DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **02-18**

2. STATE: **NC**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447-201

7. FEDERAL BUDGET IMPACT:
a. FFY 03 ($ 23,037)
b. FFY 04 ($ 23,728)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Section 7, Page 5

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Section 7, Page 5

10. SUBJECT OF AMENDMENT:
Payments for Infusion Therapy services

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Not Required

12. SIGNATURE OF STATE AGENCY OFFICIAL: Carmen Hooker Odom

13. TYPED NAME: Carmen Hooker Odom

14. TITLE: Secretary

15. DATE SUBMITTED: December 23, 2002

16. RETURN TO:
Office of the Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 31, 2002

18. DATE APPROVED: March 25, 2003

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL: Rhonda R. Cottrell

21. TYPED NAME: Rhonda R. Cottrell

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

C. HOME INFUSION THERAPY

In-home parental and enteral therapies are reimbursed at the lower of billed customary charges or the comparable Medicare Part B allowable amount in effect as of February 1 of each year. If comparable Medicare fees are not available, fees will be based on average charges and updated each February 1 based on the forecast of the Gross National Produce Implicit Price Deflator. Notwithstanding any other provision, if specified these rates will be adjusted as shown on Attachment 4.19-B, Supplement 2, Page 1 of the state plan.

Payment for home IV drug therapies is made at 100 percent of the lesser of the actual charge or the applicable per diem fee schedule allowance. Drug prices will be established in accordance with the Pharmacy Plan in Section 12 of Attachment 4.19-B.