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**NORTH CAROLINA MEDICAID
BENEFIT STUDY**

Appendices to the Final Report

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North Carolina General Assembly

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Falls Church, Virginia • San Francisco, California • Boston, Massachusetts
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Adult Care Home—Personal Care Services (Basic and Enhanced)

1. Management Information

DMA section	Community Care
Service description location	Adult Care Home Manual
Populations covered	Adult, Blind, Disabled
Utilization review contractor	None
Copay	None
Primary care provider referral required for Carolina ACCESS participants?	No
Reimbursement	Basic ACH/PC is paid at two daily fixed rates based on the size of the facility (e.g., number of licensed beds). Enhanced ACH/PC is paid at four daily rates based upon the type of assistance needed by the heavy care resident.

2. Budget and Utilization Information

	Expenditures		Recipients	
	<i>Amount</i>	<i>% of Total</i>	<i>Number</i>	<i>% of Total</i>
State Fiscal Year 1999	\$72,294,345	1.8%	N/A	N/A
State Fiscal Year 2000	\$86,941,136	1.9%	N/A	N/A
Change from SFY 99 to 00	20%		N/A	

3. Service Definition and Limitations

Personal care services are an optional Medicaid service covered by 30 state Medicaid programs. Adult care home personal care (ACH/PC) includes the performance of one or more personal care tasks daily for the resident by qualified personal care aides. Assistance with personal care tasks under ACH/PC may include supervising and prompting a resident's self-performance of tasks, as well as providing hands-on and weight-bearing assistance when necessary.

4. System Edits and Audits to Support Policies

Requirement	Supported in Claims System?	Edit/Audit Number
Residents who meet Medicaid criteria for being "heavy care" also qualify for higher enhanced Adult Care Home payments to cover the costs of their extra needs.	Yes. Case managers conduct evaluation of need and contact EDS for prior authorization number. Providers cannot receive the enhanced rate without this confirmation number.	Edit 0238: ACH/PC - no authorization for enhanced ACH/PC.
A resident is limited to no more than 60 days of therapeutic leave (nursing facility and ACH combined) per calendar year. Leave of more than 15 consecutive days requires prior authorization from EDS.	Yes. The claims system monitors the frequency revenue code 183 is billed for recipients, regardless of institutional setting.	Audit 0964: Review for therapeutic leave over 15 consecutive days. Edit 0233: Suspend consecutive therapeutic leave days over 15.
CAP MR/DD personal care services cannot be provided in an adult care home.	Yes.	Audit 0030: PCS and ACH PCS not allowed same day as CAP-MR/DD Supported Living.

5. Utilization Review Process

ACH/PC providers must assess the resident's need for personal care assistance and develop a plan of care using a preprinted DMA form or an the facility's own authorization and care plan form, provided that form documents the same information as DMA's version. The assessment is in accordance with the following timeframes:

- Within 72 hours of the date of admission
- Whenever there is a "significant" change in the resident's condition;
- At least annually.

The assessor (usually the ACH administrator) must sign and date the authorization and care plan, retain a record, and forward the original to the resident's attending physician.

The attending physician must approve the authorization and care plan within 15 calendar days from the assessment date. The physician's certification indicates that the resident has a medical diagnosis with associated physical and/or mental limitations that warrant assistance with personal care tasks as outlined in the resident's care plan.

To receive reimbursement under the enhanced ACH/PC rate, providers must obtain an independent assessment of the resident's condition from an adult care home case manager.

6. Other Notes

In the 1995 legislative session of the North Carolina General Assembly, coverage began for personal care assistance provided to residents who are eligible for Special Assistance for Adults (SA) and Medicaid. Previously, Special Assistance for Adults had been funded only by the state and counties; moving some SA services to Medicaid enabled the state to receive a federal contribution for these services. Beginning January 1, 1996, Medicaid covered "enhanced" adult care home personal care (ACH/PC) and adult care home case management services (ACH/CMS) for certain residents of adult care homes who met the Medicaid criteria for being a "heavy care" resident.

Community Alternatives Program for Persons with AIDS

1. Management Information

DMA section	Community Care
Service description location	Community Care Manual 2000
Populations covered	Adult, Blind, Disabled (Disabled includes SSI children)
Utilization review contractor	EDS, AIDS Care Branch in the Division of Public Health
Copay	None
Primary care provider referral required for Carolina ACCESS participants?	No
Reimbursement	Payments are based on the lower of the providing agency's usual and customary charge and the Medicaid maximum allowable rate.

2. Budget and Utilization Information

	Expenditures		Recipients	
	<i>Amount</i>	<i>% of Total</i>	<i>Number</i>	<i>% of Total</i>
State Fiscal Year 1999	N/A	N/A	N/A	N/A
State Fiscal Year 2000	~\$300,000	<0.1%	40*	<0.1%
Change from SFY 99 to 00	N/A		N/A	

**About 25 beneficiaries were enrolled at any given time, for a total of 40 persons over the course of the year. Enrollment in the program is capped at 250 persons in 2001 and 300 persons in 2002.*

3. Service Definition and Limitations

The Community Alternatives Program for Persons with AIDS (CAP/AIDS) operates under special authority from the federal Department of Health and Human Services. DHHS "waived" certain Medicaid rules to allow participants in CAP to receive additional services that are not provided to the general Medicaid population. The CAP/AIDS program is a collaborative effort between the AIDS Care Branch in the Division of Public Health and the Community Care Section in the Division of Medical Assistance. The AIDS Care Branch handles the day-to-day program operation, while DMA provides oversight.

Adult Day Health Services

Adult Day Health Care is care for the client for four or more hours on a regularly scheduled basis. It is provided for one or more days per week in a certified Adult Day Health Care facility. This type of care is for aged, disabled, and handicapped adults who need a structured day program of activities and services with nursing supervision. It is an organized program of services during the day in a community group setting. The program supports the adult's independence and promotes social, physical, and emotional well-being. Services include health services and a variety of program activities designed to meet the individual needs and interests of the clients, and referral to and assistance in using appropriate community resources. Food and food services include a nutritional meal and snacks as appropriate to the program. Transportation to and from the service facility is provided or arranged for when needed and not otherwise available within the geographic area specified by the day health program.

CAP/AIDS In-Home Aide Services

CAP/AIDS In-Home Aide Services are assistance with personal care and basic home management tasks for individuals who are unable to perform these tasks independently due to physical or mental impairments. Personal care is help with activities such as bathing, dressing, and grooming. Home management is assistance with tasks such as light housekeeping, laundry, and meal preparation.

The services are provided at two levels: In-Home Aide Level II and In-Home Aide Level III – Personal Care.

CAP/AIDS Waiver Supplies

The following items may be provided to a CAP/AIDS participant to promote the health and well-being of the individual.

- Nutritional supplements taken by mouth when ordered by a physician.
- Reusable incontinence undergarments with disposable liners.
- Medication dispensing boxes. These are boxes with compartments that can be pre-filled to proportion doses of medication for specific time and days so that the client can independently take the medication, or an individual can safely assist the client in the taking of medications.

Case Management

Case management is assessing client needs and planning care as well as locating, obtaining, coordinating, and monitoring services to maintain the client's health, safety, and well-being in the community. The case manager's responsibilities are in the CAP/AIDS Manual.

Home Mobility Aids

Home Mobility Aids are the following items provided to give the client mobility, safety, and independence in the home. They are used to adapt the client's home environment to help overcome specific functional limitations:

- Wheelchair ramps
- Safety rails

- Grab bars
- Non-skid surfaces
- Handheld showers
- Widening of doorways for wheelchair access for the CAP/AIDS client

Personal Emergency Response System (PERS)

This service pays for the monthly service charge or monthly rental charge for a system that uses phone lines to alert a response center of medical emergencies that threaten the clients' well-being. This service may also alert the response center of other situations that threaten the client's safety. The response center is staffed by appropriately trained professionals who can respond to an emergency. The service is for clients who live alone or who are alone for significant parts of the day and who would otherwise require extensive routine supervision.

NOTE: This service does not pay for the purchase or installation of equipment in the client's home

Preparation and Delivery of Meals

This service, often referred to as "Meals on Wheels," provides for the preparation and delivery of one nutritious meal per day, which may include special diets, to the client's home.

Respite Care

Respite Care is the provision of temporary support to the primary unpaid caregiver(s) of the client by taking over the tasks of that person(s) for a limited period of time. This service may be used to meet a wide range of needs, including family emergencies; planned special circumstances (such as vacations, hospitalizations, or business trips); relief from the daily responsibility and stress of caring for a special needs person; or the provision of time for the caregiver(s) to shop, run errands, and perform other tasks. It also may be used to provide respite to the client from the primary caregiver(s). Respite Care is available as In-Home Respite, in which the respite worker goes into the client's home; and as Institutional Respite, in which the client goes into a facility that is licensed to provide the appropriate level of care. The tasks covered under In-Home Respite/Aide Level are identical to those provided under CAP/AIDS In-Home Aide services. When a client requires tasks that may only be done by a licensed nurse, In-Home Respite/Nurse Level is provided.

Limitations

Prior Approval

Prior approval in the CAP/AIDS Plan of Care is required for each CAP/AIDS service provided to the client.

Amount of service

The amount of service is limited to that which is approved in the CAP/AIDS Plan of Care. The individual service limits considered in approving the plan include:

- Home Mobility Aids: Up to \$1,500 is allowed for a State fiscal year (July-June).

- Respite Care: Respite care may not exceed 30 days (720 hours) in a State fiscal year. Each day of Institutional Respite counts as 24 hours against this limit.
- Preparation and Delivery of Meals: This service is limited to one meal per day.

Other Limitations

Medicaid payment is restricted in relation to the following services:

- All CAP/AIDS Services: Providers not bill for a CAP/AIDS service furnished when a client is in an institution such as a hospital, nursing facility or ICF/MR. (There is an exception for case management that is described in the CAP/AIDS Manual.)
- Adult Day Health Care: This service may not be provided at the same time of day that a client receives In-Home Aide Services, Respite, or one of the regular Medicaid services that works directly with the client, such as Personal Care Services.
- CAP/AIDS In-Home Aide services: Providers may not bill for this service if it is provided on the same day that a client receives a substantially equivalent service such as regular Medicaid PCS. Providers may not bill for this service if it is provided at the same time of day as a Home Health Aide visit, Respite or Adult Day Health Care.

4. System Edits and Audits to Support Policies

Requirement	Supported in Claims System?	Edit/Audit Number
Client has been approved for CAP/AIDS services.	Yes. Edit prevents providers from billing for CAP procedures for non-eligible clients.	Edit 0264: Recipient not eligible for CAP services. Edit 0273: CAP procedure not valid for recipient program code.
Amount of service is limited to what is approved in recipient's plan of care.	No. The authorized limits from an individual's plan of care are not entered into the claims system. The recipient's case manager is responsible for authorizing and enforcing service limits in accordance with the plan of care. The system can only enforce maximum limits of service (see audits to the right).	Audit 0050: CAP meals allowed once per day. Audit 0717: CAP waiver supplies limit is one per day. Audit 0800: CAP medical supplies limit of one per day. Audit 0961: CAP/AIDS respite care limited to 720 hours per fiscal year Audit 1082: CAP institutional respite care daily limit.

Requirement	Supported in Claims System?	Edit/Audit Number
Providers cannot bill for a CAP/AIDS service furnished when a recipient is in an institution (hospital, nursing facility, or ICF/MR).	Yes.	Audit 0946: CAP services not allowed the same date of service as inpatient stay.
Providers cannot bill for CAP/AIDS in-home aide services if it is provided on the same day that a client receives a substantially equivalent service such as regular Medicaid PCS.	Yes.	Audit 0250: PCS not allowed same DOS as CAP in-home aide level II and level III services. Reverse Audit 0252
Providers cannot bill for CAP/AIDS in-home aide services if it is provided at the same time of day as home health, respite, regular PCS, or adult day health care.	Yes and no. There are audits that prevent regular PCS from being billed on the same date as CAP/C PCS. However, there is no way to identify the time of day a service was provided.	Audit 0250: PCS not allowed same DOS as CAP in-home aide level II and level III services. Reverse Audit 0252

5. Utilization Review Process

Each CAP/AIDS client has a case manager from a CAP/AIDS case management agency. (Availability of a CAP/AIDS case management provider is key to whether the program is available in a given location.) The case manager assesses the client's needs, develops a plan of care, and handles getting the plan of care approved by the AIDS Care Branch. Following approval, the case manager arranges, coordinates, and monitors CAP/AIDS services as well as other aspects of the client's home care.

Community Alternatives Program for Children

1. Management Information

DMA section	Community Care
Service description location	Community Care Manual 2000
Populations covered	Blind, Children (IAS/adoption assistance & HSF/foster care), Disabled
Utilization review contractor	EDS, Medical Review of North Carolina, DMA
Copay	None
Primary care provider referral required for Carolina ACCESS participants?	No
Reimbursement	Payments are based on the lower of the providing agency's usual and customary charge and the Medicaid maximum allowable rate.

2. Budget and Utilization Information

	Expenditures		Recipients	
	<i>Amount</i>	<i>% of Total</i>	<i>Number</i>	<i>% of Total</i>
State Fiscal Year 1999	\$10,658,987	0.3%	~200	<0.1%
State Fiscal Year 2000	\$12,324,578	0.3%	~200*	<0.1%
Change from SFY 99 to 00	16%			

* Enrollment in the program is capped at approximately 350-400 children.

3. Service Definition and Limitations

The Community Alternatives Program for Children (CAP/C) operates under special authority from the federal Department of Health and Human Services. DHHS "waived" certain Medicaid rules to allow participants in CAP to receive additional services that are not provided to the general Medicaid population.

This services covered under CAP/C include:

Case Management

Case management includes assessing the client for CAP/C participation, planning care and locating, obtaining, coordinating, and monitoring social and medical services as well as other services related to the purpose of the program. The case manager's responsibilities are in the *CAP/C Manual*.

CAP/C Nursing Services

CAP/C Nursing Services are continuous, complex and substantial nursing care ordered by the physician. Nursing care to monitor for potential complications is not covered. The service may include performance of specialized procedures, preparation of equipment and material for treatment, assistance in learning appropriate self-care techniques, and other medical tasks performed on an ongoing, daily basis. The nurse may also assist the child with eating or feeding, transfers, ambulation, and other personal care tasks when needed as an integral part of the child's day-to-day treatment plan. In addition to providing care in the home, the nurse may accompany a child outside of the home when the child's normal life activities (such as attending school during the day) take the child away from the home during the day. If the care is to be provided in another private residence, such as a relative's home, the setting must be assessed and approved by the case manager prior to the delivery of the service.

CAP/C Personal Care Services

CAP/C Personal Care Services is assistance for children who need help with personal hygiene, ambulation, and feeding due to a medical condition. The service also includes help with home management tasks that are essential, although secondary, to the personal care tasks that are necessary for maintaining the child's health. This service includes the same tasks as those included in regular Medicaid Personal Care Services as described in 6.1. In addition to performing these tasks, the CAP/C Personal Care aide may also function in a supportive role by accompanying the client outside the home and facilitating participation in activities of daily living.

CAP/C is not meant to replace services covered by other reimbursement sources. For example, CAP/C Personal Care services may not be provided to a child at school during school hours. It also may not be provided in a day care center as the center is being paid for the care of the child.

CAP/C Waiver Supplies

Waiver Supplies include

- Reusable incontinence undergarments with disposable liners for children age two and above.
- Nutritional supplements prescribed by a physician that are taken by mouth (such as "Enrich", "Ensure" and similar supplements covered by Medicaid for tube feedings).

Home Mobility Aids

Home mobility aids are the following items provided to give mobility, safety and independence to the client in his private residence. They are used to adapt the home environment to the client's specific disabilities.

- Wheelchair Ramps
- Grab Bars
- Handheld Showers
- Safety Rails
- Non-skid Surfaces
- Widening of Doorways for Wheelchair ACCESS

Respite Care

Respite care provides temporary support to a family caring for a CAP/C child. It may be used as day, evening or overnight care to meet a range of client needs. These include family emergencies; planned absences, such as vacations, hospitalizations or business trips; relief from

the stresses of caregiving; shopping and giving a child respite from his family. Respite care is available as **In-Home Respite** in which the respite worker goes into the client's home, and as **Institutional Respite** in which the client goes into a facility licensed to provide the appropriate level of care.

Limitations

Prior Approval

Prior approval in the CAP/C Plan of care is required for each CAP/C service provided to a client.

Amount of Service

The amount of service is limited to that which is approved in the CAP/C POC. The individual service limits that are considered in approving the plan include:

- **Home Mobility Aids:** The cost of aids is limited to \$1,500 for a state fiscal year (July-June).
- **Respite Care:** The amount of respite care may not exceed 30 days (720 hours) in a state fiscal year (July-June).

Other Limitations

Medicaid payment is restricted in relation to the following services:

- **CAP/C Services:** Providers may not bill for a CAP/C service while a client is in an institution such as a hospital, nursing facility or ICF/MR. CAP/C case management agencies should refer to the *CAP/C Manual* for an exception for certain case management activities.
- **CAP/C Personal Care Services:** Providers may not bill for this service if it is provided on the same day that the client receives a substantially equivalent service such as regular Medicaid PCS or a home health aide visit.

4. System Edits and Audits to Support Policies

Requirement	Supported in Claims System?	Edit/Audit Number
Client has been approved for CAP/C services.	Yes. Edit prevents providers from billing for CAP procedures for non-eligible clients.	Edit 0264: Recipient not eligible for CAP services. Edit 0273: CAP procedure not valid for recipient program code.

Requirement	Supported in Claims System?	Edit/Audit Number
Amount of service is limited to what is approved in recipient's plan of care.	No. The authorized limits from an individual's plan of care are not entered into the claims system. The recipient's case manager is responsible for authorizing and enforcing service limits in accordance with the plan of care. The system can only enforce maximum limits of service (see audits to the right).	<p>Audit 0584: CAP/C screening limit once per fiscal year.</p> <p>Audit 0593: CAP/C home mobility aid dollar limit.</p> <p>Audit 0808: CAP/C hourly RN nursing limit is 96 units.</p> <p>Audit 0717: CAP waiver supplies limit is one per day.</p> <p>Audit 0719: CAP-C/CAP-DA case management daily limit is 96 units.</p> <p>Audit 0724: CAP-DA/CAP-C screening limit is one per fiscal year.</p> <p>Audit 0800: CAP medical supplies limit of one per day.</p> <p>Audit 1082: CAP institutional respite care daily limit.</p>
Providers cannot bill for a CAP/C service furnished when a recipient is in an institution (hospital, nursing facility, or ICF/MR).	Yes.	Audit 0946: CAP services not allowed the same date of service as inpatient stay.
Providers cannot bill for CAP/C PCS on the same day that the client receives substantially equivalent service such as regular Medicaid PCS or home health visit.	Yes and no. There are audits to prevent CAP PCS from being billed on the same date of service as regular PCS. However, there are no audits that prevent regular Medicaid PCS from being billed at the same time of day.	<p>Audit 0250: PCS not allowed same DOS as CAP in-home aide level II and level III services.</p> <p>Reverse Audit 0252</p>

5. Utilization Review Process

The Division of Medical Assistance Home Care Initiatives Unit determines if a child is eligible for the CAP/C program and designates a local case manager for each eligible child. The local case manager gives approval for any CAP/C services the child receives. The case manager

arranges, coordinates, and monitors these services as well as other aspects of the child's home care.

6. Other Notes

DMA has had problems finding agencies to serve as CAP/C lead agencies, and is looking into the case management rate to see if it might be affecting participation (e.g., if it is too low, agencies will not want to provide case managers).

Community Alternatives Program for Disabled Adults

1. Management Information

DMA section	Community Care
Service description location	Community Care Manual 2000
Populations covered	Adult, Blind, Disabled
Utilization review contractor	EDS, Medical Review of North Carolina (MRNC)
Copay	None
Primary care provider referral required for Carolina ACCESS participants?	No
Reimbursement	Payments are based on the lower of the providing agency's usual and customary charge and the Medicaid maximum allowable rate.

2. Budget and Utilization Information

	Expenditures		Recipients	
	<i>Amount</i>	<i>% of Total</i>	<i>Number</i>	<i>% of Total</i>
State Fiscal Year 1999	\$150,461,450	3.7%	N/A	N/A
State Fiscal Year 2000	\$172,223,094	3.8%	~12,000*	<0.1%
Change from SFY 99 to 00	14%		N/A	

* Enrollment in the program is limited by the budget, in 2001 approximately 12-13,000 persons will enroll. DMA allots portions of the enrollment cap to individual counties. There are approximately 6,000 persons on a waiting list.

3. Service Definition and Limitations

The Community Alternatives Program for Disabled Adults (CAP/DA) operates under special authority from the federal Department of Health and Human Services. DHHS "waived" certain Medicaid rules to allow participants in CAP to receive additional services that are not provided to the general Medicaid population. CAP/DA is administered on a county level by a lead agency selected by the county commissioners. The lead agency is usually the county DSS, health department, agency for the aged, or local hospital.

What CAP/DA Covers

Adult Day Health Services - This is care in an Adult Day Health Care Facility certified by the NC Division of Social Services. It provides a structured program of activities and services with nursing supervision. Services must include health services and a variety of program activities

designed to meet the individual needs and interests of the clients. Services also include referral to and assistance in using appropriate community resources, and nutritious meals and snacks appropriate to the program. Transportation to and from the facility is provided or arranged when needed, and not otherwise available within the area specific y the day health program.

CAP/DA In-Home Aide Services - This service includes basic household tasks such as light housekeeping, laundry, meal preparation, essential shopping, simple household repairs and yard maintenance. It also includes personal care tasks such as assistance in eating, bathing, dressing and grooming. The services are provided at two levels – In-Home Aide Level II and In-Home Aide Level III – Personal Care

CAP/DA Waiver Supplies – CAP/DA waiver supplies include:

- Reusable incontinence undergarments with disposable liners
- Nutritional supplements prescribed by a physician that are taken by mouth (such as “Enrich,” “Ensure” and similar supplements covered by Medicaid for tube feedings).

Case Management – Case management includes assessing the client for CAP/DA participation, planning care, and locating, obtaining, coordinating and monitoring social, habilitative and medical services as well as other services relative to the purpose of the program. The case manager’s responsibilities are in the CAP/DA Manual.

Home Mobility Aids – Home mobility aids are the following items provided to give the client mobility, safety and independence in his private residence. They are used to adapt the home environment to the client’s specific disabilities.

- Wheelchair ramps
- Safety rails
- Grab bars
- Non-skid surfaces
- Handheld showers
- Widening of doorways for wheelchair access

Preparation and Delivery of Meals – This service, often referred to as “Meals on Wheels,” provides for the preparation and delivery of one nutritious meal per day, including special diets, to the client’s home.

Respite Care – Respite care is temporary support to the client’s primary unpaid caregiver(s) by taking over the task of the caregiver(s) for a limited time. It may be used to meet a wide range of needs, including family emergencies; planned absences (such as vacations, hospitalizations or business trips); relief from the daily responsibility and stress of caring for a special needs person; or to provide time for the caregiver(s) to shop, run errands and perform other tasks. It may also be used to provide respite to the client from the primary caregiver(s). Respite is available as in-home respite, in which the respite worker goes into the client’s home; or as institutional respite in which the client goes into a facility that is licensed to provide the appropriate level of care.

Telephone Alert – This service pays for the monthly service charge or monthly rental charge for a system that uses phone lines to alert a central monitoring facility to medical emergencies and other situations that threaten the client’s safety and well being.

Limitations

Prior Approval – Prior approval in the CAP/DA Plan of Care is required for each CAP/DA service provided to the client.

Amount of Service – The amount of service is limited to that which is approved in the CAP/DA Plan of Care. The individual service limited considered in approving the plan include

- **Home Mobility Aides:** Up to \$1,500 is allowed for a state fiscal year (July – June)
- **Respite Care:** Respite care may not exceed 30 days (720 hours) in a state fiscal year.

Other Limitations – Medicaid payment is restricted in relation to the following services:

- **All CAP/DA Services:** Providers may not bill for a CAP/DA service furnished when a client is in an institution such as a hospital, nursing facility or ICF/MR.
- **CAP/DA In-Home Aide Services:** Providers may not bill for this service if it is provided on the same day that a client receives a substantially equivalent service such as regular Medicaid PCS. Providers may not bill for this service if it is provided at the same time of day as a home health aide visit.

4. System Edits and Audits to Support Policies

Requirement	Supported in Claims System?	Edit/Audit Number
Client has been approved for CAP/DA services.	Yes. Edit prevents providers from billing for CAP procedures for non-eligible clients.	Edit 0264: Recipient not eligible for CAP services. Edit 0273: CAP procedure not valid for recipient program code.
Providers cannot bill for a CAP/DA service furnished when a recipient is in an institution (hospital, nursing facility, or ICF/MR).	Yes.	Audit 0946: CAP services not allowed the same date of service as inpatient stay.
CAP/DA in-home aide services cannot be billed on the same day that a client receives a substantially equivalent service such as regular Medicaid PCS.	Yes.	Audit 0250: PCS not allowed same DOS as CAP in-home aide level II and level III services. Reverse Audit 0252

Requirement	Supported in Claims System?	Edit/Audit Number
Amount of service is limited to what is approved in recipient's plan of care.	No. The authorized limits from an individual's plan of care are not entered into the claims system. The system can only enforce maximum limits of service (see audits to the right).	<p>Audit 0512: CAP/DA respite care limit (720 hours per fiscal year).</p> <p>Audit 0598: CAP/DA mobility aid dollar limitation (\$1,500 per fiscal year).</p> <p>Audit 0717: CAP waiver supplies limit is one per day.</p> <p>Audit 0719: CAP-C/CAP-DA case management daily limit is 96 units.</p> <p>Audit 0724: CAP-DA/CAP-C screening limit is one per fiscal year.</p> <p>Audit 0727: CAP-DA non-institutional respite care daily limit is 96 units.</p> <p>Audit 0791: CAP-DA in-home aid level II daily limit is 96 units.</p> <p>Audit 0800: CAP medical supplies limit of one per day.</p> <p>Audit 0802: CAP telephone alert allowed one per month.</p> <p>Audit 1080: CAP adult day health screening allowed once per day.</p> <p>Audit 1082: CAP institutional respite care daily limit.</p>
CAP/DA providers cannot bill for in-home aide services at the same time of day as a home health aide visit.	No. There is no way to identify services provided by the time of day.	

5. Utilization Review Process

Each CAP/DA client is assigned a case manager designated by the local lead agency. The case manager arranges, coordinates, and monitors CAP/DA services as well as other aspects of the client's home care. In addition, Medical Review of North Carolina reviews 105 CAP/DA cases each month for quality assurance (e.g., appropriate billing, provision of services in accordance with recipient's care plan).

6. Other Notes

The CAP/DA program is available statewide; however, funding limitations and a shortage of local resources limit capacity in many parts of the state. 90 percent of expenditures are for in-home aides.

Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities

1. Management Information

DMA section	Behavioral Health
Service description location	Community Care Manual 2000
Populations covered	Disabled
Utilization review contractor	EDS, DMH/DD/SAS
Copay	None
Primary care provider referral required for Carolina ACCESS participants?	No
Reimbursement	Payments are based on the lower of the providing agency's usual and customary charge and the Medicaid maximum allowable rate.

2. Budget and Utilization Information

	Expenditures		Recipients	
	<i>Amount</i>	<i>% of Total</i>	<i>Number*</i>	<i>% of Total</i>
State Fiscal Year 1999	\$134,482,336	3.3%	5,016	<0.1%
State Fiscal Year 2000	\$181,279,890	4.0%	5,685	<0.1%
Change from SFY 99 to 00	35%		N/A	

**DMH/DD/SAS allots a portion of the state's enrollment limit to each participating Area Program. Annual enrollment refers to waiver year, not fiscal year, which runs from December 1 to November 30.*

3. Service Definition and Limitations

The Community Alternatives Program for Persons with Mental Retardation/ Developmental Disabilities (CAP-MR/DD) operates under special authority from the federal Department of Health and Human Services. DHHS "waived" certain Medicaid rules to allow participants in CAP to receive additional services that are not provided to the general Medicaid population. CAP-MR/DD is operated by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS).

The amount of service is limited to that approved in the CAP-MR/DD Treatment/Habilitation Plan. The individual service limits considered in approving the Plan are state in the *CAP-MR/DD Manual*.

Other Limitations

Medicaid payment is restricted as follows:

- **All CAP-MR/DD Services:** Providers may not bill for a CAP-MR/DD service furnished when a client is in an institution such as a hospital, nursing facility, or ICF/MR. Also, CAP-MR/DD services are not covered during the school day while a child is attending a public school.
- **Adult Day Care Services:** Providers may not bill for this service if it is provided on the same day that the client receives Institutional Respite Care.

Providers may not bill for this service if it is provided at the same time of day that the client receives:

Adult Day Health Services	CAP-MR/DD In-Home Aide Level I
CAP-MR/DD Personal Care	Community Inclusion
Respite Care	Developmental Day Care Services
Prevocational Services	Supported Employment

Or one of the regular Medicaid services that works directly with the client, such as PCS, Home Health Services, the area program services or the individual therapies.

- **Adult Day Health Services:** Providers not bill for this service if it is provided on the same day that the client receives Institutional Respite Care.

Providers may not bill for this service if it is provided at the same time of day that the client receives:

Adult Day Health Services	CAP-MR/DD In-Home Aide Level I
CAP-MR/DD Personal Care	Community Inclusion
Respite Care	Developmental Day Care Services
Prevocational Services	Supported Employment

or one of the regular Medicaid services that works directly with the client, such as PCS, Home Health Services, the area program services or the individual therapies.

- **CAP-MR/DD In-Home Aide Level I Services:** Providers may not bill for this service if it is provided on the same day that the client receives Supported Living Services or Institutional Respite.

Providers may not bill this service if it is provided on the same time of day that the client receives:

Adult Day Care Services	Adult Day Health Services
CAP-MR/DD Personal Care	Community Inclusion
Developmental Day Care Services	Prevocational Services
Respite Care	Supported Employment

or one of the regular Medicaid services that works directly with the client, such as the area program services or the individual therapies

- **Community Inclusion:** Providers may not bill for this service if it is provided on the same day as the client receives supported Living Services or Institutional Respite.

Adult Day Care Services
CAP-MR/DD In-Home Aide Level I
Developmental Day Care Services
Respite Care

Adult Day Health Services
CAP-MR/DD Personal Care
Prevocational Services
Supported Employment

or one of the regular Medicaid services that works directly with the client, such as PCS, home Health Services, the area program services or the individual therapies.

- **Crisis Stabilization:** Providers may not bill for this service if it is provided on the same day that the client receives Institutional Respite.
- **Developmental Day Care Services:** Providers may not bill for this service for school age children (kindergarten and above) in place of public school placement. Providers may not bill for this service if it is provided on the same day that the client receives Institutional Respite Care.

Providers may not bill for this service if it is provided at the same time of day that the client receives:

Adult Day Care Services
CAP-MR/DD In-Home Aide Level I
Community Inclusion
Respite Care

Adult Day Health Services
CAP-MR/DD Personal Care
Prevocational Services
Supported Employment

or one of the regular Medicaid services that works directly with the client, such as PCS, Home Health Services, the area program services or the individual therapies.

- **Family Training:** Providers may not bill for this service to train family members to qualify as personal care aides or to cover the training requirements of an agency, which employees the family member of a client. Providers may not bill for this service if it is provided on the same day that the client receives Institutional Respite Care.
- **Prevocational Services:** Providers may not bill for this service if it is provided on the same day that the client receives Supported Employment or Institutional Respite. Providers may not bill for this service if it is provided at the same time of day that the client receives:

Adult Day Care Services
CAP-MR/DD In-Home Aide Level I
Community Inclusion
Developmental Day Care Services

Adult Day Health Services
CAP-MR/DD Personal Care
Respite Care

or one of the regular Medicaid services that works directly with the client, such as PCS, Home Health Services, the area program services or the individual therapies.

- **Respite Care:** Providers may not bill for any type of Respite if it is provided at the same time of day that the client receives:

Adult Day Care Services	Adult Day Health Services
CAP-MR/DD In-Home Aide Level I	CAP-MR/DD Personal Care
Community Inclusion	Prevocational Services
Developmental Day Care Services	Supported Employment

or one of the regular Medicaid services that works directly with the client, such as PCS, Home Health Services, the area program services or the individual therapies.

Providers may not bill for Institutional Respite Care if it is provided on the same day as Adult Day Care, Adult Day Health Care, Prevocational Services, Supported Employment Crisis Stabilization, Community Inclusion, Family Training, Non-Institutional Respite or Supported Living Services.

- **Supported Employment:** Providers may not bill for any type of Respite if it is provided at the same time of day that the client receives Prevocational Services or Institutional Respite.

Providers may not bill for this service if it is provided at the same time of day that the client receives:

Adult Day Care Services	Adult Day Health Services
CAP-MR/DD In-Home Aide Level I	CAP-MR/DD Personal Care
Community Inclusion	Respite Care
Developmental Day Care Services	

or one of the regular Medicaid services that works directly with the client, such as PCS, Home Health Services, the area program services or the individual therapies.

- **Supported Living Services:** Providers may not bill for Supported Living if it is provided on the same day that a client receives a Home Health Aide visit, regular Medicaid Personal Care Services, CAP-MR/DD Personal Care Services, CAP-MR/DD In-Home Aide Level I, Institutional Respite or Community Inclusion.

4. System Edits and Audits to Support Policies

Requirement	Supported in Claims System?	Edit/Audit Number
Client has been approved by DMH/DD/SAS for CAP MR/DD services.	Yes. Edit prevents providers from billing for CAP procedures for non-eligible clients.	Edit 0264: Recipient not eligible for CAP services. Edit 0273: CAP procedure not valid for recipient program code.

Requirement	Supported in Claims System?	Edit/Audit Number
<p>Amount of service is limited to what is approved in recipient's treatment/habilitation plan.</p>	<p>No. The authorized limits from an individual's plan of care are not entered into the claims system. The recipient's case manager is responsible for authorizing and enforcing the service limits noted in the recipient's plan of care. The system can only enforce maximum limits of service (see audits to the right).</p>	<p>Audit 0514: CAP-MR/DD institutional respite care limit</p> <p>Audit 0572: CAP-MR/DD home mobility aid dollar limit</p> <p>Audit 0717: CAP waiver supplies limit is one per day.</p> <p>Audit 0728: CAP/MR adaptive behavior training daily limit is 96 units</p> <p>Audit 0729: CAP-MR/DD screening limit one per fiscal year</p> <p>Audit 0731: CAP-MR/DD personal care service daily limit is 96 units</p> <p>Audit 0732: CAP-MR/DD adult day health service limit is one per day</p> <p>Audit 0736: CAP-MR parent/caregiver training daily limit is 96 units</p> <p>Audit 0737: CAP-MR community skills training daily limit is 96 units</p> <p>Audit 0740: CAP-MR developmental day care daily limit is 96 units</p> <p>Audit 0748: CAP-MR counseling daily limit is 96 units</p> <p>Audit 0800: CAP medical supplies limit of one per day.</p> <p>Audit 0897: CAP-MR/DD Personal Response dollar limit</p> <p>Audit 1081: CAP-MR/DD adult day care allowed once per day</p> <p>Audit 1082: CAP institutional respite care daily limit.</p>

Requirement	Supported in Claims System?	Edit/Audit Number
Providers cannot bill for a CAP MR/DD service furnished when a recipient is in an institution (hospital, nursing facility, or ICF/MR).	Yes.	Audit 0946: CAP services not allowed the same date of service as inpatient stay.
CAP MR/DD services are not covered during the day when children are in school.	No. There is no way to identify services by the time of day.	
Adult day care services may not be provided on the same day that the client receives institutional respite care.	Yes.	Audit 0029: Institutional respite care not allowed on same day as related CAP services.
Adult day health services and development day care services may not be provided on the same day that the client receives institutional respite care.	Yes.	Audit 1088: CAP-MR/DD adult day health or developmental day care not allowed on same day as institutional respite.
CAP MR/DD in-home aide level I services may not be provided on the same day that the client receives supported living services or institutional respite.	Yes.	Audit 0032: CAP-MR/DD supported living not on same date of service as related procedure. Reverse audit: 0033
Community inclusion may not be billed on the same day that the client receives supported living or institutional respite.	Yes.	Audit 0032: CAP-MR/DD supported living not on same date of service as related procedure (e.g., CAP MR/DD PCS, institutional respite, community inclusion) Reverse audit: 0033

Requirement	Supported in Claims System?	Edit/Audit Number
Crisis stabilization may not be billed on the same day that the client receives institutional respite.	Yes.	Audit 0034: Deny CAP crisis stabilization on same date of service as institutional respite.
Family training may not be billed on the same day that the client receives institutional respite care.	Yes.	Audit 0029: Institutional respite care not allowed on same day as related CAP services.
Prevocational services may not be billed on the same day that the client receives supported employment or institutional respite.	Yes.	<p>Audit 0025: CAP prevocational service not allowed on same day as supported employment or respite care.</p> <p>Audit 0027: CAP individual supported employment not on same date of service as prevocational service or respite care.</p> <p>Audit 0028: CAP group supported employment not on same date of service as prevocational service or respite care.</p> <p>Audit 0029: CAP institutional respite care not on same date of service as supported employment or prevocational service.</p>
The following services may not be billed at the same time of day: Adult day care Adult day health CAP MR/DD PCS Developmental day care Respite care Community inclusion Prevocational services Supported employment.	No. There is no way to identify the time of day a service was provided.	

Requirement	Supported in Claims System?	Edit/Audit Number
Supported living services may not be billed on the same day that a client receives home health aide visit, regular Medicaid PCS, CAP MR/DD PCS, CAP MD/DD in-home aide Level I, institutional respite or community inclusion.	Yes and no. CAP related services are in the audits but regular Medicaid services (such as home health or PCS) are not identified.	Audit 0032: CAP MR/DD supported living services not allowed on same day as related CAP services (e.g., institutional respite, CAP MR/DD PCS, CAP MR/DD in-home aide level I, community inclusion) Reverse audit: 0034

5. Utilization Review Process

Area MH/DD/SAS programs, known as Area Programs, administer the CAP-MR/DD program on the local level. Each CAP-MR/DD client has a case manager designated by the Area Program. The case manager arranges, coordinates, and monitors CAP-MR/DD service as well as other aspects of the client's care in the community.

Dental Services

1. Management Information

DMA section	Medical Policy
Service description location	Dental Services Manual 2000
Populations covered	Adult, Blind, Disabled, Children, Medicaid Pregnant Women
Utilization review contractor	EDS
Copay	\$3, none for children under 21, CAP participants, Medicaid Pregnant Women, Medicare/Medicaid dual eligibles, or nursing or psychiatric facility residents
Primary care provider referral required for Carolina ACCESS participants?	No
Reimbursement	Statewide fee schedule. Rates for dental services were increased in 2000. No measurable improvements were noted in dental utilization.

2. Budget and Utilization Information

	Expenditures		Recipients	
	<i>Amount</i>	<i>% of Total</i>	<i>Number</i>	<i>% of Total</i>
State Fiscal Year 1999	\$52,609,470	1.3%	215,196	18.3%
State Fiscal Year 2000	\$57,586,942	1.3%	219,902	18.3%
Change from SFY 99 to 00	9%		2.2%	

3. Service Definition and Limitations

Medical and surgical dental services (e.g., oral surgery following a facial injury, extraction of a diseased tooth) are mandatory Medicaid services. Preventive and primary dental services (e.g., periodic cleanings and x-rays, fillings) are optional Medicaid services covered by 41 state Medicaid programs.

Necessary and essential dental services

Subject to the criteria and restrictions in the manual, are covered for all eligible Medicaid recipients. For purposes of determining proper use of codes for payment, the Division of Medical Assistance (DMA) has adopted the procedure codes and their respective descriptions as defined in the most recent edition of American Dental Association Current Dental Terminology (DCT-3) code book. Only the procedure codes listed in this Medicaid manual are covered under the North Carolina Medicaid Dental Program.

Routine Services

The Administrative Procedure Act (APA) defines routine services (R) as “examinations, radiographs, preventive services, tooth extractions, minor oral surgical procedures, restorative services, prosthetic repairs, and certain adjunctive services such as general anesthesia, professional consultations and visits, and the intramuscular injections of medicaments and drugs”. These services may be performed without prior approval (PA).

Emergency Services

The APA defines emergency services (EM) as procedures that are “necessary to control bleeding, relieve pain or eliminate acute infection, including emergency endodontic therapy; operative procedures which are required to prevent pulpal death and the imminent loss of teeth or treatment of injuries to the teeth or supporting structure (e.g., bone or soft tissues contiguous to the teeth); prosthetic repairs that, if delayed for prior approval, would adversely affect the health of the patient may be considered emergency procedures”.

When submitting a claim for payment on emergency services (EM), the nature of the emergency must be documented in the recipient’s chart as well as on the claim form (a simple descriptive statement will suffice). See “Completing a Claim for Routine or Emergency Services” for further information.

4. System Edits and Audits to Support Policies

Where applicable, the claims system is fully capable of enforcing limits on dental services.

5. Utilization Review Process

Prior Approval Services

DMA defines prior approval services (PA) as procedures that require a written request for approval for the EDS Prior Approval Unit before rendering treatment. In addition to having prior approval, the recipient must be Medicaid eligible on the date the service is rendered to qualify for payment.

Special Approval Services

DMA provides an opportunity for approval of services not routinely covered by Medicaid. These services require a written request for approval from the EDS Prior Approval Unit. A brief narrative and “special consideration” must be written on the form.

If the procedure receives special approval and the recipient is Medicaid eligible on the date the service is rendered, the dentist can file for reimbursement. If there are questions about prior authorizations or payment denials, call EDS for specific instructions. See “Denied Claims” for further information.

6. Clinical Evaluation

The dental service package provided under Medicaid is comprehensive and similar to a benefit package that would exist under a private dental plan.

1. *Do policies utilize medical necessity criteria appropriately?*

The principle control on the use of dental services is the shortage of participating providers.

2. *Do policies utilize utilization controls appropriately?*

The only utilization controls are placed on certain elaborate types of procedures in the realm of oral surgery, which are appropriately peer-reviewed.

3. *Are policies relevant or do they need to be changed to reflect current trends in the provision of acute care and long term care?*

Yes.

4. *Are policies so flexible or broad that services are almost never limited?*

No.

5. *Are policies so rigid or narrow that needed services are routinely denied?*

No.

Durable Medical Equipment

1. Management Information

DMA section	Community Care
Service description location	Durable Medical Equipment Manual 1999
Populations covered	Adult, Blind, Children, Disabled, Medicaid Pregnant Women (DME provided for MPW only for a pregnancy-related condition)
Utilization review contractor	EDS, some DMA in-house
Copay	None
Primary care provider referral required for Carolina ACCESS participants?	Yes
Reimbursement	Fee schedule

2. Budget and Utilization Information

	Expenditures		Recipients	
	<i>Amount</i>	<i>% of Total</i>	<i>Number</i>	<i>% of Total</i>
State Fiscal Year 1999	N/A	N/A	N/A	N/A
State Fiscal Year 2000	~\$36,000,000	~0.8%	N/A	N/A
Change from SFY 99 to 00	N/A		N/A	

3. Service Definition and Limitations

What DME Covers

DME covers the equipment and related supplies listed in Appendix C when the item is medically necessary and appropriate for use in a patient's home. An item is medically necessary if it is needed to maintain or improve a patient's medical, physical or functional level. Convenience items or features are not covered.

Payment for all items includes delivery to the patient's home as well as any required fitting or assembly. Rental payments also include any needed service and repair of the item as well as supplies for use with the equipment during the rental period.

There are six categories of covered equipment.

- Inexpensive or Routinely Purchased:** These items are purchased for a patient.
- Capped Rental/Purchased Equipment:** These items are rented or purchased as follows:

- The item is **rented** if the physician documents that the anticipated need is six months or less.
- The item may be **rented** or **purchased** if the physician documents that the anticipated need exceeds six months. Once rental is initiated on an item, a subsequent request for prior approval of purchase of that item will be denied. The item becomes the property of the patient when the accrued rental payments reach Medicaid's allowable purchase price.

EXAMPLE: If the monthly rental for an item is \$30 and the new purchase price is \$200, Medicaid will pay six full months of rental, plus no more than \$20 in the seventh month of rental. At that time, the item becomes the property of the patient, and no more rental payments are made.

3. **Equipment Requiring Frequent and Substantial Servicing:** These items are rented.
4. **Customized Equipment:** This is equipment prescribed due to a patient's unique physical needs. Patients who need this type of equipment generally have permanent, severe disabilities and require these items to perform even the most basic functions. These items are purchased for the patient.
5. **Oxygen and Oxygen Equipment:** Oxygen and items dealing with oxygen delivery are in this category.
6. **Prosthetics and Orthotics:** Prosthetics and orthotics are purchased, and are available only for patients from birth through age 20.

The service and repair of a DME item owned by a patient is covered over the useful life of the item.

Limitations

Prior Approval – Required for all orthotics and prosthetics, as well as selected DME items.

Amount of Service – The amount of service is limited to that which is medically necessary as determined by Medicaid policies.

Other Limitations – Medicaid payment is restricted in relation to the following services:

- **Hospice Care:** A patient receiving Hospice under Medicaid or Medicare may not receive DME coverage for items related to the treatment of the terminal illness. A patient who meets the requirements of both services may choose which service he wants to receive.
- **HIT – Drug Therapy:** A patient receiving drug infusion therapy through Medicaid HIT coverage may not receive DME coverage for items related to the therapy.

4. System Edits and Audits to Support Policies

Requirement	Supported in Claims System?	Edit/Audit Number
Items must be billed to Medicare first for dually eligible recipients.	Yes. To the extent possible DMA bills Medicare first for DME items. The DME vendor, though, is ultimately responsible for knowing when an item provided to dual eligibles should be billed to Medicare first.	Edit 0274: Medicare covered DME for Medicare eligible recipient.
All orthotics and prosthetics require prior approval.	Yes. The supply items that are covered are included in the procedure code master reference file. The file includes both national and state-only codes for supplies.	
Once rental is initiated on an item, a subsequent request for prior approval for purchase of that item will be denied.	Yes. There are numerous audits in the system that prevent an item from being purchased after it is rented.	Audits 1528-1549.
A patient receiving hospice under Medicare or Medicaid may not receive DME coverage for items related to the treatment of the terminal illness.	No. Currently, there is no audit in the system to enforce this policy, though a "hospice" indicator was recently added to the system that would enable this audit to be developed in the future. Moreover, it is very difficult to ascertain from the claim whether the DME provided is related to the terminal illness. Program Integrity does check for overlap of services during postpayment reviews.	
Supplies must notify CAP case managers of all items provided to CAP recipients.	No. It remains the responsibility of the supplier and the CAP case manager to coordinate services. The claims system cannot enforce this policy.	

Requirement	Supported in Claims System?	Edit/Audit Number
A patient receiving HIT cannot receive DME coverage for items related to the therapy.	Yes.	Audit 0445: HIT services same day as inpatient services. Audit 0448: Suspend inpatient claim. HIT services paid. Audit 0455: Reporting Audit – Hospice billed same day as HPN/HIT.
Suppliers must coordinate with home health agencies to prevent duplicating supply items.	No. It remains the responsibility of the providers to coordinate their services and prevent overlap.	
DME items expected to last: Motorized components: 4 years Manual wheelchairs: 3 years Hospital beds: 5 years	Yes. There is a range of audits that prevent replacement of items before their expiration date.	Audit 0848: DME wheelchairs allowed once in two years. Audit 0845: DME hospital beds allowed once in five years. Audit 0851: DME walkers allowed once in three years. Audit 0852: DME canes allowed once in three years. Audit 0853: DME crutches allowed once in three years. Audit 0854: DME tub stools allowed once in three years. Audit 0855: DME cervical spine traction allowed once in three years. Audit 0856: DME side-lying positioner allowed once in three years. Audit 0857: DME prone stander allowed once in three years. Audit 0858: DME suction pumps allowed once per day. Audit 0861: DME nebulizer and IPPB allowed once per day. Audit 0862: DME portable oxygen system allowed once per day.

5. Utilization Review Process

Although the patient's physician is responsible for prescribing DMA and DME-related supplies, it is the responsibility of the DME vendor to ensure the appropriateness and medical necessity of the requested items. The vendor completes the appropriate form to document the medical necessity of the requested items. For most items, the vendor completes the Certificate of Medical Necessity/Prior Approval (CMN/PA) form. For children's mobility systems, though, the vendor completes the CMN/PA form as well as an authorization form for Children's Special Health Services. The vendor then forwards the appropriate forms to the EDS Prior Approval Unit or to the DME consultant in the Medical Policy Unit for items that require prior authorization.

6. Clinical Evaluation

The expenditures for durable medical equipment are in the range of \$36,000,000 per year and are growing. The DME industry is marketing a variety of newer and more elaborate devices, and there is little evidence based data to guide prescribers or utilization managers in arriving at decisions about the appropriateness of equipment and devices as dispensed for a particular patient.

The list of approved devices is lengthy and apparently has not been systematically reviewed recently. The staff assigned to the function of reviewing these requests is very small considering the size of this budget item. There is no process in place for the review of the new technologies and for review of particularly expensive modalities (such as home ventilators) or the appropriate diagnostic measures required for the appropriate prescription of the devices. Usage of such devices is not systematically studied. Appropriate clinical follow-up of the patients prescribed these devices is not monitored.

1. *Do policies utilize medical necessity criteria appropriately?*

It is likely that the criteria need to be more tightly written.

2. *Do policies utilize utilization controls appropriately?*

As in the above comment, the controls should more carefully account for establishing appropriate usage, through criteria other than physician declaration of medical necessity.

3. *Are policies relevant or do they need to be changed to reflect current trends in the provision of acute care and long term care?*

This area is in need of frequent and careful updating. Much of the work of developing workable criteria has been done for the Medicare programs and is readily accessible.

4. *Are policies so flexible or broad that services are almost never limited?*

They may be too flexible or broad at present.

5. *Are policies so rigid or narrow that needed services are routinely denied?*

No.

7. Other Notes

Providers cannot accept prescriptions from any physician with an ownership interest in the supplier. Medicaid DME suppliers must also be approved by Medicare. The supplier must be able provide services 24-hours-a-day, 7-days-a-week for life-sustaining equipment. The supplier must be located in North Carolina or near the border.

Home Health

1. Management Information

DMA section	Community Care
Service description location	Community Care Manual 2000
Populations covered	Adult, Blind, Disabled, Children, Medicaid Pregnant Women
Utilization review contractor	None
Copay	None
Primary care provider referral required for Carolina ACCESS participants?	Yes
Reimbursement	Paid the lesser of the customary charge to the public or DMA maximum per visit rate for each type of service.

2. Budget and Utilization Information

	Expenditures		Recipients	
	<i>Amount</i>	<i>% of Total</i>	<i>Number</i>	<i>% of Total</i>
State Fiscal Year 1999	N/A	N/A		
State Fiscal Year 2000	\$56,000,000	1.2%	30,298	2.5%
Change from SFY 99 to 00	N/A		N/A	

3. Service Definition and Limitations

Home health care is a mandatory service for people eligible for nursing facility services. Providing home health for additional groups of persons, as North Carolina does, is an optional Medicaid service.

What Home Health Covers

Home health covers the following services when they are medically necessary to help restore, rehabilitate, or maintain a patient in the home when it is the most appropriate setting for the care:

Skilled Nursing

Visits provided by a licensed registered nurse (RN) or licensed practical nurse (LPN) under the direction of a licensed RN. The services include:

- Observation and assessment of the patient's condition when only the specialized skills of a medical professional can determine the patient's medical status.

- Management and evaluation of the patient's plan of care to ensure that the care is achieving its purpose.
- Teaching and training the patient, the patient's family, or other caregivers how to manage the patient's treatment regime.
- Skilled nursing procedures that are reasonable and necessary to the treatment of the patient's illness or injury.

Physical Therapy

Services provided by a licensed physical therapist (PT) or by a licensed physical therapy assistant under direction of a licensed PT. These services help relieve pain, restore maximum body functions and prevent disability following disease, injury, or loss of a part of the body.

Speech Language Pathology and Audiology s

Services are provided by a licensed speech-language pathologist or audiologist to diagnose and treat speech and language disorders that result in communication disabilities. The services are also provided to diagnose and treat swallowing disorders (dysphagia) regardless of the presence of a communication disability.

Occupational Therapy

Services are provided by a licensed occupational therapist (OT) or by a licensed occupational therapist assistant under the direction of a licensed OT. Services help improve and restore functions impaired by illness or injury. When a patient's functions are permanently lost or reduced, occupational therapy helps improve the patient's ability to perform the tasks needed for independent living.

Home Health Aide

Services help maintain a patient's health and facilitate treatment of the patient's illness or injury. Typical tasks include:

- Assisting with activities of daily living (bathing, eating, exercising, transferring and elimination assistance).
- Assisting a patient in taking self-administered medications that do not require the skills of a licensed nurse to be provided safely and effectively.
- Assisting with home maintenance that is incidental to a patient's medical care needs, such as light cleaning, meal preparation, emptying trash, and grocery shopping.
- Performing simple medical duties such as taking a patient's temperature, pulse, blood pressure; weighing the patient; changing dressings that do not require the skills of a licensed nurse; and reporting changes in the patient's condition and needs to appropriate parties.

Medical Supplies

Listed in the Medicaid home health fee schedule.

Limitations

Prior Approval – Pregnant women require prior authorization from EDS to receive home health services.

Amount of Service – Limited to what is medically necessary as determined by Medicaid policy. In addition, the following limits apply:

- Skilled nursing visits and home health aide visits must be part-time or intermittent. Part-time means that visits can be made up to 7 days per week and the total time spent does not exceed 8 hours per day and 34 days per week. Intermittent means that visits are not provided each day of the week and the total time spent in those visits is 34 hours or less, or visits are provided each day of the week and the time used for the visits each day is not more than 8 hours. Even though Medicaid pays for skilled nursing and home health aide services by the visit, providers have to track hours to comply with the above limits. Skilled nursing visits to pre-fill insulin syringes or medication dispensers are limited to once per week.
- Home health aide visits are only for those patients who receive Medicaid-covered skilled home health services. Patients who require only aide services may be referred for Personal Care Services (PCS).
- A patient receiving hospice care under Medicare or Medicaid may not receive home health services related to the treatment of the terminal illness. If a patient meets the requirements of both services, he or she may choose which service to receive for the terminal illness.
- A patient may not receive home health aide services and PCS on the same day.

4. System Edits and Audits to Support Policies

Requirement	Supported in Claims System?	Edit/Audit Number
Medical supplies covered under home health are listed on the Medicaid home health fee schedule. The physician must specifically order the supply in the plan of care.	Yes. The supply items that are covered are included in the procedure code master reference file. The file includes both national and state-only codes for supplies.	
Home health services require prior authorization.	Yes. The prior approval number is entered into the claims system.	

Requirement	Supported in Claims System?	Edit/Audit Number
Patient may not receive home health aide services and PCS on the same day.	Yes.	Audit 0067: Home health aide service not allowed on same day as PCS.
Patient receiving hospice care may not receive home health services in relation to treatment of the terminal illness.	Unknown.	

5. Utilization Review Process

Home health services are not subject to external utilization review; responsibility for determining if services are medically necessary rests with the patient's physician. The physician must provide the home health agency with a signed, written order that details the needed services. The agency must then perform an assessment of the patient's need for home health services, considering the following criteria:

- Does the patient have a medical necessity for the service?
- Is the service to be provided in the patient's home?
- If a skilled service or home health aide service is requested, is the patient's home the most appropriate setting for the service?
- Are other sources of care available?
- Are there possible conflicts with other services?

A HCFA-485 form must be filled out to document that the ordered services are medically necessary and the patient's home is the most appropriate setting for the case. The physician must recertify the patient's need for home health services every 60 days by signing a new HCFA-485 form.

Hospice

1. Management Information

DMA section	Community Care
Service description location	Community Care Manual 2000
Populations covered	Adult, Blind, Disabled, Children, Medicaid Pregnant Women
Utilization review contractor	None
Copay	None
Primary care provider referral required for Carolina ACCESS participants?	No
Reimbursement	Payment is calculated based on the lower of usual and customary charge, and the maximum allowable rate.

2. Budget and Utilization Information

	Expenditures		Recipients	
	<i>Amount</i>	<i>% of Total</i>	<i>Number</i>	<i>% of Total</i>
State Fiscal Year 1999	\$8,500,466	0.2%	N/A	N/A
State Fiscal Year 2000	\$9,697,636	0.2%	N/A	N/A
Change from SFY 99 to 00	14%		N/A	

3. Service Definition and Limitations

Hospice is an optional Medicaid service covered by 37 state Medicaid programs. Hospice is a package of medical and support services for terminally ill patients. An individual is considered terminally ill if he or she has a medical prognosis of a six month or less life expectancy. The hospice services are related to the terminal illness. The services are provided in a private residence, an adult care home, a hospice residential care facility, or a hospice inpatient unit. They also may be provided in a hospital or nursing facility under arrangement with the hospice agency. To be considered a nursing facility patient, the patient must be in a Medicaid-certified bed.

The following services are included in the hospice benefit:

- Nursing care.
- Medical social services.

- Counseling services for the patient, family members, and other caregivers.
- Physicians' services.
- Home health aide and homemaker services.
- Physical therapy, occupational therapy, and speech language pathology services.
- Short term inpatient care (general and respite) in a hospice inpatient unit, hospital, or nursing facility under contractual arrangement with the hospice agency.
- Medical appliances and supplies, including drugs (primarily for pain relief and symptom control related to the terminal illness) and biologicals. Appliances include DME and other self-help and personal comfort items related to the palliative care of the patient's terminal illness.
- Ambulance services related to the palliation or management of the patient's terminal illness.

4. System Edits and Audits to Support Policies

Requirement	Supported in Claims System?	Edit/Audit Number
Pregnant women require prior approval to obtain hospice services.	Yes. Upon approving coverage, EDS gives provider a confirmation number that is unique to the patient and hospice. Provider must record the number and date of call in patient's file to serve as proof that EDS was contacted.	
Five day limit on inpatient respite care.	Yes.	Audit 0513: Inpatient respite care limit.

Requirement	Supported in Claims System?	Edit/Audit Number
<p>Hospice patient is not covered for the following community care services when the service is to be provided for the terminal illness and related conditions:</p> <ul style="list-style-type: none"> • PDN • HIT • Home health • DME • PCS 	Yes.	<p>Audit 0445: HIT services same day as inpatient services.</p> <p>Audit 0448: Suspend inpatient claim. HIT services paid.</p> <p>Audit 0455: Reporting Audit – Hospice billed same day as HPN/HIT.</p> <p>Audit 0545: PDN services not allowed when recipient is receiving inpatient services.</p> <p>Reverse audit: 0544</p> <p>Audit 4403: Personal Care Services versus hospice claim</p> <p>Audit 4413: Hospice claim versus Personal Care Services.</p>
Providers cannot bill at more than one level of care per day.	Yes.	<p>Audit 0418: General inpatient care not allowed same day as routine/continuous home care, respite inpatient, hospice skilled R&B.</p> <p>Audit 0419: Routine/continuous home care, general inpatient care, hospice skilled R&B not allowed same day as inpatient respite care.</p> <p>Audit 0420: Routine/continuous home care, inpatient respite care, hospice skilled R&B not allowed same day as general inpatient care.</p> <p>Audit 0421: Inpatient respite care not allowed same day as routine/continuous home care, general inpatient care, hospice skilled R&B,</p>

5. Utilization Review Process

Hospice's interdisciplinary team monitors the patient's condition and initiates changes in the plan of care as needed. The patient's attending physician also participates in the process. The

interdisciplinary team must review and update the plan of care at least every two weeks to ensure that the patient's needs are met. Each review is documented in the patient's medical record.

6. Clinical Evaluation

The benefit as defined by North Carolina Medicaid is essentially the same as the Medicare benefit definition.

1. *Do policies utilize medical necessity criteria appropriately?*

The necessity for this service is a complex function of physician/patient/family or caregivers' wishes and abilities, but the definitions are consistent with those used under Medicare.

2. *Do policies utilize utilization controls appropriately?*

The measure of this is not possible nor is any data provided about the average length of usage of hospice services, or the number of beneficiaries whose term of usage exceeds 6 months. The policies for time of review match those of Medicare.

3. *Are policies relevant or do they need to be changed to reflect current trends in the provision of acute care and long term care?*

Yes.

4. *Are policies so flexible or broad that services are almost never limited?*

These policies appear to be appropriate.

5. *Are policies so rigid or narrow that needed services are routinely denied?*

No.

Hospital (General/Inpatient)

1. Management Information

DMA section	Institutional Services
Service description location	Hospital Services Manual 1997 (updated 1999)
Populations covered	Adult, Blind, Disabled, Children, Medicaid Pregnant Women
Utilization review contractor	EDS
Copay	None
Primary care provider referral required for Carolina ACCESS participants?	Yes
Reimbursement	Inpatient hospital services paid on the basis of DRGs since 1995. (Per diem for psych unit and rehab.)

2. Budget and Utilization Information

	Expenditures		Recipients	
	<i>Amount</i>	<i>% of Total</i>	<i>Number</i>	<i>% of Total</i>
State Fiscal Year 1999	\$683,536,611	16.6%	173,906	14.8%
State Fiscal Year 2000	\$736,135,229	16.1%	188,441	15.7%
Change from SFY 99 to 00	8%		8.4%	

3. Service Definition and Limitations

Inpatient and outpatient hospital services are mandatory Medicaid services.

Inpatient Hospital Covered Services

The Medicaid program will pay the cost of inpatient services that have been determined to be covered by the program and are medically necessary. Examples of covered services (not all inclusive) include:

- Bed and board in semiprivate room except when private accommodations are medically necessary or when only private rooms are available
- Nursing services and other related services that are ordinarily furnished by the hospital for the care and treatment of inpatients (Medicaid will not pay for the services of a private duty nurse or attendant.)
- Use of hospital facilities
- Drugs and biologicals for use in the hospital
- Supplies, appliances, and equipment for use in the hospital

- Other diagnostic or therapeutic items or services not specifically listed, but are ordinarily furnished to inpatients

Noncovered Services

The following is a non-inclusive list of noncovered services. For an updated list of ICD-0-CM procedure codes that are no longer covered under North Carolina Medicaid, see Appendix D.

- Screening mammography under age 35
- Treatment and/or testing for infertility
- Paternity blood testing
- Magnetic resonance angiography
- Cosmetic surgery
- Experimental or unapproved procedure
- Telephone, television, newspapers, guest trays
- Take-home supplies
- Birth certificates, baby bracelets, layettes
- Beauty shop, barber shop
- Shrouds, morgue boxes
- Costs
- Sitters
- Private duty nurses
- Medical photography
- Leave days (overnight leave of absence)
- Late discharge for convenience of the patient or physician
- Private accommodations when the conditions listed under Inpatient Hospital Covered Services (above) are not applicable
- Prevocational evaluation

Note: Providers should call EDS if they have questions regarding the coverage of any procedures, See Appendix B for telephone numbers.

<i>Special Restrictions</i>	
Family planning	Federal and state laws and regulations dictate strict guidelines for Medicaid reimbursement for sterilizations, abortions, and hysterectomies
<i>Other Restrictions and Medical Policy</i>	
Cardiac Rehabilitation Instructions	Many hospitals offer a program of instruction to assist the cardiac patient in recovery. These instructions for cardiac rehabilitation are usually provided by members of the physical therapy, dietary, and nursing staff. Medicaid covers these services on an inpatient basis only, and includes them in the appropriate Diagnosis Related Grouping (DRG) reimbursement or per diem rate.
Routine Newborn Care	Routine newborn care is limited to care while the infant is in the hospital and must be billed on a separate claim form, not the mother's claim form.

Inpatient Hospital Tests	<p>Payments for inpatient hospital tests are subject to recoupment unless the tests re specifically ordered by the attending physician or other licensed practitioner. Additionally, the physician is responsible for the diagnosis or treatment of a particular recipient's condition. These tests must be medically necessary, and reimbursement is included in the DRG or per diem rate.</p> <p>In a teaching situation, a test may initially e ordered by an intern, resident, or medical school student; however, the supervisory physician must certify the medical necessity for the test by countersigning the medical record in a timely manner.</p>
Norplant Insertion	Payment for Norplant insertion is made in addition to the DRG payment if the diagnosis code reported is V25.5. Payment is not made for claims qualifying for outlier or other reimbursement methods than DRG.
Take Home Supplies	"Take-home" drugs, medical supplies, equipment, and appliances are not covered, except for small quantities of medical supplies, legend drugs, or insulin needed by the recipient until such time as he or she can reasonable obtain a continuing supply.

4. System Edits and Audits to Support Policies

Requirement	Supported in Claims System?	Edit/Audit Number
Medicaid will not pay for certain noncovered services (as noted in Appendix D of Inpatient Hospital Manual)	Yes. Noncovered services are identified by ICD-9 CM procedure code. Non-covered services are listed on the procedure code reference file (level III file). Claims are rejected when there is no Pricing Action Code (PAC) listed on the file.	
Federal and state laws dictate strict guidelines for Medicaid reimbursement for sterilizations, abortions, and hysterectomies.	Yes. The system has edits to check for the appropriate information needed to authorize the procedure.	<p>Edit 0197: Abortion review--consent/statement does not meet federal requirements.</p> <p>Edit 0198: Sterilization review.</p> <p>Edit 0199: Hysterectomy review.</p>

Requirement	Supported in Claims System?	Edit/Audit Number
Certain inpatient hospital services require prior approval.	Yes. The system identifies services requiring prior approval by procedure code.	<p>PA indicator is noted on procedure code reference file; the system then looks for a valid prior approval reference. Some edits that may appear on the claim denial include:</p> <p>Edit 0201: Excision of keloids requires prior approval.</p> <p>Edit 0222: Prior approval number not on file.</p> <p>Edit 0226: Prior authorization required.</p> <p>Edit 0227: Service code invalid for prior approval.</p> <p>Edit 0228: Procedure requires PA.</p>
Care rendered for an emergency medical condition outside of North Carolina does not require prior approval. Care provided within 40 miles of the NC border will be covered to the same extent as services provided in North Carolina. Other out-of-state care must require prior approval and demonstrate that the care is not available in North Carolina.	Yes. All claims for out-of-state services are suspended for manual review. Out-of-state providers have to enroll with Medicaid in order to be paid for the service.	

5. Utilization Review Process

Introduction

Admitting office personnel must determine if the physician has completed the necessary prior approval (PA) forms before admitting recipients for procedures that require such authorization. The primary surgeon is responsible for obtaining written PA approval from the EDS Prior Approval Unit. This PA number must be on claims submitted by the primary surgeon, assistant surgeon, anesthesiologist, and hospital.

The PA number is granted when medical necessity is justified. The PA gives medical approval only; it does not guarantee payment. The recipient must be eligible for Medicaid on the date the service is rendered to qualify for payment. The individual provider is responsible for obtaining proof of eligibility prior to performing the service.

Inpatient Hospital Services Requiring Prior Approval

This list is not all-inclusive, and Medicaid guidelines can change.

Call EDS Prior Approval Unit if Providers have a question about a particular service.

- Removal of keloids and scars. Include location, description, size, and cause of lesion
- Breast reconstruction after breast cancer
- Abrasion of skin for removal of scars, tattoos, or keratoses
- Blepharoplasty
- Mastectomy for gynecomastia
- Electrical stimulation to aid bone healing; percutaneous insertion of electrodes
- Rhinoplasty
- Donor cardectomy, with preparation and maintenance of homograft
- Reconstructive surgery – photographs may be requested to differentiate between cosmetic and reconstructive surgery. Cosmetic surgery is not considered medically necessary and is, therefore, not covered. Reconstructive surgery may have cosmetic effects, but is performed to enable the patient to function optimally
- Sex transformation surgery – approved if (a) the anomaly is discovered prior to age two, or (b) during puberty, if the development of pronounced secondary sex characteristic occur
- Breast reduction for hypertrophy – photographs may be requested. Mammoplasties performed for augmentation or prosthetic implants are not covered
- Transplants(excluding bone, autologous tendon, skin, kidney and corneal)
- Donor cardiectomy-pneumonectomy, with preparation and maintenance of homograft
- Bone marrow harvesting for transplantation
- Excision/incision of lingua frenum
- Frenoplasty
- Donor hepatectomy, with preparation and maintenance of homograft
- Repair of blepharoptosis
- Reduction of overcorrection of ptosis
- Correction of lid retraction repair of ectropion
- Chemonucleolysis
- Implantation of dorsal column stimulators
- Cranial-facial reconstruction
- Hyperbaric oxygen therapy
- Abdominal panniculectomy
- Surgery for morbid obesity-stapling, binding, or bypass

6. Clinical Evaluation

North Carolina Medicaid - Inpatient Hospital Admission						
Type of service	Is definition appropriate	Is medical necessity criteria appropriate	UM Appropriate	UM Relevant	Too flexible?	Too rigid?
Emergency care	Yes	Fits federal definition	Yes	Yes	No	No
Urgent care	Not well defined open to physician/patient opinion	No workable definition given	Yes	Yes	Judgment call	No
Transfers from hospitals	Appropriate	Does not exist	Yes	Yes	No	No
Deliveries	Yes	Federal standards apply	Yes	Yes	No	No
Newborn	Federal standards	Federal standards	Yes	Yes	No	No
Medicare policy	Yes	Defined by law	Yes	Yes	No	No
Admissions subject to review – all other	Defined by exclusion from above categories	Criteria set called ISD-A, as modified by Medical Review of North Carolina	Yes*	Yes *	No*	No*

* Detailed review of the specific criteria in use was not undertaken in the scope of this project.

7. Other Notes

MRNC reviews a sample of 425 cases each month, examining for upcoding, neonatal DRGs, and other quality assurance functions. Program Integrity does concurrent review for high-cost or longer term hospitalizations (e.g., transplants). Used to be a policy for precertification of all admissions but this was changed because all admissions were being approved.

Nursing Facility (Skilled/Intermediate/Ventilator)

1. Management Information

DMA section	Institutional Services
Service description location	Nursing Facility Provider Manual 2000
Populations covered	Adult, Blind, Children, Disabled
Utilization review contractor	EDS, MRNC, First Health for PASARR
Copay	None
Primary care provider referral required for Carolina ACCESS participants?	No
Reimbursement	Prospective per diem rate. Facilities are paid different amounts--indirect portion of payment based on a statewide average, direct portion is cost-based and includes an annual cost settlement process.

2. Budget and Utilization Information

Skilled Level	Expenditures		Recipients	
	<i>Amount</i>	<i>% of Total</i>	<i>Number</i>	<i>% of Total</i>
State Fiscal Year 1999	\$433,076,935	10.5%	28,998	2.5%
State Fiscal Year 2000	\$423,583,541	9.2%	29,462	2.5%
Change from SFY 99 to 00	-2%		1.6%	

Intermediate Level	Expenditures		Recipients	
	<i>Amount</i>	<i>% of Total</i>	<i>Number</i>	<i>% of Total</i>
State Fiscal Year 1999	\$357,114,498	8.3%	N/A	N/A
State Fiscal Year 2000	\$386,455,052	8.1%	N/A	N/A
Change from SFY 99 to 00	8.2%			

3. Service Definition and Limitations

Nursing facility services for adults are mandatory Medicaid services. Nursing facility services for children under age 21 are optional Medicaid services covered by all 50 states.

Services and Items Covered in NF Per Diem

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

1. Room and Board – this includes therapeutic diets with feeding assistance as needed. Nursing services are included in the room charge.
2. Therapeutic leave – Medicaid recipients are allowed sixty (60) days per calendar year. Prior approval must be obtained for greater than 15 consecutive days.
3. Non-prescription drugs and biologicals – are included as NF services.
4. Rehabilitative Services – the NF must provide or arrange for, under written agreement, specialized rehabilitative services upon the written order of the attending physician. If a facility does not offer rehabilitative services directly, it may not admit or retain recipients in need of such care, unless it arrange for qualified outside resources under which it assumes professional responsibility. Rehabilitative services include physical therapy, speech pathology, and occupational therapy.
5. Diagnostic Services – the NF must provide or provide access to prompt laboratory, radiology, and other required diagnostic services. A facility with its own laboratory or radiology department must meet the applicable conditions of participation for hospitals. A facility not providing such services must make outside arrangements for these services. Services must be provided only by orders of the attending physician. The NF must arrange for transportation to and from the source of service.
6. Social Services – the NF must provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident.
7. Activity Services – the NF must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial assessment, the interests and the physical, mental, and psychosocial well being of each resident.
8. Supplies, Appliances, and Equipment – must be furnished by the NF to inpatients for their care, treatment, and use in the facility.
9. Routine Services – the following items and services, in addition to room, dietary, medical, and psychiatric services are always considered routine in NFs:
 - All general nursing services
 - Items furnished on a routine bases to all patients (e.g., patient gowns, water pitchers, aspirins, bedpans)
 - Items stocked in gross supply and distributed or used individually in small quantities (e.g., alcohol, applicators, cotton balls, adhesive bandages, antacids, aspirin and other non-prescription drugs ordinarily kept on hand, suppositories, and tongue depressors)
 - Items used by individual residents, but are reusable and expected to be available (e.g., ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable medical equipment)
 - 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)

10. Ancillary services covered in the per diem including the following:

- Physical, speech, occupational, or other therapy
- Intravenous fluids or solutions
- Appropriate medically necessary supplies

11. Patient care items include:

- Non-prescription drugs
- Biological serums, vaccines, antigens, and antioxins
- Dressing and skin care items (See Attachment A for detailed listing)

Services and Items Not Covered In Nursing Facility Per Diem

The following is a list of some non-covered services. This list is not all inclusive. For information, contact EDS Provider Services. See Appendix B for telephone numbers.

1. Telephone, television, newspapers, magazines
2. Guest tray
3. Morgue boxes, shrouds, or burial wrappings
4. Private duty nurses and sitters
5. Tobacco products
6. Personal clothing
7. Medical photography
8. Bed-hold days

4. System Edits and Audits to Support Policies

Requirement	Supported in Claims System?	Edit/Audit Number
All applicants to a Medicaid certified NF must receive a PASARR.	No. Interviews with staff indicate that the edit in the system to check for the authenticity of the PASARR is not functional.	

Requirement	Supported in Claims System?	Edit/Audit Number
<p>Prior approval is required for:</p> <p>All new Medicaid admissions to a NF</p> <p>Private payers/3rd party insured patients who seek Medicaid assistance and currently reside in a NF</p> <p>A resident discharged home or to an Adult Care Home and later returns to a NF</p> <p>A resident transferred from one level of care to another</p> <p>Ventilator level of care</p> <p>Therapeutic leave in excess of 15 consecutive days</p> <p>Out of state placement to NF level of care</p>	<p>Yes. Due to the ITME information system upgrade, claims for services (such as NF) will not process without a Service Review Number (SRN). The SRN "tells" the claims processing system to seek out a valid prior authorization record in order to approve the claim. Prior to the upgrade, the level of care and service identification was "embedded" in the coding of the prior authorization number.</p>	

5. Clinical Evaluation

Overall the criteria seems sufficient, although some areas could be more specific. Reading further into the Utilization Review section, it is noted that all Medicaid beds are certified for both skilled and intermediate levels of care. Residents whose level of care changes from skilled to intermediate or from intermediate to skilled are not required to move from one bed or facility to another. This could present some interesting issues regarding staffing levels, monitoring the quality and level of care, and cost of maintaining potentially all beds at a skilled level.

Skilled Level of Care:

A large sector of the population utilizing skilled care is Medicare, and this most likely holds true for North Carolina Medicaid recipients. In these cases Medicare is the primary payer for health care services, therefore the state's criteria should follow closely with that of Medicare. Criteria established by commercial insurance often follow Medicare's lead as well, which also support evaluation by Medicare's standards. As such, our findings include:

- In regard to observation and assessment involving a resident's weight loss, "significant clinically" should be better defined, for example, a percentage of a baseline value.

- Teaching and instruction for self-care or instruction to care giver should be included in gastrostomy, tracheostomy, uncontrolled diabetes, treatments, and dietary.
- There is no mention of an acute care qualifying stay within a defined period prior to placement at the skilled level.

Intermediate Level of Care:

Based on experience and knowledge of West Virginia's intermediate care guideline, assistance with activities of daily living should be quantified. A patient should not qualify for intermediate level of care based solely on one deficit in ADLs. For example, if an individual cannot bathe him/her self without assistance, this alone should not qualify them for intermediate care. A threshold should be established, such as deficits in three out of five areas of ADLs.

6. Other Notes

MRNC and two RNs from Institutional Services monitor appropriateness of care by comparing 1000 FL-2's (the State's level of care document) to the DMA Level of Care Criteria. If the FL-2 does not support the recommended level of care, the facility must submit the patient's medical records. MRNC can change the recommendation to a more appropriate level if supported by the medical record. Medicaid is payor of last resort for SNFs—Medicare-eligible patients must exhaust Medicare before Medicaid will pay.

Outpatient Hospital

1. Management Information

DMA section	Institutional Services
Service description location	NC Medicaid Hospital Manual, 1997 (updated 1999)
Populations covered	Adult, Blind, Disabled, Children, Medicaid Pregnant Women
Utilization review contractor	EDS
Copay	\$3 for some services, none for children under 21, CAP participants, Medicaid Pregnant Women, Medicare/Medicaid dual eligibles, or nursing or psychiatric facility residents
Primary care provider referral required for Carolina ACCESS participants?	No
Reimbursement	Outpatient hospital services paid at 80% of actual operating costs

2. Budget and Utilization Information

	Expenditures		Recipients	
	<i>Amount</i>	<i>% of Total</i>	<i>Number</i>	<i>% of Total</i>
State Fiscal Year 1999	\$241,551,759	5.9%	493,846	42.0%
State Fiscal Year 2000	\$272,258,247	5.9%	511,679	42.6%
Change from SFY 99 to 00	13%		3.6%	

3. Service Definition and Limitations

Outpatient hospital services are mandatory Medicaid services.

Definition	Outpatient hospital services are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under direction of a physician or dentist to a recipient by an institution that is licensed or formally approved as a hospital. All Medical services performed must be medically necessary and not experimental in nature. All hospitals that elect to participate in the Medicaid program must meet the qualifications previously described in <i>Chapter Five, Inpatient Hospital Services</i> .
Availability	Outpatient hospital services are available to all eligible Medicaid recipients who are not inpatients.

Visit Limitations	For non-exempt groups, ambulatory medical visits are limited to a total of 24 visits per year beginning July 1 of each year and ending June 30 of the following year. These visits include visits to any combination of physicians, clinics, chiropractors, optometrists, and hospital outpatient facilities, other than the emergency room.
Exemptions to 24-Visit Limitations	<p><i>Exemptions to the 24-visit limit include:</i></p> <ul style="list-style-type: none"> • Recipients being treated for end-stage renal disease • Recipients receiving chemotherapy, and radiation therapy of malignancy • Recipients being treated for acute sickle cell disease • Recipients being treated for hemophilia, or other blood-clotting disorder • Recipients being treated for end-stage lung disease • Recipients being treated for unstable diabetes • Recipients being treated for terminal stage—any illness—life-threatening • Recipients under the age of 21 • Prenatal care visits • Mental health clinic visits/services
Outpatient Covered Services	<p><i>The following services are covered by Medicaid:</i></p> <ul style="list-style-type: none"> • Outpatient services incident to the services of physicians and dentists in treating their patients • Physician and dentist professional component • Outpatient diagnostic services • Outpatient therapy services • Outpatient speech pathology services • Outpatient therapeutic and rehabilitative services including <ul style="list-style-type: none"> – The use of hospital facilities – Clinic and emergency room services – Services of hospital personnel • Medical supplies, drugs, and biologicals used by physicians or hospital personnel in treatment

Outpatient Non-covered Services	<p>This list not all-inclusive, and Medicaid guidelines can change. For questions about a service or procedure, call EDS:</p> <ul style="list-style-type: none"> • Experimental drugs and procedures • Medical photography • Biofeedback • Disability, prevocational, or preschool examinations • Infertility tests • Corsets and back supports • Cervical glomectomy for asthma • Earplugs • Brain pacemaker • Penile prostheses • Telephonic pacemaker monitoring • Guest meals • Silastic gel or inflatable implant prostheses for urinary incontinence or impotence • Bladder stimulators • Charge for venipuncture
Routine Dialysis	<p>Routine hemodialysis or peritoneal dialysis is considered an outpatient service and is subject to outpatient screens regardless of the location of the bed utilized or the length of time required for completion of the dialysis. Only those hospitals that are approved end-stage renal disease providers will receive reimbursement for Medicaid.</p>
Foot Care	<p>Routine foot care is only covered when the services are medically necessary and</p> <ul style="list-style-type: none"> • Are an integral part of otherwise covered services (such as plantar warts); • And/or there exists the presence of metabolic, neurological, and/or peripheral vascular disease; • And/or there is evidence of mycotic nails that, in the absence of a systemic condition, result in pain or secondary infection <p>Foot care services, including cutting or removal of corns and calluses, trimming, cutting, clipping, and debriding of nails and other hygienic care, are normally considered routine and are not covered by Medicaid.</p>

Routine Physicals	<p>Routine physicals and related diagnostic tests are covered in the following cases:</p> <ul style="list-style-type: none"> • Patients under age 21 who receive screening examinations under health check • Annual physicals performed as part of an ongoing family planning program • Annual physicals for recipients in domiciliary care facilities, nursing facilities, or intermediate care facilities • Adult health screening <ul style="list-style-type: none"> – Only one screening per calendar year is covered by Medicaid – screening is counted toward the 24-visit limit
Take-Home Supplies	<p>“Take-home” drugs, medical supplies, equipment, and appliances are not covered, except for small quantities of medical supplies, legend drugs, or insulin needed by the patient until such time as the patient can obtain a continuing supply.</p>

4. System Edits and Audits to Support Policies

The claims system is fully capable of supporting the policies.

5. Utilization Review Process

Certain outpatient procedures require prior authorization from EDS. Hospital admitting staff must confirm that the physician has obtained the necessary prior approval (PA) forms before admitting a patient for these procedures. If there are questions regarding prior approval, contact the EDS prior approval unit.

Outpatient Mental Health/Adults

1. Management Information

DMA section	Behavioral Health
Service description location	NC Medicaid Special Bulletin, Number II, November 2000
Populations covered	Adult, Blind, Disabled
Utilization review contractor	EDS
Copay	\$3
Primary care provider referral required for Carolina ACCESS participants?	No
Reimbursement	Medicaid fee schedule.

2. Budget and Utilization Information

	Expenditures		Recipients	
	<i>Amount</i>	<i>% of Total</i>	<i>Number</i>	<i>% of Total</i>
State Fiscal Year 1999	N/A	N/A	N/A	N/A
State Fiscal Year 2000	N/A	N/A	N/A	N/A
Change from SFY 99 to 00	N/A		N/A	

3. Service Definition and Limitations

Outpatient psychiatric visits are covered. Up to two visits allow the physician to evaluate the patient's needs and do not require PA. The third outpatient psychiatric visit and each subsequent visit requires prior approval. Use form 372-115 "Prior Approval for Psychiatric Outpatient Services." PA is required when rendered in an office, clinic, outpatient hospital, domiciliary care facility, intermediate or skilled care facility. PA is not required for inpatient visits or for the services of mental health centers. Outpatient psychiatric visits are counted toward the 24-visit limit per year on all Medicaid-eligible recipients age 21 or older. Prior approval can be granted up to a maximum of 12 months.

4. System Edits and Audits to Support Policies

Outpatient psychiatric outpatient visits have been identified by procedure code as well as specific provider types. As a result, the claims system is fully capable of supporting the policies and visit limits. Area mental health providers have a separate provider type number, which exempts them from the 24 visit limit.

Personal Care Services (PCS)

1. Management Information

DMA section	Community Care
Service description location	Community Care Manual 2000
Populations covered	Adult, Blind, Disabled, Children, Medicaid Pregnant Women (services must be related to the pregnancy)
Utilization review contractor	None
Copay	None
Primary care provider referral required for Carolina ACCESS participants?	Yes
Reimbursement	Paid the lesser of the customary charge to the public or DMA maximum per visit rate for each type of service.

2. Budget and Utilization Information

	Expenditures		Recipients	
	<i>Amount</i>	<i>% of Total</i>	<i>Number</i>	<i>% of Total</i>
State Fiscal Year 1999	\$73,963,865	1.8%	N/A	N/A
State Fiscal Year 2000	\$92,949,966	2.0%	N/A	N/A
Change from SFY 99 to 00	26%		N/A	

3. Service Definition and Limitations

Personal care services are optional Medicaid services covered by 30 state Medicaid programs. PCS covers aide services in private residences to perform:

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

4. System Edits and Audits to Support Policies

Requirement	Supported in Claims System?	Edit/Audit Number
Pregnant women must receive prior authorization to obtain coverage.	No. There is no audit/edit in the system that checks for the correct prior approval information. Program Integrity found that there was nearly \$1 million in home health claims for pregnant women that did not have a prior approval number in the claims system.	
Amount of PCS services provided in accordance with care plan, up to a maximum of 80 hours per month.	Yes and no. Only the maximum limit of 80 hours per month can be enforced. The limits authorized in the care plan cannot be entered into the claims system.	
Patient may not receive PCS and another "substantially equivalent" service on the same day.	Yes.	Audit 0067: Home health aide service not allowed on same day as PCS. Audit 0250: PCS not allowed same DOS as CAP in-home aide level II and level III services. Reverse Audit 0252

5. Utilization Review Process

Personal care services are not subject to external utilization review; responsibility for determining if services are medically necessary rests with the patient's physician. The agency that will provide the personal care services must assess the patient's medical condition and home environment, and document the findings on the DMA-3000 Physician Authorization and Plan of Care form.

The following criteria are used to evaluate the need for PCS:

- The patient is medically stable in a private residence;
- The patient needs assistance with personal care tasks in the residence due to his medical condition;
- The personal care assistance needs are unmet; and
- PCS is the most cost-effective and appropriate form of care.

The agency must certify the need for PCS and completion of the plan of care by signing and dating the form. The assessment and plan of care must be sent to the patient's physician for review. If the physician agrees that the patient needs PCS, he signs and dates the form. Reassessments for continued PCS must be performed every 12 months.

Physicians

1. Management Information

DMA section	Practitioner/Clinic Services
Service description location	NC Medicaid Physician Services Manual, 1987
Populations covered	Adult, Blind, Disabled, Children, Medicaid Pregnant Women
Utilization review contractor	EDS
Copay	\$3, none for children under 21, CAP participants, Medicaid Pregnant Women, Medicare/Medicaid dual eligibles, or nursing or psychiatric facility residents; none for pregnancy-related services or family planning services
Primary care provider referral required for Carolina ACCESS participants?	Yes
Reimbursement	Service reimbursement based on CPT codes. Rates for physician services were increased from 93% to 100% of Medicare in 2000. Measurable improvements in access to primary care providers occurred. Set rates for some services (e.g., OB).

2. Budget and Utilization Information

	Expenditures		Recipients	
	<i>Amount</i>	<i>% of Total</i>	<i>Number</i>	<i>% of Total</i>
State Fiscal Year 1999	\$388,246,446	9.5%	995,962	84.8%
State Fiscal Year 2000	\$432,332,656	9.4%	1,022,362	85.1%
Change from SFY 99 to 00	11%		2.7%	

3. Service Definition and Limitations

Physician services are mandatory Medicaid services.

Physician's Personal Professional Services

Personal professional services of the physician are covered when they are medically necessary and furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere. Physicians' personal professional services include diagnosis, therapy, surgery and consultation. A physician's service is constituted when the physician examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a

third person's judgement – as in the interpretation of x-rays, electrocardiogram and electroencephalogram, tapes, tissue samples, etc.

Services and Supplies Incident to Physicians' Services

Services performed by licensed health care practitioners, other than physicians' services, are covered when the criteria stated below are met. A service must be furnished "incident to a physician's professional services." "Incident to" means that the services or supplies are furnished as an integral, although incidental, part of a physician's personal professional services. To be covered under Medicaid, "incident to" services or supplies must be of kinds that are commonly furnished in physicians' offices, are commonly rendered without charge or included in physicians' bills, and are incident to Medicaid covered services. In addition, the services of non-physicians must be rendered by employees of the physicians under his direct personal supervision.

The direct personal supervision requirement applies to services of all auxiliary personnel (except x-ray technicians under certain circumstances) employed by the private physician or group of physicians. Examples of auxiliary personnel included under this requirement are: nurses, nurse anesthetists, physician extenders, psychologists, therapists (physical therapists, speech therapists, audiologists, etc.) technicians and other aides. For example, if a physician employs a speech pathologist and includes the charges for such services in his bill, the services of the speech pathologist are considered to be incident to the physician's services. There must be a physician's personal service rendered, to which the services of the speech pathologist are incidental, and there must be direct personal supervision by the physician.

The direct personal supervision requirement does not mean that the physician must be present in the same room with the employee when the service is rendered. However, the physician must be present on the premises and immediately available to provide assistance and direction. This requirement applies wherever the service is rendered – office, home, hospital, nursing home or elsewhere.

The physician does not necessarily have to provide a personal professional service in conjunction with every incidental service. However, the "incident to" service must be furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency that reflects his actual participation in the management of the course of treatment.

Supplies, including drugs and biologicals, usually furnished by the physician in the course of treatment such as surgical trays, gauze, injections, ointments, bandages, (including ace bandages), etc., are covered as "incident to" supplies. Routine immunizations are not covered except under the EPSDT program. "Take home" drugs and medical supplies are not covered except for small quantities of medical supplies, legend drugs or insulin needed by the patient until such time as the patient can obtain a continuing supply. To be covered, supplies must represent an expense to the physician.

The guidelines for physician group practices are generally the same as those described above. However, in highly organized group practices, particularly those that are departmentalized, "direct personal physician supervision" may be the responsibility of several physicians as

opposed to an individual attending the physician. The physician ordering a particular service need not be the physician who is supervising the service.

In summary, services and supplies incident to physicians' services must meet the following requirements:

- Be furnished as an integral, although incidental, part of a physician's personal professional service.
- Be provided by an employee of the physician.
- Be furnished under the physician's direct personal supervision.
- Be of the kind commonly furnished in a physician's office.
- Be included in the physician's bill.
- Represent an expense to the physician.
- Be incident to Medicaid covered services.

Noncovered Services

Following is a list of noncovered services. Other services may not be covered. These are examples of items or services that have caused questions in the past. Please contact EDS when in doubt regarding coverage of a service or procedure.

- Experimental drugs and procedures
- Pre-vocational, athletic, pre-school or disability examinations
- Medical photography
- Biofeedback
- Brain pacemakers
- Penile prostheses
- Infertility tests
- Pre-marital VDRL
- Additional charge for routine scheduled visits "after office hours" (if the regularly scheduled office hours extend beyond those of a normal workday, or if a routine appointment is scheduled for convenience after the office closes, additional charges for "after office hours" are not allowed.)
- Depo Provera injections for birth control
- Corsets and back supports
- Cervical glomectomy for asthma
- Ear plugs
- Telephonic pacemaker monitoring
- Silastic gel implants prostheses for urinary incontinence
- Bladder stimulators

4. System Edits and Audits to Support Policies

The claims system is capable of supporting the policies.

5. Utilization Review Process

Approximately 70 percent of Medicaid recipients are enrolled in Carolina ACCESS, the primary care case management program. As such, these recipients must obtain the authorization of their primary care provider to receive specialty referrals or elective hospital admissions. Each month, primary care providers receive a report that shows specialty referrals in the past month for their ACCESS enrollees. Providers are encouraged to review this report and submit any discrepancies to the local managed care representative.

Prescription Drugs

1. Management Information

DMA section	Medical Policy
Service description location	Pharmacy Manual 1997
Populations covered	Adult, Blind, Disabled, Children, Medicaid Pregnant Women
Utilization review contractor	First Health Services Corporation
Copay	\$1 (also required for refills), none for children under 21, CAP participants, Medicaid Pregnant Women, Medicare/Medicaid dual eligibles, or nursing or psychiatric facility residents
Primary care provider referral required for Carolina ACCESS participants?	No
Reimbursement	Lesser of the usual charge to the public or of Average Wholesale Price minus 10 percent plus \$5.60 dispensing fee (fee set by legislature, not DMA--one of the only fees set by them and not the department)

2. Budget and Utilization Information

	Expenditures		Recipients	
	<i>Amount</i>	<i>% of Total</i>	<i>Number</i>	<i>% of Total</i>
State Fiscal Year 1999	\$557,772,670	13.6%	797,599	67.9%
State Fiscal Year 2000	\$754,505,194	16.5%	817,779	68.1%
Change from SFY 99 to 00	35%		2.5%	

3. Service Definition and Limitations

Prescription drugs are an optional Medicaid service provided by all 50 states.

Criteria for Coverage

Medicaid coverage of pharmacy services consists of payment for certain Federal Legend drugs and insulin when dispensed by a participating pharmacy.

Covered Services

All drugs which bear the Federal Legend statement and have Federal Drug Administration (FDA) approved indications with the exceptions of Noncovered Items are covered by the North

Caroline Medicaid Pharmacy Program. Coverage of compounded prescriptions is addressed in another section entitled "Compounded Drugs."

Noncovered Items

The following is a list of services not covered by Medicaid when billed under the pharmacy program.

1. Over the counter drugs (except insulin)
2. Federal Legend drugs or their generic equivalents which are on the Drug Efficacy Study Implementation (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, I.V. sets, T.E.D. hose, etc.
5. Diaphragms
6. Routine immunizations, flu vaccine, DPT immunization, etc.
7. Fertility and impotence drugs
8. Drugs used for cosmetic indications
9. Durable medical equipment: oxygen concentrators, wheelchairs, etc.
10. I.V. fluids (Dextrose 500ml or greater) and irrigation fluids used by Medicaid recipients in in-patient facilities are not to be billed through the Pharmacy Program, but should be billed as ancillary services by the facility.

Exemptions from the Prescription Limitation

Exemption from this limitation was authorized by the Department of Health and Human Services "when the life of the patient would be threatened without additional care." Therefore, patients being treated for one of the conditions exempt from the prescription limitation. For recipients who qualify and are not in a facility, **the prescriber must write the diagnosis in their own handwriting on EACH prescription which exceeds the prescription limitation.** It is recommended that Providers request the prescriber document the condition on each prescription for documentation on future refills (e.g. The 2nd prescription this month could be the 8th prescription in a later month). For recipients who are residents of a Skilled Nursing Facility or Intermediate Care Facility, the pharmacist must obtain a statement in one of the attending prescriber's own handwriting, specifying one of the diagnoses listed below. The statement must be kept on file, readily retrievable upon request by pharmacy auditors, and updated every six months if the recipient continues to meet the requirements for exemption. The pharmacy is at risk for recoupments if these requirements are not met.

The diagnoses allowing exemption from the prescription limitation when documented in the prescriber's own handwriting are:

1. "End-state renal disease"
2. "Chemotherapy and radiation therapy for malignancy"
3. Acute sickle cell disease"
4. "Hemophilia"
5. "End-state lung disease"
6. "Unstable diabetes"
7. "Terminal stage" any illness, or "life-threatening" any illness

Recipients who are participating in the Community Alternatives Program (CAP) are exempt from the prescription limitation and the copay requirements. The prescriber and pharmacist do not need to indicate this exemption on the prescription because CAP is on Medicaid's eligibility file. The pharmacist should check the Medicaid ID card for the CAP indicator. If there is a two-letter code in the CAP block on the card, the recipient is participating in a CAP program. The CAP block is at the top, left of the card

Recipients who are less than 21 years of age are exempt from the prescription limitation under guidelines established through the Healthy Children and Teens Program. The prescriber does not need to indicate this exemption on the prescription since it is incorporated in the eligibility files.

100 Days Supply Maximum for Medicaid Prescriptions

North Carolina Medicaid will soon begin rejecting prescriptions for more than a 100 days supply. The 100 day supply maximum will still allow dispensing of 100 pack size bottles for some maintenance medications. This limitation will be based on Days Supply submitted and the maximum daily quantity for each NDC from a national source. Please begin using the 100 day supply maximum for Medicaid prescriptions.

Generic Substitution and MAC Overrides

The General Assembly authorizes and mandates pharmacists participating in Medicaid to substitute generic drugs for brand or trade name drugs unless the prescriber specifically orders the brand name drug. A prescription for a drug designated by a brand or trade name for which one or more equivalent drugs are available shall be considered to be an order for the drug by its generic name, except when the prescribers personally indicate in their own handwriting on the prescription order, "Brand Medically Necessary" or "Dispense as Written."

The selection of a drug product shall not be more expensive than the brand or trade name originally written by the prescriber. The pharmacist shall fill the prescription with the least expensive generic in the pharmacy, unless a specific brand or trade name is specified by the prescriber in the required manner. For audit purposes, the brand name and manufacturer must be noted on the prescription.

Maximum Allowable Cost (MAC) Overrides

The North Carolina Pharmacy Program has been mandated by Federal regulations to implement a Maximum Allowable Cost (MAC) for some multiple source drugs. It is possible to override the MAC limitation if a prescriber certifies that a specific brand of drug that has a MAC limitation is medically necessary for a particular recipient. The certification must fall under Federal regulations which specify that the certification "**Dispense as Written**" or "**Brand Medically Necessary**" **must be in the prescriber's own handwriting** and signed by the prescriber. This can be written directly on the face of the prescription or on a separate document that must be attached to the original prescription.

DESI Drugs

Reimbursement is denied on drugs described by the FDA as DESI. These are products that the FDA has found to be less than effective or not proven effective as indicated. Drug products that

are identical, related, or similar to DESI drugs are also DESI. Updates or corrections will appear via newsletters or RA banner messages and is available from drug file pricing service providers.

Compounded Drugs

A compounded prescription is defined as a mixture of two or more ingredients that are physically inseparable. Each compounded prescription must contain at least one legend drug in order to be reimbursed by Medicaid.

A compounded prescription must contain a quantity of a legend drug sufficient to have a therapeutic effect. It cannot be two different drugs (capsules and/or tablets) separable but dispensed in the same bottle. All DESI drugs and combinations equivalent to a DESI drug are not reimbursable in compounded prescriptions.

4. System Edits and Audits to Support Policies

Requirement	Supported in Claims System?	Edit/Audit Number
All drugs approved by the FDA are covered.	Yes. DMA receives every week a data tape from First Databank that contains pricing updates and national drug codes (NDCs) covered by the FDA.	
Recipients are limit of six prescriptions per month.	Yes. Pharmacists can override the audit at the point of sale for individuals who are exempt from the policy.	Audit 0985: Legislative limits for prescriptions.
Maximum 100 day supply for prescription drugs.	Yes. Pharmacists translate the physician's dosage requirements into days supply (e.g., two tablets per day = 200 tablets for 100 day supply).	Edit 0907: 100 day supply exceeded. Edit 0908: 100 day supply exceeded.
Recipient lock-in to one pharmacy per month.	No. Pharmacists enforce the policy by removing "pharmacy of record" tab from recipients' Medicaid ID cards and keeping the tab on file. Pharmacist stamps card with pharmacy name, address, and telephone. There is no system barrier to prevent other pharmacists for fulfilling the recipients' prescriptions.	

Requirement	Supported in Claims System?	Edit/Audit Number
Pharmacist required to substitute generic drugs for brand unless the prescriber writes "Brand Medically Necessary" or "Dispense as Written" on prescription.	Yes. Pharmacist can override the policy at the point of sale.	
Dispensing fee of \$5.60 paid to the pharmacist for the first dispensing of drug in a calendar month. Pharmacists are not paid for repeated dispensing of the same drug within the calendar month.	Yes. The system recognizes whether the drug has been previously dispensed during the month by the national drug code (NDC).	
Cost of the drug calculated using the lower of Average Wholesale Price – 10% discount, Maximum Allowable Cost, or actual acquisition cost reported by the pharmacy.	Yes. Pricing is supplied by First Databank tape. MAC limit can be overridden if prescribers certify that a specific brand of drug is medically necessary. The certification "Dispense as Written" or "Brand Medically Necessary" must be signed and written in prescriber's handwriting.	
Prospective drug use review alerts pharmacist at the point of sale of potential therapeutic problems.	Yes. Pharmacists can resolve/override DUR conflict alerts by contacting the prescriber, discussing medication history with the patient, or using professional judgment to determine the necessity of dispensing the medication. Currently, they can override some DUR alerts by entering approved codes.	Edit 0925: POS-DUR conflict code verification. Edit 0926: POS - DUR intervention code verification. Edit 0927: POS - DUR outcome code verification. Edit 0937: POS - DUR alert override not found.

5. Utilization Review Process

Prospective Drug Utilization Review (pro-DUR) is conducted at the point-of-sale at the pharmacy. Automated alerts appear to notify pharmacists of potential therapeutic problems; pharmacists are supposed to resolve the therapeutic conflicts by discussing the patient's history

with the prescribing physician or the patient himself. As such, pharmacists have the capability to override most of the pro-DUR alerts.

Per federal regulations, North Carolina convenes a Drug Utilization Review Board to perform educational interventions to correct inappropriate dispensing or prescribing patterns. The DUR Board is comprised of practicing pharmacists and physicians from the community. Through a contract with DMA, First Health analyzes pharmacy claims data to identify physicians and pharmacists targeted for the DUR Board's educational campaigns. The DUR Board's activities are not punitive in intent; rather, the goal is to change prescribing and dispensing behavior that is inappropriate, based on examination of the medical literature and best practices from the medical field.

6. Clinical Evaluation

See Appendix H for a complete evaluation of the North Carolina Medicaid pharmacy benefit.

Private Duty Nursing

1. Management Information

DMA section	Community Care
Service description location	Community Care Manual 2000
Populations covered	Adult, Blind, Disabled, Children, Medicaid Pregnant Women (services must be related to the pregnancy)
Utilization review contractor	DMA performs in-house
Copay	None
Primary care provider referral required for Carolina ACCESS participants?	Yes
Reimbursement	Payment is calculated based on the lower of billed usual and customary charges, and the Medicaid maximum allowable rate.

2. Budget and Utilization Information

	Expenditures		Recipients	
	<i>Amount</i>	<i>% of Total</i>	<i>Number</i>	<i>% of Total</i>
State Fiscal Year 1999	N/A	N/A	N/A	N/A
State Fiscal Year 2000	N/A	N/A	N/A	N/A
Change from SFY 99 to 00	N/A		N/A	

3. Service Definition and Limitations

Private duty nursing (PDN) is an optional Medicaid service covered by 24 state Medicaid programs. PDN is continuous, substantial, and complex nursing services provided by a licensed nurse (RN or LPN) in the patient's private residence. In addition to providing care in the home, the nurse may accompany a patient outside of the home when the patient's normal life activities (such as a child attending school during the day) require that that patient leave his or her residence. "Normal life activities" does not include PDN coverage when the patient is receiving medical care in a hospital, physician's office, or other inpatient and outpatient setting.

4. System Edits and Audits to Support Policies

Requirement	Supported in Claims System?	Edit/Audit Number
Prior approval required. Pregnant women can only receive PDN for a pregnancy related condition.	Yes. The HCI unit enters the prior approval number into the claims processing system. Claims without an authentic PA number will not be paid.	
A patient receiving hospice care may not receive PDN services related to the treatment of a terminal illness.	Unknown.	
PCS, skilled nursing, home health aide visits may not be provided during the same time of day as PDN.	No. While PDN is prior authorized by the number of hours per day, there is no way to identify the time of day a service was provided.	
Self administered Home Infusion Therapy (HIT) are not allowed on the same day as PDN.	Yes.	Audit 0289: HIT self administered drugs not allowed same day as PDN. Reverse Audit 0290.

5. Utilization Review Process

Although the patient's attending physician identifies the need for private duty nursing and provides the referral, the RN/LPN is responsible for documenting the medical necessity for private duty nursing, verifying the recipient's Medicaid eligibility, and obtaining prior approval from the HCI Unit at DMA.

6. Clinical Evaluation

Private duty nursing review is very important to focus on, as cost per month can range from \$10,000.00 to \$40,000.00 to maintain a patient in the home. This cost depends upon how many hours per day/hours per week the patient is getting and what the reimbursement rate is for that state. Keep in mind, this is just the cost for the private duty nursing; not the equipment, supplies, and medications that the patient will need.

Past experience has shown that private duty nursing is best reviewed under a Case Management program; since the type of service being provided is very complicated in nature. A Nurse Case Manager is best suited for this review type, as she/he has the expertise to know what other types of services are available for the patient. They would also refer this case to a physician reviewer if there were any questions of medical necessity for private duty nursing. There needs to be better definitions of what type of eligibility and exclusions for medical necessity.

1. Do policies utilize medical necessity criteria appropriately?

Not at this point. The criteria needs to be more clearly defined. See attached examples. It also appears that the criteria is for both children and adults. There needs to be some clearly defined areas for each type of patient.

2. Do policies utilize utilization controls appropriately?

As above stated, the controls need to be more clearly defined. A better definition of medical necessity needs to be used (in conjunction with the physicians' recommendation of medical necessity).

3. Are policies relevant or do they need to be changed to reflect current trends in the provision of acute care and long term care?

As with any medical policies, there are ever changing elements that require that policies be updated frequently. There are many different policies available for private duty nursing. They are available on line in the Medicaid web sites.

4. Are policies so flexible or broad that services are almost never limited?

They appear to be too flexible at this point; and also a bit vague. There also needs to be a list of exclusions: see attached.

5. Are policies so rigid or narrow that needed services are routinely denied?

They don't appear to be too rigid.

7. Other Notes

Family members cannot be employed by the PDN agency providing the service. 1 RN in the Community Care section does all PDN PA. There is a standard referral form that docs fill out and send in that recommends a number of hours of PDN and the reason. DMA will approve number of hours and time limit (usually 30, 60, or 90 days); at the end of the approved time period the RN will review records and talk to the prescribing physician to see if PDN should be continued.

Psychiatric Hospital—Private or State

1. Management Information

DMA section	Behavioral Health
Populations covered	Children, Adults over age 65
Utilization review contractor	Value Options, First Health
Copay	None
Primary care provider referral required for Carolina ACCESS participants?	No
Reimbursement	Per diem based on the hospital's actual allowable and reasonable costs. DMA only pays for the treatment costs for level I-IV programs. Financial Ops works with PRTFs to develop facility-specific rates for above level IV services for children.

2. Budget and Utilization Information

	Expenditures		Recipients	
	<i>Amount</i>		<i>Number</i>	<i>% of Total</i>
State Fiscal Year 1999	N/A	N/A	N/A	N/A
State Fiscal Year 2000	N/A	N/A	N/A	N/A
Change from SFY 99 to 00	N/A		N/A	

3. Service Definition

Inpatient psychiatric services for children under 21 or adults over age 65 are optional Medicaid services covered by 41 states. Inpatient psychiatric services for adults between 21 and 65 can not be covered by Medicaid.

4. Utilization Review Process

Introduction	<p>North Carolina Medicaid contracts with First Mental Health, Inc. (FMH) to help ensure psychiatric admissions for recipients through age 64 are appropriate. The FMH process includes pre-admission review and certification, continued stay (concurrent) reviews, post discharge reviews, and special team (on-site) reviews.</p> <p>The FMH approval process is applicable to all psychiatric hospitals and those general hospitals with psychiatric units individually notified by</p>
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	DMA (Attachment D). Certification of length of stay is required. For specific questions refer to the First Mental Health "Provider Manual for North Carolina Psychiatric Utilization Review Services," or see Appendix B, pre-admission review: First Mental Health, for a phone number.
Concurrent Review	FMH conducts continuous monitoring and concurrent reviews until discharge for all recipients under the age of 65 receiving inpatient psychiatric care in psychiatric hospitals and the psychiatric units of selected general hospitals. See Appendix B for contact phone number.
Certification of Need	In addition to the FMH approval process, federal regulations require a certification of need (CON) for admission to a psychiatric hospital for Medicaid recipients or applicants under the age of 21 (42 CFR 441.152 and 441.153). The CON must meet all federal requirements and a copy must be kept in the recipient's medical record for federal or state audit. The CON form is needed for psychiatric hospitals only. There are no federal CON requirements for the adult population. If correct procedures for admissions approval and CON are not followed, payments for inpatient hospital services will be denied.
Medicaid Status	Under federal regulations, CON procedures vary depending upon the patient's Medicaid status at the time of admission. The hospital determines this status. If the proper procedures for admission approval are not followed, denial of Medicaid payments will be made as indicated in the information blocks. Current and accurate Medicaid status must be reported to FMH for each recipient.
Out-of-State Psychiatric Hospitals	Any admission of a recipient under age 65 to an out-of-state psychiatric hospital requires review and approval from FMH. Out-of-state stays in psychiatric hospitals are subject to continued stay and post-discharge reviews by FMH.
FMH Postdischarge Review	Post-discharge reviews are conducted to ensure medical necessity for the admission and appropriate length of stay. FMH performs post-discharge reviews of a sample of cases designated by the state DMA. The purpose of the review is to identify days of an acute hospital stay that were not medically necessary. The hospital will be required to reimburse payment for any days determined not medically necessary. The hospital will be required to reimburse payment for any days determined not medically necessary as a result of the post-discharge review. Portions of and/or the entire medical record will be requested.
Special Team Reviews	FMH may be requested and authorized by the state to perform an onsite special team evaluation. A review may be requested to evaluate the needs of a patient experiencing a long length of stay or to monitor a specific program. The FMH onsite review team includes at a minimum a clinical psychologist and a psychiatric nurse.

Appendix B Summary Of Findings

1. Increase management of the pharmacy benefit

Finding	Reference
DMA does not have a strong utilization management review program for the pharmacy benefit and consequently has little control over rising costs	III-7
The six-prescription-per-month limit currently used by DMA to restrict pharmacy access can be overridden by several mechanisms (e.g., exemptions, 100-day supply availability)	III-12
The six-prescription-per-month limit is enforced in many cases, however, and may limit access to needed prescriptions for some beneficiaries, particularly the elderly and disabled	III-12
Other states use a variety of approaches to manage pharmacy benefits, including prior authorization and other limits on access, policies to encourage greater use of generic medication forms, identifying new strategies to contain costs, and greater use of clinical consultants in forming drug coverage policy	IV-2
Several North Carolina insurers use tiered co-pays, extensive prior approval requirements, and quantity limits to manage pharmacy benefits	IV-25

2. Create a level playing field in behavioral health

Finding	Reference
North Carolina structures some benefit policies to favor publicly-supported safety net providers over private practice providers	II-2
The behavioral health program has differing benefit restrictions and prior authorization requirements for public- and private-sector providers	III-27

3. Reduce the fragmentation in the Medicaid benefit policy-making process

Finding	Reference
The Medical Policy Unit at DMA is in the process of standardizing a formerly decentralized process for policymaking that in the past may have led to inconsistencies in the Division's approach towards benefits coverage	II-5
Medicaid policies are affected by a wide variety of stakeholders who have varying levels of influence over the different DMA sections/units	II-8
Feedback on existing benefits and comparisons of actual to projected results of coverage decisions are not consistently used to refine cost and utilization projections for new benefits	II-10

4. Consider reducing physician fees

Finding	Reference
NC pays physicians a much higher fee rate (compared to Medicare fees) than any of its neighboring states, and more than most other states in the country	II-4

5. Improve the use of data and medical literature in the decision-making process

Finding	Reference
DMA uses a definition of medical necessity based on a "community standard of care," which can be subject to multiple interpretations and difficult to enforce	II-11
DMA is in the process of developing more specific criteria for nursing facility level of care decisions	III-6
DMA uses a single set of medical necessity criteria for the private duty nursing benefit, while separate criteria for adults and children might be more clinically appropriate	III-22
Several North Carolina insurers use national standards, as opposed to local practice patterns, in establishing medical policies	IV-15

6. Re-evaluate coverage of certain optional benefits

Finding	Reference
NC uses a broader definition of the amount, duration, and scope of a benefit than is required by federal law	II-1
NC covers many "optional" Medicaid services	II-2

7. Improve coordination of care and utilization review processes

Finding	Reference
Utilization management functions are sometimes divided among multiple contractors for different aspects of the same benefit	II-14
The prior approval process for entrance into nursing care is divided among multiple contractors but appears to be efficient and well-coordinated	III-3
The prior approval process for entrance into nursing care does not include an opportunity to assess whether a patient could be served through community-based care (as an alternative to full-time nursing care)	III-3
Multiple utilization management contracts handle different parts of the same behavioral health benefit (e.g., residential treatment for children) that may cause disruptions in the continuity of care	III-28
Some states surveyed, unlike North Carolina, use a single point of entry for both nursing homes and community-based services programs	IV-8

8. Strengthen program integrity controls

Finding	Reference
The claims processing system is unable to enforce some prior approval requirements and benefit limitations in certain benefit areas	II-12
The claims processing system is not always updated as quickly as new policies are put into place, so some policies can not be enforced immediately	II-13
Pressure to keep Medicaid program administrative costs low may be hampering efficiency of agency staff and program integrity	II-16

Finding	Reference
The hospital services benefit is well-defined, policies are supported by the claims system, and appropriate utilization management techniques are used to control access	III-1
The nursing facility level of care criteria (used to determine whether someone should be in skilled or intermediate care) are generally sufficient, although some areas could be more specific	III-5
The claims system cannot verify that some community care services are provided as described on the physician-authorized plan of care; manual review is required to ensure program integrity	III-18
The claims system cannot verify that some Community Alternatives Program (CAP) services are provided as described on the CAP plan of care; manual review is required to ensure program integrity	III-25

Appendix C Summary Of Recommendations

1. Increase management of the pharmacy benefit

Recommendation	Reference
Implement a meaningful prior authorization program for at least the following eight drugs: Prilosec, Prevacid, Aciphex, Ranitidine, Pepcid, Axid, Celebrex, Vioxx, and other branded NSAIDs	III-9
Replace the six prescription per month limit with a more rigorous prior authorization program to ensure that cost decisions are made based on evidence-based clinical guidelines	III-15
Expand the prior authorization program to include brand name drugs when generics are available (i.e., limit ability of pharmacists to override this requirement at the point-of-sale)	IV-6
Limit access to certain drugs to patients who present with a specific diagnosis (e.g., limit Oxycontin to patients with end-stage cancer or similar conditions)	IV-6
Evaluate other incentives to encourage use of generic drugs, such as differential dispensing fees or differential copayments	IV-6
Actively manage physician prescribing practices through provider profiling	IV-6
Contract with a pharmacy benefits manager to implement more extensive prospective drug utilization review	IV-6
Eliminate blanket 100-day pharmacy supply, and replace with shorter or tiered approaches (e.g., no more than 30 days for first fill, no more than 60 days for refills)	IV-6, IV-25
Adopt drug dosage limitations based on drugs most likely to be abused	IV-24

2. Create a level playing field in behavioral health

Recommendation	Reference
Consider eliminating preferential rules that favor public providers (maximizing federal revenue to these providers may inappropriately discourage private provider participation in delivering these benefits)	II-18

3. Reduce the fragmentation in the Medicaid benefit policy-making process

Recommendation	Reference
Continue to emphasize a more uniform approach to benefit evaluation	II-8
Continue to ensure that input from other DMA units is appropriately communicated to the Medical Policy Unit benefit managers	II-8
Formally include in the policy development process an evaluation of whether the claims payment system will enforce the benefit or whether another strategy (e.g., post-payment review, medical record review) should be used to support program integrity	II-13
Apply lessons learned from the ACCESS II and III demonstrations to the ACCESS I program and the traditional Medicaid program	IV-13
Designate internal resources to systematically review coverage policies	IV-30
Make ongoing evaluation of new policies and changes a priority	IV-30

4. Consider reducing physician fees

Recommendation	Reference
Reduce Medicaid physician fees to 91 percent of Medicare rates	II-5
Evaluate whether access would be compromised by a further reduction to 85 percent of Medicare rates (percentage paid by the highest neighboring state)	II-5

5. Improve the use of data and medical literature in the decision-making process

Recommendation	Reference
Consistently evaluate the actual utilization trends, health outcomes, and data on new services 12 to 18 months after implementation	II-10
Compare information on the projected utilization and actual utilization of existing benefits to refine beneficiary and provider behavioral modeling techniques and refine future forecasts	II-11
Adopt a definition of “medical necessity” that is consistent with current references to national standards of care	II-12, IV-19

Recommendation	Reference
Analyze which services are high-cost and high-use outliers and target prior authorization strategies accordingly	IV-18
Use expert and community sources of input to identify and evaluate new benefits or changes	IV-30

6. Re-evaluate coverage of certain optional benefits

Recommendation	Reference
Re-evaluate whether to cover benefits not offered by the majority of other state Medicaid programs	II-2
Do not add benefits simply to maximize federal funds to governmental providers; only add these benefits when clinical data suggests improvements in health care	II-2

7. Improve coordination of care and utilization review processes

Recommendation	Reference
Evaluate how to better align utilization review contractor scopes of work to reduce coordination problems	II-15
Require communication between school-based providers and a child's primary care provider regarding all school-based services	II-18
Coordinate the process for determining eligibility for institutional care and enrolling in a Community Alternatives Program	IV-8
Widely distribute the criteria to be applied to approve surgeries (not just the list of services requiring approval); consider using an Internet-based distribution vehicle	IV-26
Delegate utilization review of certain benefits to independent contractors with expertise in those benefit areas	IV-30
Provide reasonable exceptions to arbitrary limits (e.g., day or visits limits) to ensure access	IV-30

8. Strengthen program integrity controls

Recommendation	Reference
Do not implement a new benefit until either the claims payment system is ready or an alternate enforcement mechanism is in place	II-13
Pursue developing new administrative resources that are necessary to administer and manage the Medicaid benefits	II-16
Revise nursing facility level of care criteria to eliminate ambiguities	III-6
Consider hiring one or two additional hearing officers to expedite appeals of nursing facility level of care decisions	III-6
Improve the process for reviewing the delivery of personal care services through additional prior review of services, concurrent review of service delivery, or post-payment review	III-21
Actively monitor ACCESS primary care providers to ensure delivery of program benefits	IV-13
Perform active provider profiling to target authorization requirements for outlier providers	IV-18
Target limits and prior authorization requirements to a small group of benefits chosen on the basis of utilization, cost, approval or denial history, and fraud and abuse history	IV-30
Ensure that providers are aware of the plan's standards and criteria to help them better plan their patients' care	IV-30
Conduct periodic provider profiling efforts to educate doctors about their performance compared to their peers	IV-30

Appendix D Interview List

Department of Health and Human Services Division of Medical Assistance

Jeffrey Simms
Assistant Director
Managed Care

Clarence Ervin
Section Chief, Practitioner & Clinic Services
Medical Policy

Anne Rogers
Quality Assurance Manager
Managed Care

Lynne Perrin
Section Chief, Institutional Services
Medical Policy

Betty West
Program Operations
Managed Care

Carol Robertson
Section Chief, Behavioral Health
Medical Policy

Allen Gambill
Assistant Director
Financial Operations

Bruce Steel
Section Chief, Community Care
Medical Policy

Jim Panton
Rate Setting Supervisor
Financial Operations

Jency Abrams
LEA/School Health Consultant
Medical Policy

Barbara Brooks
Assistant Director
Recipient & Provider Services

Mary Jo Littlewood
Manager, Community Alternatives Program
Medical Policy

Jane Johnson
Manager, Claims Analysis
Recipient & Provider Services

Ronda Owen
Optical and Hearing Aid Consultant
Medical Policy

Marjorie Morris
Chief, Medicaid Eligibility
Recipient & Provider Services

C.B. (Benny) Ridout
Pharmacy Director
Medical Policy

Darlene Pilkington
Manager, Provider Services
Recipient & Provider Services

Kate Short
HIV/AIDS Manager, Community Care
Medical Policy

George Packingham
Assistant Director
Medical Policy

Kathie Smith
Manager, Home Care Initiative, Community Care
Medical Policy

Dr. Raphael Dinapoli, Jr.
Medical Director
Medical Policy

Dr. Betty King Sutton
Dental Program Director
Medical Policy

Janet Tudor
Medical Svcs Nurse, Practitioner & Clinic Services
Medical Policy

Carleen Massey
Chief, Provider Medical Review
Program Integrity

Melody Yeargan
Physical Therapy Consultant
Medical Policy

Robyn Reasor
Chief, Home Care Review
Program Integrity

Robert Nowell
Assistant Director
Program Integrity

Mary Williford
Chief, Pharmacy Review
Program Integrity

Pat Delbridge
Chief, Provider Administrative Review
Program Integrity

Chuck Brownfield
Program Integrity

Geoff Elting
Chief, Third Party Recovery and Systems Support
Program Integrity

Debra Stewart
Assistant Chief, Third Party
Program Integrity

Sharman Leinwand
Chief, Drug Utilization Review
Program Integrity

Marilyn Vail
Post Payment Support, Third Party Recovery and
Systems Support
Program Integrity

Division of Mental Health, Developmental Disabilities, Substance Abuse Services

Tara Larson
Assistant Director for Quality Assurance and
Management

Laura Nuss
Branch Head, Developmental Disabilities Services

Flo Stein
Chief of Substance Abuse Services

Dr. Philip Veenhuis
Medical Director

Division of Public Health

Dr. A. Dennis McBride
State Health Director

Kevin Ryan
Chief, Women's and Children's Section

Joy Reed
Administrative Consultant

Other State Agencies

Paul Sebo
Director, Plan Services and NC HealthChoice
State of North Carolina Comprehensive Major
Medical Plan

Torlen Wade
Associate Director
Office of Rural Health

EDS

Dr. Sarah Morrow
Medical Director

Tre Sauls
Provider Services Unit

Lana Horton
Manager, Prior Approval Unit

Rena Barnett
Medical Policy Unit

Chris Boser
Provider Services Unit

Tina George
Medical Policy Unit

Kristina Merrell
Provider Services Unit

Sharon Greeson
Financial Unit

Susie Pezzoni
Provider Services Unit

ValueOptions

Charlotte Craver
Account Executive

First Health Inc.

Dr. Wayne Watkinson
Director of Operations

Ed Borovatz
Vice President of Pharmacy

Other State Medicaid Programs

Mr. Ray Hanley
Director
Division of Medical Services
Arkansas Department of Human Services

Mr. Dennis E. Headlee
Administrator
Division of Medical Services
Iowa Department of Human Services

Ms. Wendy Warring
Commissioner
Massachusetts Division of Medical Assistance

Ms. Peg J. Dierkers, Ph.D.
Deputy Secretary
Pennsylvania Department of Public Welfare

Mr. Gary B. Redding
Director
Georgia Department of Medical Assistance

Mr. Richard Allen
Director
Office of Medical Assistance
Colorado Department of Health Care Policy &
Financing

Ms. Linda Wertz
Deputy Commissioner Medicaid and CHIP
Texas Health and Human Services Commission

Ms. Barbara Edwards
Deputy Director
Office of Medicaid
Ohio Department of Human Services

Mr. Mike Fogarty
CEO
Oklahoma Health Care Authority

Mr. Bob Sharpe
Acting Medicaid Director
Florida Agency for Health Care Administration

Mr. Hersh Crawford
Director
Office of Medical Assistance Programs
Oregon Department of Human Resources

Ms. Lee Bezanson
Medicaid Director
Medicaid Administration Bureau
New Hampshire Department of Health and Human
Services

Ms. Margaret Murray, Director
Division of Medical Assistance & Health Services
New Jersey Department of Human Services

North Carolina Private Insurers

CIGNA HealthCare of North Carolina
Todd E. Slawter
Director of Sales and Marketing

BlueCross BlueShield North Carolina
Gary Ward
Product Manager

United Healthcare of North Carolina
Chris Stanley, Medical Director
Beth Kasai, Director of Actuarial Services
Sandra Berry, Analyst

Appendix E

Optional Services Covered by North Carolina Medicaid¹

Optional Medicaid Services	Covered by North Carolina? *	Number of Other States that Cover
Age 65 or Older in Institutions for Mental Diseases / Inpatient Hospital Services	✓	40
Age 65 or Older in Institutions for Mental Diseases / Nursing Facility Services	✓	31
Care Management Services	✓	45
Chiropractors' Services	✓	26
Christian Science Nurses		
Christian Science Sanitoriums		
Clinic Services	✓	49
Dental Services	✓	41
Dentures	✓	33
Diagnostic Services	✓	29
Emergency Hospital Services	✓	40
Eyeglasses	✓	43
Hospice Care Services	✓	37
ICF/MR Services	✓	50
Inpatient Psychiatric Services – Under 21	✓	41
Medical Social Workers' Services		
Nurse Anesthetists' Services	✓	28
Nursing Facilities Services – Under 21	✓	50
Occupational Therapy	✓	32
Optometrists' Services	✓	47
Personal Care Services	✓	30
Physical Therapy	✓	40
Podiatrists' Services	✓	44
Prescribed Drugs	✓	50
Preventive Services	✓	27
Private Duty Nursing	✓	24
Prosthetic Devices	✓	50
Psychologists' Services		
Rehabilitative Services	✓	49
Respiratory Care Services		
Screening Services	✓	27
Speech, Hearing & Language Disorders	✓	39
Transportation Services	✓	49
Tuberculosis-Related Services		

*North Carolina covers 27 of the 34 optional Medicaid services. Only 16 other states cover 27 or more optional Medicaid services.

¹ Source: "Medicaid Survival Kit," Table I-8, National Conference of State Legislators, June 1999.

Appendix F State Medicaid Programs – Comparison of Physician and Dental Fees¹

Aggregation of Fee Rankings, Various Physician Services

State	Average Medicaid Fee As % Of Medicare Allowable Charge	Volume-Weighted Ranking, Straight Fees	Volume-Weighted Ranking, Geographically Adjusted Fees	Ranking by % Of Medicare Allowable Charge
Alabama	88.5%	15	18	18
Alaska	126.8%	1	1	1
Arizona	102.8%	4	4	4
Arkansas	88.9%	21	16	17
California	65.2%	37	42	40
Colorado	74.1%	30	31	31
Connecticut	82.1%	11	25	23
Delaware	89.2%	9	17	15
District of Columbia	55.5%	46	48	48
Florida	65.1%	40	40	41
Georgia	82.6%	20	21	21
Hawaii	66.4%	33	38	38
Idaho	97.2%	10	9	10
Illinois	67.0%	36	36	36
Indiana	77.8%	29	28	27
Iowa	100.1%	8	8	7
Kansas	73.7%	38	34	32
Kentucky	84.5%	24	20	20
Louisiana	80.8%	27	24	25
Maine	64.2%	44	41	42
Maryland	66.9%	39	37	37
Massachusetts	77.2%	19	30	29
Michigan	59.7%	42	46	46
Minnesota	82.5%	22	22	22
Mississippi	91.4%	16	12	12
Missouri	56.2%	48	47	47
Montana	90.6%	14	13	13
Nebraska	97.4%	12	10	9
Nevada	103.2%	2	3	3
New Hampshire	63.4%	41	44	44
New Jersey	40.8%	50	50	50
New Mexico	110.7%	3	2	2
New York	35.9%	51	51	51
North Carolina	100.1%	7	7	8
North Dakota	89.1%	17	15	16
Ohio	73.2%	32	33	34
Oklahoma	76.2%	35	29	30
Oregon	73.3%	34	32	33
Pennsylvania	63.5%	43	43	43
Rhode Island	43.7%	49	49	49
South Carolina	66.2%	45	39	39
South Dakota	90.4%	18	14	14
Tennessee	85.0%	23	19	19
Texas	77.6%	28	27	28
Utah	62.1%	47	45	45
Vermont	100.6%	5	6	6
Virginia	81.7%	25	23	24
Washington	72.7%	31	35	35
West Virginia	92.5%	13	11	11
Wisconsin	80.8%	26	26	26
Wyoming	101.6%	6	5	5

* Figures derived through volume-weighted average of each state's Medicaid fees across 31 CPT codes in the following areas: Evaluation/Management, Surgery, Delivery, Radiology, Laboratory, Medicine/Testing, and Vision.

¹ Source: "Comparison of Physician and Dental Fees Paid by State Medicaid Programs," Exhibit G, Medi-Cal Policy Institute, April 5, 2001.

Aggregation of Fee Rankings, Various Dental Services²

State	Volume-Weighted Ranking, Straight Fees*	Volume-Weighted Ranking, Geographically Adjusted Fees*
Alabama	8	7
Alaska	1	1
Arizona	4	5
Arkansas	24	18
California	21	27
Colorado	9	12
Connecticut	44	44
Delaware	NA	NA
District of Columbia	45	45
Florida	37	38
Georgia	NA	NA
Hawaii	43	43
Idaho	16	14
Illinois	29	30
Indiana	42	41
Iowa	14	10
Kansas	20	17
Kentucky	25	21
Louisiana	30	31
Maine	NA	NA
Maryland	28	28
Massachusetts	10	20
Michigan	41	42
Minnesota	35	34
Mississippi	NA	NA
Missouri	40	39
Montana	31	29
Nebraska	19	15
Nevada	2	4
New Hampshire	22	24
New Jersey	38	40
New Mexico	6	6
New York	18	25
North Carolina	11	11
North Dakota	15	9
Ohio	17	19
Oklahoma	5	3
Oregon	26	23
Pennsylvania	23	22
Rhode Island	33	36
South Carolina	3	2
South Dakota	34	32
Tennessee	NA	NA
Texas	36	35
Utah	39	37
Vermont	7	8
Virginia	12	16
Washington	27	26
West Virginia	NA	NA
Wisconsin	32	33
Wyoming	13	13

*Note: Rankings apply only to those states where fees were available.
45 states were included in the weighted average.

² Source: "Comparison of Physician and Dental Fees Paid by State Medicaid Programs," Exhibit H, Medi-Cal Policy Institute, April 5, 2001.

Baseline Medicaid Fee Data³

Procedure Code	Description	North Carolina		Geographically Adjusted
		Current (Dec '00) Medicaid Fee	% of Medicare	
Evaluation and Management Services				
99203	OFFICE OR OTHER OUTPATIENT VISIT F	\$83.37	100.0%	\$89.13
99204	OFFICE OR OTHER OUTPATIENT VISIT F	\$120.71	100.0%	\$129.05
99213	OFFICE OR OTHER OUTPATIENT VISIT F	\$44.46	100.0%	\$47.53
99222	INITIAL HOSPITAL CARE, PER DAY, FOR	\$109.26	100.0%	\$116.80
99232	SUBSEQUENT HOSPITAL CARE, PER DA	\$52.92	100.0%	\$56.57
99283	EMERGENCY DEPARTMENT VISIT FOR T	\$60.04	100.0%	\$64.19
99431	HISTORY AND EXAMINATION OF THE NO	\$76.72	108.0%	\$82.02
Anesthesia Services				
00840	ANESTHESIA, SURGERY OF ABDOMEN	\$0.00		\$0.00
00850	ANESTHESIA, C SECTION	\$0.00		\$0.00
00955	ANALGESIA, VAGINAL DELIVERY	\$216.11		\$231.03
one 15 min time unit	ONE 15 MINUTE TIME UNIT	\$14.85	92.8%	\$15.88
Surgical Services (excluding maternity/delivery)				
11721	DEBRIDE NAIL	\$38.51	100.0%	\$41.17
29881	KNEE ARTHROSCOPY W/ MENISCECTO	\$571.63	100.0%	\$611.10
33533	CABG, ARTERIAL, SINGLE	\$1,848.09	100.0%	\$1,975.71
43239	UPPER GASTROINTESTINAL ENDOSCOPE	\$239.03	105.1%	\$255.54
66984	EXTRACAPSULAR CATARACT REMOVAL	\$701.42	100.0%	\$749.86
Maternity/Delivery				
59025	FETAL NON-STRESS TEST	\$39.25	100.0%	\$41.96
59400	ROUTINE OBSTETRIC CARE INCLUDING	\$1,382.67	100.0%	\$1,478.15
59409	VAGINAL DELIVERY ONLY (WITH OR WIT	\$775.47	100.0%	\$829.02
59510	ROUTINE OBSTETRIC CARE INCLUDING	\$1,571.45	100.0%	\$1,679.97
59514	CAESAREAN DELIVERY ONLY;	\$912.86	100.0%	\$975.90
Radiology				
70450	COMPUTERIZED AXIAL TOMOGRAPHY,	\$208.29	100.0%	\$222.67
71020	RADIOLOGIC EXAMINATION, CHEST, TW	\$32.90	100.0%	\$35.17
76092	SCREENING MAMMOGRAPHY, BILATERA	\$67.81	97.1%	\$72.49
76805	ECHOGRAPHY, PREGNANT UTERUS, B-S	\$123.64	100.0%	\$132.18
Lab/Pathology				
80074	HEPATITIS PANEL	\$64.41	100.0%	\$68.86
85025	BLOOD COUNT; HEMOGRAM AND PLATE	\$10.74	100.0%	\$11.48
87490	INFECT AGT DET BY NUCL ACID DNA/RN	\$27.71	100.0%	\$29.62
87590	INFECT AGE DET BY NUCL ACID DNA/RN	\$27.71	100.0%	\$29.62
Psychiatry				
90804	INDIVIDUAL PSYCHOTHERAPY, INSIGHT	\$58.74	100.0%	\$62.80
90805	INDIVIDUAL PSYCHOTHERAPY, INSIGHT	\$65.62	100.0%	\$70.15
90806	INDIVIDUAL PSYCHOTHERAPY, INSIGHT	\$89.97	100.0%	\$96.18
90807	INDIVIDUAL PSYCHOTHERAPY, INSIGHT	\$95.66	100.0%	\$102.27
Medicine and Testing				
97140	MANUAL THERAPY TECHNIQUES (EG, M	\$25.11	100.0%	\$26.84
93000	ELECTROCARDIOGRAM, ROUTINE ECG	\$26.54	100.0%	\$28.37
93307	ECHOCARDIOGRAPHY, TRANSTHORACI	\$195.19	100.0%	\$208.67
94010	SPIROMETRY, INCLUDING GRAPHIC RE	\$27.22	100.0%	\$29.10
94060	BRONCHOSPASM EVALUATION: SPIROM	\$52.36	100.0%	\$55.98
95904	NERVE CONDUCTION, AMPLITUDE AND	\$29.20	100.0%	\$31.22
Vision/Ophthalmology				
V2020	FRAMES, PURCHASES	\$24.58	40.3%	\$26.28
92004	OPHTHALMOLOGICAL SERVICES: MEDIC	\$99.98	100.7%	\$106.88
92014	OPHTHALMOLOGICAL SERVICES: MEDIC	\$72.61	100.0%	\$77.62
Audiology/Hearing				
V5010	ASSESSMENT FOR HEARING AID	\$0.00		\$0.00
V5050	HEARING AID, MONAURAL, IN THE EAR	\$0.00		\$0.00
92525	EVALUATION OF SWALLOWING AND OR	\$97.82	100.0%	\$104.57
Dental Services				
D1110	PROPHYLAXIS-ADULT	\$25.53		\$27.29
D2150	AMALGAM-TWO SURFACES, PERMANEN	\$65.10		\$69.60
D7110	EXTRACTION - SINGLE TOOTH	\$45.46		\$48.60
Durable Medical Equipment				
E0245	TUB STOOL OR BENCH	\$0.00		\$0.00
E0450	VOLUME VENTILATOR, STATIONARY OR	\$749.55		\$801.31
L3020	FOOT, INSERT, REMOVABLE, MOLDED T	\$71.63		\$76.58
L8160	GRADIENT COMPRESSION STOCKING, F	\$0.00		\$0.00

³ Source: "Comparison of Physician and Dental Fees Paid by State Medicaid Programs," Attachment 1, Medi-Cal Policy Institute, April 5, 2001.

State Specific Rankings Overview⁴

Procedure Code	Description	# of States For Which Fee Was Obtained	North Carolina		
			Unadjusted Fee	Geographically Adjusted Fee	% of Medicare Allowed Charge
Evaluation and Management Services					
99203	OFFICE OR OTHER OUTPATIENT VISIT FOR TH	51	2	2	3
99204	OFFICE OR OTHER OUTPATIENT VISIT FOR TH	51	2	2	2
99213	OFFICE OR OTHER OUTPATIENT VISIT FOR TH	51	3	2	2
99222	INITIAL HOSPITAL CARE, PER DAY, FOR THE EV	51	4	4	4
99232	SUBSEQUENT HOSPITAL CARE, PER DAY, FOR	51	3	3	4
99283	EMERGENCY DEPARTMENT VISIT FOR THE EV	51	5	5	4
99431	HISTORY AND EXAMINATION OF THE NORMAL	51	9	7	8
E&M Weighted Average Ranking		51	3	2	2
Surgical Services (excluding maternity/delivery)					
11721	DEBRIDE NAIL	51	9	8	10
29881	KNEE ARTHROSCOPY W/ MENISCECTOMY (ME	51	16	16	15
33533	CABG, ARTERIAL, SINGLE	51	18	15	13
43239	UPPER GASTROINTESTINAL ENDOSCOPY INCL	51	11	10	10
66984	EXTRACAPSULAR CATARACT REMOVAL WITH I	51	29	26	27
Surgical Services Weighted Average Ranking		51	15	13	13
Maternity/Delivery					
59025	FETAL NON-STRESS TEST	51	16	15	14
59400	ROUTINE OBSTETRIC CARE INCLUDING ANTEP	40	10	7	7
59409	VAGINAL DELIVERY ONLY (WITH OR WITHOUT	51	18	15	14
59510	ROUTINE OBSTETRIC CARE INCLUDING ANTEP	41	10	9	8
59514	CAESAREAN DELIVERY ONLY;	51	18	18	17
Maternity Weighted Average Ranking*		51	16	15	13
Radiology					
70450	COMPUTERIZED AXIAL TOMOGRAPHY, HEAD O	51	16	14	14
71020	RADIOLOGIC EXAMINATION, CHEST, TWO VIEW	51	13	12	11
76092	SCREENING MAMMOGRAPHY, BILATERAL (TWO	51	11	11	11
76805	ECHOGRAPHY, PREGNANT UTERUS, B-SCAN A	51	10	9	8
Radiology Weighted Average Ranking		51	11	12	9
Lab/Pathology					
80074	HEPATITIS PANEL	51	16	9	18
85025	BLOOD COUNT; HEMOGRAM AND PLATELET C	51	8	14	9
87490	INFECT AGT DET BY NUCL ACID DNA/RNA;	51	4	13	5
87590	INFECT AGE DET BY NUCL ACID DNA/RNA	51	4	13	5
Lab/Pathology Weighted Average Ranking		51	14	9	16
Psychiatry					
90804	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIEN	45	4	5	5
90805	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIEN	44	5	5	5
90806	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIEN	44	4	5	6
90807	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIEN	43	6	6	5
Psychiatry Weighted Average Ranking		43	5	5	6
Medicine and Testing					
97140	MANUAL THERAPY TECHNIQUES (EG, MOBILIZA	51	5	5	2
93000	ELECTROCARDIOGRAM, ROUTINE ECG WITH A	51	12	11	11
93307	ECHOCARDIOGRAPHY, TRANSTHORACIC, REA	51	8	7	6
94010	SPIROMETRY, INCLUDING GRAPHIC RECORD, T	51	21	18	17
94060	BRONCHOSPASM EVALUATION: SPIROMETRY	51	12	10	10
95904	NERVE CONDUCTION, AMPLITUDE AND LATEN	51	15	13	12
Medicine/Testing Weighted Average Ranking		51	13	10	10
Vision/Ophthalmology					
92004	OPHTHALMOLOGICAL SERVICES: MEDICAL EXA	51	2	2	2
92014	OPHTHALMOLOGICAL SERVICES: MEDICAL EXA	51	2	2	3
Vision Weighted Average Ranking		51	2	2	2
Dental Services					
D1110	PROPHYLAXIS-ADULT	45	33	32	NA
D2150	AMALGAM-TWO SURFACES, PERMANENT	48	8	8	NA
D7110	EXTRACTION - SINGLE TOOTH	48	18	18	NA
Dental Services Weighted Average Ranking		45	11	11	NA

* The Maternity Weighted Average only includes codes 59025, 59409, and 49514.

⁴ Source: "Comparison of Physician and Dental Fees Paid by State Medicaid Programs," Attachment 4, Medi-Cal Policy Institute, April 5, 2001.

Appendix G

North Carolina Medicaid Managed Care Programs

Division of Medical Assistance – Managed Care Programs¹

DMA has four managed care programs available for Medicaid recipients. The programs are Carolina ACCESS, ACCESS II, ACCESS III, and HMO Risk Contracting. A Medicaid Managed Care Representative (MCR) is located in each North Carolina county (except Mecklenburg County) and coordinates the managed care program in the county. MCRs provide:

- Follow-up education to recipients, providers, and county departments of social services (DSS) as necessary.
- Assistance with contract participation requirements, patient compliance, and provider enrollment issues.

Carolina ACCESS

Carolina ACCESS (CA) is Medicaid's primary care case management program. CA is active in 99 counties and links Medicaid recipients with primary care providers (PCPs) who act as gatekeepers in providing and coordinating the recipients' health care. PCPs bill fee-for-service and are reimbursed based on the Medicaid fee schedule. They also receive a monthly fee (\$3.00 each for the first 250 enrollees, and \$2.50 for each additional enrollee) for coordinating the care of recipients enrolled with their practice.

Information on a recipient's Medicaid identification (MID) card identifies CA enrollees. "Carolina ACCESS Enrollee" appears on the card along with the name, address, daytime, and after-hours telephone numbers of the PCP.

CA recipients are responsible for all copayments required by Medicaid.

As a gatekeeper to health care, the PCP plays a key role in achieving the dual goals of managed care – improved access to care and reduction of unnecessary costs. PCPs set their own enrollment limits, up to a maximum of 2,000 patients per physician or physician extender.

The following North Carolina Medicaid provider types may participate as PCPs:

- | | |
|-------------------------|-------------------------------|
| • Family Medicine | • Gynecologists |
| • General Practitioners | • Internists |
| • Nurse Practitioners | • Community Health Centers |
| • Physician Assistants | • Health Clinics |
| • Pediatricians | • Hospital Outpatient Clinics |
| • Specialists* | • Health Departments |
| • Obstetricians | • Rural Health Clinics |

** In some circumstances, a specialist willing to provide primary care services may be enrolled as a PCP.*

¹ North Carolina Medicaid Special Bulletin: Provider Enrollment Guidelines, January 2001.

To participate with CA, North Carolina Medicaid providers must sign a contract agreeing to:

1. Operate the office a minimum of 30 hours a week for patient care.
2. Provide or arrange for access to medical care for enrollees, 24 hours per day, 7 days per week. There must be prompt access to a qualified medical practitioner who is able to provide medical advice, consultation, and authorization for service when appropriate.
3. Develop patient/physician relationships.
4. Manage the health care needs of enrollees.
5. Provide essential preventive services.
6. Provide after-hours coverage that does not automatically refer to the emergency room.
7. Maintain hospital admitting privileges or have a formal arrangement for admissions.
8. Authorize and arrange referrals when necessary.
9. Review monthly and quarterly utilization reports.

ACCESS II and ACCESS III

ACCESS II and ACCESS III are primary care programs designed to build upon the principles and infrastructure of the CA program. The programs promote a health care system that retains dollars in the local delivery of services, while assisting local providers in the development of organized managed care systems that coordinate a full continuum of care with processes to influence cost and quality of care.

ACCESS II and ACCESS III are sponsored by the Department of Health and Human Services. Program direction is provided by the Office of Research, Demonstrations, and Rural Health Development. Technical assistance is provided by the North Carolina Foundation for Advanced Health Programs, Inc. with funding from the Kate B. Reynolds Health Care Trust.

The ACCESS II and ACCESS III demonstration sites are paid an additional \$2.50 per member per month care management fee to develop and implement managed care strategies. These managed care strategies include:

- Risk assessment process – utilizing an "at-risk" screening tool that identifies both medical and social risk factors.
- Reviewing emergency department utilization – integrating appropriate outreach, follow-up, and educational activities based on emergency department use by patients.
- Implementing disease management processes – including pediatric and adult asthma, sickle cell anemia, congestive heart failure, and diabetes.
- Implementing a care management process – identifying and targeting care management activities based on the screening process and other methods of identifying those patients at risk.
- Identifying high cost and high users – developing and implementing activities that impact utilization and cost.

ACCESS III, active in Pitt and Cabarrus counties, includes countywide plans that are community partnerships involving physicians, hospitals, health departments, departments of social services, and other community providers. Networks are assuming responsibility for managing the care of eligible Medicaid populations in the entire county.

HMO Risk Contracting

HMO Risk Contracting is a Medicaid managed care program whereby DMA contracts with three health maintenance organizations (HMOs) to operate in Davidson, Forsyth, Gaston, Guilford, Mecklenburg, and Rockingham counties to provide and coordinate medical services for certain Medicaid eligibles on a full-risk capitated basis. DMA also contracts with a Federally Qualified Health Center in Mecklenburg County to provide an additional health plan option for Medicaid recipients on a fee-for-service basis.

The recipient's MID card shows the HMO's name, address, and telephone number. Enrolled recipients also receive a member identification card from the plan. HMO enrollment may also be verified through the Automated Voice Response (AVR) System. Newborns of HMO members are automatically enrolled and covered by the mother's plan, effective from the date of the child's birth.

Appendix H Detailed Pharmacy Analysis

April 9, 2001

Mr. Charles Milligan
Vice President
The Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church, VA 22042

Dear Mr Milligan:

Enclosed please find my focused review of the North Carolina Medicaid Pharmacy Benefit Program. At the request of Dr John G Brehm, Medical Director, West Virginia Medical Institute, I have reviewed portions of the North Carolina Medicaid Pharmacy Benefit, focusing on the Drug Use Review programs and selected coverage policies. I was specifically asked to evaluate the potential for a prior authorizations program to achieve efficiencies in medication expenses while maintaining quality care, and to comment on the 6 prescription per month limit and the 100 day supply limit as they relate to the scope of benefits.

In this report I have provided recommendations focusing on selected medication prior authorizations programs that would accomplish the goal of efficient use of resources while maintaining quality care. The recommendations in this focused review are based on review of information regarding the North Carolina Medicaid Program and my past experience as Chair of the Prior Authorizations Committee for the State of Missouri Medicaid Pharmacy Benefits Program, my current knowledge of the Prior Authorizations Programs for the State of Iowa Medicaid Pharmacy Benefits, and available evidence from the medical and pharmaceutical literature.

It has been my pleasure to participate in this review process. I hope that you and the North Carolina Medicaid Program directors find my comments helpful as they reevaluate benefit policies and provisions.

Sincerely,



Kevin G Moores, PharmD
Director, Iowa Drug Information Network,
Assistant Professor (Clinical)
The University of Iowa College of Pharmacy

Focused Review of North Carolina Medicaid Pharmacy Benefit Program

Prepared by Kevin G Moores, PharmD,
Director, Iowa Drug Information Network,
Assistant Professor (Clinical) The University of Iowa College of Pharmacy

April 9, 2001

At the request of Dr John G Brehm, Medical Director, West Virginia Medical Institute, I have reviewed portions of the North Carolina Medicaid Pharmacy Benefit, focusing on the Drug Use Review programs and selected coverage policies. I was specifically asked to evaluate the potential for a prior authorizations program to achieve efficiencies in medication expenses while maintaining quality care, and to comment on the 6 prescription per month limit and the 100 day supply limit as they relate to the scope of benefits.

In this report I will provide recommendations focusing on selected medication prior authorizations programs that would accomplish the goal of efficient use of resources while maintaining quality care. To form the basis of these recommendations I have reviewed: the North Carolina Pharmacy Services Manual (dated February 1997), the North Carolina Drug Use Review Annual Report for Federal Fiscal Year 1999, Minutes from the North Carolina DUR Board Meeting September 21, 2000, and the North Carolina Medicaid TOP 100 Drugs report for January 2000 to December 2000. I have also examined North Carolina Medicaid State Fiscal Year 1999 reports available at <http://www.dhhs.state.nc.us/dma>. The recommendations in this focused review are also based on my past experience as Chair of the Prior Authorizations Committee for the State of Missouri Medicaid Pharmacy Benefits Program, my current knowledge of the Prior Authorizations Programs for the State of Iowa Medicaid Pharmacy Benefits, and available evidence from the medical and pharmaceutical literature.

The North Carolina Medicaid program has active prospective and retrospective drug use review (DUR) programs. The North Carolina Medicaid DUR Board includes members with substantial experience and expertise. The drug use expense per eligible recipient and drug use expense as a percent of total Medicaid expense are not above the national averages. However due to current budget constraints the program is evaluating possible areas within the system to gain efficiencies.

Several of the drugs in the top 100 drugs report by expense are relatively new, high cost drugs which have been responsible for high expenses in many Medicaid programs, as well as in private sector drug benefit programs. Prior authorization programs used by Iowa Medicaid appear to have been effective in limiting the expense for several of these high cost drugs. The general sense among the Iowa Medicaid program is that providers and patients accept the requirements of prior authorization as a necessary mechanism to maintain quality services within the State's budgetary limits. Based on the general sense within the provider community and a formal study (described below), the Iowa Medicaid prior authorization program has been judged to be both operationally and fiscally efficient. The level of expense of the identified (see table below) high cost high use drugs in the Iowa Medicaid program is substantially less than in the North Carolina Medicaid program. This difference is most likely due in large part to the prior authorization program. It is with these background considerations that the following suggestions are offered for consideration by the North Carolina Medicaid Drug Benefits Program.

Specific Recommendations for Prior Authorization:

The specific drugs recommend for prior authorization are:

Drug Name	Total Expense 2000 ¹	Projected Potential Expense Reduction ²
Prilosec	\$ 36,282,850	\$ 25,500,000
Prevacid	\$ 23,481,230	\$ 13,800,000
Aciphex	\$2,562,802	\$1,500,000
Ranitidine 150mg	\$6,371,835	(\$ 2,000,000)
Pepcid	\$5,366,912	(\$ 1,700,000)
Axid	\$2,308,959	(\$ 700,000)
Celebrex	\$ 15,036,600	\$ 11,200,000
Vioxx	\$ 10,010,600	\$ 7,750,000
"other branded NSAIDs"		neutral
		\$55,350,000

1. This is based on data in the January 2000 to December 2000 top 100 report, if there are additional dosage forms or strengths of these drugs that did not appear on the top 100 list they would not be included in these data.

2. These projections are estimates only. The actual reduction will depend on the effectiveness of the program implementation process, and the demographic comparison of the Medicaid population in the respective states, which was not considered in the calculations. These projections are based on estimates considering the expenses for these drugs as a percentage of total expenses for medications in North Carolina to the comparable data in Iowa, where prior authorization is required. (Attachment I) Expenses for H2RA may increase as some of the PPI use is shifted to H2RA. Other NSAIDs will be used to replace the COX-2 inhibitors, with an emphasis on use of generic NSAIDs the effect is expected to be neutral, however this is based on limited information about current NSAID use.

Rational and justification for recommendation for prior authorization

Prior authorization is a method currently used by 42 state Medicaid programs.¹² Approximately 90% of managed care organizations require prior authorization for some drugs.¹

The Institute of Medicine recently conducted a study of formulary systems. In that study it was noted that Humana's on-line formulary identifies 12 drug products and some injectables that require prior authorization. United Health Care's on-line list of preferred drugs includes 19 products that require prior authorization and 69 that have some type of quantity limit. Aetna US Health Care lists 46 drug products that require precertification and more than 120 that are excluded from the formulary.¹²

Most managed care plans and pharmacy benefit management companies in the United States are using some combination of formulary control mechanisms which include open as well as closed formularies, prior authorization, three-tier copay systems (with copay costs from \$5 to \$10 to \$25 per prescription), annual deductibles, annual dollar caps, drug use review, provider education, disease management programs, generic substitution or therapeutic substitution, in addition to negotiated discounts. Many of the formulary mechanisms are not available for use in Medicaid programs because of federal restrictions. Provider education and DUR are valuable programs to increase the overall quality of pharmacotherapy, however they are frequently not effective in controlling overprescribing of selected medications. Prior authorization programs have been demonstrated in several examples to be effective.

The Iowa Medicaid Program implemented prior authorizations for medications in 1992. All guidelines for the PA program were developed by the Iowa Medicaid Drug Use Review Commission. There are currently 17 classes of drugs that require prior authorization (see attachment). The attachment, from the Iowa Medicaid Provider Manual, provides further detail on the specific drugs and drug classes and the procedures required to obtain approval. Approval is obtained through the fiscal agent, requests may be made via telephone, FAX, or mail, to the Consultec, Inc. Drug Prior Authorization Unit.

Charles R Phillips, PHD, assistant professor and Lon N Larson, PHD, Professor at Drake University College of Pharmacy and Health Science, conducted an evaluation of the operational performance and estimated the effects of PA on drug use and expenses in the Iowa Medicaid program in 1995.² The results showed response times well below the HCFA mandated guidelines with relatively high approval rates (74%). The total net savings for antiarthritics, benzodiazepines, antiulcer drugs, and antihistamines was estimated to be between \$2.5 million and \$3.83 million; which represents 2% to 3% of vendor payments.

The West Virginia University School of Pharmacy created the Rational Drug Therapy Program (RDTP) in 1995 for the Medicaid Program of the West Virginia Bureau for Medical Services (WVBMS) recipients. The primary goal of the program is to promote the safe rational and cost effective use of drugs within the population served by the WVBMS.

The WVBMS reports the following information concerning the RDTP in their prior authorization report to the Health Care Finance Agency for the fiscal year ending June 30, 1997. Using the pre-program implementation data as the baseline, the WVBMS estimates that the RDTP saved \$6,505,297 in the Peptic Acid Disease Program, \$316,023 in the GI Motility drug category and \$2,448,575 in the Brand Name Non-Steroid Anti-Inflammatory Drug (NSAIDs) category. The total saving of just these three programs, out of fifteen programs, was estimated to be \$9,269,895.

For the fiscal year ending June 30, 1997, the total cost of all fifteen programs provided by the RDTP to the WVBMS was \$579,507. Therefore, using the above information, the WVBMS drug program saved a net total of \$8,690,388 and had a net return on investment of \$16.00 returned for every \$1.00 spent on just the three-program list.

The WVBMS also independently contracted a WVU School of Pharmacy doctoral graduate student to conduct a study to determine if the Peptic Acid Disease Program was having any negative patient outcomes or promoting cost-shifting from the drug budget to other parts of the WVBMS's budget. The doctoral dissertation study reviewed the medical claims of approximately 15,000 continuously eligible WVBMS recipients for one-year prior and one year after the program's implementation. The conclusion of the study was that there were no other increases within WVBMS's budget except for the average number of endoscopies being preformed. The figure only increased an average of six per month for the period of study. This increase could be due more appropriate clinical approach to treating the peptic acid disease instead of symptomatically treating the patient.

Although there are relatively few published studies of the evaluation of the effect of implementation of prior authorization programs, two other relevant studies of NSAID prior authorization programs are worthy of noting. Both studies reported savings from increased use of generic NSAIDs as a replacement for proprietary single source drugs. Kotzen et al analyzed 19 months of utilization and cost data, 12 months before and 7 months after beginning PA for 80,064 continuously enrolled patients in the Georgia Medicaid system. They found an immediate decrease in the use of single source NSAIDs and an increase in generic products. The program resulted in a savings for NSAID therapy of \$3 million, projected to \$7 million for a full year. There was no increase in the use or cost of physician or hospital services during the seven months after the program began.³

The findings of Smalley et al were similar. They studied the effect of prior approval for single source NSAIDs in the Tennessee Medicaid program. They found that by increasing the use of generic drugs and an overall reduction in the total use of NSAIDs, expenditures fell by 53%. This resulted in a savings of approximately \$12.8 million over a 2 year period, with no concomitant increase in other Medicaid medical expenditures.⁴

The most recent report from the Institute of Medicine, released March 1, 2001, *Crossing the Quality Chasm: A New Health System for the 21st Century*,⁵ provides strong recommendations for the improvement of quality of health care. One emphasis in this report is the need to make decisions in health care based on the best available evidence. Basing treatment decisions for use of medication on the best available evidence based guidelines is consistent with this strong recommendation.

Clinical rational for selected drugs

Proton pump inhibitors

Proton pump inhibitors are very effective and very well tolerated. However, perhaps in some part because of this, and also in some part due to over promotion including directly to the public, these drugs are known to be overprescribed when equally effective less expensive therapy is available. The clinical practice guidelines for the treatment of peptic ulcer disease⁶ and for the treatment of gastroesophageal reflux disease (GERD)⁷ from the American College of Gastroenterology provide excellent direction for the development of algorithms for the appropriate use of proton pump inhibitors.

Keep in mind that a generic form of omeprazole will be available perhaps this fall and the criteria for prior authorization of PPI may need to be reevaluated at that time to adjust to the most cost effective therapy. In addition to the guidelines from the American College of Gastroenterology, prior authorizations criteria are available from several Medicaid programs and from the Veterans Administration Formulary that may be reviewed for consideration for use in North Carolina Medicaid.

Histamine-2 receptor antagonists

All H2RA should be prior authorized at the same time that requirements for prior authorization of PPI's are implemented. Although the cost of generic H2RA is much less per dose unit than proton pump inhibitors, unrestricted availability could lead to inappropriate use of H2RA when a PPI is the more appropriate and cost effective therapy. For example, patients with Grade II or higher GERD should be treated with a proton pump inhibitor. Therefore as the prior authorization of PPIs is initiated a program should also be initiated for H2RA at the same time, similar to the programs used by Iowa. (see attachment)

There should also be a provider education program to emphasize testing and treating for *H. pylori* infection in all patients with duodenal or gastric ulcer. Appropriately treating patients with ulcer and *H. pylori* infection greatly reduces the rate of ulcer recurrence and eliminates the need for long-term suppressive acid blocking therapy in most patients. The guidelines from the American College of Gastroenterology for the treatment of peptic ulcer disease, and for GERD, should serve as a guide to the construction of education programs and for algorithms for the prior authorization of PPI and H2RA drugs. These guidelines are prepared using evidence based methodology and are nationally accepted to direct optimal quality of care.

It is critical that appropriate evidence based algorithms be used for prior authorization of both the PPIs and H2RA to ensure that they do not restrict appropriate use of these drugs in patients with GERD. GERD is a chronic condition that if not appropriately

treated can result in esophagitis, strictures, and in some cases esophageal carcinoma. Patients with nonulcer dyspepsia, or mild heartburn, do not require treatment with a PPI or long term use of H2RA.

Cyclooxygenase (COX) 2 specific inhibitors

The Cyclooxygenase (COX) 2 specific inhibitors have been referred to as the "next generation of nonsteroidal anti-inflammatory drugs (NSAIDs) or the aspirin of the new millennium. The two marketed drugs are celecoxib (Celebrex, Searle) and rofecoxib (Vioxx, Merck). These drugs have been heavily promoted to health professionals and heavily advertised to the public. The advertising to the public has been criticized as implying that these drugs are more effective than the older NSAIDs. This is not true, the efficacy is similar to the branded and generically available NSAIDs.

The primary advantage which has been anticipated with these new drugs, based on the selectivity of the COX 2 enzyme inhibition, is greater safety in the gastrointestinal tract. Studies clearly show that endoscopically identified gastric and duodenal ulcers are much less frequent with these two drugs than with nonselective NSAIDs. However, the two major studies conducted to determine if this effect results in actual clinically significant reductions in the complications of ulcer development in people who takes these medications compared to the older NSAIDs, have been disappointing. The two major studies have been published in the peer reviewed literature are the CLASS study for celecoxib⁸, and the VIGOR study for rofecoxib.⁹

The FDA Arthritis Advisory Committee reviewed these data and other data at their February 7-8, 2001 meeting.¹⁰ The issues are complex in terms of what risks are reduced and what risks are increased with these drugs. The essence of the conclusion with celecoxib at this time is that patients who are taking low dose aspirin for prevention of cardiovascular events did not experience a benefit of reduction of gastrointestinal events in this study as the primary outcome was originally defined. The experience with rofecoxib was also disappointing. Although the data showed a reduction in risk of gastrointestinal complications, there was an increase in the risk of cardiovascular complications (myocardial infarction) such that overall risk was not reduced. Low dose aspirin was not used in the rofecoxib study.

There are several arguments to attempt explanation of the final analysis, and meaning of these data, but the FDA Advisory Committee was not convinced that these new drugs are safer overall than the older NSAIDs. The key to proper use of these drugs will be appropriate patient selection. There are algorithms available for estimating high gastrointestinal risk from NSAIDs. These algorithms are being used by the VA National Formulary and some Medicaid programs for prior authorization of the COX 2 selective inhibitors. COX 2 selective drugs are not needed in patients who are not at high risk for gastrointestinal complications. The continuing collection of data on the safety of these drugs should be monitored for additional changes.

Note, at the same time the new COX 2 nonsteroidal anti-inflammatory drugs are placed on prior authorization, all brand specific NSAIDs should require prior authorization. Failure to do that would result in switching from one high cost branded drug to another without therapeutic benefit. The prior authorization program for these drugs in the State of Iowa has been successful.

6 prescription per month limit:

The majority of Medicaid programs (34 of 48), do not have a specific limit on the number of prescriptions.¹² Based on data provided for North Carolina Medicaid, the 100 day supply appears to allow the intent of this limit to be negated. The majority of studies of the effects of Medicaid

prescription limits have found that prescription limits lead to an immediate reduction in pharmaceutical utilization, but not necessarily in overall Medicaid spending, and they may adversely effect clinical outcomes.¹² Consideration should be given to eliminating the 6 prescription limit and reducing the supply to 30 or 34 days except for maintenance drugs after the first refill, which may then be a 100 day supply. It is difficult to predict the economic impact of this change and it should be monitored if implemented.

Additional recommendations regarding the DUR program:

Drugs which should have focused DUR reviews and provider education programs include: Claritin and other "nonsedating antihistamines", Ambien, and all sedative hypnotics. These drugs are known to be overused and in many case inappropriately used. Lower cost equally effective therapies are available and provide quality care for many patients. The benzodiazepine sedative hypnotics are frequently prescribed for a longer duration of therapy than recommended. If a provider education program is not successful, a prior authorization program should be strongly considered. Other states have successfully implemented prior authorizations for these drugs. Considering the number of new drugs recommended above to receive prior authorization, these additional drugs are recommended for an education approach first so that there are not so many new prior authorizations implemented at the same time.

Strong consideration should be given to implementing a program to encourage use of generic products. The Iowa Medicaid program utilizes a prior authorization program for selected brand name drugs for which there is available an "A" rated bioequivalent generic product. (see attachment)

A study should be conducted to determine the extent that calcium channel blockers are being selected as first choice therapy for hypertension in patients without other specific indications for one of these drugs. If it is determined that calcium channel blockers are overused, a provider education program regarding the appropriate treatment of hypertension is recommended. Considering that in most studies done in the last 5 years, the success of treating patients with hypertension to goal is about 25%, it may be a reasonable education program on that basis alone. Calcium channel blockers are currently relatively high on the list of top 100 drugs and are generally not recommended as first choice antihypertensive drugs for the majority of patients.

Overuse of antibiotics in upper respiratory tract infections is a known problem in the United States and is a growing national and worldwide concern due to resulting increased antibiotic resistance of *Streptococcus pneumoniae*. The Centers for Disease Control and Prevention, in collaboration with other federal organizations and professional associations has coordinated the preparation of guideline documents "Principles of Appropriate Antibiotic Use for Treatment of Acute Respiratory Tract Infections in Adults. These guidelines have been published in 9 separate reports in the March 20, 2001 issue of *Annals of Internal Medicine*, Volume 134 • Number 6. These guidelines in addition to previous similar guidelines for pediatrics,¹¹ may be considered for a special focus education program for providers.

It was noted in the North Carolina Drug Use Review Annual Report for Federal Fiscal Year 1999, and Minutes from the North Carolina DUR Board Meeting September 21, 2000, that the DUR program has initiated focus studies to identify potentially inappropriate use of selected drugs or combinations of medications, or underuse of needed medications. One study was directed at identification of patients with asthma using more than 2 units of inhaled beta-agonist bronchodilator therapy per month without inhaled anti-inflammatory medication. Another was intended to identify patients with a diagnosis of HIV who were not receiving triple antiretroviral therapy (HAART) during at least one month of the three month period. Another study evaluate the use of NSAIDs in combination with proton pump inhibitors with a diagnosis of osteoarthritis. The DUR Board decided to focus the treatment of osteoarthritis using the guidelines endorsed by the American College of Rheumatology. The Board has also implemented a project involving a pharmacy student which will focus on elderly Medicaid recipients and the use of acetaminophen

for osteoarthritis, calcium for osteoporosis, and aspirin for the prevention of myocardial infarction and stroke. There was a program to evaluate and intervene to correct the underuse of ACE inhibitors in chronic heart failure, and the underuse of beta-blockers post myocardial infarctions. These are all valuable studies to identify areas of quality needs and improve overall appropriate pharmaceutical care, not just cost controlling programs. Other chronic health care conditions, and indicators included in the HEDIS criteria, may be considered for additional such programs.

Considerations for the near future:

The following comments are offered as considerations for additional techniques which are in use to varying degrees in different Medicaid programs or in the private sector to manage care and manage medication use to provide quality cost-effective care.

Formulary: The Institute of Medicine recently completed a review and analysis of the Veterans Administration National Formulary and concluded that: formularies and formulary systems (the many policies and procedures necessary to manage implementation of formularies) are an essential part of modern health care systems.¹² They found that the VA National Formulary was not overly restrictive and that it has probably meaningfully reduced drug expenditures without demonstrable adverse effects on quality. They also stated that it is difficult to imagine a modern health care system that does not employ a formulary. The 260 page IOM report provides an extensive review of formularies and formulary systems including review of formularies in Medicaid programs. It is strongly recommended that a study be undertaken to evaluate the information in this report and consider possible applications to the drug benefits in the North Carolina Medicaid system.

A coalition of national organizations representing health care professionals, government, and business leaders formed a working group to develop a set of principles specifying the essential components that contribute to a sound drug formulary system. This group has published a document "Principles of a Sound Formulary System" which may be obtained at <http://www.amcp.org/public/legislative/DrugFormulary.pdf>. Participants in this process include Academy of Managed Care Pharmacy, American Society of Health-System Pharmacists, Department of Veterans Affairs, Pharmacy Benefit Strategic Healthcare Group, National Business Coalition on Health, and the US Pharmacopeia. This document is another valuable resource for evaluation of the potential applications of formulary management.

Disease management: It is recognized that North Carolina has demonstration projects in disease management in asthma and diabetes. There are additional major resources in the state to consider for collaboration for overall improvement of the quality and efficiency of pharmaceutical and other Medicaid services. The University of North Carolina Chapel Hill has created a multidisciplinary Program on Health Outcomes where government and private health organizations can obtain expertise for a wide range of applications for bringing about superior health outcomes.

Disease management involves using evidence-based resources, such as published guidelines, to monitor and improve the treatment of patients with chronic treatable conditions. Disease management focuses on patient education, coordination of care, and reducing variation in services provided among physicians and other providers. Disease management emphasizes providing a continuum of care for those at risk or that have chronic illness, and measures outcomes.

Dr Alfred Lewis, in a presentation at the Agency for Health Care Research and Quality User Liaison Program May 8-10 presented what he called the "secrets of success in selecting a population for disease management: High prevalence of the condition to be managed; low turnover among the enrollee population (a potential problem with the low

percent of Medicaid recipients who are continuously eligible), an ability to identify patients who are at risk for getting the disease, a patient population that has a high illness severity and consequently high use of medical services.

At the same AHRQ meeting Charles D Kight, Administrator Florida Agency for Health Care Administration, Tallahassee Florida presented the Florida Medicaid's disease management program which began in 1997. In the first year the legislature reduced the Medicaid budget by about \$ million, the amount of the projected savings for the program. In 1998, the legislature reduced the budget by an additional \$38 million for continuation and expansion for the program. Similar budget reductions have continued in subsequent years. Florida's program involves a number of contracts with private disease management organizations.

Dr Michelle Whitehurst-Cook, Associate Professor of Family Medicine, Department of Family Practice, School of Medicine, Virginia Commonwealth University, discussed the Virginia Health Outcomes partnership (VHOP), the disease management program of Virginia Medicaid. Dr Whitehurst-Cook remarked that the effectiveness of VHOP is due to several specific factors: increased use of clinical guidelines and established protocol; a focus on communication and feedback between patients, providers, and payers; integration of pharmaceuticals and educational interventions into clinical guidelines; education of targeted physicians about the guidelines for specific diseases such as asthma.¹³

For additional information regarding implementation of a Medicaid disease management program see <http://www.dmnnow.org/>.

Pharmaceutical case management: The North Carolina Center for Pharmaceutical Care (NCCPC) is nationally recognized for what has been referred to as the Asheville Project. This was a collaborative of the North Carolina Society of Hospital Pharmacists, the North Carolina Pharmaceutical Association, Campbell University, University of North Carolina, the pharmaceutical industry and Pharmacy Network National Corporation. In 1997 the NCCPC teamed with Mission St. Joseph's Health System in Asheville, local pharmacists in Asheville, and the City of Asheville to conduct a year long study of the impact pharmacists can have on the ability of people with chronic illness to manage their disease. Working with physician patients and pharmacists this project demonstrated positive effects on quality of life and disease indicators in patients with diabetes and resulted in a reduction in total costs for inpatient and outpatient services. It has since been expanded to asthma. Additional collaboration of this type with Medicaid patients should be investigated if not already begun.

Pharmacists at 126 pharmacies are participating in the Iowa Medicaid Pharmaceutical Case Management Program (PCM). PCM was authorized by the state legislature in 1999 and implemented in October 2000. The Iowa Department of Human Services identified 1561 patients in the project's first quarter and 540 additional patients in the second quarter to receive the service. To qualify patients must have at least one of twelve chronic illnesses and be using at least four regularly scheduled prescription drugs. Pharmacists work with the patient's physician to help patients use their medications safely and effectively. Pharmacists of physicians are paid a fee of \$75 to meet with and provide initial assessment of patients. Additional fees are paid for follow-up assessment. Researchers from the University of Iowa will measure the clinical and fiscal impacts of PCM and present a final report to the legislature in December 2002.¹⁴

In 1998 the Mississippi Medicaid program obtained a demonstration waiver from HCFA to allow pharmacists to be reimbursed for disease management services. This disease management program used pharmacists in cooperation with physicians to manage the pharmaceutical care of patients with asthma, hyperlipidemia, coagulation disorders and

diabetes. The program is under the direction of Joseph Byrd, PharmD, Chair of the Department of Clinical Pharmacy Practice at the University of Mississippi Medical Center. Successes of the demonstration include 500 registered patients and the early findings that the disease management program has helped to reduce medical costs and improve quality of care by reducing emergency room visits and hospitalizations.¹⁵

¹ Novartis Pharmacy Benefit Report. Trends and Forecasts. East Hanover NJ Novartis Pharmaceuticals Corp 1999

² Phillips CR, Larson LN. Evaluating the operational performance and financial effects of a drug prior authorization program. *J Managed Care Pharm* 1997;3:699-706.

³ Kotzan JA, McMillian JA, Jankel CA, Foster AL. Initial impact of a Medicaid prior authorization programs for NSAID prescriptions *J Res Pharmaceut Econ* 1993;5:25-41.

⁴ Smalley WE, Griffin M, Fought, Sullivan L, Ray WA. Effect of a prior authorization requirement on the use of nonsteroidal anti-inflammatory drugs by Medicaid patients. *N Engl J Med* 1995;322:1612-1617.

⁵ Institute of Medicine. Crossing the quality chasm: A new health system for the 21st century. National Academy Press Washington DC 2001

⁶ Soll AH, Achord JL, Bozymski G et al. Medical treatment of peptic ulcer disease: practice guidelines *JAMA* 1996;275:622-629

⁷ Devault K R; Castell D O; ET AL. Updated Guidelines for the diagnosis and treatment of gastroesophageal reflux disease. *Am J Gastroenterol* 1999;94:1434-1442

⁸ Silverstein FE, Faich G, Goldstein JL, et al. Gastrointestinal toxicity with celecoxib vs nonsteroidal anti-inflammatory drugs for osteoarthritis and rheumatoid arthritis. The CLASS study. *JAMA* 2000;284:1247-1255.

⁹ Bombardier C, Laine L, Reicin A, et al. Comparison of upper gastrointestinal toxicity of rofecoxib and naproxen in patients with rheumatoid arthritis. *N Engl J Med* 2000;343:1520-1528.

¹⁰ FDA Center for Drug Evaluation and Research Arthritis Advisory Committee meeting Feb 7, 2001 and Feb 8, 2001 <http://www.fda.gov/ohrms/dockets/ac/cder01.htm#Arthritis> accessed April 7, 2001

¹¹ Dowell SF, Marcy SM, Phillips WR. Principles of judicious use of antimicrobial agents for pediatric upper respiratory tract infections. *Pediatrics* 1998;101:163-165.

¹² David Blumenthal. Institute of Medicine Description and analysis of the VA National Formulary. 2000 National Academy Press Washington DC

¹³ Whitehurst-Cook M Virginia Health Outcomes Partnership Agency for Health Care Research and Quality User Liaison Program, Using Evidence, May 8-10, Omaha <http://www.ahrq.gov/news/ulp/evidence/ulpevdnc8.htm> accessed March 13, 2001.

¹⁴ Landis NT Early reports on Iowa pharmaceutical case management seem encouraging. *Am J Health-Syst Pharm* 2001;58:560-561.

¹⁵ Anon. Management tools and new programs, what can states do? Agency for Health Care Research and Quality User Liaison Program. January 10, 2000 <http://www.ahrq.gov/news/ulp/ulprxcov3.htm> accessed March 13 2001.

Attachment I

This table provides background for the projected cost reduction which may be achieved by prior authorization of these drugs. The projections were made by comparing the expenses for each drug as a percentage of total expenses of these drugs in North Carolina to the expenses for these drugs in Iowa. There was no adjustment made for possible demographic differences in the Medicaid populations in the respective states, however this effect would not be expected to be large. The expenses are based on data from a report of the top 100 drugs in expense for each state in 2000. If a medication, or one of the dosage forms of one of the medications, was not present in the top 100 drugs, no data were available for its expense and it would not be included in these estimates. The total expenses for North Carolina for 2000 were not available so the expenses for State Fiscal Year 2000 were used.

Drug	North Carolina Total Paid	North Carolina % of total RX \$	Iowa Total Paid	Iowa % of total Rx \$
Prilosec 20mg	\$ 33,903,658	4.49%	\$ 2,733,134	1.30%
Prilosec 40 mg	\$ 2,379,192	0.32%	Not in top 100	Not in top 100
	\$ 36,282,850	4.81%		
Prevacid 30 mg	\$ 19,816,758	2.63%	\$ 2,260,839	1.08%
Prevacid 15 mg	\$ 3,664,472	0.49%	Not in top 100	Not in top 100
	\$ 23,481,230	3.11%		
Aciphex 20mg	\$ 2,562,802	0.34%	Not in top 100	Not in top 100
Ranitidine 150mg	\$ 6,371,835	0.84%	\$ 2,608,910	1.24%
Pepcid 20 mg	\$ 5,366,912	0.71%	Not in top 100	Not in top 100
Axid 150 mg	\$ 2,308,959	0.31%	Not in top 100	Not in top 100
	\$ 14,047,706	1.86%		
Celebrex 200 mg	\$ 11,584,300	1.54%	\$ 819,200	0.39%
Celebrex 100 mg	\$ 3,452,300	0.46%	Not in top 100	Not in top 100
	\$ 15,036,600	1.99%		
Vioxx 25mg	\$ 7,731,600	1.02%	\$ 484,800	0.23%
Vioxx 12.5 mg	\$ 2,279,000	0.30%	Not in top 100	Not in top 100
	\$ 10,010,600	1.33%		

**Appendix I
Survey Instruments**

PCCM Survey

Name of State: _____

Name of Person Completing Survey: _____

Number of Medicaid Recipients in PCCM Program: _____

Year Your PCCM Program Began: _____

.....

1. What do you pay participating PCPs on a per-enrollee, per-month basis in your PCCM Program? _____

2. What Medicaid eligibility categories do you include in your PCCM Program? _____

3. A. What services require authorization from a PCP?

Non-behavioral health specialists.

All specialists.

All inpatient admissions.

Some inpatient admissions. Please explain. _____

Other. Please explain. _____

B. What services are available without a PCP referral/authorization? _____

4. What criteria did you use in establishing those services that require PCP authorization when compared to these services that do not? Please explain. _____

5. For inpatient hospital admissions, when the patient is first presented in the hospital's emergency room, which of the following applies:

No prior approval of the inpatient hospital admission by the PCP is required due to the initial emergency room contact.

The admissions must be authorized by the PCP, in consultation with the ER physician.

Other. Please explain. _____

6. Do you use other utilization review (U/R) agents, besides the PCP, to approve certain services received by individuals enrolled in your PCCM Program?

Yes

No

IF THE ANSWER TO QUESTION 6 IS YES, PLEASE COMPLETE THE FOLLOWING

7. We use other utilization review agents to authorize the services listed below:

Inpatient admissions and stays are reviewed and approved by a separate U/R agent.

Behavioral health care is reviewed and approved by a separate U/R agent.

Other. Please explain. _____

IF THE ANSWER TO QUESTION 6 IS YES, PLEASE COMPLETE THE FOLLOWING

8. Please explain how the patient's PCP and your other utilization review agent(s) work together/coordinate care for a recipient:

Formal contact is required by our agreements with each party to ensure that the PCP is kept abreast of the care authorized by another agent. Please describe the formal mechanism. _____

Informal contact is required on a case-by-case basis. Please describe.

No contact is required.

Other. Please explain. _____

9. Please explain how your claims payment system enforces your PCCM program's requirements about PCP approval.

Each referral or admission receives a unique authorization code and the specialist or hospital cannot be paid without knowing and including the unique referral code on a claim form.

Each PCP has a unique provider code and a specialist or hospital cannot be paid without knowing and including the unique PCP identifier on the claim.

Other. Please describe. _____

10. Please explain all measures taken to evaluate the quality of care delivered in your PCCM Program, including the frequency and type of data and reports you collect and review, and how you use this information to manage the quality of care. _____

11. A central premise of a PCCM Program is that it will improve access to primary care and reduce the need for inappropriate specialty and emergency room services. In light of this:

A. Does your data show an increase in PCP visits when compared to pre-PCCM utilization of primary care providers; and, if so, by what magnitude:_____

B. Does your data show a decrease in specialty care when compared to per-PCCM utilization and, if so, by what magnitude:_____

C. Does your data show an increase in emergency room services when compared to pre-PCCM utilization and, if so, by what magnitude._____

13. Has your state significantly changed your Medicaid fees (on your Medicaid fee-for-service fee schedule) while you have operated you PCCM Program?

Yes No

IF THE ANSWER TO QUESTION 13 IS YES, PLEASE COMPLETE THE FOLLOWING

14. What steps have you taken, if any, to evaluate how much access and utilization has changed as a result of your state's fee schedule instead of your state's PCCM Program?_____

15. What tools, incentives, data, or reports do you utilize to ensure that improvements in access do not inadvertently lead to overutilization of services?_____

Behavioral Health Survey

Name of State: _____

Name of Person Completing Survey: _____

1. Please identify those services where your state requires prior and/or concurrent authorization in order for providers to deliver care:

Inpatient psychiatric hospitals.

Residential care.

Outpatient visits.

Other. Please explain. _____

2. For each service identified in Question 1, please:

A. Describe the units traditionally authorized and the limits on the number of units authorized (e.g., 10 outpatient visits at a time or 14 day stays in residential care at a time, etc.). _____

B. Identify who performs the authorization functions (outside private contractor, sister agency, Medicaid agency staff, etc.). _____

C. Describe what criteria you use, if any, to determine the cost effectiveness of your utilization review system (i.e., how you determine whether the cost of the utilization review, administrative process results in equal or greater savings in unnecessary care that is avoided).

3. Please provide copies of the portions of your state plan describing the behavioral health services available in your Medicaid program.

4. Please provide each of the service-specific definition(s) you utilize in determining whether services are "medically necessary." _____

5. Please describe the sources of your utilization review standards, diagnosis categories, and service definitions (state-generated, national standards, etc.), and how you use them: _____

6. What criteria do you use when deciding to add or expand a behavioral health benefit in Medicaid? _____

7. Please describe the role(s) played by non-Medicaid behavioral health agencies including, but not limited to, the state mental health or DD program administrators (please check all that apply):

Another public agency(ies) has the lead responsibility for designing and/or administering the Medicaid behavioral health benefit, as a provider.

Another public agency(ies) has the lead responsibility for providing services in the Medicaid behavioral health benefit, as a provider.

Another public agency(ies) participates with the Medicaid agency in design, but the Medicaid agency retains the lead role.

Other? Please describe. _____

8. Does your state treat community mental health care providers under the same reimbursement, authorization, referral, and other rules as private providers?

- Yes No

IF THE ANSWER TO QUESTION 8 IS NO, PLEASE COMPLETE THE FOLLOWING

9. In what ways are community mental health centers treated in a different way than private providers (please check all that apply):

They receive different reimbursement rates. Please describe. _____

They are not subject to the same authorization/utilization review rules. Please describe.

They are not subject to the same referral rules. Please describe. _____

They participate in policy and utilization activities. Please describe. _____

10. How does your state coordinate behavioral health services with a client's physical health services? Please describe. _____

Pharmacy Survey

Name of State: _____

Name of Person Completing Survey: _____

10. Please provide:

10. A list of all drugs for which you require prior authorization.

B. For each drug listed above, what are your prior authorization guidelines, exceptions to the prior authorization requirement, and exceptions procedures: _____

C. Who performs the prior authorization and exceptions review role (state, contractor, etc.)?

D. How many reviewers perform that function and what are their qualifications? _____

2. Are certain drugs only available if the patient has a specific diagnosis? If yes, please provide the relevant details. _____

3. For drugs that required prior approval, what are the limits in terms of doses per prescription and maximum refills: _____

4. Please describe what criteria you use, if any, to determine the cost effectiveness of your utilization review system (i.e., how you determine whether the cost of the utilization review administrative process results in equal or greater savings in unnecessary drug expenditures that are saved): _____

10. What is the maximum number of days permitted to be dispensed for routine medications (e.g., 35, 100, etc.)? _____

10. A. Does your state limit the number of prescriptions, per month, that each Medicaid eligible is allowed to receive?

- Yes No

10. If the answer to 6.A. is yes, please provide the number of prescriptions permitted per month and please describe how any exceptions process to this rule operates: _____

10. What strategies has your state adopted, or is considering adopting, to contain the rate of growth of your Medicaid pharmacy benefit? _____

10. What technique(s) do you use, or do you plan to use, to encourage the dispensing of generics (please complete for all that apply):

- Differential dispensing fee between generic and brand-name drugs. Please describe. _____

Differential prior authorization requirements for certain brand-name drugs. Please describe as well as describe any exceptions process. _____

Differential cost-sharing obligations for the patient. Please describe. _____

Provider profiling to identify and educate other physicians. Please describe. _____

10. Other. Please explain. _____

10. How active is your DUR Board and how much authority does it possess? _____

10. Please discuss how your state's pharmacy benefit utilization approach compares to the approach used by large insurers in your state. _____

Long-Term Care Survey

Name of State: _____

Name of Person Completing Survey: _____

1. Please describe:

- The services in your array of long term care services (defined as those services to support people with long term and chronic needs), including Medicaid waivers, Medicaid state plan services, and non-Medicaid health and social support services. _____

- The nature of formal and informal working relationships between the various agencies involved in long term care (Medicaid, aging, DD, mental health, child welfare, etc.). _____

- The location and role of the eligibility (functional and financial) entry point(s) to your long term care system. _____

- Each of your Medicaid 1915(c) waivers (number of funded slots, services in the waiver, administrative responsibility by agency, etc.). _____

2. Please describe the efforts in your state, if any, that were prompted by the Olmstead decision (please check all that apply):

Agencies having responsibility for long term care are working together more closely in the development of long term care services. Please describe: _____

New services or benefits were created, or will be created, to serve people in the community. Please describe: _____

Existing services or benefits were expanded, or will be expanded, to serve people in the community. Please describe: _____

Reimbursement policies in institutional care and/or community-based care have been/will be revised to incentivize community-based care. Please describe: _____

Entry into the long term care system (institutions and/or community-based care) is being performed/will be performed in a different manner. Please describe: _____

Other. Please describe. _____

3. When your state is evaluating whether or not to add a new service to your long term care continuum, what is your process?

Estimate the number of people who will utilize the new service. Please describe in detail.

Estimate the average units of service that will be utilized per recipient. Please describe in detail.

Estimate the effect the potential new service will have on the utilization of existing services (e.g., the effect the addition of personal care or a new HCBC waiver would have on nursing home utilization). Please describe in detail.

Other. Please describe in detail:

4. Have you analyzed the so-called "woodwork effect" when you add new services to your long term care continuum(the woodwork effect" means a sudden increase in demand caused by the new supply of services)?

Yes No

IF THE ANSWER TO QUESTION 4 IS YES, PLEASE COMPLETE THE FOLLOWING

5. What did your analysis tell you? _____

IF THE ANSWER TO QUESTION 4 IS YES, PLEASE COMPLETE THE FOLLOWING

6. What data did you use and how did you use it to perform your analysis? _____

7. What is the average cost per recipient of the service per year in your:

Nursing homes: _____

ICF/MRs: _____

1915(c) Waiver: _____ Waiver #1

(please complete _____ Waiver #2

separately for each _____ Waiver #3

1915(c) waiver)

8. How many unduplicated users did you have in each service?

Nursing homes: _____

ICF/MRs: _____

1915(c) Waiver: _____ Waiver #1

(please complete _____ Waiver #2

separately for each _____ Waiver #3

1915(c) waiver)

9. How many beds are licensed in your state, as follows:

Private nursing homes: _____

Public nursing homes: _____

Private ICF/MR: _____

Public ICF/MR: _____

10. How many beds are filled (i.e., the average daily census), as follows:

Private nursing homes: _____

Public nursing homes: _____

Private ICF/MR: _____

Public ICF/MR: _____

11. How many beds are Medicaid reimbursements at any given time, as follows:

Private nursing homes: _____

Public nursing homes: _____

Private ICF/MR: _____

Public ICF/MR: _____

12. Please describe all service limits imposed on long term care services (institutional and community-based)? _____

13. Who performs your utilization review functions as follows:

A. Approves institutional level of care determinations: _____

B. Approves community-based care plans of care or services such as personal care: _____

C. Other. Please describe: _____

14. What is the length of your bedhold (i.e., the number of days Medicaid will pay for an empty bed while a resident is temporarily away from his/her institution):

Number of days: _____

15. For each of the services requiring approval (as set forth above), please provide the criteria used in the utilization management process: _____

16. If a utilization review entity denies a level of care request after a resident has been receiving care at that level, does the state seek recoupment?

Yes No

17. Please provide any other pertinent information regarding your service creation, definition or management: _____

Appendix J

Drugs Requiring Prior Approval by Private Plans in North Carolina

	Partners Health Plan	United Healthcare	Blue Cross Blue Shield of NC	Mid-Atlantic Medical Services	State Employees' Health Plan
Actos	√				
Adderall	√				
Agenerase	√				
Anadrol - 50 tablet				√	
Antabuse and generics				√	
Aricept tablet				√	
Arthrotec	√				
Avandia	√				
Avita	√	√			
Botulinum-A Toxin injection			√		
Celebrex	√				
Clomid	√				
clominphene	√				
Cognex capsule				√	
Crinone	√				
Depo-Provera	√				
Desoxyn	√				
Dexedrine	√				
Dextrostat	√				
Differin		√			
Diflucan	√				
Dolophine and generics				√	
Enbrel	√				
Epogen injectable				√	
Evista	√				
Fertinex	√				
Follistim	√				
Fosamax 40 mg				√	
Gonal F	√				
Humegon	√				
Lamisil	√				
Leukine injectable				√	
Lupron	√				
Metrodin	√				
Neumega injectable				√	
Neupogen injectable				√	
Nutropin/AQ	√				

	Partners Health Plan	United Healthcare	Blue Cross Blue Shield of NC	Mid-Atlantic Medical Services	State Employees' Health Plan
<i>Specific Drugs</i>					
Oxandrin tablet				√	
Prandin	√				
Pregnyl	√				
Procrit injectable				√	
Profasi HP	√				
progesterone powder				√	
progesterone supp	√				
Proscar	√	√			
Protropin	√				
Regetron	√				
Repronex	√				
Retin-A	√	√			
Retin-A micro	√				
Roferon-A injectable				√	
Serophene	√				
Serostim	√				
Sporanox	√				
Stimate	√				
Targretin	√				
Ultram	√				
Vancocin	√			√	
Vioxx	√				
Wellbutrin		√			
Wellbutrin/SR	√	√			
Winstrol tablet				√	
Xenical capsule				√	
Zyban tablet				√	
Zyvox	√				
<i>Drug Types</i>					
Anti-wrinkle drugs					√
CNS stimulants,				√	
Compound drugs over \$100				√	
Erectile dysfunction					√
Fertility agents, injectables only				√	
Growth Hormones, injectable			√	√	√
Hair loss					√
Weight loss					√

Appendix K BlueCross BlueShield of North Carolina – Surgery Criteria¹

Policy: Breast Surgeries

Medical Policy – Reduction Mammoplasty

A reduction mammoplasty is performed to remove substantial breast tissue, including skin and underlying glandular tissue. It results in a significant reduction in the size of the breast, change in shape and an uplifting effect on the breast tissue. It differs from mastectomy where the entire breast is removed. When medically necessary, a reduction mammoplasty is used to relieve symptoms resulting from breast hypertrophy such as shoulder pain, back pain, and shoulder grooving. The surgery requires general anesthesia.

When Reduction Mammoplasty is covered

Reduction mammoplasty for symptomatic breast hypertrophy may be considered medically necessary and eligible for coverage when all of the following criteria are met:

- A. The patient has significant symptoms that interfere with normal activities, including at least one of the following:
 1. symptomatic neck, back or shoulder pain not related to other causes (e.g. poor posture, acute strains, poor lifting techniques)
 2. inability to sleep in a reclined position due to shortness of breath
 3. clinical, nonseasonal submammary intertrigo
- B. The patient's physical exam documents at least two of the following:
 1. significant shoulder grooving
 2. obvious breast hypertrophy (pictures are not necessary)
 3. suprasternal to nipple measurement of greater than 28 cm for women greater than or equal to 5' 2" tall, or 25 cm for women less than 5' 2" tall
 4. physical exam is consistent with symptoms precipitating request for reduction mammoplasty
- C. Failure of conservative measures including
 1. for back, neck, or shoulder pain, failure of 6 weeks of conservative treatment, including all of the following:
 - a. appropriate support bra
 - b. NSAIDs (if not contraindicated)
 - c. exercises and heat or cold application
 2. for submammary intertrigo, 6 weeks of conservative treatment, including all of the following:
 - a. appropriate hygiene
 - b. appropriate medical/pharmacologic treatment
 - c. utilization of an appropriate support bra
- D. For patients with a Body Mass Index (BMI) greater than 27, a documented and legitimate medically based attempt to reduce and maintain weight. This requirement relates specifically to patients with low back pain and intertrigo, when obesity is a documented risk factor. In the absence of weight loss to a BMI less than or equal to 27, a legitimate attempt at weight loss includes the following:

¹ BlueCross BlueShield of North Carolina, April 2001

1. initial consultation with a physician or mid-level practitioner (Nurse Practitioner, Physician's Assistant) regarding weight loss
2. the weight loss attempt includes all of the following.
 - a. regular visits with a practitioner, nutritionist, or other recognized weight loss program over 3 months
 - b. the weight loss program includes reasonable dietary modifications and appropriate aerobic exercise
 - c. the record indicates that the patient has made reasonable attempts to comply with the weight loss program
3. proposed surgery is anticipated and documented to remove
 - a. at least 400 gm of tissue from each breast for patients 5' or under and 110 pounds or less
 - b. at least 500 gm of tissue from each breast for patients over 5' or more than 110 pounds.

When Reduction Mammoplasty is Not Covered

Reduction mammoplasty is not covered when the criteria listed above has not been met.

Policy Guidelines

Member's attending physician in consultation with the patient will determine length of the hospital stay if member is hospitalized.

Managed care guidelines requires prior plan approval for reduction mammoplasty.

Billing/Coding/Physician Documentation Information for Reduction Mammoplasty

- ◆ Applicable code: 19318.

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often used, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

**Appendix L
Resumes**

**JOHN G. BREHM, MD
MEDICAL DIRECTOR**

EDUCATION

Intermountain Advanced Course	Advanced Degree, 1997
Internal Medicine, University of Iowa Hospitals and Clinics	Residency, 1970-1973
University of Pennsylvania School of Medicine	MD, 1966-1970
Franklin and Marshall College	BA, Chemistry, 1962-1966

PROFESSIONAL EXPERIENCE

West Virginia Medical Institute Charleston, WV
Medical Director – 2000-Present

Responsible for all clinical aspects of WVMI's utilization management and health care quality improvement programs. Works with the Chief Executive Officer on WVMI policies and administration. Manages WVMI's research and development programs and coordinates the work of WVMI's clinical leadership. Represents the Institute at the state and national level.

John Deere Health (Heritage National Healthplan)
Vice-President-Medical Management – 1997-2000

Responsibilities included physician credentialing, utilization management, transplant case management, physician profiling, benefit determination, utilization review, NCQA standards compliance, technology assessment, supervision of Medical Directors, and legislative activity.

Medical Associates HMO Dubuque, IA
Medical Director – 1995-1997

Iowa Foundation for Medical Care Des Moines, IA
Executive Committee of the Board of Directors and Treasurer – 1991-1997

Dubuque County Medical Society Dubuque, IA
President – 1991-1992

Medical Associates Dubuque, IA
Chairman of the Section of Internal Medicine – 1986-1990

Xavier Hospital Dubuque, IA

Chief of Staff – 1980

Medical Associates Clinic Dubuque, IA

Private Practice of Internal Medicine – 1973-1997

PROFESSIONAL ACTIVITIES AND ACCOMPLISHMENTS

Memberships and Certification

Certification, American Board of Internal Medicine, 1999 current - 2009

Member, American College of Physicians

Member, American Society of Internal Medicine

Member, American Medical Association (AMA)

Member, Illinois State Medical Society

Licensure

Currently licensed in Illinois, Iowa and Tennessee

Now applying for licensure in Virginia and West Virginia

KEVIN G MOORES, PharmD**EDUCATION**

University of Iowa	8/74-5/76	Pharmacy	
University of Nebraska Medical Center	8/76-5/79	Pharmacy	Pharm. D.

ACADEMIC AND PROFESSIONAL EXPERIENCE

Pharmacy Resident	University of Iowa Hospitals	7/79-6/80	
Clinical Pharmacist Drug Information Poison Control Center	University of Iowa Hospitals	7/80-8/83	
Pharmacy Supervisor Drug Information Poison Control Center	University of Iowa Hospitals	8/83-7/92	
Adjunct Asst. Professor	University of Iowa	7/87-7/92	Drug Info Rotation
Clinical Asst. Professor Director, Drug Information	University of Missouri-Kansas City	8/92-12/95	Drug Info, Disease Processes, Therapeutics, Seminar, Drug Info Rotation
Ex-officio member DUR Board and DI consultant	State of Missouri Medicaid System	8/92-12/95	
Chair, Prior Authorizations Committee	State of Missouri Medicaid System	9/94-12/95	
Asst Professor (Clinical), Director, Iowa Drug Information Network	University of Iowa College of Pharmacy	12/95-Present	Drug Info Rotation, Literature Evaluation, Co-director drug informatics residency program

PROFESSIONAL LECTURES/PRESENTATIONS/CE PROGRAMS

Moore KG. How to conduct a journal club with pharmacy students on clinical rotations. 1 hour CE program as part of Working with students: Setting goals providing feedback, discussing journal articles. Presented over the Iowa Communications Network, The University of Iowa College of Pharmacy, Iowa City IA March 8, 2001

Moore KG. Program Director, Get Evidence Into Practice: An Introductory Workshop in Primary Literature Evaluation, Iowa Pharmacy Association Educational EXPO 2001, 6 hour CE program. January 19, 2001, Des Moines. Sponsored by Boehringer Ingelheim.

- Moore KG. Evidence-Based Practice and Clinical Practice Guidelines. University of Iowa College of Pharmacy Faculty Seminar Series. 1 hour CE program, October 18, 2000, Iowa City
- Moore KG, Seaba HS, A drug information network for community pharmaceutical care practice sites. 60th International Congress of FIP, Vienna, August 30, 2000
- Catney C, Seaba HS, Moore KG, Implementing Team Learning to Improve Students' Participation in a drug literature evaluation course. AACP annual meeting, San Diego, July 11, 2000
- Moore KG Program Director, Drug information skills development workshop, Iowa Pharmacy Association Educational EXPO 2000, 6 hour CE program, January 21, 2000
- Moore KG Clinical practice guidelines: Development methods, evaluation, and uses. Grand Rounds invited presentation 1 hour CE program. Immunex Corporation, Seattle Washington, November 18, 1999
- Moore KG Keeping up with the medical literature. 1 hour CE program. The University of Iowa College of Pharmacy, Iowa City IA October 6, 1999
- Moore KG Internet searches: a case study. 1 hour CE program. Iowa Pharmacy Association Annual Meeting, Cedar Rapids, Iowa, June 11, 1999
- Moore KG. Introduction to the resources and services in the Iowa Drug Information Network. 1 hour CE program, Iowa Pharmacy Association Education EXPO Des Moines, Iowa, January 15, 1999
- Moore K, Program Director, Get Wired! Computer Based Resources for Pharmacists. 7-hour continuing education program Sponsored by the University of Iowa College of Pharmacy, The Department of Internal Medicine and the Department of Pharmaceutical Care UIHC. Iowa City Iowa November 7 1998
- Moore K, Use of Technology to Build an Internet-based Drug Information Network, invited presentation, Drug Information Technology session, American Society of Health-System Pharmacists Annual Meeting, Baltimore, June 3, 1998
- Moore K, Evidence Based Medicine, invited presentation, Iowa Society of Health-System Pharmacists Annual Meeting, Des Moines Iowa May 2, 1998
- Moore KG Peptic Ulcer Disease 3 hour CE program. Published by Pharmat Inc. Lawrence Kansas February 1998
- Moore KG The Iowa Drug Information Network. Iowa Pharmacy Education Expo. Pharmaceutical Care Documentation Systems A Hands-on Workshop, 1 hour CE program. Des Moines Iowa January 16, 1998
- Moore K. Solutions to Pharmacotherapy Questions: Informatics Skills for Practicing Pharmacists. 6 hour continuing education program Sponsored by the Iowa Drug Information Network and the Iowa Pharmacists Association, Iowa City Iowa, November 16, 1997

- Moore K, Seaba HH, Currie JD, McDonough R, Pursel M. Development of a WWW Based Drug Information Network to Link the University of Iowa College of Pharmacy with Community Pharmaceutical Care and Family Practice Experiential Teaching Sites. Redefining Education in Primary Care: Teaming Communities, Practitioners, and Educators. Conference Sponsored by The University of Iowa Health Sciences Center and The University of Iowa Integrated Health Professions Education Program. Iowa City, Iowa April 16 1997 (abstract)
- Moore K. Introduction to drug informatics and evidence-based practice. 4-hour continuing education program. Sponsored by the Iowa Drug Information Network, The University of Iowa College of Pharmacy and the Iowa Pharmacists Association. Iowa City, Iowa. November 17, 1996.
- Moore K. Drug Information Services and Evaluation of the Literature. Presented to Dean's Advisory Council Meeting. Kansas City, Missouri, May 5, 1995.
- Moore K. Drug Information Services and the Formulary Evaluation Process. Provided for pharmacists with the Veterans Administration Medical Centers Kansas City and Levenworth and Truman Medical Center. Sponsored by the UMKC Drug Information Center and Marion Merrell Dow, Inc. Kansas City, Missouri, March 22, 1995.
- Moore K. Current Therapy of Benign Prostatic Hyperplasia. Presented at Pharmacology for Health Professionals. CE Program Sponsored by UMKC School of Pharmacy, Marion Merrell Dow, Inc., The Upjohn Company and Abbott Laboratories. Kansas City, Missouri, March 29, 1994.
- Moore K. Current Therapy of Benign Prostatic Hyperplasia. CE program Presented to Managed Care and Hospital Pharmacists in Albuquerque, New Mexico, December 1, 1993.
- Moore K. Role of Antihypertensive Therapy in Prevention and/or Mitigation of Target-Organ Disease. Presentation at the University of Missouri-Kansas City School of Pharmacy Continuing Education Program Role of Calcium Channel Blockers in Contemporary Therapy of Hypertension, Kansas City, Missouri, June 27, 1993.
- Moore K. Current treatments of benign prostatic hyperplasia. Presentation at the Boone and Story County Pharmacist Meeting, Ames, Iowa, May, 1993.
- From September 1992 to December 1999 Presented 50 formulary reviews to Truman Medical Center Pharmacy and Therapeutics Committee. Kansas City, Missouri. or to Department of Veterans Affairs Medical Center Pharmacy and Therapeutics Committee. Kansas City, Missouri.
- Moore K, Bergquist S, Einhellig R, et al. Prescribing Protocols Used to Control And Monitor Use of Select Antibiotics. Platform Presentation at ASHP Midyear Clinical Meeting, Orlando, Florida, December, 1992
- Sarrazin EF, Einhellig R, Bergquist S, Hobbs R, Moore K, Mutnick A. Interdisciplinary Program To Improve Documentation of Serum Sampling Data. Platform Presentation at ASHP Midyear Clinical Meeting, Orlando, Florida, December, 1992

- Sarrazin EF, Kayser J, Peterson C, Willhite L, Dick R, Moores K, Mutnick A. Antimicrobial Prophylaxis in Surgery. Poster Presentation at ASHP Midyear Clinical Meeting, Orlando, Florida, December, 1992
- Kallsen LL, Killion DS, Moores K, Putnam LA. Development of Pharmacy Department Policy and Procedure for Clozapine Dispensing and Patient Monitoring, Poster Presentation at ASHP Midyear Clinical Meeting, New Orleans, Louisiana, December, 1991.
- Sarrazin EF, McFadden DB, Moores K, Black HJ. Antibiotic Dose Standardization in Adult Patients. Poster Presentation at ASHP Midyear Clinical Meeting, New Orleans, Louisiana, December, 1991.
- Clem MJ, Sarrazin EF, Moores K. Fluconazole: Drug Use Evaluation. Poster Presentation at ASHP Midyear Clinical Meeting, New Orleans, Louisiana, December, 1991.
- Moores K. Drug Literature Evaluation, Continuing Education Program, Pharmacy Department, University of Iowa Hospitals and Clinics, December 1989.
- Moores K. The Systematic Approach to Drug Information Questions, Thirty-Seventh Annual Pharmacy Seminar, The University of Iowa College of Pharmacy, November 1989.
- Moores K. Functions of a Poison Control Center. Environmental Health, 063:202, University of Iowa, April 1987.
- Moores K. Famotidine - Another H₂ Receptor Antagonist, Clinical Pharmacology Seminar, University of Iowa College of Medicine, December 1986.
- Moores K. Poisoning in Children, Mercy Hospital, Iowa City, Iowa, November 1986.
- Moores K. Drug Overdose and Poisoning, Pharmacology 71:120, University of Iowa, February 1986.
- Moores K. Use of Activated Charcoal in the Management of Acute Poisoning, Case Study Program, Pharmacy Department, University of Iowa Hospitals and Clinics, December 1985.
- Moores K. Drug Information Skills for Hospital Pharmacists, 1985 Educational Expo, IPA Midyear ISHP Annual Meeting, Ames, IA, August 1985.
- Moores K. Poisoning, Pediatric Advanced Life Support, Emergency Medical Services Learning Resources Center, University of Iowa Hospitals and Clinics, May 1984.

PUBLICATIONS

Book Chapters

- Moores KG. Evidence-based clinical practice guidelines. pp 235-292. In: Malone PM, ed. Drug Information: A Guide for Pharmacists. 2nd Ed New York: McGraw Hill, 2001
- Moores K. Drug Information Skills for Pharmaceutical Care. In: Rovers JP, Currie JD, Hagel HP, McDonough RP, Sobotka JL, eds A practical Guide to Pharmaceutical Care APhA Washington DC. 1998

Moore KG. Evidence-based clinical practice guidelines. pp 307-341 In: Malone PM, ed. Drug Information: A Guide for Pharmacists. Stamford CT: Appleton & Lange, 1996.

Journals/National Newsletters

Moore KG, New evidence for beta-blockers and spironolactone in chronic heart failure. Journal of the Iowa Pharmacy Association. 1999;54(5):24-27

Moore KG, Bade L. Results of the United Kingdom Prospective Diabetes Study. Journal of the Iowa Pharmacy Association. 1999;54(1):22-25

Moore KG. Evidence-based practice in health care. Journal of Pharmacy Practice 1998;11:251-267

Moore KG. NSAID induced GI complications: What's new. World of Drug Information 1998;9:1-5

Moore KG. Evidence-based Medicine. World of Drug Information 1997;8:3-5

Moore KG Evidence-based clinical practice guidelines. Drug Benefit Trends 1997;9:37-45

Moore, KG. Nefazodone for treatment of depression. Internal Medicine Alert 1995;17(13):101-102.

Moore KG. Fluvoxamine maleate for OCD. Internal Medicine Alert 1995;17(5):37-39.

Moore KG. Metformin - A new old drug. Internal Medicine Alert 1995;17(3):21-23.

Moore KG. Step therapy for GERD. Internal Medicine Alert 1995;17(2):13-15. Moore, KG. Famciclovir for the treatment of shingles. Internal Medicine Alert 1994;16(21):165-167.

Moore, KG. Acne: pathogenesis and topical treatment. Internal Medicine Alert 1994;16(19):149-151

Moore, KG. Lodoxamide ophthalmic solution. Internal Medicine Alert 1994;16:142-143.

Moore KG. Torsemide: another loop diuretic. Internal Medicine Alert 1994;16(14):108-11

Moore KG. Granisetron for relief of nausea/vomiting. Internal Medicine Alert 1994;16(13):101-102.

Moore KG. "Fluvastatin: a lower cost statin?" Internal Medicine Alert 1994;16(10):78-79.

Moore KG. "Interferon-beta for multiple sclerosis." Internal Medicine Alert 1994;16(8):62-63.

Moore KG. "Venlafaxine: a new anti-depressant." Internal Medicine Alert 1994;16(6):45-47.

Moore KG. "Mesalamine (Pentasa®) for Crohn's Disease?" Internal Medicine Alert 1994;16(3):21-23.

Moore KG. Cisapride: potential off-label use. Internal Medicine Alert 1993;15(24):190-191.

Moore KG. Cisapride: a prokinetic drug for GERD. Internal Medicine Alert 1993;15(23):180-182.

Moore KG. Nedocromil: a new drug for asthma. Internal Medicine Alert 1993;15(18):141-143.

Moore KG. Butorphanol - a new nasal spray. Internal Medicine Alert 1993;15(12):94-95.

- Moore KG. EMLA - a new topical skin anesthetic. *Internal Medicine Alert* 1993;15(8):62-63.
- Moore KG. Calcium channel blockers for atrial fibrillation. *Internal Medicine Alert* 1993;15:53-55.
- Moore KG. Interferon for chronic hepatitis B and C. *Internal Medicine Alert* 1993;15:46-47.
- Moore KG. Alpha adrenergic antagonists for benign prostatic hyperplasia. *Internal Medicine Alert* 1992;14:181-183.
- Moore KG, Lange PG. Formulation/Manufacturing: A basic bibliography. *Hospital Pharmacy* 1988;23:1039.

Regional/Local Publications

- Moore K, Meyer C. Asthma therapy update. *Drug Use Review Newsletter - State of Missouri Medicaid Program* January 1995;1(1):1-3.
- From September 1992 to December 1999 authored 50 formulary reviews for Truman Medical Center Pharmacy and Therapeutics Committee. Kansas City, Missouri, or Department of Veterans Affairs Medical Center Pharmacy and Therapeutics Committee. Kansas City, Missouri.
- Lange PG, Moore K. Holiday hazards. *Iowa Medicine* 1987; 77:612-614.
- Lange PG, Moore K. Antidotes in the treatment of acute poisoning. *Iowa Medicine* 1987; 77:396-404.
- Moore K, Spector R. Activated charcoal for gastrointestinal decontamination of the poisoned patient. *Iowa Medicine* 1986; 76:231-238.

Research and Scholarly Work in Progress:

Development of a WWW-based drug information network to link the College of Pharmacy with community pharmaceutical care practice sites and family practice sites. This network provides access to computerized full text and bibliographic drug and medical information databases, access to expert drug information consultation for patient specific questions, and electronic communications to facilitate exchange of information and ideas among network members to advance the practice of pharmaceutical care in the community setting. In addition a new drug information resource is being developed that is a structured, controlled language, electronically searchable database of the questions and answers generated from the activities of the Network. This new database will be particularly valuable for pharmacists and other health care providers in the community to optimize the therapeutic use of medications because it will be based on the drug therapy issues specific to their environment. New methods of continuing education are being implemented and evaluated which are designed to improve the drug informatics and literature evaluation skills of community pharmacists and other practitioners providing pharmaceutical care. This Network also serves as a clinical clerkship experiential training site for students.

Development and evaluation of an international model for a drug information network. Co-investigator with Hazel Seaba, University of Iowa and Andrew Gilbert University of South Australia. The primary goal of the international drug information network is to assist pharmacists in their role of providing pharmaceutical care to patients by offering them DI support.

Other areas of exploration include contract formulary management for hospitals or other healthcare provider groups, participation in the development of disease management programs or evidence based clinical practice guidelines for use in disease management programs.

Professional Service (past five years)

Johnson County Pharmacists Association	Board of Trustees	7/98-7/00
Johnson County Pharmacists Association	Chair, elections committee	4/99
Iowa Pharmacists Association	Communications Committee	10/98-10/00
Truman Medical Center	Member, P&T Committee and consultant for new drug evaluation formulary management, DUE	8/92-12/95
VA Medical Center-Kansas City	Member, P&T Committee and consultant for new drug evaluation formulary management, DUE	8/92-12/95
State of Missouri Medicaid System	Ex-officio member DUR Board and drug information consultant	8/92-12/95
State of Missouri Medicaid System	Chair, Prior Authorizations Committee	9/94-12/95
American Society of Health-Systems Pharmacists	Manuscript review	
Annals of Pharmacotherapy	Manuscript review	
Hospital Pharmacy	Manuscript review	
ePocrates qRx	Contributing editor	
Micromedex Computerized Clinical Info. System	Assistant Editor	1/94-12/95
Marion Merrell Dow	Consultant, Pharmacoconomics Focus Group	6/93-12/95
Marion Merrell Dow	Consultant, Development of practice guidelines for treatment of hypertension and angina	8/94

Other Noteworthy Activities and Achievements

Participated in organizing and conducting marketing research and promotional activities in collaboration with the Iowa Pharmacists Association. Two programs were conducted via the Iowa Communications Network; October 15, 1997 12 Iowa pharmacists participated, July 21, 1998 45 Iowa pharmacists participated

Participate as an active member in The Consortium for the Advancement of Medication Information, Policy, and Research (CAMIPR). This Consortium is a national group of drug information leaders in practice and academics. The primary mission of this group is to define and secure the future of medication information specialty practice. The goals of the group include fostering inter- and intradisciplinary collaborative efforts for education growth, research and scholarly activity particularly in the areas of: outcomes management, medication use policy development, critical pathway and clinical practice guideline development, and use of technology for information management.

GRANTS/CONTRACTS AWARDED:

Co-investigator, WHO fellowship for specialized drug information training for FDA Commissioner from India, 1999

Co-investigator. WHO fellowship for specialized drug information training for two pharmacist from Malaysia, 1998

Co-investigator, develop and evaluate an international drug information network. Funding from University of Iowa/South Australia Transnational Alliance, 1998

Unrestricted Educational Grant, Astra, 1998

Unrestricted Educational Grant, Pharmacia Upjohn, 1997

Pharmaceutical Care Services for Identification and Management of Patients Who Will Benefit from Therapy for Helicobacter Pylori Eradication. Submitted to Tri Source Health Care/Blue Cross Blue Shield, Kansas City, Missouri, May 1995

Drug Information Service Contract. Truman Medical Center. Annual contract 1992, 1993, 1994, 1995.

Drug Information Service Contract. Veterans Administration Medical Center Kansas City. Annual contract 1992, 1993, 1994, 1995.

Drug Information Service Contract. State of Missouri Medicaid Program. Annual contract 1992, 1993, 1994, 1995.

Unrestricted Educational Grant, Eli Lilly, 1995.

Unrestricted Educational Grant, Marion Merrill Dow, Inc., 1995.

Unrestricted Educational Grant, Miles Pharmaceutical Co., 1993.

Unrestricted Educational Grant. Merck, Sharp & Dohme, 1993.

RALPH S. SMITH, JR., M.D.
CHARLESTON PSYCHIATRIC GROUP, INC.

EDUCATION

- 1963 Bachelor of Arts, West Virginia University, Major in Premedicine
- 1966 Doctor of Medicine, Northwestern University, Chicago, Illinois
- 1966-1967 Medical Internship, Evanston Hospital, Evanston, Illinois
- 1967-1969 Residency in General Psychiatry, University of Cincinnati Medical Center
- 1969-1971 Fellowship in Child Psychiatry, University of Cincinnati Medical Center
- 1976 Aerospace Medicine Primary, School of Aerospace Medicine, Brooks AFB, San Antonio, TX
- 1989 Master of Business Administration, University of Charleston, Charleston, WV
- 1994 Air War College, United States Air Force (Correspondence), Maxwell Air Force Base, AL

EXPERIENCE

- 1970-1971 Part-time practice of Adult and Child Psychiatry and Coordinator, Alcoholism Clinic of Cincinnati
- 1971 Staff Psychiatrist, Municipal Court Psychiatric Clinic, Cincinnati and Teaching Fellow in Child Psychiatry, University of Cincinnati Medical Center
- 1971-1974 Major, Medical Corps, United States Air Force Staff Psychiatrist, USAF Hospital Clark, Clark Air Base, Philippines
 Chief, Psychiatric Inpatient and Psychiatric Consultation Services
 Consultant, Child Guidance Clinic, DOD Schools, Clark AFB
 Presenter at monthly Premarriage Clinic, Clark AFB
 Consultant to Alice House (crisis center) and Hotline, Clark AFB
 Consultant in Psychiatry to 13th Air Force Staff Surgeon (Thailand and Taiwan)
 Director, Psychiatric Teaching Program for Philippine Military Psychiatrists and Philippine Resident Psychiatrists assigned to USAF Hospital Clark
- 1974-Present Private practice, Adult, Child and Forensic Psychiatry
- 1979-1981 Consultant, Gallia Meigs Mental Health Center, Gallipolis, Ohio, 8 hours weekly for staff and program development, inservice training, supervision and case consultation.
- 1981-1986 Medical Advisor - Bureau of Hearings and Appeals, Social Security Administration
- 1974 -1987 Commander, 130th TAC Clinic, West Virginia Air National Guard, Yeager Airport, Charleston WV
- 1987-1997 State Air Surgeon, Headquarters, West Virginia Air National Guard

- 1997-2001 Commander, West Virginia Air National Guard
- 1991-1992 Co-Medical Director, Parkside Recovery Units (Adult and Adolescent) at Charleston Area Medical Center, Charleston, WV
- 1991-1999 Health Care Advisory Panel, West Virginia Workers' Compensation Division, Chair 1995-1999
- 1992-1993 Interim Medical Director for Adolescent Psychiatric Services, Charleston Area Medical Center, Charleston, WV
- 1993-1994 Treating Psychiatrist, Forensic Unit, South Central Regional Jail, South Charleston, WV
- 1995-1997 Physician Advisor, Green Spring Health Service (now Magellan) on call service
- 1996-1998 Medical Director, West Virginia Bureau of Employment Programs, Workers' Compensation Division
- 1996-1999 Associate Medical Director, CareLink Health Services

APPOINTMENTS

- President, Charleston Psychiatric Group, Inc., Charleston, WV
- Assistant Adjutant General (Air), West Virginia National Guard
- Adjunct Professor, Department of Community Medicine, West Virginia University
- Associate Clinical Professor, Department of Behavioral Medicine & Psychiatry, West Virginia University, Charleston Division
- Active Medical Staff - Highland Hospital, Charleston, (Past President of Medical Staff).
- Active Medical Staff - Charleston Area Medical Center
- Consulting Medical Staff - Thomas Memorial Hospital, South Charleston
- Consulting Medical Staff - St. Francis Hospital, Charleston, WV
- Senior Aviation Medical Examiner, Federal Aviation Administration
- Psychiatric Examiner - West Virginia Division of Workers' Compensation

PROFESSIONAL ORGANIZATIONS

- American Medical Association
- West Virginia Medical Association
- The Kanawha Medical Society
- West Virginia Psychiatric Association (Past President)
- American Psychiatric Association
- American Academy of Psychiatry and the Law
- American Academy of Child and Adolescent Psychiatry
- National Guard Association of the United States
- National Guard Association of WV
- American Society of Addiction Medicine
- American Academy of Psychiatrists in Alcoholism and Addiction
- American Family Foundation

SCIENTIFIC ARTICLES

- "The Psychiatrically Impaired Injured Worker", Parts I & II, The West Virginia Medical Journal, Vol 75, No. 6 & 7, Jun and Jul 1979 pp 154 to 158 and 175 to 179
- "Psychiatric Impairment/Disability Evaluations Abstracts", 2nd Pacific Congress of Psychiatry APCS No. 3 Exerpta Medica, 1980.
- "The Use of Haloperidol in Alcoholism" in Haloperidol Update 1958-1980, edited by Frank J. Ayd, Jr., M.D., Ayd Medical Communications, Baltimore, 1980.
- "A Critical Appraisal of Amoxapine", with Frank J. Ayd, coauthor, The Journal of Clinical Psychiatry, Vol 42, No. 6, pp. 238-242, Jun, 1981.
- Letter to The Editor, JAMA Vol 266, No 13 pg 1773, Oct. 2, 1991, regarding "Maharishi Ayur-Veda: Modern Insights Into Ancient Medicine", by Sharma HM, Triguna BD, Chopra D
- "Identifying The Correctional Officer Under Stress: A Psychological Screening Test", with Smith, RL and Suppa, CH, in The Correctional Psychologist, Vol. 26, No. 1, pp. 8-10, Jan, 1994.
- "The Impact of Communication Apprehension and Fear of Talking with a Physician on Perceived Medical Outcomes", with Richmond VP, Heisel AM and McCroskey JC, in Communication Research Reports 15 No 4, pp 344-353, Fall 1998

RECENT PROFESSIONAL PRESENTATIONS

- "Cults and Mental Illness", lecture presented to Clinical Staff, Highland Hospital, Charleston, WV, Jan 29, 1990
- "Cults and Mental Illness", lecture presented to Clinical Staff, Department of Behavioral Medicine and Psychiatry, West Virginia University Medical Center, Charleston Division, Feb 22, 1990.
- "Forensic Child Psychiatry" presented at The Child Integrative Conference, WVU Department of Behavioral Medicine and Psychiatry, Charleston Division, May 31, 1990
- "Assessment and Evaluation of Competence", presented to the Psychology Assessment Seminar, West Virginia University, Department of Behavioral Medicine and Psychiatry, Jan 4, 1991.
- "Update on Psychiatric Treatment of Alcoholism" presented to Medical Staff, Highland Hospital, Charleston, WV, Jul 23, 1991
- "Diagnosis and Treatment of Alcoholism in the Medical and Surgical Patient", presented to Medical Staff, St. Francis Hospital, Charleston, WV, Aug 20, 1991
- "Cults: Therapeutic and Forensic Aspects", presented to The American Academy of Psychiatry and The Law Annual Meeting Oct 19, 1991, Orlando, FL

- "Psychiatric and Neurological Impairment", presented at "Facts in Litigation: Impairment Rating in Workers' Compensation - a workshop." Institute of Occupational Health and Safety, West Virginia University School of Medicine Health Sciences Center/Charleston Division, Oct 26, 1991
- "The Psychiatric Expert Witness", presented to the Department of Behavioral Medicine and Psychiatry, West Virginia University Medical Center Charleston Division, Jan 9, 1992
- "Please Take The Stand - Expert Advice For the Occasional Expert Witness in Court", presented at the Mid-Winter Clinical Conference, West Virginia State Medical Association, Radisson Hotel, Huntington, WV, Jan 26, 1992
- "Substance Abuse Workshop, presented to the Department of Behavioral Medicine and Psychiatry, WVU Med Center, Charleston Division Grand Rounds, Sep 17 and 18, 1992
- "Cults and Dentistry", presented to the Dental Study Group, Chesterfield House, Charleston, WV, Feb 11, 1993
- "Cults and Mental Health", presented to the Adult Service Network, Department of Human Service Bldg, Charleston, Aug 19, 1993
- "False Memory Syndrome: An Iatrogenic Disorder?" Panel Presentation with David Halperin, M.D., at The American Academy of Psychiatry and the Law 24th Annual Meeting, Oct 22, 1993, Palacio Del Rio Hotel, San Antonio, TX
- "Psychiatric and Psychological Injuries, at "Medicine for Layers" Seminar, WVU Building, Charleston, WV, May 13, 1994. Sponsored by the WV State Bar and WVU College of Law
- "West Virginia Psychiatric Impairment Guidelines" presented Nov 11, 1994, to Workers' Compensation, West Virginia Continuing Legal Education at WVU Medical Center, Charleston Division
- "Psychiatric Exam Guide" presented to Current Methods in Rating Impairments and Monitoring Treatment, Workers' Compensation Impairment Ratings Seminar Nov 12, 1994 at the WVU Education Building, Charleston, WV
- "Psychopharmacology for Psychologists" presented to West Virginia State Psychological Association, Oct 13, 1995, Pipestem State Park, WV
- Seminar Moderator and presenter of "Psychiatric Evaluation Guides" at the Current Methods in Rating Impairments and Monitoring Treatment Seminar, West Virginia University School of Medicine, Robert C. Byrd Health Sciences Center of WVU, Morgantown, Nov 11, 1995
- "Psychiatric Impairment in WV Workers' Compensation", presented at the Medical Training Seminar for Office of Judges for Workers' Compensation, John XXIII Pastoral Center, Charleston, Jan 26, 1996
- "Psychiatric Evaluation and Management, Independent Medical Examination by Psychiatrists for WV Workers' Compensation", presented to staff of Health Care Excellence, Charleston, WV Feb 21, 1996

- “Health Care Advisory Panel for WV Workers’ Compensation” and “The Psychiatric Evaluation Guides”, “Treatment Monitoring For Claims Management”, presented at the Current Methods in Rating Impairments and Monitoring Treatment Seminar, WV School of Osteopathic Medicine, Lewisburg WV, Mar 30, 1996
- “Impairment Rating of Mental and Behavioral Disorders and Chronic Pain (Chapters 14 & 15) presented to the AMA Guides (Fourth Edition) Update Course, American Academy of Disability Evaluating Physicians, The Westin Hotel, Cincinnati, OH, Jun 29, 1996
- “Update - WV Workers’ Compensation Medical System”, presented to the Tri-State Occupational Medicine Association Annual Scientific Meeting, Lakeview Resort, Morgantown, WV, Sep 28, 1996
- “WV Workers’ Compensation Guidelines For Back Exam, Chronic Pain Evaluation and Treatment, and Psychosocial Issues”, presented at the Second Annual Cost-effective Evaluation and Management of Lower Back Pain, West Virginia University School of Medicine, Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown, WV, Nov 1, 1996
- “Good News From Workers’ Compensation Fund”, presented to the 1996 General Practice Update, West Virginia Society of Osteopathic Medicine, Inc., The Greenbrier, White Sulfur Springs, WV, Nov 10, 1996
- “Psychiatric Impairment of the Workers’ Compensation Patient”, presented to the 1996 General Practice Update, West Virginia Society of Osteopathic Medicine, Inc., The Greenbrier, White Sulfur Springs, WV, Nov 10, 1996
- “Update on WV Workers’ Compensation Medical System”, presented to the WV State Medical Association Council, Headquarters Building, Charleston, Nov 17, 1996, Proclamation of support given and published in Wesgram Vol 12, No 12, Dec 1996.
- “Update on Workers’ Compensation Medical System and Psychosocial Factors with Chronic Pain: Getting People Back To Work.”, presented to the Hand Conference, Charleston Area Medical Center Sports Medicine Center, Charleston, WV, Jan 30, 1997
- “HCAP Guidelines and Other Medical Service Issues.”, presented to the 12th Annual Conference, The West Virginia Self-Insurers Association. Jun 3, 1997, Charleston Marriott
- “West Virginia Workers’ Compensation and Chiropractic Practice”, presented to the West Virginia Chiropractic Society Annual Meeting, Jun 21, 1997, Lakeview Resort and Conference Center, Morgantown, WV
- “Impairment Rating of Mental and Behavioral Disorders and Chronic Pain (Chapters 14 & 15) presented to the AMA Guides (Fourth Edition) Update Course, American Academy of Disability Evaluating Physicians, The Marriott Hotel, Lexington, KY, Jul 19, 1997
- “Update - West Virginia Workers’ Compensation Medical System,” presented at the 1997 Scientific Meeting of the Tri-State Occupational Medical Association, Marriott City Center, Pittsburgh, PA, Sep 13, 1997, “Occupational and Environmental Medicine: Learning from the Past, Looking Towards the Future”

- "Neuropsychiatric Testing and Evaluation," presented at the Clinical Training Program, American Academy of Disability Evaluating Physicians, Renaissance Hotel, Chicago, IL, Sep 16, 1997
- "Neuropsychiatric Testing in Impairment and Disability Medicine," presented at the Expanded Update in Disability Medicine and Certification Review Course of the American Academy of Disability Evaluating Physicians, Jan 29, 1998, Disney Institute, Lake Buena Vista, FL
- "The Impact of Communication Apprehension and Fear of Talking with a Physician on Perceived Medical Outcomes," co-author with Richmond VP, Heisel AM and McCroskey JC, presented to the Eastern Communication Association annual meeting, Marriott Hotel, Charleston, WV, May 1, 1999
- "Sex Offender Evaluations," presented to the Kanawha County WV Office of Public Defenders Feb 23, 2000
- "Sex Offender Evaluations," presented to the Cabell County WV Office of Public Defenders Mar 3, 2000
- "Psychiatric and Psychology Testing," presented to the Circuit Judges Education Conference, Marriott Hotel, Charleston, WV Dec 6, 2000

ACADEMIC COURSES TAUGHT

- 1971 "Introduction to Child Psychiatry", University of Cincinnati Medical Center
- 1972-1974 "Military Psychiatry", USAF Hospital Clark, Philippines
- 1977-1979 "Child Development, Normal and Pathological" WVU Medical Center, Charleston Division
- 1979-1982 "Assessment in Child Psychiatry" and Case Conference, weekly, WVU Medical Center, Charleston
- 1986 "Forensic Psychiatry", 8 presentations to Department of Behavioral Medicine & Psychiatry

CIVIC ACTIVITIES:

- 1978-1979 Governor's Advisory Committee to Revamp Mental Health Laws, West Virginia Department of Health
- 1986-1987 Protection and Advocacy Mental Health Advisory Board
- Mental Health Association of West Virginia Life Member
- 1976-present West Virginia National Guard Youth Leadership Camp Sponsor
- 1989-1996 Contact Person, State of WV, for Cult Awareness Network
- 1990-1991 Member, Board of Trustees, Highland Hospital
- 1997-present Military Awards Board, State of West Virginia (appointed)

CHARLES J. MILLIGAN, JR.
VICE PRESIDENT

EDUCATION

1990	M.P.H., University of California at Berkeley (with honors)
1986	J.D., Harvard Law School (with honors)
1983	B.B.A., University of Notre Dame (with honors)

EXPERIENCE

Mr. Milligan is a Vice President with The Lewin Group, where he has a Medicaid and S-CHIP consultation practice for state and federal government clients. His projects at Lewin have included designing Medicaid managed care programs, developing coverage expansions, counseling states on growing community-based care programs in light of the Olmstead decision, and performing a comprehensive audit of a Medicaid agency on behalf of a state legislature.

Previously Mr. Milligan was the State Medicaid and S-CHIP Director in New Mexico, where among other things he was responsible for implementing New Mexico's statewide risk-based Medicaid managed care program. He also chaired the HCFA Medicaid Managed Care National Technical Advisory Group until December 1999, and was a member of the HCFA Long Term Care Technical Advisory Group before that.

Mr. Milligan is an attorney, and prior to his role as Medicaid Director he was the General Counsel for the New Mexico Human Services Department, which included the Medicaid, welfare, food stamps, and child support enforcement programs. Before that he had a private sector health and elder law practice in California.

Selected examples of Mr. Milligan's work at Lewin include the following projects:

- On behalf of a state legislature, performed a comprehensive performance audit of a Medicaid agency, including reviewing the program's benefit design, cost sharing rules, eligibility process and administrative cost structure.
- Led a Gubernatorial Commission in redesigning the structure of a statewide capitated Medicaid managed care program.
- Developed a strategy for a state to expand its community-based care delivery system, in a budget neutral manner, in response to the Supreme Court's Olmstead decision.
- On behalf of a foundation, wrote an Issue Brief on a Medicaid coverage expansion for uninsured adults who do not have minor or dependent children.

PRIOR PROFESSIONAL EXPERIENCE

New Mexico Human Services Department (1/95 – 12/99)

State Medicaid Director (2/97–12/99). Chief responsibility for \$1.2 billion (annual) state Medicaid program, and chief responsibility for approved S-CHIP program expanding eligibility to 235% of the federal poverty level. Implemented statewide full-risk managed care, including children with special health care needs, SSI populations, Native Americans, and extensive integrated benefits (behavioral health, pharmacy, dental, transportation, vision).

Beginning August 1996, had project management oversight responsibility for managed care 1915(b) waiver development, procurements and contracting, policy and regulatory development, actuarial work, information system integration, and other activities to support managed care.

Also performed all other Medicaid Director duties, including oversight of long term care waivers, expansive outreach program for Medicaid-eligible children, outreach for eligible elders for QMB/SLMB, supervision of 200 member direct and indirect staff, planning for dual eligibles' long-term managed care, eligibility policy development, budget projections, provider fee setting and cost reporting procedures, fraud & abuse activities, and Department's primary Medicaid liaison with HCFA, state Legislature, Congressional delegation, advocacy organizations, provider groups, and media.

General Counsel (1/95–4/97)

Responsible for legal activities for state Medicaid, welfare, food stamps and child support enforcement agency. Supervised eight staff attorneys. Oversight responsibility for all Departmental contracting, procurements, regulatory matters, litigation defense, personnel matters, administrative fair hearings, and legislative review. For a period of three months, performed these duties in addition to Medicaid Director responsibilities.

Law Office of Charles Milligan (3/91–1/95)

Private health law practice, including Medicaid, Medicare, insurance advocacy, and nursing home rights.

McCutchen, Doyle, Brown & Enersen (12/87–8/89) (San Francisco, CA)

Health law practice, including Medicaid and Medicare reimbursement, managed care and insurance representation, financing, credentialing and staff privileges, contracting, fraud and abuse, licensure and accreditation, and 501(c)(3) tax-exemption matters.

Heller, Ehrman, White & McAuliffe (9/86–12/87; 8/89 – 2/91) (San Francisco, CA)

General civil litigation practice, including health care antitrust litigation.

OTHER RELEVANT EXPERIENCE

Chair, HCFA Medicaid Managed Care Technical Advisory Group (12/98-12/99)

Appointed as chair of task force of HCFA and State Medicaid officials regarding Medicaid managed care.

Chair, HCFA Medicaid UPL Task Force (6/99-12/99)

Appointed as Chair of Task Force of HCFA, State Medicaid officials, and industry leaders formed to make recommendations to HCFA on revisions to the Medicaid managed care "upper payment limit" regulation

Member, HCFA Long Term Care Technical Advisory Group (12/97-12/98)

Appointed by states and HCFA as member of HCFA LTC advisory group.

Steering Committee Member, National Medicaid/SCHIP Purchasing Institute (7/99-current)

One of 12 members of the Steering Committee of a Robert Wood Johnson/Center for Health Care Strategies funded Purchasing Institute to train senior state officials.

Board Member, National Health Law Program (1993-1998)

Board member of leading national law center for poverty health law issues.

Member, Alpha Center Focus Group on Best Practices in Public Health Care Purchasing (April 1998)

Member, HCFA Task Force to Determine Proper Approach to Enrolling Children with Special Health Care Needs in Medicaid Managed Care (6/99-12/99)

Member, Invitation-Only Panel on the Future of Federally-Qualified Health Centers in an Era of Medicaid Managed Care.

SELECTED PRESENTATIONS

Medicaid/CHIP Purchasing Institute (November 2000): Taught sessions at Center for Health Care Strategies Purchasing Institute on managing the pharmacy benefit in Medicaid, and on developing managed care programs for special needs populations.

Robert Wood Johnson Foundation (September 2000): Presentation at a national meeting on implementing the Olmstead decision. The topic is "Assessing the Community-Based Service Delivery System."

American Association of Health Plans (September 2000): Keynote speech at the annual conference on Medicaid managed care.

National Congress on Managed Medicare and Medicaid (June 2000): Presentations on two topics: controlling pharmacy expenditures in the health system, and predictions on the future of managed Medicaid.

American Public Human Services Association (April 2000): Presentation to state Medicaid, mental health, developmental disabilities and aging directors on the implications of the U.S. Supreme Court's Olmstead decision.

- Medicaid/CHIP Purchasing Institute (March 2000): Taught sessions at Center for Health Care Strategies Purchasing Institute on designing Medicaid managed care programs for special needs populations, and for populations in long term care.
- National Governors' Association (February 2000): Led national teleconference for the NGA on the implications of the U.S. Supreme Court's Olmstead decision.
- National Congress on Managed Medicare and Medicaid (February 2000): Presentation on best practices in the implementation of Medicaid managed care in rural areas.
- National Association of State Medicaid Directors (December 1999): Co-chair (with Roger Auerbach of Oregon) of a national conference on the implications of the U.S. Supreme Court's Olmstead decision. Led two sessions: the first on the legal context for future state decision-making, and the second leading attendees through a hypothetical state decision-making process.
- National Association of State Medicaid Directors Annual Fall Meeting (October 1999): Moderated session on best practices in Medicaid primary care case management programs.
- National Academy for State Health Policy Annual Meeting (August 1999): Presentation on the future of long term care, following the Supreme Court's Olmstead decision.
- AAHP Annual Meeting (June 1999): Presentation on sustaining managed care organization participation in Medicaid.
- National Association of State Medicaid Directors Annual Spring Meeting (June 1999): Presentation on HCFA's plans in managed Medicaid, including rates, grievances and appeals, and quality assurance.
- HCFA Managed Care Waiver Conference (May 1999): Keynote speech to HCFA central and regional office staff entitled "What States Need and Want from HCFA."
- HCFA Medicaid Managed Care Conference (February 1999): Keynote address on five pressure points that will determine the future of Medicaid managed care.
- HRSA/APHSA Public Health Collaborative (January 1999): Presentation on collaborative efforts between Medicaid and Public Health.
- AHLA Managed Care Law Institute (December 1998): Presentation to the American Health Lawyers Association on the legal issues of Medicaid managed care.
- National Association of State Medicaid Directors (October 1998): Presentation entitled "Best Practices in Medicaid Managed Care."
- 6th Annual Congress on Medicaid Managed Care (June 1998): Presentation on Best Practices in Quality Assurance Activities in Medicaid Managed Care.

TEACHING EXPERIENCE

University of California, Berkeley, School of Social Welfare (1994-1995).

Adjunct professor; taught "Law, Ethics and Aging" in M.S.W. program.

St. Mary's College of California (1993-1995)

Adjunct professor; taught "Health Law" in Master's degree program for health facility administration.



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