
MEDICAID COVERED SERVICES

MA-2905- MEDICAID COVERED SERVICES

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I. INTRODUCTION

This section contains information on Medicaid covered services. Each service may have certain limitations, including the need for a prior approval. The guidelines and restrictions for each service are outlined in this section. Refer to the DMA website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific clinical coverage criteria and requirements.

A. EPSDT for Recipients Under 21 Years of Age

Although Medicaid covered services have strict limitations on scope, amount, duration, and/or frequency, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that mandates state Medicaid agencies to provide services, products, or procedures requested by physicians and licensed clinicians for Medicaid recipients under 21 years of age if the services are medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified by a screening examination. EPSDT or Medicaid for children is administered under the name Health Check in North Carolina and is jointly overseen by Clinical Policy and Programs and Managed Care. Services provided under EPSDT include periodic screening, vision, dental, and hearing services. There is no requirement that the requested service, product, or procedure be included in the state Medicaid plan. However, the requested service, product, or procedure must be within the scope of the services listed in the Social Security Act (the Act) at 1905(a). A listing of federal Medicaid covered services can be found at <http://www.ncdhhs.gov/dma/epsdt/> on DMA's website.

Service limitations on scope, amount, duration, and/or frequency described in this manual or in the clinical coverage policies may be excluded or may not apply provided documentation supports that the requested service is medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a licensed clinician. In accordance with EPSDT requirements, health care services shall be provided in a frequency and amount to reasonably achieve their purpose and shall be consistent with the recipient's medical needs.

B. When providing Medical services to recipients under 21 years of age, it is important to adhere to the following:

1. There are no recipient co-payments.
2. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does NOT eliminate the requirement for prior approval.

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3. All requests for services, products, or procedures that are not covered in the North Carolina State Medicaid Plan **MUST** be approved before the service is rendered. To request a service, product, or procedure not covered under the North Carolina State Medicaid Plan for a recipient under 21 years of age, the recipient's physician or other licensed clinician should submit an EPSDT request on behalf of the recipient to:

Director
c/o Assistant Director for Clinical Policy and Programs
Division of Medical Assistance
EPSDT Request
2501 Mail Service Center
Raleigh, NC 27699-2501

FAX 919-715-7679

Recipients should be advised to consult with their medical provider or the Medicaid ombudsman at the state office, for further information regarding covered services, including EPSDT services. For Medicare covered services, please refer to the Medicare website at

<http://www.medicare.gov/Coverage/Home.asp>.

For additional information regarding EPSDT and Health Check, refer to the website at <http://www.ncdhhs.gov/dma/healthcheck/>. Also, see XXXVIII. of this manual section.

II. POLICY PRINCIPLES**A. Medicaid recipients receive 22 mandatory and 8 optional annual medical professional services visits per State fiscal year (July 1st through June 30th).**

Mandatory professional services visits include visits to any one or combination of visits to a physician's office, Nurse Practitioner, Nurse Midwife, health department, Rural Health Center and Federally Qualifies Health Clinic.

Optional professional services visits include visits to any one or combination of visits to optometrists, chiropractors and podiatrists.

1. The following services do not count toward the **22 mandatory annual** visit limit:
 - a. Services provided to recipients under the age of 21,
 - b. Health Check examinations provided to recipients under the age of 21,
 - c. Home health services,
 - d. Inpatient hospital services,

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- e. Services provided to residents of nursing facilities or ICF-MRs,
 - f. Prenatal and pregnancy-related services,
 - g. Dental services,
 - h. Mental health services requiring prior approval,
 - i. Recipients receiving Community Alternatives Program (CAP) services,
 - j. Services covered by both Medicare and Medicaid and,
 - k. **Physical, occupational and speech therapy.**
2. An exemption to the **22 mandatory annual professional services visit limits** must be requested by the primary doctor and may be granted for recipients with the following conditions:
- a. End stage renal disease,
 - b. End stage lung disease,
 - c. Chemotherapy and/or radiation therapy for malignancy,
 - d. Acute sickle cell disease,
 - e. Unstable diabetes (does not apply to diabetic recipients whose condition is controlled by oral medications, diet, or insulin),
 - f. Hemophilia or other blood clotting disorders, and
 - g. Any life threatening illness or terminal stage of any illness (as supported by the physician's documentation).

Refer to <http://www.ncdhhs.gov/dma/provider/AnnualVisitLimit.htm> for more information regarding the annual professional services visit limit.

- B. Medicaid recipients without Medicare are limited to 8 prescriptions per month. At the discretion of the pharmacist, the monthly prescription limit may be overridden with three (3) additional prescriptions per recipient per month. Recipients under the age of 21 or residents of intermediate care facilities/mental retardation centers, skilled level of care facilities and recipients residing in assisted living facilities and group homes are exempt from the 8 prescription limit.**

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CAP recipients are no longer exempt from the 8 prescription limit.

Medicare/Medicaid recipients have no prescription drug coverage (with a few exceptions), through Medicaid. Medicare recipients have prescription drug coverage through Medicare Part D unless they have coverage through a private insurance company.

C. Pharmacy Management Requirements

Medicaid recipients requiring more than 11 prescriptions per month are restricted to a single pharmacy each month except for emergencies. These recipients are identified under the **Recipient Opt-In Program** and are locked into a single pharmacy. Under the **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. Every 6 months, **Opt-In Program** recipients will be systematically removed from the opt-in program when fewer than 12 prescriptions were dispensed in 2 out of the last 3 months, or if fewer than 12 prescriptions were dispensed in the sixth month. The recipient's primary care physician and pharmacy provider can contact DMA's fiscal contractor to request changes to the pharmacy opt-in provider.

Emergency fills are allowed for recipients who are locked into a pharmacy when situations occur where the recipient may not be able to get to his pharmacy, but are limited up to a 4-day supply and a copayment will apply.

Note: Recipients under 21 years of age, recipients in a nursing facility, assisted living facility, group home, or recipients in an intermediate care facility/mental retardation center are EXEMPT from the **Recipient Opt-In Program**.

D. Recipient Management Lock-in Program

Medicaid recipients who over utilize opioid analgesics, benzodiazepines and certain anxiolytics will be locked-in to one prescriber and one pharmacy in order to obtain opioid analgesics, benzodiazepines and certain anxiolytics.

These recipients are identified under the Recipient Management Lock-in Program. The recipient must obtain all prescriptions for these medications from their lock-in prescriber and lock-in pharmacy in order for the claim to pay. Recipients who qualify for the program will be notified and locked in for one year after which time they will be removed from the program if they no longer meet the criteria.

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E. Copayments

Copayments apply to all Medicaid recipients except those specifically exempted by law from copayments. Providers cannot deny services to any Medicaid patient because of the individual's inability to pay a deductible, coinsurance, or co-payment amount. An individual's inability to pay shall not eliminate his liability for the cost sharing charge. The provider may open an account for the patient and collect the amount owed at a later date. Providers may not charge copayments for the following services:

1. Services to individuals under the age of 21
2. Prescribed drugs related to pregnancy
3. Health Check related services
4. Services provided to participants in the Community Alternative Program (CAP)
5. Family planning services and prescribed drugs (birth control medication)
6. Services provided to residents of nursing facilities, intermediate care facilities for mental retardation (ICF-MR), and psychiatric hospitals
7. Hospital emergency department services including physician services delivered in the emergency department
8. Services in state owned psychiatric hospitals
9. Rural Health Clinic (RHC) core services
10. Federally Qualified Health Center (FQHC) core services
11. Non-hospital dialysis facility services
12. Hospital inpatient services (inpatient physician services are not exempt)
13. Home health services
14. Hearing aid services
15. Ambulance services
16. Area Program/Local Management Entity (LME) Mental health clinic services
17. Hospice services
18. Durable medical equipment (DME)
19. Private duty nursing (PDN) services
20. Home infusion therapy (HIT)

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21. Dental services provided in a health department
 22. In Home Care (IHC). This includes In Home Care for Adults (IHCA) and In Home Care for Children (IHCC).
 23. Routine Eye Exams
 24. Eyeglasses and Visual aids.
- F. The Medicaid identification card must be presented to the provider at each visit. If the provider accepts Medicaid as the payment source, the Medicaid payment must be accepted as payment in full, with the exception of applicable copayment amounts.**
- G. Prior approval may be required for some services.**
1. Prior approval (PA) may be required to verify medical necessity before rendering some services. PA is for medical procedure approval only. Obtaining PA does not guarantee payment or ensure recipient eligibility on the date of service.
 2. Prior approval is required for all non-covered state Medicaid plan services **and for covered state Medicaid plan services that exceed clinical coverage policy limits**. See the website identified below for further information.
<http://www.ncdhhs.gov/dma/epsdt/>
 3. Before admitting patients for procedures requiring PA, hospital staff must determine that the physician has completed all of the necessary PA forms and obtained PA. **NOTE:** The primary surgeon is responsible for obtaining PA from Medicaid.
 4. Unless a service is exempt from the CCNC/Carolina ACCESS (CCNC/CA) referral authorization requirement, providers must obtain a referral authorization from the CCNC/CA enrollee's primary care provider in addition to requesting PA for any service or procedure that requires PA.
 5. Most requests for PA are submitted in writing. However, requests for approval for services to recipients with a diagnosis of mental retardation may be faxed. Other services may be approved verbally and followed up with the written request.
 6. Confirmation for routine eye exams and refraction only, are obtained through the Automated Voice Response System.
 7. Prior approval requests for Outpatient Specialized Therapies should be submitted electronically.
 8. Except in emergency situations, **all** services provided to Medicaid recipients by **out-of-state** providers, **beyond a 40 mile radius**, must be approved prior to rendering the service.

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H. Medicaid Recipient Due Process Rights

When a Medicaid service request is denied, reduced, terminated, or suspended, recipients (or their personal representatives) must receive written notice of the adverse decision and have an opportunity for a fair hearing pursuant to the Social Security Act, 42 C.F.R. 431.200 et seq., and N.C.G.S. §108A-70.9

If the recipient decides to *appeal* Medicaid's decision to deny, terminate, reduce, or suspend the services requested by the CCNC/CA provider, the recipient or personal representative must sign and date the appeal request form and send it to the Office of Administrative Hearings (OAH) by mail or fax within **30 days of the date the notice was mailed**. The mailing address and telephone and fax numbers for OAH are located on the appeal request form. Providers may not file appeals on behalf of recipients unless the recipient lists the provider as the representative on the appeal request form.

Services may be provided while the appeal is pending under maintenance of services, as long as the recipient remains otherwise Medicaid eligible, unless he gives up this right. For more information refer to Medicaid Recipient Due Process Rights and Prior Approval Policies and Procedures
<http://www.ncdhhs.gov/dma/provider/index.htm>

III. PHYSICIAN SERVICES

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements and service limitations.

A. Covered Services

Medicaid covers the professional services of the physician when service is medically necessary and furnished in the physician's office, the recipient's home, a hospital, a nursing facility or other setting, as appropriate. The services covered include diagnosis, treatment, surgery, and consultation.

B. Non-Covered Services

Non-covered services include, but are not limited to:

1. Medications given by injection when the drug can be effectively administered to the patient orally with no adverse effects
2. **Unsafe, ineffective or experimental/investigational drugs and/or procedures**
3. Routine physicals and related tests, except through Health Check or adult preventive medicine services, family planning, or annual physical for a nursing home or rest home patient

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4. Sterilization reversal
5. Routine newborn circumcision
6. Services rendered for diagnosis or treatment of infertility
7. Routine foot care, except for recipients with diabetes or a vascular disease
8. Incidental appendectomy
9. Any service or procedure that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment
10. Cosmetic procedures to improve appearance

NOTE: Relative to numbers 7 and 8 above and for recipients under the age of 21 in regard to EPSDT requirements, see I. and XXXVIII. of this manual section.

C. Restrictions

Outpatient physician visits count towards a recipient's 22 mandatory and 8 optional annual medical professional services visits, except as noted in II.A.

D. Copayments

1. \$3.00 per visit
2. Copayments apply to all Medicaid covered services except as noted in II.E.

E. Prior Approval

It is the provider's responsibility to obtain prior approval if needed. (See II.G.)
Procedures that require prior approval include, but are not limited to:

1. Surgical procedures, such as gastric bypass, breast reconstruction, reduction mammoplasty, gender transformation, and craniofacial procedures
2. Surgical transplants, except for bone, tendon, and corneal
3. Non-emergency out-of-state services beyond a 40 mile radius of the N.C. border
4. Excision of keloids
5. Surgical insertion of nuclear powered cardiac pacemakers
6. Outpatient psychiatric visits after the first twenty-six for recipients under age 21 and after eight visits for recipients age 21 and over

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7. Outpatient Specialized Therapies (refer to <http://www.thecarolinascenter.org/HIVCM>)
8. Certain prescription drugs (refer to <http://www.ncmedicaidpbm.com>)
9. Inpatient psychiatric treatment
10. Hyperbaric oxygenation therapy
11. All mental health/substance abuse services
12. **Certain imaging procedures** (refer to <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>)

IV. CLINIC SERVICES

Clinics include certified rural health clinics, federally qualified health centers and local health departments.

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>, for specific coverage criteria, prior approval requirement, and service limitations.

A. Covered Services

1. Core services

Core services are covered by both Medicare and Medicaid. The service must be a face-to-face encounter between the recipient and the provider in the clinic or the recipient's home.
2. Pharmacy services
3. Physician hospital services
4. Obstetrical services
5. Onsite oncology services
6. Health Check examinations
7. Family Planning
8. Childbirth
9. Enhanced nutrition counseling

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10. Dental services
11. Durable medical equipment
12. Mental health/ substance abuse services

B. Restrictions

Outpatient clinic visits count towards a recipient's **22 mandatory and 8 optional annual** medical professional services visits, except as noted in II.A. Multiple diagnostic visits on the same date of service count as one visit.

C. Copayments

1. There are no copayments for core services.
2. Copayments for other clinical services are as follows:
 - a. Physicians - \$3.00 (except for inpatient hospital and emergency room)
 - b. Pharmacy - \$3.00 for generics and selected over-the-counter medications
\$3.00 for brand name
 - c. On-site radiology - \$3.00 (not applicable for health department clinics)
 - d. Dental - \$3.00
3. Copayments apply to all Medicaid recipients except as noted in **II.E.**

D. Prior Approval

It is the provider's responsibility to obtain prior approval if needed. Refer to **II.G.**

V. HOSPITAL INPATIENT SERVICES

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

1. Room and board charges for semiprivate room, except when a private room is medically necessary or where only private rooms are available
2. Nursing services (other than the services of a private duty nurse, unlicensed personnel, sitters/companions/attendants)
3. The use of hospital facilities

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4. Medical social services
5. Drugs and biologicals for use in the hospital
6. Supplies, appliances, and equipment for use in the hospital
7. Other diagnostic or therapeutic items or services not specifically listed, but are ordinarily furnished to inpatients

B. Non-covered Services

Non covered services include, but are not limited to those below.

1. Private rooms, unless the diagnosis indicates medical necessity or no other room is available
2. Telephone
3. Television
4. Overnight leave days
5. Services rendered for diagnosis or treatment of infertility
6. Prevocational evaluation
7. Late discharge for convenience purposes
8. Procedures that are experimental, unsafe, ineffective, and/or not in keeping with the current standard of practice
9. Private duty nurses, unlicensed personnel, sitters/companions/attendants
10. Take-home supplies or equipment, including drugs from the hospital pharmacy
11. Medical photography
12. Day of discharge

NOTE: Relative to numbers 8, 9, 10, 11, and 12 immediately above and for recipients under the age of 21 in regard to EPSDT requirements, see Sections I. and XXXVIII. of this manual section.

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C. Restrictions

1. Abortions, hysterectomies, and sterilizations procedures are subject to the restrictions listed in section XXXIII.
2. Inpatient hospital services do not count towards the recipient's **professional services** visit limit. However, inpatient physician services do count towards a recipient's **professional services** visit limit. Refer to II.A. for exceptions.

D. Copayments

1. Physician copayments are \$3.00 per inpatient visit.
2. Copayments apply to all Medicaid recipients except as noted in II.E.

E. Prior Approval

It is the provider's responsibility to obtain prior approval if needed. Refer to II.G. for additional information.

VI. HOSPITAL OUTPATIENT SERVICES

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

The Medicaid program covers outpatient hospital services related to physician's and dentist's services that are needed for treating patients and for the physician's and dentist's professional component, outpatient diagnostic services, outpatient specialized therapies such as physical, speech, and occupational therapies. Covered outpatient therapeutic and rehabilitative services provided by the hospital include the use of hospital facilities, including clinic services and emergency room services.

B. Non-Covered Services

Non-covered services include, but are not limited to:

1. Take-home supplies or equipment, EXCEPT for small quantities of supplies, legend drugs, or insulin needed by the patient until such time as the patient can obtain a continuing supply.

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2. Well-baby care, EXCEPT Health Check screenings
3. Biofeedback
4. Blood tests to determine paternity
5. Infertility tests and treatment
6. Experimental drugs or procedures
7. A portion of outpatient mental health services (responsibility of the recipient)
8. Routine physicals
9. Brain pacemaker
10. Telephonic pacemaker monitoring

NOTE: Relative to numbers 8, 9, and 10 above and for recipients under the age of 21 in regard to EPSDT requirements, see I. and XXXVIII. of this manual section.

C. Restrictions

Outpatient hospital visits count toward the recipient **professional services visits** limit, EXCEPT as noted in II.A.

D. Copayments

1. \$3.00 per visit
2. Copayments apply to all Medicaid recipients except as noted in II.E.

E. Prior Approval

It is the provider's responsibility to obtain prior approval if needed. (Refer to II.G. for additional information.)

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Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

While not all inclusive, items stated below are covered in the per diem for each facility:

1. Room and board, including therapeutic diets with feeding assistance and general nursing services as needed.

NOTE: The Medicaid per diem rate is for semiprivate room, unless the recipient's attending physician orders a private room or a private room is the only available room.

2. Therapeutic leave.
3. Non-prescription drugs, such as aspirin, antacids, etc.
4. Biological serums and vaccines, such as flu vaccines and TB skin test.
5. Physical therapy, speech and language pathology, and occupational therapy.
6. Diagnostic services, including laboratory, radiology, and other required diagnostic services.
7. Medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well being of the resident.
8. Activity services to meet the interests and physical, mental, and psychosocial well being of the resident.
9. Personal laundry (no dry cleaning).
10. Supplies and equipment
 - a. Medical supplies such as IV solutions and tubing, tracheostomy supplies, catheters, colostomy bags and supplies
 - b. Dressings, adhesive tapes, antiseptic solutions, and skin care items used in the treatment of wounds, decubitus ulcers, skin tears, etc.

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- c. Personal hygiene items such as soap, shampoo and conditioner, toothbrush and toothpaste, lotion, tissues, razors, deodorant, denture adhesive, incontinency pads and pants, etc.
 - d. Items furnished to all patients on a routine basis such as gowns, water pitchers, bedpans, linens, etc.
 - e. Medical equipment such as canes, crutches, walkers, wheelchairs, etc.
 - f. Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet (these supplements have been classified by the FDA as a food not a drug)
 - g. Other miscellaneous items such as tube feeding equipment/solutions, restraints, etc.
11. Transportation is directly paid to the nursing facility. **DMA directly reimburses long term care facilities for non-ambulance transportation of Medicaid eligible patients to receive medical care that cannot be provided in the facility. This reimbursement is included in the total cost of care paid to the facility.**

See [MA-2910](#), Medicaid Transportation, for detailed coverage and procedures.

B. Non Covered Services

1. Private rooms, EXCEPT if ordered by a physician for medical necessity or if another room is not available
2. Reservation of bed during an absence, e.g. hospitalization
3. Patient monthly liability as determined by county Department of Social Services
4. Personal items, such as telephones, televisions, clothing, cosmetics, tobacco products, etc.
5. Non-routine hair care such as set, hair color, permanent wave
6. Guest trays
7. Morgue boxes, shrouds, or burial wrappings
8. Some transportation (See [MA-2910](#), Medicaid Transportation, for detailed coverage and procedures)

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9. Private duty nurses, unlicensed personnel, sitters/attendants/companions
10. Medical photography

NOTE: Relative to numbers 9 and 10 above for recipients under the age of 21 in regard to EPSDT requirements, see I. and XXXVIII. of this manual section.

C. Restrictions

Physician visits made to a recipient in a nursing facility are not counted toward a recipient's **professional services** visit limit.

D. Copayments

Medicaid recipients who are residents of a nursing facility are exempt from copayments.

E. Prior Approval

It is the provider's responsibility to obtain prior approval if needed. (Refer to II.G. for additional information.)

VIII. PSYCHIATRIC AND PSYCHOLOGICAL SERVICES

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

1. Psychiatrists
2. Licensed Psychologists
3. Licensed Clinical Social Workers
4. Certified Psychiatric Nurse Practitioner
5. Clinical Nurse Specialists
6. Licensed Professional Counselors
7. Licensed Marriage and Family Therapist
8. Licensed Psychological Associates
9. Licensed Clinical Addictions Specialist
10. Licensed Clinical Supervisors

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1. Visits to a private practice psychiatrist are not restricted by the age of the recipient.
2. Visits to licensed psychologists, licensed clinical social workers, certified psychiatrist nurse practitioners and clinical nurse specialists, licensed professional counselor, licensed psychological associates, licensed marriage and family therapists, licensed clinical addictions specialist and licensed clinical supervisors are not limited to age.
3. Visits for recipients **age 21 and over** when subject to prior approval do not count towards the recipient's **professional services** visit limit.
4. Medicaid covers 26 unmanaged visits for recipients **under the age of 21** in a calendar year without prior approval.
5. Medicaid recipients age 21 and over receiving outpatient mental health services will require prior approval after the eighth visit in a calendar year.

C. Copayments

1. \$3.00 per visit for private practice psychiatrists.
2. Copayments apply for all Medicaid recipients except as noted in II.E.

D. Prior Approval

1. Prior approval is required for outpatient mental health services after twenty-six visits for recipients under age 21 and after the eighth visit for recipients age 21 and over.
2. It is the provider's responsibility to obtain prior approval. (Refer to II.G. for additional information.)
3. A referral authorization is required for children under 21 from the local management entity, Medicaid enrolled psychiatrist, or Carolina Access PCP.

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Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

1. Level II, III, IV - Residential Services
2. Psychiatric Residential Treatment Facility Services (PRTF)

B. Restrictions

1. This service is available for recipients **under the age of 21** or who are in treatment at age 21. Continued treatment can be provided until the recipient turns 22 as long as it is medically necessary.
2. Residential services can be accessed through screening and triage at the mental health center or through a community supports provider after a diagnostic assessment has determined the need.

C. Prior Approval

1. It is the provider's responsibility to obtain prior approval if needed. (Refer to II.G. for additional information.)
2. A referral is required for children under age 21 from the local management entity, Medicaid enrolled psychiatrist, or Carolina Access PCP.

X. MENTAL HEALTH CENTERS

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

Local management entities (old mental health programs) are responsible for access, screening and triage of recipients who come to them for services. They are no longer a Medicaid service provider (except with the Secretary's approval for a limited time period). They are responsible for building community capacity, for monitoring providers and for management of state dollar services.

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Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

Recipients age 65 or older or under age 21

B. Restrictions

1. A recipient who turns age 21 as an inpatient will be covered until he is discharged or reaches age 22.
2. Federal regulations require a certification of need (CON) form for admission to a psychiatric hospital for Medicaid recipients under age 21.

C. Admission Approval

Inpatient admissions require prior approval. Refer to II.G. for additional information.

XII. NORTH CAROLINA SPECIALTY HOSPITALS

North Carolina specialty hospitals are a covered service for inpatient care of recipients with chronic diseases (i.e., pulmonary or tuberculosis). See V. above.

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

XIII. DENTAL SERVICES

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

1. Most general routine services such as exams, cleanings, fillings, sealants, x-rays, extractions, partial **dentures and complete** dentures.
2. Periodontal surgery for recipients with gum disease complicated by an underlying medical condition.
3. Periodontal services **are** limited to **four quadrants of** scaling and root planning per recipient annually.
4. Endodontic (root canal) treatment for anterior (front) teeth. Endodontic (root canal) treatment for posterior (back) teeth, for recipients **under age 21**.

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5. Stainless steel crowns (caps) for primary (baby) teeth and permanent premolars and permanent first and second molars on recipients under age 21.
6. A space maintainer to hold a space when a primary (baby) molar, primary (baby) canine or permanent first molar is removed prematurely for recipients under age 21.

Note: This is only covered as a fixed appliance; not allowed as a removable appliance.
7. Fluoride treatment two times a year for recipients under age 21.
8. Sealants are limited to primary molars for recipients under age 8 and permanent first and second molars for recipients under age 16.
9. Full mouth x-rays and panoramic x-ray once every 5 years.
10. Complete dentures once every 10 years.
11. Partial dentures once every 10 years.
12. Denture relines are allowed six months after delivery, and no more than once every five years.
13. Craniofacial reconstruction for congenital abnormalities or post-traumatic reconstruction.
14. Orthodontic services for recipients under age 21 with functionally impairing malocclusions.

NOTE: Relative to number 14 above and for recipients under the age of 21 in regard to EPSDT requirements, see I. and XXXVIII. of this manual section.

B. Non-Covered Services

Non-covered services include, but are not limited to those identified below.

1. Fixed bridgework
2. Experimental procedures
3. Prescription drugs dispensed by the dentist
4. Implants/transplants and treatment involving them
5. Precious metals sold for removable appliances and treatment involved

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6. Precision attachments for partials
7. Gold or porcelain restorations **or** crowns
8. Temporary or interim dentures
9. Removable space maintainers and orthodontic retainers
- 10. Cosmetic procedures (bleaching, whitening, bonding, veneers)**
11. TMJ splints, night guards and mouthpieces

NOTE: Relative to all services enumerated above and for recipients under the age of 21 in regard to EPSDT requirements, see I. and XXXVIII. of this manual section.

C. Restrictions

Dental visits do not count toward a recipient's **professional services** visit limit. Routine dental services are covered for Medicaid for Pregnant Women (MPW) recipients only through the date of delivery.

D. Copayments

1. \$3.00 per visit (No copayment if rendered in Health Department).
2. Copayments apply to all Medicaid recipients except as noted in II.E.
3. Only one copayment should be collected for services requiring more than one visit but which are billed as one procedure, such as dentures

E. Prior Approval

1. It is the provider's responsibility to obtain prior approval if needed.
2. Procedures that require prior approval include, but are not limited to those stated below.
 - a. Gum treatment or periodontal services
 - b. Orthodontic services
 - c. Complex oral surgical procedures
 - d. Complete dentures
 - e. Partial dentures

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- f. Denture relines
- g. Any service by a dentist who has demonstrated aberrant billing patterns to Medicaid

XIV. CHIROPRACTORS

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

1. Manual manipulation of the spine to correct a subluxation
2. X-rays to document the condition for which manual manipulation of the spine is appropriate

B. Non-Covered Services

1. Office visits
2. Nutritional supplements
3. Physical therapy
4. Any other diagnostic or therapeutic service

NOTE: Relative to all services listed above and for recipients under the age of 21 in regard to EPSDT requirements, see I. and XXXVIII. of this manual section.

C. Restrictions

1. The subluxation must be supported by an x-ray dated within six months of the date of service and an appropriate diagnosis.
2. Office visits count toward a recipient's **professional services** visit limit except as noted in II.A.
3. Prior approval is required for MPW recipients.

D. Copayments

1. \$2.00 per visit
2. Copayments apply to all Medicaid recipients except as noted in II.E.

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Prior approval is required for MPW recipients. (Refer to II.G. for additional information.)

XV. PODIATRISTS

A doctor of podiatric medicine is included within the definitions of "physician" for Medicaid purposes. The professional services must fall within the scope of podiatric practice legally authorized by the State of North Carolina.

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

Medicaid covered procedures performed in the surgical, medical, or mechanical treatment of the foot and ankle, and related soft tissue structures to the level of the myotendinous junction.

B. Non-Covered Services

Non-covered services include, but are not limited to:

1. Procedures unrelated to the foot itself
2. Routine foot care (cutting or removal of corns or calluses, trimming of toenails, including cutting, clipping, or debridement of ingrown toenails, club nails, mycotic nails, and other routine hygienic care, such as cleaning and soaking the feet)
 - a. The only circumstances in which routine foot care service is reimbursed by Medicaid are those that are medically necessary and are an integral part of otherwise covered services (such as plantar warts); and/or the presence of metabolic, neurological, and/or peripheral vascular diseases exists; and/or there is evidence of mycotic nails that, in the absence of a systemic condition, result in pain or secondary infection.
 - b. The recipient must be under the active care of a doctor of medicine or osteopathy for such a condition to warrant Medicaid reimbursement. Medical documentation must be available to support the need for this service.

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3. Orthotics
4. Arch supports, pads, or shoe inserts

NOTE: Relative to all services identified above and for recipients under the age of 21 in regard to EPSDT requirements, see I. and XXXVIII. of this manual section.

C. Restrictions

Office visits count toward a recipient's **professional services** visit limit except as noted in II.A.

D. Copayments

1. \$3.00 per visit
2. Copayments apply to all Medicaid recipients except as noted in II.E.

E. Prior Approval

1. It is the provider's responsibility to obtain prior approval if needed. Refer to II.G. for additional information.
2. Prior approval is required for MPW recipients.

XVI. HOSPICE

Hospice is a package of medical support services for terminally ill individuals, defined as persons with a medical prognosis of six months or less to live. Hospice care may be provided in a private residence, hospice residential care facility, adult care homes, or hospice inpatient unit. Hospice care may also be provided in a hospital or nursing facility provided there is a contractual arrangement with the hospice agency.

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

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The services identified below are covered by Medicaid when related to the recipient's terminal illness. Services are provided as needed on an individual basis and according to a plan of care developed by the hospice interdisciplinary team.

1. Nursing care
2. Physician services
3. Medical social services
4. Counseling services, including dietary and bereavement counseling, for the patient, family members, and others caring for the patient
5. Home health aide and homemaker services
6. Physical therapy, occupational therapy, speech-language pathology services
7. Short-term inpatient care (general or respite) provided in a hospice inpatient unit or in a hospital or nursing facility
8. Medical appliances and supplies, including drugs and biologicals, and durable medical equipment, used for pain relief and symptom control related to the terminal illness

B. Restrictions

1. The physician must certify that the recipient is terminally ill; that is, in the physician's professional opinion, the recipient has a prognosis of six months or less to live if the disease or illness follows its usual course.
2. The recipient or his representative must elect Medicaid hospice coverage by signing an agreement.
3. The agreement spells out that by electing hospice the patient agrees to waive Medicaid coverage of certain other services for the treatment of the terminal illness and related conditions.
4. Hospice services do not count towards a recipient's **professional services** visit limit.

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There are no copayments for hospice service.

D. Prior Approval

1. It is the provider's responsibility to obtain prior approval if needed. (Refer to II.G. for additional information.)
2. Prior approval is required for MPW recipients.

XVII. DURABLE MEDICAL EQUIPMENT (DME)

Refer to the DME website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements and restrictions.

Sterile pads are not “durable medical equipment” but are covered under “home health supplies.” Recipients must go through a Medicare certified home health agency to get sterile pads. Refer to home health care agencies by counties at the following website. <http://www.homeandhospicecare.org/directory/homecare/home.html>.

A. Covered Services

1. Wheelchairs, walkers, canes, hospital beds, and other medically necessary medical equipment suitable for use in the home
2. Prosthetics such as artificial limbs, etc., and orthotics such as leg braces, etc., for recipients **under age 21**
3. Oxygen and oxygen equipment
4. Related medical supplies when provided for use with DME items
5. Service/repair of a DME item when it is owned by a recipient
6. Enteral Nutrition equipment

B. Non-Covered Service

Non-covered items include, but are not limited to those stated below.

1. Convenience items or features
2. Equipment for an individual in a nursing facility. Medical equipment is included in the facility's per diem rate. See VII.

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3. Lift chairs
4. 3-wheeled scooters

NOTE: Relative to all products specified above and for recipients under the age of 21 in regard to EPSDT requirements, see I. and XXXVIII. of this manual section.

C. Restrictions

1. Prosthetics and orthotics are covered for recipients **under age 21** only.
2. A recipient receiving hospice under Medicaid or Medicare may not receive DME coverage for items to treat the terminal illness.
3. A recipient receiving drug infusion therapy through Medicaid home infusion therapy (HIT) coverage may not receive DME coverage for items related to the HIT therapy.
4. Oxygen and oxygen equipment cannot be covered unless arterial blood gas or oxygen saturation studies indicate that a medical necessity exists.

D. Copayments

There are no copayments for durable medical equipment (DME).

E. Prior Approval

1. The provider is responsible to obtain prior approval if needed. Refer to II.G. for additional information.
2. Required for some DME and oxygen items
3. Required for DME service/repair
4. Required for some prosthetics/orthotics
5. MPW recipients – (All equipment must be medically necessary for pregnancy related conditions and requires prior approval.)

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Home health services are medically necessary intermittent skilled services (skilled nursing, physical therapy, speech and language pathology and occupational therapy) and non-skilled services (home health aide services and medical supplies) provided to recipients who reside in private residences. Home health skilled services and medical supplies can be provided to recipients in an adult care home. 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.

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

Home health services include skilled nursing, home health aide services, physical therapy, speech and language pathology, occupational therapy, and medical supplies. Home health skilled services and aide services are provided on a per visit basis. Medical supplies may be provided to a recipient even when no home health services are needed.

B. Restrictions

1. Home health services do not count towards a recipient's **professional services** visit limit.
2. 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

Home health services are deemed appropriate when the recipient's medical record accurately documents one or more of the reasons specified below relative to why the services should be provided in the recipient's home instead of the physician's office, clinic, or other outpatient setting.

- a. The recipient would require ambulance transportation.
- b. The recipient requires assistance in leaving the home, such as with opening doors and other routine activities.
- c. The recipient is wheelchair bound with a medical condition that precludes leaving home on a regular basis.
- d. The recipient is medically fragile or unstable.
- e. Leaving the home would interfere with the effectiveness of the services.

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3. All services must be ordered by a physician and rendered according to an authorized plan of care.
4. Recipients residing in an adult care home are only eligible to receive skilled nursing, skilled therapy services, and medical supplies.
5. 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.

NOTE: Relative to number 5 above and for recipients under the age of 21 in regard to EPSDT requirements, see I. and XXXVIII. of this manual section.

C. Copayments

There are no copayments for home health services.

D. Prior Approval

1. It is the provider's responsibility to obtain prior approval if needed. (Refer to II.G. for additional information.)
2. Required for recipients receiving MPW coverage.

XIX. IN-HOME CARE FOR ADULTS (IHCA) AND IN-HOME CARE FOR CHILDREN (IHCC)

Beginning June 1, 2011 the North Carolina Department of Health and Human Services Division of Medical Assistance (DMA) discontinued the Medicaid Personal Care Services Program and implemented two new programs: In-Home Care for Adults (IHCA) age 21 and over and In-Home Care for Children (IHCC) under age 21.

The In-Home Care (IHC) Programs provide person-to-person, hands-on assistance with common Activities of Daily Living (ADL). This assistance is delivered by a paraprofessional aide in the recipient's home. The program is for recipients who need assistance to supplement care provided by family members and other caregivers.

IHC is non-skilled care is not considered as a substitute for skilled home health care services (e.g., nursing, physical therapy, occupational therapy, speech therapy, etc.), which may be indicated to improve the patient's function/condition.

Refer to, <https://www.thecarolinascener.org/default.aspx?pageid=176> for specific coverage criteria, prior approval requirements, and service limitations regarding In Home Care for Adults (IHCA) and In-Home Care for Children (IHCC).

NOTE: For recipients under the age of 21 relative to EPSDT requirements, see I. and XXXVIII. of this manual section.

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A. In Home Care (IHC) Covered Services

In Home Care (IHC) tasks may include assistance with such activities as bathing, toileting, positioning, ambulation, and taking and recording vital signs, etc. Housekeeping and home management tasks that are *essential*, although secondary, to the **in home** care tasks necessary for maintaining the recipient's health are also covered.

B. Non-Covered Services

1. Skilled medical care performed by licensed professionals, such as a registered nurse or licensed practical nurse
2. **IHC 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 for personal assistance**
3. Housekeeping and home management tasks not directly related to maintaining the recipient's health status
4. Medical transportation

C. Restrictions

1. **IHCA and IHCC** services do not count towards a recipient's **professional services** visit limit.
2. **IHC** must be authorized by recipient's attending physician
3. The recipient must have a medical condition that requires the direct ongoing care of the physician prescribing **IHC**.
4. The recipient must need help with personal care tasks because of the medical condition.
5. The recipient must be medically stable at maintenance level.
6. **IHC** must be the most cost-effective and appropriate form of care.
7. Medicaid covers **IHC** only for recipients in a private residence
8. The recipient may not receive both **IHC** and another substantially equivalent service, such as Home Health Aide Services, In-Home Aide Level II, or In-Home Aide Level III-Personal Care, on the same day

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NOTE: Relative to number 9 above and for recipients under the age of 21 in regard to EPSDT requirements, see I. and XXXVIII. of this manual section.

D. Copayments

There are no copayments for IHCA or IHCC.

E. Prior Approval

1. Prior approval is required for IHCA or IHCC services.

Refer to, <https://www.thecarolinascener.org/default.aspx?pageid=176> for specific coverage criteria, prior approval requirements, and service limitations regarding In Home Care for Adults (IHCA) and In-Home Care for Children (IHCC).

2. Prior approval is required for MPW recipients.

XX. HOME INFUSION THERAPY (HIT)

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

Home Infusion Therapy (HIT) covers self-administered infusion therapies in a recipient's home when medically necessary. The types of infusion therapies are stated below.

1. Total parenteral nutrition (TPN)
2. Enteral nutrition (EN)
3. Chemotherapy for cancer treatment
4. Antibiotic therapy
5. Pain management therapy
6. Tocolytic therapy

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B. Restrictions

1. HIT services do not count towards a recipient's **professional services** visit limit.
2. HIT must be ordered by the physician who is actively treating the recipient for whom the referral is made.
3. HIT is provided either in a recipient's private residence or an adult care home.
4. To receive any of the therapies listed above, the recipient must require on an ongoing basis the infusion therapy that is medically indicated for the treatment of his condition and have a clinical status that allows the infusion to be safely administered in the home.
5. HIT services must be provided in accordance with HIT clinical coverage policies found at: www.dhhs.state.nc.us/dma.
6. A recipient receiving hospice under Medicare or Medicaid cannot receive HIT for treatment related to terminal illness. The recipient must choose HIT or hospice for treatment of the terminal illness.
7. A recipient may not receive HIT drug therapy when receiving Medicaid Private Duty Nursing (PDN). It is expected that the PDN nurse would provide the needed service while caring for the recipient. PDN can bill for supplies and the pharmacy can bill for the drug.

C. Copayments

There are no copayments for HIT services.

D. Prior Approval

1. It is the provider's responsibility to obtain prior approval. (Refer to **II.G.** for additional information.)
2. Prior approval is required for MPW recipients.

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Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

Medically necessary continuous, substantial, and continuous skilled nursing services that require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of a hospital or nursing facility.

B. Restrictions

1. PDN must be authorized by the recipient's attending physician.
2. PDN must be provided in the recipient's private and primary residence.
3. The required recipient care tasks can only be performed by a nurse (registered or licensed) licensed by N.C. Board of Nursing.
4. A recipient receiving PDN services must meet all criteria as specified in the PDN clinical coverage policy found at: www.dhhs.state.nc.us/dma.
5. PDN services shall be rendered in accordance with the clinical coverage policy at www.dhhs.state.nc.us/dma.
6. A recipient receiving hospice under Medicare and Medicaid cannot receive PDN.
7. PDN may not be provided during the same time of day as personal care services.
8. If a recipient chooses to receive HIT as a separate, reimbursable service, he is not eligible for PDN services. HIT nutrition therapy can be provided at the same time as PDN services, with PDN nurses providing needed nursing care.
9. PDN does not count toward a recipient's professional services visit limit.

C. Copayments

There are no copayments for PDN visits.

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D. Prior Approval

1. It is the provider's responsibility to obtain prior approval. Refer to II.G. for additional information.
2. Prior approval is required for **all** recipients.

XXII. PRESCRIPTION DRUGS

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

1. The prescribed drug must have Federal Drug Administration (FDA) approved indications.
2. The prescribed drug must bear the federal legend statement.
3. A legend drug must be manufactured by a company that has signed a National Medicaid Rebate Agreement with the Centers for Medicare and Medicaid Services (CMS).
4. Selected over-the-counter (OTC) medications and insulin products are covered.
5. **Routine immunizations, flu vaccine, DPT immunization, etc.**

B. Non-Covered Services

1. OTC drugs (except Insulin and selected OTC products per General Medical Policy No. A-2).
2. Federal Legend drugs or their generic equivalents that are on the DESI list established by the FDA.
3. Any drug manufactured by a company who has not signed a rebate agreement.
4. Medical supplies or devices: needles, syringes, catheters, IV sets, TED hose, etc.
5. Diaphragms.

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6. Fertility drugs.
7. Drugs used for cosmetic indications.
8. Durable medical equipment (DME): (Oxygen concentrators, wheelchairs, etc.)
9. IV fluids (Dextrose 500 ml or greater) and irrigation fluids used by Medicaid recipients in an inpatient facility (Must be billed by the facility as ancillary services).
10. Erectile Dysfunction drugs.
11. Weight loss and weight gain drugs.

NOTE: Relative to all services, products, or procedures specified above and for recipients under the age of 21 in regard to EPSDT requirements, see I. and XXXVIII. of this manual section.

C. Restrictions

1. Medicaid recipients are limited to eight prescriptions each month except as noted in II.B. above. At the discretion of the pharmacist, the monthly prescription limit may be overridden with three additional prescriptions per recipient per month.
2. Medicaid recipients who are entitled to or enrolled in Medicare Part A and/or B have no prescription drug coverage through Medicaid. These recipients must enroll in a prescription drug plan or have other prescription drug coverage.
3. Medicaid recipients requiring more than 11 prescriptions per month are restricted to a single pharmacy each month except for emergencies. Recipients under 21 years of age, recipients in a nursing facility receiving a skilled level of care, recipients in an intermediate care facility/mental retardation center and recipients residing in assisted living facilities and group homes are EXEMPT from the pharmacy opt-in program.
4. Pharmacies participating in Medicaid are required to substitute generic drugs for brand name or trade name drugs unless the prescriber specifically orders the brand name drug by personally indicating in his own handwriting on the prescription order “**medically necessary**”.
5. The maximum days supply for all drugs is a 34-day supply unless the medication meets the criteria described below to obtain a 90-day supply:
 - a. A generic, non-controlled, maintenance medication when the recipient has had a previous 30-day fill of the same medication.

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- b. Birth control medications.
 - c. Prepackaged hormone replacement therapies.
6. Some medications may have limitations such as age, gender or amount.

D. Prior Approval

1. Prior approval is required for certain drugs prescribed to Medicaid recipients.
2. It is the responsibility of the prescribing physician to obtain approval through DMA's contracted Pharmacy Benefits Manager (PBM).

E. Copayments

1. \$3.00 generic drug and selected over-the-counter medications
\$3.00 per brand name drug
2. Copayments apply to all Medicaid recipients except as noted in **II. E.**
3. Recipients residing in assisted living facilities, Adult Care Homes (ACH), and rest homes pay copayments as stated above.

XXIII. HEARING AID SERVICES

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

1. Hearing aids are covered services for Medicaid eligible recipients under age 21.
2. Initial care kit (one per lifetime)
3. Custom ear molds
4. Cords, garments, harnesses, and other accessories
5. Batteries
6. Repairs
7. Dispensing fees
8. FM systems

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B. Non-Covered Services

Non-covered services include, but are not limited to those specified below.

1. Battery chargers or testers
2. Adapters for telephones, televisions, or radios
3. Shipping/handling fees, postage, or insurance
4. Loss, damage, or theft insurance
5. In-the-ear aids for cosmetic purposes
6. Hearing devices other than those specified

NOTE: Relative to number 6 and for recipients under the age of 21 in regard to EPSDT requirements, see I. and XXXVIII. of this manual section.

C. Restrictions

1. Hearing aids, related supplies, and services are not covered for anyone over age 20.
2. Recipient must receive a medical examination from a physician, preferably an otologist (includes otolaryngologist and otorhinolaryngologist) and documentation/certification of the need for the initiation of the hearing aid selection process.
3. Recipient must receive a hearing evaluation, including audiogram, and a hearing aid selection/evaluation test performed by a licensed audiologist.
4. Recipient must be given a trial period for hearing aids and hearing aid accessories.
5. Medically necessary in-the-ear aids generally limited to children 12 years of age or older.

NOTE: Relative to number 5 above and for recipients under the age of 21 in regard to EPSDT requirements, see I. and XXXVIII. of this manual section.

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D. Prior Approval

1. It is the provider's responsibility to obtain prior approval if needed. (Refer to II.G. for additional information.)
2. Prior approval is required for all covered services EXCEPT batteries.
3. Individual consideration is given to requests for replacement hearing aids (lost, stolen, damaged) if the request is confirmed in writing by the county DSS and the parent or guardian.
4. Replacement of an inadequate hearing aid (too weak, too strong) will be given consideration **when the prior approval request is accompanied by** test results and documentation by a physician/audiologist.

XXIV. OPTICAL SERVICES

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

1. Routine eye examinations by an ophthalmologist or an optometrist to determine refractive errors **are covered for recipients under age 21.**
2. Eyeglasses and certain other visual aids dispensed by an ophthalmologist or optometrist or an optician **are covered for recipients under age 21.**
3. Medically necessary contact lenses and backup eyeglasses **are covered for recipients under age 21.**
4. Office visits to the ophthalmologist or optometrist to monitor for certain medical eye diseases (cataracts, macular degeneration, or complications associated with diabetes, etc.) **are covered for adults and children.** (These do not require prior approval.)

B. Non-Covered Services

Non-covered services include, but are not limited to those listed below.

1. Rimless frames
2. Safety glasses
3. Extended wear or disposable contact lenses
4. Contact lens supplies

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5. Tinted lenses, such as photogray, photosun, UNLESS medically justified by diagnosis
6. Sunglasses
7. Sport straps or chains
8. Affixing initials or engraving initials/names on frames or lenses
9. Hand-held magnifiers or any visual aid that can be purchased without a prescription
10. Repairs costing less than \$5.00
11. Cosmetic lenses such as progressive multifocals, blended bifocals, etc.

NOTE: Relative to all services and products stated above and for recipients under the age of 21 in regard to EPSDT requirements, see I. and XXXVIII. of this manual section.

C. Restrictions

1. Visits to ophthalmologists or optometrists, including exams and visits, are counted toward the **professional services** visits limit EXCEPT the dispensing of supplies, glasses, or contact lenses.
2. Only one **routine eye exam** (eye exam to determine prescription) and one pair of **eyeglasses** (frames and lenses) per year for individuals under age 21.
3. The time limitation is based on the date of previous the prior approval. For example, an individual receiving prior approval July 23 will be eligible again the next July 23, even if he did not receive his glasses until August 15.
4. Generally, a change in lens power of **0.50** diopter or greater in either eye may justify approval for new lens/lenses within the time limitation. Documented medical justification is required.
5. Repairs may be covered unless the cost is under \$5.00.
6. Coverage of frames is limited to those designated by the Medicaid program, unless medical necessity dictates otherwise.

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7. Lenses are covered when the strength of the prescription is above a specific minimum criterion as stated in the clinical coverage policy found at: www.dhhs.state.nc.us/dma.
8. A recipient who chooses frames/lenses which are not covered by Medicaid must pay the full cost of the frames and lenses and all related services.
9. Pink or gray tint are the only tints that are generally covered for photophobia.
10. Other tints (UV, photogray, etc) can be approved for post-cataract recipients, albinos, etc.
11. Contact lenses are covered only when medically necessary, i.e., keratoconus, progressive myopia, and aphakia etc.
12. Magnifiers, readers, telescopic lenses, etc. are non-covered. Refer these requests to Division of Services for the Blind.
13. Lenses are available in glass or plastic.

NOTE: Relative to all services, products, or procedures identified above and for recipients under the age of 21 in regard to EPSDT requirements see I. and XXXVIII. of this manual section.

D. Copayments

1. \$2.00 per pair of eyeglasses and all other optical supplies
2. \$2.00 per repair exceeding \$5.00
3. \$3.00 per visit to optometrist
4. \$3.00 per visit to ophthalmologist
5. Copayments apply to all Medicaid recipients except as noted in II.E

E. Prior Approval

1. It is the optical services provider's responsibility to obtain prior approval if needed. (Refer to II.G. for additional information.)
2. **Prior approval** is required for all visual aids
 - a. Special approval within the time limit may be given due to extenuating circumstances and/or medical necessity.

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- b. The special prior approval request for lost, stolen, or damaged visual aids must be accompanied by a letter of explanation (what the recipient reported) from the county DSS and a police report or fire department report if glasses are stolen or destroyed by fire respectively.

If visual aids are damaged, the county DSS staff should instruct the recipient to take the letter, all supporting documents (police and /or fire reports) and broken glasses to the provider for review and evaluation.

If visual aids are lost or stolen, the county DSS staff should instruct the recipient to take the letter to the provider or the county DSS staff can fax the letter to the provider.

3. Required for a second refraction within the time limit.
4. Required for repairs costing over \$5.00.

XXV. LABORATORY SERVICES

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

Medicaid only covers services provided by a physician or independent laboratory when they have CLIA certification to perform the tests.

B. Non-Covered Services

Laboratory tests for paternity testing. Contact local child support enforcement (IV-D) agency

C. Restrictions

1. Must be ordered by a licensed practitioner.
2. The physician can bill directly for lab fees or the lab can bill.
 - a. The only fee that a physician may bill, if the physician sends the lab work to an independent lab, is for venipuncture collection.
 - b. The independent lab should then bill the Medicaid program for performance of the test.

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- c. Medicaid covers lab work performed in a physician's office only when the physician has CLIA certification to perform the test.
3. Outpatient lab work or work done by independent laboratories is not counted toward the **professional services** visit limit.

D. Copayments

There are no copayments for laboratory services.

XXVI. RADIOLOGICAL (X-RAY) SERVICES

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

1. Mammograms
 - a. Screening mammograms are reimbursed on an annual basis for all recipients age 40 and older.
 - b. One screening mammogram will be reimbursed from age 35 through 39.
2. Magnetic Resonance Imaging (MRI) scans.
3. Positron Emission Tomography (PET) scans.

B. Restrictions

1. Must be ordered by a licensed practitioner.
2. Counts toward a recipient's **professional visits** visit limit, EXCEPT as noted in II.A. and:
 - a. Radiation therapy for malignancy, or
 - b. If performed as the result of a referral and the service is given and billed on the same date of referral.

C. Copayments

There are no copayments for radiological (x-ray) services.

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Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

Evaluations, re-evaluations, and or **disciplinary** evaluations **and/or treatment services** for:

1. Audiology Services
2. Speech/Language Services
3. Occupational Therapy
4. Physical Therapy
5. Respiratory Therapy-Only when provided by Independent Practitioners

B. Non-Covered Services

1. Unauthorized visits
2. Maintenance therapy

NOTE: Relative to number 2 above and for recipients under the age of 21 in regard to EPSDT requirements, see I. and XXXVIII. of this manual section.

C. Restrictions

1. Medically necessary services are covered for recipients **age 21 and over only** when provided by home health providers, hospital outpatient departments, physician offices, and area mental health centers.
2. Outpatient specialized therapies do not count towards a recipient's **professional services** visit limit.
3. **Must be ordered by a physician**

D. Copayments

1. \$3.00 per visit in outpatient hospital setting and physician's office.
2. Copayments apply to all recipients except as noted in **II.E.**

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E. Prior Approval

For prior approval requirements, refer to The Carolinas Center for Medical Excellence website at <http://www.medicaidprograms.org/nc/therapyservices>

XXVIII. HEALTH RELATED SERVICES PROVIDED BY INDEPENDENT PRACTITIONERS

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

1. Physical Therapy
2. Occupational Therapy
3. Respiratory Therapy
4. Speech/Language Therapy
5. Audiology services

B. Restrictions

1. Must be ordered by a physician
2. Coverage limited to Medicaid eligible recipients **under age 21**
3. Services covered when provided in the following settings: office, home, school, day care

C. Prior Approval

1. Required for treatment services
2. Not required for assessment services

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Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

1. Audiology services
2. Speech/language services
3. Occupational therapy
4. Physical therapy
5. Psychological/Counseling services
6. **Nursing Services**

NOTE: Relative to all services above and for recipients under the age of 21 in regard to EPSDT requirements, see I. and XXXVIII. of this manual section.

B. Restrictions

1. Treatment services must be ordered by a physician.
2. Coverage is limited to Medicaid recipients in public schools who are applying for or receive special education as part of Individualized Family Services Plan (IFSP) or Individualized Education Plan (IEP).
3. Services rendered to recipients in public schools must be provided in the setting identified on the IEP.
4. A maximum of one assessment service per service type is billable in a six month period.

XXX. ANESTHESIOLOGY SERVICES

Anesthesiology services are covered if medically necessary and rendered by an anesthesiologist or a certified registered nurse anesthetist under his employ.

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

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Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

1. Consultation, examination, and treatment prescribed by a physician and furnished by or under the physician's supervision
2. Laboratory examinations and tests
3. Medically approved methods, supplies, and devices to prevent conception
 - a. Depo Provera and Lunelle
 - b. IUDs
 - c. Oral contraceptives
 - d. Norplant
 - e. Ortho Evra

B. Restrictions

Family planning services do not count toward a recipient's **professional services** visit limit.

C. Copayments

There are no copayments for family planning services.

D. Prior Approval

It is the provider's responsibility to obtain prior approval if needed. Refer to **II.G.** for additional information.

XXXII. OB/GYN SERVICES

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

1. Family Planning services. Refer to section XXXI.

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2. Laboratory examinations and tests.
3. Medically approved methods, supplies, and devices to prevent conception, including:
 - a. Depo Provera
 - b. IUDs
 - c. Oral contraceptives
 - d. Ortho Evra
 - e. Sterilization procedures for men (vasectomy) and women (including the Essure procedure)
 - f. Implanon
 - g. Nuva Ring
 - h. Emergency Contraception
4. Preventative health annual health assessment

Pap smear (Limited to once per year unless medical diagnosis covers more frequent testing.)
5. Pregnancy related services including:
 - a. Antepartum visits – prenatal care
 - b. Laboratory and radiological services
 - c. Diagnostic tests, such as amniocentesis, fetal stress and non-stress tests, and ultrasounds
 - d. Outpatient hospital visits for pregnancy related tests/procedures
 - e. Pharmacy services
 - f. Delivery, including anesthesiology services (i.e., epidurals)
6. Postpartum services including family planning services and any medical services that are needed as a result of a complication of the pregnancy.

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7. Sterilizations. Refer to section XXXIII
8. Hysterectomies. Refer to section XXXIII
9. Abortions. Refer to section XXXIII

B. Restrictions

OB/GYN services count toward a recipient's **professional services** visit limits except as noted in II.A.

C. Copayments

1. \$3.00 per office visit
2. Copayments apply to all recipients except as noted in **II.E.**

D. Prior Approval

It is the provider's responsibility to obtain prior approval if needed. (Refer to **II.G.** for additional information.)

XXXIII. STERILIZATIONS/HYSTERECTOMIES/ABORTIONS**A. Sterilizations (tubal ligations and vasectomies)**

N.C. Medicaid is bound by stringent federal guidelines in regard to the coverage of sterilization procedures. Federal funding is available for an individual to be sterilized only if the requirements in 42 CFR 441.253 are met. These requirements are stated below.

1. The appropriate Medicaid consent form must be signed at least 30 days prior to the service date and must be completed in its entirety. The consent form is valid for 180 days. An exception can be made to the 30 day waiting period if the consent form has been signed and at least 72 hours have elapsed, **and**
 - a. The recipient requires emergency abdominal surgery, **or**
 - b. The recipient has a premature delivery. In this case informed consent must have been obtained at least 30 days before the expected date of delivery. The expected date of delivery must be stated on the claim.
2. The recipient must be age 21 or over on the day the consent form is signed.

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3. The recipient must voluntarily give informed consent.
4. The recipient must be mentally competent.
5. If sterilization is ordered by a judicial court and the recipient is a ward of the county, the county will be responsible for reimbursing the provider for the services rendered. Medicaid funds do not reimburse for the sterilization procedure.

B. Hysterectomies

When a hysterectomy is medically necessary for a condition and/or diagnosis, the recipient must be informed as to the nature and consequences of the surgery.

1. The Hysterectomy Acknowledgement Statement signed by the individual must be on or attached to the claim form: “I have been informed orally and in writing that a hysterectomy will render me permanently incapable of bearing children”.
2. The Hysterectomy Acknowledgement Statement is not required in the circumstances specified below and Medicaid will cover the procedure when the appropriate documentation is obtained.
 - a. The recipient was sterile before the date of the surgery. The physician who performs the hysterectomy must certify that the recipient was sterile at the time of the hysterectomy, and the physician must also state the cause of the sterility.
 - b. The recipient requires a hysterectomy because of a life-threatening emergency situation (i.e., the recipient was in imminent danger of loss of life - for example, secondary to a perforated uterus or uteroplacental apoplexy), the physician determines that prior acknowledgement is not possible, he performs the hysterectomy and:
 - (1) Certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which he determined prior acknowledgement was not possible, AND
 - (2) Describes the nature of the emergency,
 - c. In accordance with instructions in (1) or (2), above, the written certification by the physician must accompany the claim in order for reimbursement to be made.

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C. Therapeutic Abortions

Therapeutic abortion coverage is limited to the conditions stated below.

1. In the case where an eligible recipient suffers from a physical disorder, physical injury, or physical illness, including a life threatening physical condition caused by or arising from the pregnancy itself that would, as certified by the physician, place the recipient in danger of death, unless an abortion is performed
 - a. Medicaid must receive a physician's abortion statement that has the wording "that the abortion be necessary in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would as certified by a physician, place the woman in danger of death unless an abortion is performed"
 - b. The medical diagnosis and records must support the statement.
 - c. If the abortion was necessary to save the life of the mother, regardless of whether the pregnancy was a result of rape or incest, the diagnosis and medical records must support the medical situation.
2. Incest
 - a. The physician's statement that the recipient was a victim of incest must accompany the claim. The statement must contain the complete name and address of the recipient.
 - b. The medical record documentation must support the diagnosis and statement.
 - c. Parental consent of a minor for an abortion is required pursuant to current state law. The requirements for parental consent shall not apply when a medical emergency exists that so complicates the pregnancy as to require an immediate abortion.
3. Rape
 - a. The physician's statement that the recipient was a victim of rape must accompany the claim. The statement must contain the complete name and address of the patient.
 - b. The medical record documentation must support the diagnosis and statement.

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- c. The parental consent of a minor for an abortion is pursuant to current state law. The requirements of parental consent shall not apply when a medical emergency exists that so complicates the pregnancy as to require an immediate abortion.

XXXIV. BABY LOVE

Baby Love services include a group of services that assist pregnant women and postpartum women and children.

Refer to DMA's website at <http://www.ncdhhs.gov/dma/services/babylove.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

Maternal services include,

1. Childbirth Education
2. Health and Behavior Intervention
3. Home Visit for Postnatal Assessment and Follow-up Care
4. Maternal Care Skilled Nurse Home Visit
5. Home Visit for Newborn Care and Assessment

B. Restrictions

Baby Love services do not count toward a recipient's professional services visit limit.

C. Copayments

There are no copayments for Baby Love services

D. Prior Approval

It is the provider's responsibility to obtain prior approval if needed. (Refer to II.G. for additional information.)

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Selected services are allowed for pregnant women whose aid category is Medicaid for Pregnant Women (MPW).

A. Services Related to the Pregnancy

Services for MPW recipients are limited to services related to the pregnancy or for treatment of illness or injury trauma that in the physician's judgment may complicate the pregnancy. This includes:

1. Conditions related to the pregnancy,
2. Pre-existing conditions, and/or
3. New pathological conditions that may adversely affect the best possible outcome from the pregnancy

B. Covered services

1. Prenatal Care
2. Outpatient prenatal testing
3. Inpatient hospital services
4. Labor and delivery services
5. Family planning services
6. Pharmacy services
7. Baby Love services
8. Physician services
9. Medical consultation
10. Routine dental care – covered only through the date of delivery
11. Behavior health services

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12. Postpartum services
 - a. Postpartum is defined as the period of time from the last day of pregnancy through the last day of the month in which the 60th post-delivery day occurs. Services are covered for live births, miscarriages, fetal deaths, molar pregnancies, neonatal deaths, and therapeutic abortions.
 - b. Postpartum services include medical services needed as a result of a complication of the pregnancy or family planning services.

C. Restrictions

Pregnancy related services provided to an MPW recipient do not count toward the recipient's **professional services** visit limit.

D. Copayments

There are no copayments for MPW recipients.

E. Prior Approval

1. It is the provider's responsibility to obtain prior approval if needed. (Refer to II.G. for additional information.)
2. The following services require prior approval for MPW recipients.
 - a. Podiatry
 - b. Chiropractic services
 - c. Optical services, except for medical services or treatment for conjunctivitis, eye infections, eye injury, etc.
 - d. Durable medical equipment
 - e. Home health services
 - f. Hospice
 - g. Home infusion therapy (HIT)
 - h. Private duty nursing (PDN)

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Medicaid covers nurse midwives who are licensed and approved by the Board of Nursing and who practice under the supervision of a physician who is licensed by the Board of Medicine to practice and who is actively engaged in the practice of obstetrics.

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

XXXVII. NURSE PRACTITIONERS

Medicaid covers nurse practitioners who are licensed and approved by the Board of Nursing and who practice in collaboration with a supervising physician who is licensed by the Board of Medicine to practice medicine.

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

XXXVIII. EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) AND HEALTH CHECK**A. Covered Services**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) or Medicaid for children is administered under the name Health Check in North Carolina and is jointly overseen by Clinical Policy and Programs and Managed Care. EPSDT is a federal requirement that mandates state agencies to provide services, products, or procedures requested by physicians and licensed clinicians for Medicaid recipients under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified by a screening examination. Services provided under EPSDT include periodic screening, vision, dental, and hearing services. There is no requirement that the requested service, product, or procedure be included in the state Medicaid plan. However, the requested service, product, or procedure must be within the scope of the services listed in the Social Security Act (the Act) at 1905(a). For additional information about EPSDT, please refer to Section I. of this manual section and the website at <http://www.ncdhhs.gov/dma/medicaid/healthcheck.htm>.

B. Restrictions

Health Check and EPSDT services do not count toward a recipient's annual **professional services** visit limit. Service limitations on scope, amount, duration, and/or frequency described in this manual and in clinical coverage policies may be exceeded or may not apply provided documentation supports that the requested service is medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a licensed clinician. In accordance with EPSDT requirements, health care services shall be provided in a frequency and amount to reasonably achieve their purpose and shall be consistent with the recipient's medical needs.

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C. Copayments

There are no copayments.

D. Prior Approval

Prior approval may be required for some covered state Medicaid plan services, products, or procedures before they can be provided. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval. Additionally, all services, products, or procedures that are not covered in the North Carolina State Plan **MUST** be approved before the service is rendered.

XII. PREVENTIVE MEDICAL SERVICES

Annual health assessments for individuals over age 21 with the expectation that they will prevent serious illness through early detection and treatment

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

1. Health history
2. Physical examination
3. Laboratory procedures
4. Counseling, education, and limited intervention
5. Pap smear
6. Mammograms

B. Restrictions

1. Medicaid covers only one screening per calendar year
2. Preventive **medical** services count toward a recipient's **professional services** visit limit except as noted in II.A.
3. Medicaid covers only one pap smear per year except when diagnosis supports more frequent testing.

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C. Copayments

1. \$3.00 per patient visit
2. Copayments apply to all Medicaid recipients except as noted in II.E.

XL. REFUGEE HEALTH ASSESSMENTS PROVIDED IN HEALTH DEPARTMENTS

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

Health assessments performed in local health department settings. The assessment includes the components specified below.

1. Medical history
2. Physical examinations
3. Review of BCIS documents
4. Determination of immunization status/upgrade immunizations
5. TB skin testing
6. Ova and parasite testing
7. Sexually transmitted disease testing
8. Other lab tests as indicated
9. Treatment or referral as appropriate.

B. Restrictions

1. Recipient must be documented by the Bureau of Citizenship and Immigration Services (BCIS) on form I-94 and have been in the United States for less than 18 months.
2. Refugee health assessment is allowed once per lifetime.

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C. Copayments

1. \$3.00 per visit
2. All Medicaid recipients are subject to copayments except as noted in II.E.

XLI. DIALYSIS SERVICES

Dialysis is a covered service when provided by appropriate Medicaid enrolled providers.

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

XLII. COMMUNITY ALTERNATIVES PROGRAMS (CAP)

Community Alternatives Program for children (CAP/C), for disabled adults (CAP/DA), CAP/Choice and for the mentally retarded/developmentally disabled (CAP-MR/DD), are covered programs under North Carolina Medicaid. Refer to MA-2280, Community Alternatives Program (CAP) Medicaid Eligibility, of the M-AABD manual and other appropriate manuals as well as the clinical coverage policies found on DMA's website at www.dhhs.state.nc.us/dma.

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

XLIII. CASE MANAGEMENT FOR ADULTS AND CHILDREN AT RISK OF ABUSE, NEGLECT, AND EXPLOITATION (AT-RISK CASE MANAGEMENT)

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

Targeted case management services for at-risk adults and children are a group of interrelated activities under which responsibility for locating, coordinating, and monitoring appropriate services for an individual rest with a specific person or organization. The activities include those specified below.

1. Evaluating recipient's situation to determine the need for initial or continuing case management services
2. Assessing and reassessing the service needs of the recipient
3. Developing and implementing a client/family service plan to meet the service needs of the recipient

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4. Assisting the recipient in locating and contacting providers and programs for needed services
5. Coordinating delivery of services when multiple providers or programs are involved in care provision
6. Monitoring services to ensure that they are received and adequate to meet recipient's needs and are consistent with quality care

B. Restrictions

1. Medicaid recipients are not eligible for at-risk case management while in a hospital or in a nursing facility.
2. Medicaid recipients are not eligible for at-risk case management if receiving one of the following:
 - a. Community Alternatives Program for children (CAP/C), disabled adults (CAP/DA), CAP/Choice and mentally retarded/developmentally disabled (CAP-MR/DD)
 - b. Targeted case management provided to the chronically mentally ill and the developmentally disabled
3. Recipients eligible for Protective Services through dss are covered for at-risk case management services.

XLIV. CASE MANAGEMENT FOR HIV

Refer to DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for specific coverage criteria, prior approval requirements, and service limitations.

A. Covered Services

Targeted case management for recipients with HIV is a client-focused plan for coordinating care. It involves assessing a recipient's need for specific health, psychological, and social services, and facilitating access to services that will address those needs. Services must be provided in accordance with the clinical coverage policy found at: www.dhhs.state.nc.us/dma.

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B. Restrictions

1. Recipient must have documented HIV disease or HIV seropositivity.
2. HIV case management is not covered as stated below.
 - a. In a general hospital, psychiatric hospital, nursing facility, or intermediate facility for the mentally retarded;
 - b. Under Community Alternatives Program services for the children (CAP/C), disabled adults (CAP/DA), CAP/Choice and mentally retarded/developmentally disabled (CAP-MR/DD) ;
 - c. If receiving at-risk case management services
 - d. If receiving case management provided through the area mental health program for the chronically mentally ill and developmentally disabled.

XLV. MEDICAL TRANSPORTATION

Medicaid is required to assure transportation to medical appointments for all eligible individuals who need and request assistance with transportation. The transportation is coordinated through each county department of social services. Refer to MA-2910, Medicaid Transportation for detailed coverage and procedures.

XLVI. BUY-IN PROGRAM

- A. Payment of Medicare Part A premiums for Medicaid recipients not entitled to free Part A who are M-QB or dually eligible AABD with "Q" class.
- B. Payment of Medicare Part B premiums for all individuals eligible for Medicare benefits.
- C. Refer to the Aged, Blind and Disabled Medicaid manual section, [MA-2410, Medicare Enrollment and Buy-In](#), for eligibility requirements.

XLVII. MISCELLANEOUS NON-COVERED ITEMS

Includes but not limited to:

- A. Diet programs in weight loss centers
- B. Diet products
- C. Penile implant
- D. Wigs

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- E. Paternity testing - contact local child support enforcement office
- F. Outpatient cardiac rehabilitation
- G. Sterilization under age 21
- H. Sterilization reversal
- I. Exercise equipment
- J. Experimental drugs and procedures
- K. Dental crowns if 21 years or older
- L. TMJ splints, night guards, and mouthpieces
- M. Braces on teeth if 21 years or older
- N. Fixed bridgework
- O. Dental implants/transplants and treatment involved
- P. Precious metals for dental removable appliances and treatment involved
- Q. Precision attachments for partials
- R. Gold or porcelain restorations
- S. DESI drugs - drugs indicated by the FDA to be “less than effective for their prescribed use”
- T. Drugs from manufacturers who have not signed a rebate agreement with Medicaid
- U. Lift chairs
- V. Smoking cessation classes
- W. Hypnosis
- X. Acupuncture
- Y. Breast reconstructive surgery for diagnosis other than breast cancer
- Z. Breast reduction under age 19

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- AA. Dental coverage in post partum period for MPW clients
- BB. Blood pressure cuffs
- CC. Mattress covers, pillow covers, air purifier for allergy sufferers
- DD. Vaporizers, humidifiers
- EE. Medic alert bracelets
- FF. Diaphragms
- GG. Fertility treatments
- HH. Anti-bedwetting devices
- II. Breast pumps
- JJ. YMCA or YWCA memberships for pool therapy
- KK. Exercise programs at a gym or wellness center
- LL. Circumcision - routine newborn
- MM. Van conversions for people in wheelchairs
- NN. Liposuction
- OO. Tummy tuck
- PP. Radial Keratotomy
- QQ. Lasix Surgery
- RR. Visual training
- SS. Eye patch
- TT. **Initial** Cochlear ear implant for ages 21 and over
- UU. Hearing aids for individuals over age 21

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VV. Education programs such as Sylvan Learning Center

WW. Ultrasound to determine sex of a child

XX. Medical services provided out of the country

YY. Tattoo removal

ZZ. Payment for copies of medical records

NOTE: relative to all services, products, and procedures specified above and for recipients under the age of 21 in regard to EPSDT requirements, see I. and XXXVII. of this manual section.