that people get while they are in the hospital that are covered by Medicaid 	<p>These services do require Community Care of North Carolina/Carolina ACCESS PCP referral.</p> <p>Not applicable to children under age 21</p> <p>Visits are counted toward the annual Professional Services visit limit, EXCEPT for emergency room visit, and services such as physical therapy, labs, and x-rays.</p>	
<p>Hospital Services: Outpatient</p>	<p>Services from a physician or dentist in the hospital.</p> <p>Outpatient diagnostic services.</p> <p>For therapy or rehabilitation, covers the use of the hospital facilities, clinic services, and emergency room services.</p>		

HEALTH CHECK (EPSDT) MEDICAID RECIPIENTS UNDER AGE 21 MAY RECEIVE ADDITIONAL ANNUAL PROFESSIONAL SERVICES VISITS AND SERVICES

<p align="center">WHEN YOU RECEIVE:</p>	<p align="center">MEDICAID and NC HEALTH CHOICE FOR CHILDREN COVERS THE FOLLOWING SERVICES:</p> <p align="center">NOTE: NC Health Choice for Children only covers children age 6-18.</p>	<p align="center">RESTRICTIONS</p>	<p align="center">MEDICAID and NC HEALTH CHOICE FOR CHILDREN DOES NOT COVER:</p> <p align="center">**Incomplete list. Talk with your provider before having a procedure done. **</p>
<p>In-Home Care (IHC) Services</p> <ul style="list-style-type: none"> • For Adults (IHCA) (Covers recipients age 21 and over) • For Children (IHCC) (Covers recipients under age 21.) 	<p>Does not count toward the annual Professional Services visit limit.</p> <p>These 2 programs provide person-to-person hands on assistance with common activities of daily living, delivered by a paraprofessional aide in the recipient's home. May include assistance with:</p> <ul style="list-style-type: none"> • bathing • toileting • positioning • ambulation • taking and recording vital signs 	<p>These services do require Community Care of North Carolina/Carolina ACCESS PCP referral.</p> <p>Prior authorization by the recipient's attending physician is required.</p> <p>Must be the most cost-effective and appropriate form of care.</p> <p>RN or LPN must be employed by a home care agency licensed by the Division of Health Services Regulation.</p>	<p>Skilled medical care performed by licensed professionals, such as a registered nurse or licensed practical nurse.</p> <p>In-home care provided by the recipient's spouse, child, parent, sibling, grandparent, grandchild, or equivalent step or in-law relationship to the recipient or willing/able family members or other informal caregivers available on a regular basis adequate to meet the recipient's need of personal assistance.</p> <p>Housekeeping and home management tasks not directly related to maintaining the recipient's health status.</p>
<p>Lab Services</p>	<p>Lab services do not require PCP referral.</p> <p>Outpatient lab work or work done by an independent lab is not counted toward the annual Professional Services visit limit</p> <p>Covers lab work (blood, urine) ordered by a physician or other licensed practitioner.</p>	<p>Must be ordered by a licensed practitioner.</p>	<p>Medicaid does not cover routine physicals (except Health Check).</p> <p>Does not cover lab tests to determine the father of a child. Contact your local Child Support Enforcement (IV-D) agency.</p>

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<p>Medical Transportation</p> <p>Non-Ambulance Services</p>	<p>Medically necessary transportation services do not require Community Care of North Carolina/Carolina ACCESS PCP referral.</p> <p>Recipients should apply for transportation through the local department of social services.</p> <p>Covers non-ambulance transportation to medical appointments for eligible people who have no other available means of transportation.</p> <p>Covers non-emergency medically necessary transportation for recipients in nursing or domiciliary care facilities if care cannot be provided in facility.</p> <p>Covers transportation by ambulance if individual's condition is such that any other means would endanger the individual's health or requires transport by stretcher.</p>	<p>NC Health Choice for Children requires prior approval for transportation by ambulance for a distance greater than 50 miles.</p>	<p>NC Health Choice for Children does not cover non-emergency medical transportation</p>
<p>Air Ambulance Transportation</p> <p>State-to-State Transportation</p>	<p>Covers fixed wing or helicopter when medically and physically necessary. Must be to the nearest hospital with appropriate facilities.</p> <p>Covers non-emergency medically necessary transportation (ground or air) for out-of-state services or to return to North Carolina.</p>	<p>Prior approval must be given by DMA's fiscal agent before the service for state-to-state transportation.</p>	

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<p>Mental Hospital Services</p>	<p>These services do not require Community Care of North Carolina/Carolina ACCESS PCP referral.</p> <p>Covered for a recipient 65 and older.</p> <p>Covered for a recipient under age 21. A recipient who turns 21 as an inpatient will be covered until age 22.</p> <p>Covered for inpatient care for chronic diseases (like pulmonary or tuberculosis)</p>	<p>People under 21 must have a certification of need (CON) form to be admitted to a psychiatric hospital.</p>	
<p>NC Specialty Hospital Services</p> <p>Nursing Facility Services</p>	<p>No co-payment is required after patient liability is paid.</p> <p>Covered services</p> <ul style="list-style-type: none"> • A semi-private or private room that is ordered by your physician because it is medically necessary. • Therapeutic leave days (only 60 days per calendar year). • Over the counter drugs, such as aspirin, milk of magnesia, etc. • Personal hygiene items and services. • Personal laundry services. • Any medically necessary vaccine or test you need to have while you are in the facility. • Antiseptics, dressings, and medications. • Equipment like walkers, wheelchairs, canes, air mattresses, bed pans, etc. • Any physical, speech, or occupational therapy. • Other items that may need to be used for your feeding, health, or safety. 	<p>Prior approval is required for all admissions to a nursing facility.</p> <p>Physician visits do not count toward the annual Professional Services visit limit</p> <p>Recipients admitted to a nursing facility are not required to participate in any managed care program.</p>	<p>Non-covered services: (incomplete list)</p> <ul style="list-style-type: none"> • Private rooms when they are unnecessary. • Reserving a bed while you are in the hospital. • Private duty nurses or sitters. • Any amount that the county DSS tells you that you have to pay with your savings or monthly income. • Telephones, televisions, or anything that you bring into the facility yourself. • Hair care that you would not get under ordinary circumstances, such as a permanent, hair color, or a set.

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Nursing Services			NC Health Choice for Children does not cover prenatal care or child birth services.
Nurse-Midwife	Covered if licensed, approved by the Board of Nursing, and whose practice is under the supervision of a doctor licensed to practice obstetrics.		NC Health Choice for Children will cover preventive annual health assessments.
Nurse Practitioners	Covered if licensed, approved by the Board of Nursing and whose practice is with a licensed physician or independent practitioner in collaboration with a licensed physician.		
OB/GYN Services (Also see Family Planning services)	<ul style="list-style-type: none"> • Preventative annual health assessment. • Prenatal visits. • Diagnostic tests, such as amniocentesis, fetal stress and non-stress tests and ultrasounds. • Outpatient hospital visits for pregnancy related tests/procedures. • Delivery, including anesthesiology services • Postpartum services. 	<p>Visits are counted toward the annual Professional Services visit limit, EXCEPT for prenatal and pregnancy related services.</p> <p>Pap smear limited to one a year unless medical diagnosis covers more frequent testing</p>	<ul style="list-style-type: none"> • Circumcision-routine newborn • Breast pump

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<p>Optical Services</p>	<p>Optical services are routine eye exams with refraction, eyeglasses and medically necessary contact lenses.</p> <p>Optical services do NOT require Community Care of North Carolina/Carolina ACCESS PCP authorization.</p> <p>Routine eye exams are counted toward the annual Professional Services visit limit.</p> <p>Visits for fitting and picking up eyeglasses and medically necessary contact lenses are NOT counted toward the annual Professional Services visit limit.</p> <ul style="list-style-type: none"> • One routine eye exam per year if you are under age 21 • One pair of eyeglasses per year if you are under age 21 • Replacement lenses under some circumstances • Pink or gray-tinted lenses with medical justification • Replacement of stolen or damaged glasses may be possible when you get a letter from a county DSS worker, or get a copy of a medical, police, fire or automobile accident report • Repairs on glasses over \$5.00 (prior approval required) • Medically necessary contact lenses for keratoconus, progressive myopia, or aphakia, etc. • Back-up glasses for recipients who get approval for medically necessary contact lenses 	<p>Prior approval required for all visual aids.</p> <p>Visits are counted toward the annual Professional Services visit limit. Not applicable to children under age 21.</p> <p>Optical services are not covered for adults age 21 and older.</p> <p>Optical services are not a covered benefit under the MPW program. Exceptions are allowed, on rare occasions, when the need for glasses is pregnancy related. Prior approval is required for MPW eligible pregnant women under age 21. Prior approval is required for MPW eligible pregnant women.</p> <p>Medicaid will pay only for frames designated by the program.</p> <p>Plastic eyeglass lenses must have prescription strength above a certain criteria to be covered.</p> <p>Eyeglasses are made by the State optical laboratory contractor unless your doctor's office gets prior approval to use a different source.</p>	<ul style="list-style-type: none"> • Rimless frames. • Safety glasses. • Extended wear or disposable contact lenses, and contact lens supplies. • Tinted lenses unless medically necessary. • Sport straps, straps, or chains • Initials/names on frames or lenses. • Magnifying glasses you get at the store. • Repairs that cost under \$5.00. • Cosmetic lenses. • Photochromatic lenses • Progressive (No-line) bifocals • Anti-reflective coating

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Pharmacy Services	Prescribed drugs with U.S. Food and Drug Administration (FDA) approval Routine immunizations, flu vaccines, DPT immunizations.		<ul style="list-style-type: none"> • Prescription cough and cold medicine • Medical supplies or devices: needles, syringes, catheters, IV sets TED hose, etc. • Drugs used for cosmetic indications. • Weight loss and weight gain drugs • Erectile Dysfunctional drugs
Physician (Doctor) Services	Diagnosis and Consultation Therapy. Some supplies usually given by physician during treatment may be covered. Surgery	For Community Care of North Carolina/Carolina ACCESS recipients, all visits to a specialist's office, including therapists or surgeons, need PCP authorization. Visits are counted toward the annual Professional Services visit limit. Not applicable to children under age 21 Prior approval required for some surgical procedures.	
Podiatrist Services	Office visits are counted toward the annual Professional Services visit limit. Covers any medical, mechanical, or surgical procedure involving the foot. Routine foot care, ONLY IF you have a disease such as diabetes mellitus or peripheral vascular disease. (You must be under the care of a physician for the condition and have documentation to support the need for the service.)	Prior approval required for MPW eligible pregnant women. Visits are counted toward the annual Professional Services visit limit. Not applicable to children under age 21.	Non-covered services (incomplete list) <ul style="list-style-type: none"> • Cutting or removal of corns and calluses • Trimming of toenails • Clipping, cutting, or debridement of ingrown toenails • Club nails and Mycotic nails • Routing hygienic care, such as soaking and cleaning the feet • Orthotics, Arch supports, pads or shoe inserts • Diabetic shoes

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<p>Private Duty Nursing Services (PDN)</p>	<p>PDN is medically necessary continuous, substantial, and complex nursing services by a licensed nurse (RN or LPN) that is needed by a patient as documented by the patient's attending physician for care in the patient's home. It is for patients who live in private residences.</p>	<p>Prior approval is required.</p> <p>RN or LPN must be employed by a home care agency licensed by the Division of Health Services Regulation.</p>	<p>Medicare and Medicaid Hospice patients may not receive Private Duty Nursing.</p> <p>Having a nurse monitoring a patient in case something happens is not considered "continuous nursing care" that qualifies for PDN coverage.</p>
<p>Psychiatric and Outpatient Behavioral Health Services</p>	<p>Services provided by a psychiatrist, a psychologist, a licensed clinical social worker, a licensed marriage and family therapist, licensed professional counselor, a nurse practitioner, clinical nurse specialist or a physician's assistant employed by a physician, an Area Mental Health program, or an agency or person that contracts with the Local Management Entity or LME.</p> <p>For adults, these services do not require Community Care of North Carolina/Carolina ACCESS PCP referral.</p> <p>For children under 21 years of age, these services do require a referral from a psychiatrist, a PCP, or the LME.</p>	<p>Certain services provided by a psychiatrist may count toward your annual visit limit. Ask your doctor about this during your visit.</p> <p>Coverage is limited to 16 unmanaged outpatient visits per calendar year (inclusive of assessment and psychological testing codes). Visits beyond 16 per calendar year require a written order by a medical doctor, licensed psychologist (doctorate level), nurse practitioner or physician assistant, and prior approval from the utilization review contractor. To ensure timely prior authorization, requests should be submitted prior to the 17th visit. A new written order is required within 12 months of the initial visit and at least annually thereafter.</p> <p>Prior approval is required for behavioral health outpatient services after the first eight visits for adults and after the 16th visit for children under age 21.</p>	

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<p>Therapy by Independent Practitioners</p>	<p>Outpatient specialized therapies do not count toward the annual Professional Services visit limit .</p> <p>Covers physical therapy, occupational therapy, respiratory therapy, speech/language therapy, and audiology services.</p> <p>Services must be provided in the following settings: office, home, school, Head Start, or daycare.</p>	<p>Limited to recipients under 21</p> <p>Prior approval required for treatment, but not for assessment.</p> <p>Must be ordered by a physician.</p>	
<p>X-rays</p>	<p>These services do not require Community Care of North Carolina/Carolina ACCESS PCP referral.</p> <p>Covers all x-ray services: (includes)</p> <ul style="list-style-type: none"> • Mammograms • Magnetic Resonance Imaging (MRI) scans • Positron Emission Tomography (PET) scans 	<p>Must be ordered by a physician.</p>	<p>Does not cover x-rays taken during a routine physical.</p>

YOUR RIGHT TO APPEAL A DECISION ABOUT A MEDICAID SERVICE

If you are denied medical care or services because Medicaid did not approve the care, you will receive a letter explaining the decision and telling you how you can appeal the denial. The letter will come from the N.C. Division of Medical Assistance, or one of its vendors.

Medicaid may also decide to reduce or stop the services you are getting. You will receive a letter before the change happens. If you appeal the decision by the deadline in the letter, your services will continue during the appeal in accordance with state and federal requirements as noted below. The letter will explain how to appeal.

If you decide to appeal Medicaid's decision to deny, terminate, reduce, or suspend the services requested by your provider, you or your personal representative must appeal the decision in writing within **30 days of the date the notice was mailed**.

When filing an appeal, you are requested to only use the completed, computer generated appeal form preprinted with your name, address, and Medicaid identification number enclosed in your mailing.

Services may be provided during the appeal process as long as the recipient remains otherwise Medicaid eligible, unless he/she gives up this right.

If your appeal request form is received by the Office of Administrative Hearings (OAH) within **ten (10) days of the date the notice was mailed**, payment authorization for services will continue without a break in service.

If your appeal request form is received by OAH **more than ten (10) calendar days but within 30 calendar days of the date the notice is mailed**, authorization for payment must be reinstated, retroactive to the date the completed appeal request form is received by the OAH.

Services will **not** be authorized if:

- OAH receives your completed appeal request form more than 30 days after the date the notice was mailed.
- Your service request was submitted after your current authorization for services expired. Medicaid will treat this request as an initial rather than a reauthorization or continuing request.

If you lose your appeal, you (the recipient) may be required to pay for the services that continue because of the appeal. Please note that if you lose your appeal, you can appeal the final agency decision to court.

For further information about Medicaid recipient due process and prior approval, please visit our website at <http://www.ncdhs.gov/dma/provider/priorapproval.htm>

For further questions about the Medicaid recipient appeals process, contact the Office of Administrative Hearings or to the Medicaid Recipient Appeals/EPSDT Section as indicated below.

AGENCY	TELEPHONE NUMBERS	FAX NUMBERS
Office of Administrative Hearings	919-431-3000	919-431-3100
Division of Medical Assistance	919-855-4350	919-733-2796

Free legal aid may be available to assist the recipient with his/her appeal. The recipient or personal representative may contact their 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 their community. If the recipient is a person with a disability, Disability Rights North Carolina may also be contacted at 919-856-2195 or toll-free at 1-877-235-4210.

YOUR RIGHT TO REQUEST A REVIEW OF A DECISION ABOUT A NC HEALTH CHOICE FOR CHILDREN (NCHC) SERVICE

A NC Health Choice for Children recipient may seek review of any delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services, through a two-level review process. Recipients have the right to request an internal first level review of the decision with the North Carolina Department of Health and Human Services (DHHS), Division of Medical Assistance (DMA) followed by an external second level review with the DHHS Hearing Office. Both levels of review must be completed within 90 calendar days of the date of receipt of the internal first level review request.

To Request a Review:

Recipients and/or legal guardians or authorized representatives may request an internal first level review of an adverse prior approval decision or a claims denial within 30 calendar days of the date on the adverse notice or the date the claim was adjudicated. If the recipient and/or legal guardian are not satisfied with the outcome of the internal first level review decision, they may request a second level review within 15 calendar days of the internal first level review decision date. An authorized representative may submit completed request forms for an internal first level review or external second level reviews, or submit a letter of request. If a letter of request is submitted, each item of information specified below must be included with the request.

- A. Child's name
- B. Child's NC Health Choice for Children identification number
- C. Telephone number
- D. Address
- E. Date the service was provided
- F. Name(s) of the provider(s) of the service
- G. Reason for review request
- H. The letter about the benefit decision
- I. Name of the representative in Customer Service who handled the inquiry if applicable
- J. Completed NC Health Choice for Children Authorized Representative Form if an attorney or other representative is assisting the recipient or authorized representative in the review process
- K. Authorized representative's signature and date on the review request form or letter requesting a review
- L. Both the review request form and the authorized representative form are available at: <http://www.ncdhhs.gov/dma/healthchoice/index.htm>. Hard copy forms will be included with the adverse decision letter that is mailed to the recipient.

Additional or supplemental information (such as medical records, letters from a doctor, etc.) may be included with the request for review.

Internal first level review requests (completed form or letter requesting a review and a completed NC Health Choice for Children Authorized Representative Form, if applicable) shall be mailed or faxed to NC Health Choice for Children.

NC Health Choice for Children Review Coordinator
2501 Mail Service Center
Raleigh, NC 27699-2501
FAX: (919) 733-6608

Internal First Level Review: Recipients have the right to an internal first level review by the Clinical Medical Director of the Division of Medical Assistance or clinical designee, who will review the determination and any other information submitted.

- The recipient must submit the request for an internal first level review within 30 days of the date of the adverse decision notice.
- The recipient will receive a written decision by certified mail.
- The internal decision notice will provide further information about how the recipient may request a second level review.

If recipients disagree with the internal first level review decision, they may request an external second level review with the DHHS Hearing Office by writing a letter or filling out an External Second Level Review Request Form. External second level review requests (completed form or letter requesting a review and a completed NC Health Choice for Children Authorized Representative Form, if applicable), shall be mailed or faxed to the Department of Health and Human Services (DHHS) Hearing Office.

DHHS Hearing Office
2501 Mail Service Center
Raleigh, NC 27699-2501
FAX: (919) 715-6394

External Second Level Review: If a recipient is not satisfied with the internal first level review decision, he or she may request an external second level review by the DHHS Hearing Office.

- The recipient must request this review within 15 days of the date of the first level review decision.
- The DHHS Hearing Office will conduct a hearing in Raleigh, which the recipient may attend in person or by telephone.
- At the hearing, the recipient may represent him/herself or have a representative, including an attorney at the recipient's expense.
- The recipient will receive a written decision by certified mail.

Expedited Review: If a NC Health Choice for Children recipient's physician determines that the standard 90-day time frame could seriously jeopardize the child's life or health or ability to attain, maintain, or regain maximum function, the recipient may request that the review be completed within an expedited time frame. Under the expedited time frame, each level of review must be completed within 72 hours unless the recipient requests additional time (no more than 14 days may be allowed).

Review Decisions: All review decisions are based on coverage noted in the North Carolina General Statutes and in the NC Health Choice for Children clinical coverage policies.

When a Review Will Not Be Held: A review will not be held if the sole basis of the decision is a provision in the State Plan or in a Federal or State law requiring an automatic change in eligibility, enrollment; or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

Services Provided During the Review Process: Maintenance of service is not provided during the review process. When the decision is a reduction, suspension, termination, or denied request for increase of existing services, the services shall be covered in accordance with the decision under review. Services which are terminated or suspended shall not be covered, unless and until the decision is overturned on review.

Enrollment: A NC Health Choice for Children recipient will remain enrolled in the NC Health Choice for Children program during the review process as long as he or she is eligible.

