CHAPTER 39 - ADULT HEALTH

SUBCHAPTER 39A - CHRONIC DISEASE

SECTION .0200 - HOME HEALTH SERVICES

10A NCAC 39A .0201 GENERAL

~~The Home Health Services program is administered by the Health Care Section, Division of Adult Health, 1915 Mail Service Center, Raleigh, NC 27699-1915~~

Authority G.S. 130A-5(3); 130A-223.

10A NCAC 39A .0202 DEFINITIONS

~~The following definitions shall apply throughout this Section:~~

~~(1) "Home Health Services" means skilled nursing, home health aide, therapy, and medical social services and ancillary medical supplies and durable medical equipment provided to an essentially homebound patient at the patient's place of residence on physician's orders as a part of a written plan of care.~~

~~(2) "Home Health Agency" means a public, private non-profit or private proprietary home health agency certified by Medicaid and Medicare.~~

~~(3) "Program" means the Home Health Services Program.~~

~~(4) "Skilled Nursing Services" means skilled nursing services as defined in Home Health Medicaid Manual (HHMM) Section 5202.1 which is adopted by reference in accordance with G.S. 150B-14(c). Copies of the HHMM may be inspected at or obtained from the Home Health Services Program Office.~~

~~(5) "Home Health Aide Services" means home health aide services as defined in HHMM Section 5202.2 which is adopted by reference in accordance with G.S. 150B-14(c).~~

~~(6) "Therapy Services" means therapy services as defined in HHMM Section 5202.3 which is adopted by reference in accordance with G.S. 150B-14(c).~~

~~(7) "Medical Social Services" means medical social services as defined in HCFA – Pub. 11 Section 206.1 which is adopted by reference in accordance with G.S. 150B-14(c). Copies of the definition may be inspected at or obtained from the Home Health Services Program Office.~~

~~(8) "Durable Medical Equipment (DME)" means durable medical equipment as defined in HHMM Section 5202.5 which is adopted by reference in accordance with G.S. 150B-14(c). Copies may be inspected at or obtained from the Home Health Services Program Office.~~

~~(9) "Medical Supplies" means medical supplies as defined in HHMM 5202.4 which is adopted by reference in accordance with G.S. 150B-14(c).~~

~~(10) "Program Reimbursement Rate" means the:~~

~~(a) Medicaid maximum for nursing services, home health aide services, therapy services, durable medical equipment, and ancillary medical supplies; and~~

~~(b) Interim Medicare rate for medical social services.~~

~~(11) "Third party payor" means any person or entity that is or may be indirectly liable for the cost of service furnished to a patient. Third party payors include, without limitation, Medicaid, Medicare, private insurance, Veterans Administration, Children's Special Health Services and Workers Compensation.~~

Authority G.S. 130A-223.

10A NCAC 39A .0203 REIMBURSEMENT FUNDS

~~(a) The Home Health Services Program may provide reimbursement funds to home health agencies to pay for home health services they provide to eligible patients.~~

~~(b) Application for reimbursement funds shall be made to the program and shall include the following information in a format specified by the HHSP:~~

~~(1) a written plan which includes agency background, counties agency serves, services provided, and referral sources;~~

~~(2) a list of the agency's charges, a copy of the most recently filed Medicare cost report;~~

~~(3) a statement concerning the agency's efforts to serve patients who are unable to pay for services.~~

~~(c) The program will allocate reimbursement funds according to community needs and performance records of the respective home health agencies, and contracts will be signed with agencies approved by the program. The program will consult with the North Carolina Association for Home Care and other providers in developing an allocation formula. This allocation formula will establish a maximum amount that each home health agency may be reimbursed.~~

~~(d) In order to maximize the utilization of the reimbursement funds, in the event the agency is being reimbursed at a rate which will, if continued, result in an underexpenditure of funds at the end of the contract period, the program may reduce the amount of funds budgeted by an amount consistent with the projected level of underexpenditure. Funds projected to be unexpended may be reallocated to home health agencies in accordance with community needs and performance records. The program shall notify the agency in writing prior to any reduction of funds.~~

(e) Contracts for reimbursement funds are subject to annual renewal and are subject to the availability of funds.

Authority G.S. 130A-223.

10A NCAC 39A .0204 PATIENT FINANCIAL ELIGIBILITY

(a) Home Health Services program reimbursement funds shall be used to pay for services provided to financially eligible patients. Financial eligibility shall be determined by the home health agency by a signed declaration of gross income and family size by the patient or a person responsible for the patient. A patient whose gross family income is 125 percent or less of Federal Poverty Guidelines shall be financially eligible for full coverage under the program. A patient whose gross family income is between 125 percent and 200 percent of Federal Poverty Guidelines shall be eligible for partial coverage as defined in Rule .0211(b) of this Section under the program. A patient whose gross family income is 200 percent or more of Federal Poverty Guidelines is not eligible for coverage under the program. The Federal Poverty Guidelines are adopted by reference in accordance with G.S. 150B-14(c). Copies of the Federal Poverty Guidelines may be inspected at or obtained from the Home Health Services Program.

(b) Once a patient is determined to be financially eligible, that eligibility shall continue for the duration of the physician's plan or care for the patient, up to a maximum of one year.

(c) The home health agency shall document each financial eligibility determination on a form provided by the program.

(d) The home health agency is authorized to require substantiating documentation when making financial eligibility determinations.

Authority G.S. 130A-5(3); 130A-223.

10A NCAC 39A .0205 COVERED SERVICES

Home Health Services program reimbursement funds shall be used to pay for the provision of home health services under a physician's plan of care to eligible patients.

Authority G.S. 130A-5(3); 130A-223.

10A NCAC 39A .0206 BILLING THE PROGRAM

(a) If a patient's gross family income is 125 percent or less of Federal Poverty Guidelines, the home health agency may bill the HHSP the Program Reimbursement Rate [Rule .0202(10)]. The agency shall not bill a patient in this income category.

(b) If a patient's gross family income is between 125 percent and 200 percent of Federal Poverty Guidelines, the home health agency may bill the program as follows:

(1) 85 percent of the Program Reimbursement Rate if the patient's gross family income is between or includes 126 percent and 140 percent of Federal Poverty Guidelines. The patient is responsible for the remaining 15 percent of the Program Reimbursement Rate;

(2) 70 percent of the Program Reimbursement Rate if the patient's gross family income is between or includes 141 percent and 155 percent of Federal Poverty Guidelines. The patient is responsible for the remaining 30 percent of the Program Reimbursement Rate;

(3) 55 percent of the Program Reimbursement Rate if the patient's gross family income is between or includes 156 percent and 170 percent of Federal Poverty Guidelines. The patient is responsible for the remaining 45 percent of Program Reimbursement Rate;

(4) 40 percent of the Program Reimbursement Rate if the patient's gross family income is between or includes 171 percent and 185 percent of Federal Poverty Guidelines. The patient is responsible for the remaining 60 percent of the Program Reimbursement Rate;

(5) 25 percent of the Program Reimbursement Rate if the patient's gross family income is between or includes 186 percent and 199 percent of Federal Poverty Guidelines. The patient is responsible for the remaining 75 percent of the Program Reimbursement Rate; or

(6) in the case of agencies with nominal fee provider status, if a patient's gross family income is between 125 and 200 percent of Federal Poverty Guidelines, the home health agency may bill the program at the agency's usual and customary charge.

Authority G.S. 130A-5(3); 130A-223.

10A NCAC 39A .0207 RATES OF REIMBURSEMENT

(a) Home health agencies that contract for reimbursement funds shall be reimbursed for home health services provided to eligible patients in an amount and percentage based on the Program Reimbursement Rate in effect at the time service is rendered, as specified in Rule .0202(10) of this Section.

(b) In the case of agencies with nominal fee provider status, if the patient is otherwise eligible and has any third party coverage, the agency shall not charge any of the cost of their care to HHSP.

(c) Claims for reimbursement from the Home Health Services Program must be documented and reported on a quarterly basis on a form provided by the program. No claims for reimbursement will be accepted by the program more than 180 days after the date of delivery of services. If after charging the program, the agency receives payment from the patient or other third party that would result

in the agency receiving more than the Program Reimbursement Rate, the agency shall reimburse the program the difference between the total amount reimbursed from all sources and the Program Reimbursement Rate.

Authority G.S. 130A-5(3); 130A-223.

10A NCAC 39A .0208 REIMBURSEMENT FUNDS: THIRD PARTY PAYORS

Home Health Services program reimbursement funds shall be used to pay for services not reimbursed by a third party payor. A home health agency must take reasonable measures to determine and subsequently collect the full legal liability of third party payors to pay for services reimbursed by the program before requesting payment from the HHSP.

Authority G.S. 130A-5(3); 130A-223.

10A NCAC 39A .0209 MONITORING

Each home health agency receiving reimbursement funds shall submit the following information in a form as prescribed by the program:

(1) Home Health Services Program Quarterly Report;
(2) Quarterly Expenditure Report; and
(3) Other information requested by the program necessary for the effective administration of the program.

Authority G.S. 130A-223;

10A NCAC 39A .0210 AUDITS

Agency financial and statistical records, patient records, and any other pertinent information may be audited by the state as part of the overall monitoring and evaluation effort.

Authority G.S. 130A-5(3); 130A-223.

10A NCAC 39A .0211 SPECIAL PROVISION

(a) Notwithstanding Rules .0203 and .0205 of this Section, Home Health Services Program funds may be used to pay for the provision of in home health care services, as defined in 10A NCAC 39A .0701, when such services are provided by a certified home health agency which participates in the Health Care Services in the Home Demonstration Program codified at 10A NCAC 39A .0700.
(b) Home Health Services Program funds may be used by certified home health agencies which participate in the Health Care Services in the Home Demonstration Program to meet the matching fund requirements imposed by 10A NCAC 39A .0711(a).

Authority G.S. 130A-5(3); 130A-223.

SECTION .0800 - HOME AND COMMUNITY-BASED HIV HEALTH SERVICES PROGRAM

10A NCAC 39A .0801 GENERAL

The Home and Community-based HIV Health Services Program is administered by the Division of Public Health, 1915 Mail Service Center, Raleigh, NC 27699-1915

Authority G.S. 130A-223.

10A NCAC 39A .0802 DEFINITIONS

The following definitions shall apply throughout this Section:

(1) "Home and Community-based HIV Health Services" means durable medical equipment, home health aide, services, personal care services, day treatment or other partial hospitalization, home intravenous (I.V.) therapy (including prescription drugs administered intravenously) and routine diagnostic services provided to an eligible patient in the patient's home according to a written plan of care established by a health care professional.
(2) "HIV Health Services Program" means the Home and Community-based HIV Health Services Program.
(3) "Durable Medical Equipment (DME)" means durable medical equipment as defined in HHMM Section 5202.5 which is adopted by reference in accordance with G.S. 150B-14(c). Copies of the HHMM may be inspected at or obtained from the HIV Health Services Program.
(4) "Home Health Aide Services" means home health aide services as defined in HHMM Section 5502.2 which is adopted by reference in accordance with G.S. 150B-14(c). Copies of the HHMM may be inspected at or obtained from the HIV Health Services Program.
(5) "Personal Care Services" means personal care services as defined in the Medicaid Provider Manual which is adopted by reference in accordance with G.S. 150B-14(c). Copies of the Medicaid Provider Manual may be inspected at or obtained from the HIV Health Services Program.
(6) "HIV Health Services Program Reimbursement Rate" is:

(a) the local health department rate or the maximum Medicaid rate, whichever is lower, for home health aide services and personal care services;

(b) interim Medicare rate for durable medical equipment; and

(c) schedule of payments that shall be developed by the Division of Public Health for Home Intravenous (I.V.) therapy services, routine diagnostic services, day treatment or partial hospitalization and other services for which neither Medicaid nor Medicare has an established rate.

(7) "Third Party Payor" is any person or entity that is or may be indirectly liable for the cost of service furnished to a patient. Third party payors include, without limitation, Medicaid, Medicare, and private insurance, Veterans Administration, Children's Special Health Services and Workers' Compensation.

(8) "Medically dependent" means a patient has been certified by a physician as:

(a) requiring the routine use of appropriate medical services (which may include home intravenous drug therapy) to prevent or compensate for the individual's serious deterioration of physical health or cognitive function, arising from infection with the etiologic agent for acquired immune deficiency syndrome; and

(b) being able to avoid long-term or repeated care as an inpatient or resident in a hospital, nursing facility, or other institution if home and community-based health services are provided to the individual.

(9) "Chronically dependent" means a patient has been certified by a physician as:

(a) being unable to perform, without substantial assistance from another individual, at least two activities of daily living because of physical or cognitive impairment arising from infection with the etiologic agent for acquired immune deficiency syndrome. Activities of daily living include bathing, dressing, toileting, moving from seat to bed or bed to seat, and eating; or

(b) having a level of disability due to cognitive impairment equivalent to the level of disability for impairments under Paragraph (9)(a) of this Rule.

Authority G.S. 130A-223.

10A NCAC 39A .0803 ELIGIBLE PROVIDERS

The HIV Health Services Program may contract with local health departments and other public and private organizations, institutions, and agencies in order to carry out the purposes of the Program. Only local health departments shall be eligible to contract for HIV Health Services Program reimbursement funds.

Authority G.S. 130A-223;

10A NCAC 39A .0804 FINANCIAL ELIGIBILITY

(a) HIV Health Services Program reimbursement funds shall be used to pay for home and community based HIV health services provided to financially eligible patients. Financial eligibility shall be determined by the local health department by a signed declaration of gross income and family size by the patient or a person responsible for the patient. A patient whose gross family income is 125 percent or less of Federal Poverty Guidelines shall be financially eligible for full coverage under the program. A patient whose gross family income is between 125 percent and 199 percent of Federal Poverty Guidelines shall be eligible for partial coverage as described in Rule .0806 of this Section under the program. A patient whose gross family income is 200 percent or more of Federal Poverty Guidelines is not eligible for coverage under the program. Copies of the Federal Poverty Guidelines may be inspected at or obtained from the HIV Health Services Program.

(b) Once a patient is determined to be financially eligible, that eligibility shall continue for the duration of the plan of care for the patient, up to a maximum of one year.

(c) The local health department shall document each financial eligibility determination on a form provided by the HIV Health Services Program.

(d) The local health department is authorized to require substantiating documentation when making financial eligibility determinations.

Authority G.S. 130A-223.

10A NCAC 39A .0805 MEDICAL ELIGIBILITY

A person who is certified by a physician to be HIV+ and medically or chronically dependent and who is in need of home and community-based HIV health services is eligible for services under this program.

Authority G.S. 130A-223.

10A NCAC 39A .0806 BILLING THE HIV HEALTH SERVICES PROGRAM

(a) If a patient's gross family income is 125 percent or less of Federal Poverty Guidelines, the local health department may bill the HIV Health Services Program Reimbursement Rate (Rule .0802). The local health department may not bill a patient in this income category.

(b) If a patient's gross family income is between 126 percent and 199 percent of Federal Poverty Guidelines, the local health department may bill the program as follows:

(1) 85 percent of the HIV Health Services Program Reimbursement Rate if the patient's gross family income is between or includes 126 percent and 140 percent of Federal Poverty Guidelines;
(2) 70 percent of the HIV Health Services Program Reimbursement Rate if the patient's gross family income is between or includes 141 percent and 155 percent of Federal Poverty Guidelines;
(3) 55 percent of the HIV Health Services Program Reimbursement Rate if the patient's gross family income is between or includes 156 percent and 170 percent of Federal Poverty Guidelines;
(4) 40 percent of the HIV Health Services Program Reimbursement Rate if the patient's gross family income is between or includes 171 percent and 185 percent of Federal Poverty Guidelines; or
(5) 25 percent of the HIV Health Services Program Reimbursement Rate if the patient's gross family income is between or includes 186 percent and 199 percent of Federal Poverty Guidelines.

Authority G.S. 130A-223.

10A NCAC 39A .0807 RATES OF REIMBURSEMENT

(a) Local health departments that contract for reimbursement funds shall be reimbursed for home and community based HIV health services provided to eligible patients in an amount and percentage based on the HIV Health Services Program Reimbursement Rate in effect at the time service is rendered, as specified in Rule .0802 of this Section.

(b) Claims for reimbursement from HIV Health Services Program must be documented and reported on a quarterly basis on a form provided by the program. No claims for reimbursement will be accepted by the HIV Health Services Program more than 180 days after the date of delivery of services. If after charging the program, the agency receives payment from the patient or other third party that would result in the local health department receiving more than the HIV Health Services Program Reimbursement Rate, the local health department shall reimburse the program the difference between the total amount reimbursed from all sources and the HIV Health Services Program Reimbursement Rate.

Authority G.S. 130A-223.

10A NCAC 39A .0808 REIMBURSEMENT FUNDS: THIRD PARTY PAYORS

HIV Health Services Program reimbursement funds shall be used to pay for services not reimbursed by a third party payor. A contracting local health department must take reasonable measures to determine and subsequently collect the full legal liability of third party payors to pay for services reimbursed by the program before requesting payment from the HIV Health Services Program.

Authority G.S. 130A-223.

10A NCAC 39A .0809 MONITORING

Each local health department receiving reimbursement funds shall submit the following information in a form as prescribed by and in the time frames established in the contract:

(1) HIV Health Services Program quarterly report;
(2) HIV Health Services Program annual report;
(3) Quarterly expenditure report;
(4) Report the fairly evaluated cost of unreimbursed care provided to patients eligible for the HIV Health Services Program; and
(5) Other information necessary for the effective administration of the HIV Health Services Program.

Authority G.S. 130A-223.

10A NCAC 39A .0810 AUDITS

Local health department financial and statistical records, patient records, and any other pertinent information may be audited by the state as part of the overall monitoring and evaluation effort.

Authority G.S. 130A-223.

CHAPTER 40 - DENTAL HEALTH

SUBCHAPTER 40A – SCHOOL WATER FLUORIDATION

SECTION .0100 - PURPOSE

10A NCAC 40A .0104 SCHOOL FLUORIDATION INFORMATION

Information outlining the procedures for instituting a school fluoridation program is available from the Division of Public Health, 1915 Mail Service Center, Raleigh, North Carolina 27699-1915.

Authority G.S. 130A-366.

10A NCAC 40A .0105 DEFINITIONS

~~Throughout this Subchapter, "School" means an institution providing education for children in counties and towns in North Carolina.~~

Authority G.S. 130A-366.

SECTION .0200 - ELIGIBILITY

10A NCAC 40A .0206 WATER SUPPLY

~~(a) To be eligible for the school fluoridation program, the school shall have its own, separate water supply.~~

~~(b) To be eligible for the school fluoridation program, the school shall be the sole user of the fluoridated portion of the water supply. Users other than the school may use the school water system if they are not connected to the fluoridated portion of the system.~~

Authority G.S. 130A-366.

10A NCAC 40A .0207 INSPECTION

~~To be eligible for the school fluoridation program, the school's water system must be inspected by the Division of Public Health.~~

Authority G.S. 130A-366.

~~**10A NCAC 40A .0208 APPLICATION AND APPROVAL**~~

~~(a) To be eligible for the school fluoridation program, the local board of education must request permission from the Division of Public Health to fluoridate the water supplies of specific schools.~~

~~(b) The following information shall be included in the application submitted by the school and shall be used in evaluating the school for final approval to participate in the school fluoridation program:~~

- ~~(1) location of the school;~~
- ~~(2) proximity to existing service areas;~~
- ~~(3) number of children enrolled in the school;~~
- ~~(4) the percentage of children enrolled in the school whose primary residence has a fluoridated water source;~~
- ~~(5) the report of the Division of Public Health's inspection;~~
- ~~(6) formal approval of fluoridation of the schools by the local board of education; and~~
- ~~(7) formal approval of fluoridation of the schools by the local board of health.~~

~~(c) The Division of Public Health shall provide staff to assist local boards of education in completing applications for school water fluoridation.~~

~~(d) All approvals for school water fluoridation are subject to the availability of funds.~~

Authority G.S. 130A-366.

SECTION .0300 - ADMINISTRATION

10A NCAC 40A .0306 NOTIFICATION

~~(a) The local health director, with assistance from the regional dentist supervisor, shall notify local physicians, dentists, and pharmacists when individual schools institute fluoridation.~~

~~(b) The local health director shall inform new physicians, dentists and pharmacists of school water fluoridation programs in their practice community.~~

~~(c) The principals of affected schools, with assistance from the regional dental supervisor, shall notify the parents of all students enrolled in the participating schools of the presence of school water fluoridation.~~

Authority G.S. 130A-366.

10A NCAC 40A .0307 RENOVATION

~~(a) The local board of education shall modify the school water system under the supervision of the Division of Public Health to meet the standards necessary for installation and maintenance of the fluoridation equipment.~~

~~(b) The local board of education shall provide the necessary labor, materials, and equipment required for the proper installation of the fluoridation equipment.~~

~~(c) The fluoridation equipment shall not be disconnected or removed without prior approval of the Division of Public Health.~~

~~(d) The Division of Public Health shall be notified before any construction, modification or repair to any part of the school water system is undertaken.~~

Authority G.S. 130A-366.

10A NCAC 40A .0308 EQUIPMENT AND MAINTENANCE

(a) The Division shall furnish the fluoridation equipment, chemicals, and the laboratory equipment, and replacement fluoridation equipment and chemicals to the school system.
(b) The Division shall provide required maintenance services to the school fluoridation system.
(c) The local board of education shall provide required replacement parts and chemicals if there is willful neglect or destruction of the fluoridation equipment.

Authority G.S. 130A-366.

10A NCAC 40A .0309 TRAINING
The local school principal shall designate and the Division shall train two persons from each school to be responsible for performing surveillance in accordance with instructions set forth in Rule .0310 of this Section.

Authority G.S. 130A-366.

10A NCAC 40A .0310 SURVEILLANCE
(a) Water samples shall be collected by school personnel and analyzed for fluoride content daily before the students arrive and water consumption begins.
(b) A split water sample shall be collected on Monday and Thursday of each week. One-half of the split sample shall be analyzed by school personnel in the manner prescribed by the Division. The other half of the split sample and the results of the school analysis shall be mailed to the Division of Public Health, 1915 Mail Service Center, Raleigh, North Carolina 27699-1915. If a school is closed on the preceding Monday or Thursday because of holidays, snow days, or other closures, a split water sample shall be collected on the next day that the school reopens.
(c) The Division shall be responsible for the cost of mailing the required water samples to the Division of Public Health.
(d) Irregularities of fluoride content in the water or of the fluoride feeding equipment shall be reported immediately by phone to the Division if the water sample reading is below 4.5 parts per million or above 6.5 parts per million.

Authority G.S. 130A-366.

SECTION .0400 - FORMS

10A NCAC 40A .0403 SCHOOL FLUORIDATION AGREEMENT
(a) The Division is authorized to maintain a school fluoridation agreement with the local county board of education for the purpose of maintaining a school water fluoridation system.
(b) Noncompliance with the requirements of the agreement may result in termination of the agreement and removal of the school fluoridation equipment.
(c) The agreement form is available from the Division.

Authority G.S. 130A-366.

10A NCAC 40A .0404 WATER ANALYSIS FORM
The schools submitting water samples for analysis to the State Laboratory of Public Health, 1918 Mail Service Center, Raleigh, NC 27699-1918, shall complete the required Water Analysis Form. Forms are available from the Division of Laboratory Services at the aforementioned address.

Authority G.S. 130A-366.

CHAPTER 41 – HEALTH: EPIDEMIOLOGY

SUBCHAPTER 41A – COMMUNICABLE DISEASE CONTROL

SECTION .0500 - PURCHASE AND DISTRIBUTION OF VACCINE

10A NCAC 41A .0502 VACCINE FOR PROVIDERS OTHER THAN LOCAL HEALTH DEPARTMENTS
(a) The Division of Public Health shall provide vaccines required by law free of charge to the following providers for administration to individuals who need vaccines to meet the requirement of G.S. 130A-152, 130-155.1 and 10A NCAC 41A .0401:
(1) Community, migrant, and rural health centers;
(2) Colleges and universities for students; and
(3) Physicians and other health care providers.
(b) Upon request of the Division, required vaccines may be distributed by local health departments operating as agents of the State to providers listed in Subparagraphs (a)(1), (2) and (3) of this Rule.
(c) Providers authorized in Paragraph (a) of this Rule shall receive free vaccines from the Division only if they sign an agreement with the Division. This agreement shall be prepared by the Division of Public Health and shall require the provider to:

(1) Charge vaccine administration fees at no more than the rates established by the State's Medicaid program. The State's Medicaid rates may be inspected at the Division of Public Health. Copies may also be obtained from the Division of Public Health at no charge;
(2) Provide all vaccines needed during a visit unless a specific contraindication exists to one or more of the vaccine;
(3) Charge no office fee in addition to an administration fee for an immunization only visit;
(4) Agree not to charge an administration fee to an individual who states that he/she is unable to pay;
(5) Impose no condition as a prerequisite to receiving vaccine;
(6) Submit a monthly doses administered report by the tenth of each month electronically through the North Carolina Immunization Registry or on a form provided by the Immunization Section;
(7) Report adverse vaccine reactions through the Vaccine Adverse Event Reporting System (VAERS);
(8) Provide the latest edition of the applicable Important Information Statement (IIS), or Vaccine Information Statement (VIS) to the parent, guardian, or person standing in loco parentis for each dose of vaccine administered; document this action within the patient's permanent medical record; retain the documentation for a period of 10 years following the end of the calendar year in which the vaccine dose was administered, or for 10 years following the recipient's age of majority, whichever is longer; upon request, furnish copies of the documentation to the local health department or the Division; and keep a record of the vaccine manufacturer, lot number, and date of administration for each dose of vaccine administered;
(9) Allow periodic inspection of their vaccine supplies and records by the Division of Public Health; and
(10) Comply with the rules of this Section.

(d) A provider who fails to submit timely and accurate reports as required each month shall have vaccine shipments withheld until that month's report is received by the Immunization Section.

Authority G.S. 130A-433.

SUBCHAPTER 41G - VETERINARY PUBLIC HEALTH

SECTION .0100 - VETERINARY PUBLIC HEALTH PROGRAM

10A NCAC 41G .0102 FEES FOR RABIES TAGS, LINKS, AND RIVETS

(a) The Division of Epidemiology shall charge a fee to be paid by veterinarians or local health departments for the provision of rabies tags, links, and rivets. This fee shall be determined on the basis of actual cost plus transportation, and an additional five cents ($.05) per tag to be used to fund rabies education and prevention programs.

(b) The Division of Epidemiology shall charge a fee to be paid by veterinarians or local health departments for the provision of I Care rabies tags. This fee shall be determined on the basis of actual cost plus transportation, an additional five cents ($.05) per tag to be used to fund rabies education and prevention programs plus an additional fifty cents ($0.50) per tag. The fifty cents ($0.50) fee per tag shall be credited to the Spay/Neuter fund established in G.S. 19A-62.

Authority G.S. 130A-190.

CHAPTER 43 – PERSONAL HEALTH

SUBCHAPTER 43D – WIC/NUTRITION

SECTION .1200 - MATERNAL AND CHILD HEALTH BLOCK GRANT NUTRITION PROGRAM

10A NCAC 43D .1201 GENERAL

The Maternal and Child Health Block Grant Nutrition Program is administered by the Division of Public Health, 1915 Mail Service Center, Raleigh, North Carolina 27699-1915.

Authority G.S. 130A-361.

10A NCAC 43D .1202 PROVIDER ELIGIBILITY

Local health departments are eligible to receive Maternal and Child Health Block Grant Nutrition Program funds from the Division. All providers that contract for the receipt of MCH Block Grant Nutrition Program funds are required to provide services in accordance with rules of this Section.

Authority G.S. 130A-361.

10A NCAC 43D .1203 ALLOCATION OF FUNDS

Maternal and Child Health Block Grant Nutrition Program funds for nutrition services are allocated to local health departments on an annual basis and are subject to periodic review and redistribution. Expansion of program services is based on availability of funding and requests from local health departments.

Authority G.S. 130A-361.

10A NCAC 43D .1204 CLIENT ELIGIBILITY

~~In order to be eligible for Maternal and Child Health Block Grant Nutrition Program services, a person must be in the maternal and child health population, ineligible for WIC Program services, and have one or more of the following medical/nutritional risk indicators: cardiovascular disease; anthropometic problem (overweight, underweight, growth failure); metabolic disorder; previous poor pregnancy outcome; immunological condition; or other significant nutritional stress as determined by the primary medical care provider. Categorical and medical/nutritional eligibility must be documented in the client's health record.~~

Authority G.S. 130A-361.

10A NCAC 43D .1205 SCOPE OF SERVICES

~~Maternal and Child Health Block Grant funds shall be used to reimburse for nutrition services provided to eligible individuals. Required services include:~~

~~(1) a complete nutritional assessment of appropriate anthropometric, biochemical, clinical, eco social, and dietary indicators; and~~

~~(2) a plan of care based on the individual's nutritional needs; and~~

~~(3) an individual counseling session.~~

Authority G.S. 130A-361.

10A NCAC 43D .1206 SERVICE PROVIDER QUALIFICATIONS

~~Maternal and Child Health Block Grant nutrition services must be provided by a Registered Dietitian, registered with the Commission on Dietetic Registration; or a Licensed Dietitian/Nutritionist, licensed by the North Carolina Board of Dietetic/Nutrition; or a Registry Eligible Dietitian (i.e., an individual who has a statement from the Commission on Dietetic Registration saying he is registry eligible; that is, eligible to sit for the examination to become a Registered Dietitian).~~

Authority G.S. 130A-361.

10A NCAC 43D .1207 PAYMENT FOR REIMBURSABLE SERVICES

~~(a) Payments shall not be made for services which are available from the WIC Program.~~

~~(b) Maternal and Child Health Block Grant funds for nutrition services are reimbursable at a rate of thirty-five dollars ($35.00) per hour.~~

~~(c) Billable time is limited to activities necessary to:~~

~~(1) perform a nutritional assessment;~~

~~(2) counsel a patient individually (not including telephone counseling);~~

~~(3) teach a class (based on class time, not on number of participants);~~

~~(4) travel to home, school, or day care to do an individual or class session;~~

~~(5) document nutrition care provided in the health record;~~

~~(6) prepare for an individual counseling session or class; or~~

~~(7) make referrals, seek information from other health professionals, or write letters or make telephone calls to primary health care providers.~~

Authority G.S. 130A-361.

SUBCHAPTER 43E - CHILD HEALTH

SECTION .0300 - PEDIATRIC PRIMARY CARE PROGRAM

10A NCAC 43E .0301 GENERAL

~~The Pediatric Primary Care Program is administered by the Division of Public Health, 1915 Mail Service Center, Raleigh, North Carolina 27699-1915.~~

Authority G.S. 130A-124.

10A NCAC 43E .0302 DEFINITIONS

~~The definitions in 10A NCAC 43B .0103 shall apply throughout this Section.~~

Authority G.S. 130A-124.

10A NCAC 43E .0303 PROVIDER ELIGIBILITY

(a) Local health departments are eligible to receive pediatric primary care funds from the Division.
(b) Pediatric primary care funds may be awarded to any public or private nonprofit agency if the Division determines that a local health department is unwilling or unable to provide pediatric primary care services. All providers which contract for the receipt of pediatric primary care funds are required to provide services in accordance with the plan submitted under Rule .0305 of this Section and approved by the Division.

Authority G.S. 130A-124.

10A NCAC 43E .0304 CLIENT ELIGIBILITY

To be eligible for pediatric primary care services provided by pediatric primary care program funds, clients must meet the eligibility criteria established by the local provider. Financial eligibility requirements may not be more restrictive than the official poverty line issued annually by the United States Department of Health and Human Services.

Authority G.S. 130A-124.

10A NCAC 43E .0305 APPLICATION FOR FUNDS: PROGRAM PLAN: RENEWAL

(a) Grants for pediatric primary care funds shall be awarded through a request for proposal (RFP) process that includes notification of all local providers of the eligibility criteria and requirements for funding.
(b) Grant proposals for pediatric primary care project funds shall be sent to the Division of Public Health, 1915 Mail Service Center, Raleigh, North Carolina 27699-1915. The grant proposal shall include the following:

(1) A definition of the target population to be served, including a description of patient eligibility requirements.
(2) A description of quantifiable program objectives, strategies for meeting these objectives, and methods for measuring their accomplishment.
(3) A description of the medical services to be provided by the local provider including weekly clinic hours when pediatric primary care services will be made available. The plan shall specify, at a minimum, that pediatric primary care will be available at least four hours per day during regular workdays, and that all patients within the target population who present themselves during established clinic hours with symptoms or complaints requiring medical care will have a medical history taken, an appropriate examination, a written diagnosis of identified problem(s), treatment for a variety of medical conditions and referral as indicated.
(4) A description of the laboratory services which will be provided, or contracted for, by the local provider. The plan shall specify at a minimum that the local provider will provide or contract for basic laboratory services essential to the immediate diagnosis and treatment of the patients as medically indicated.
(5) A description of the backup services available for patients in need of care when the pediatric primary care clinic is not in operation.
(6) A description of the staff to be utilized in the Pediatric Primary Care Program, including duties of the staff.
(7) A description of how pediatric primary care services will be integrated with other services provided by the local provider for children in order to ensure a smooth blending of resources.
(8) A description of the quality assurance program to be utilized. The quality assurance program must contain at a minimum medical reviews and an annual program evaluation. Physicians serving as medical supervisors shall participate in the medical review.

(c) Technical assistance in preparing an application for pediatric primary care funds shall be available from central and regional Division of Public Health staff.
(d) The Division shall approve or deny an application for funds or request additional information within 60 days after receipt of an application. If additional information is requested, the local provider shall have 45 days to submit the information. Failure by the local provider to submit the additional information requested within 45 days shall be grounds for denying the application. Upon receipt of the additional information, the Division shall approve or deny the application within 45 days.
(e) Contracts for pediatric primary care funds shall be subject to annual renewal based upon past performance and the continued need for pediatric primary care services as indicated by the Health Services Information System reports and program reviews performed by the Division to assess compliance with the requirements of this Section. Approved project proposal and plans must be reviewed annually and updated as needed by the local provider staff. Plans shall be made available upon request to State staff during annual program reviews.
(f) Within the service limitations of this Section and commensurate with funds available to pay for those services as specified in the approved contract budget, the number and type of service offered will be negotiated annually with each local provider, approved by the program, and detailed in the addendum to the contract.
(g) In order to maximize the utilization of pediatric primary care funds, in the event a local provider is expending funds at a rate which will, if continued, result in an underexpenditure of funds at the end of the contract period, the Division may after consulting with the local provider reduce the amount of funds budgeted by an amount consistent with the projected level of underexpenditure. Funds projected to be unexpended may be reallocated to other local providers in accordance with community needs and performance records. The Division shall notify the local provider in writing prior to any reduction of funds.

Authority G.S. 130A-124.

10A NCAC 43E .0306 BUDGETING OF GRANT FUNDS

~~Upon approval by the Division of an application for grant funds, a budget will be negotiated and a contract will be signed between the local provider and the Division.~~

Authority G.S. 130A-124.

10A NCAC 43E .0307 MEDICAL RECORDS

~~A local provider which receives pediatric primary care funds shall establish and implement written policies and procedures for medical record usage that address at least the following areas:~~

~~(1) Documentation of all patient care provided (for example, Problem Oriented Health Record).~~
~~(2) Method for transferring and retrieving pertinent patient information.~~
~~(3) Assuring confidentiality of patient information.~~
~~(4) Obtaining an informed consent and release of information.~~
~~(5) Retaining and retrieving patient records according to the county records manual.~~

Authority G.S. 130A-124.

10A NCAC 43E .0308 CLIENT AND THIRD PARTY FEES

~~(a) If patient fees are charged by a local provider, such fees:~~

~~(1) Will be applied according to a public schedule of charges.~~
~~(2) Will not be imposed on low-income individuals or their families.~~
~~(3) Will be adjusted to reflect the income, resources, and family size of the individual receiving the services.~~

~~(b) If the client fees are charged, providers must make reasonable efforts to collect from third party payors.~~

~~(c) Client and third party fees collected by the local provider for the provision of pediatric primary care services must be used, upon approval of the program, to enhance, expand or maintain child health services. No person shall be denied services because of an inability to pay.~~

Authority G.S. 130A-124; P.L. 95-818.

10A NCAC 43E .0309 MONITORING AND EVALUATION

~~(a) A local provider who has been granted pediatric primary care funds shall participate in the Health Services Information System.~~

~~(b) The Division shall conduct annual program reviews to assess compliance with the requirements of this Section and to provide technical assistance.~~

Authority G.S. 130A-124.

SUBCHAPTER 43F - CHILDREN'S SPECIAL HEALTH SERVICES: CHILDREN AND YOUTH SECTION

SECTION .0100 - GENERAL PROVISIONS

10A NCAC 43F .0101 PURPOSE

~~The purpose of Children's Special Health Services is to provide non-custodial medical and surgical care for individuals below the age of 21 who have a chronic organic disease, defect or condition which may hinder the achievement of normal growth and development.~~

Authority G.S. 130A-124.

10A NCAC 43F .0102 DEFINITIONS

~~The following definitions shall apply throughout this Subchapter:~~

~~(1) "Appliances and equipment" means wheelchairs, braces, hearing aids, prostheses, respiratory aids, and similar items authorized for program patients.~~
~~(2) "Augmentative communication aids" are individually prescribed devices designed to facilitate communication for non-verbal individuals. These include, but are not limited to communication boards, scanning devices, strip printers, etc.~~
~~(3) "Authorization or authorized service" means a request for service which has been approved by Children's Special Health Services. Authorization is indicated by the signature of the program director or his designee on an application for cost service.~~
~~(4) "Cost service" means any service which requires submission of an application for approval and payment. These services include:~~
~~(a) medical or surgical care in a hospital or clinic;~~
~~(b) consultation;~~
~~(c) appliances and equipment;~~
~~(d) medication (see Rule .0408 of this Subchapter);~~

(e) physical therapy;
(f) occupational therapy;
(g) speech-language pathology and audiology services;
(h) dental care limited to that specified in Rule .0406 of this Subchapter;
(i) physicians' fees;
(j) x-rays and laboratory tests;
(k) psychological services.

(5) "Date of service" is the date that the approved authorization is to become effective.

(6) "Encumbrance or encumbered money" is the money obligated to pay for services authorized by the Children's Special Health Services.

(7) "Expendable supplies" designates those appliances and equipment that are not recyclable, such as disposable gauze sponges, bandages, detergents and similar items.

(8) "Extension of hospital stay" is an approved additional number of days of hospitalization beyond those initially authorized.

(9) "Extension of validity" is an approved change of the period of validity during which an authorization for hospitalization or outpatient surgery is in effect.

(10) "Inpatient" is a person who is admitted to the hospital as a bed patient on a hospital ward.

(11) "Low Income" means an individual or family with an income determined to be below the nonfarm income official poverty line defined by the Office of Management and Budget and revised annually in accordance with Section 624 of the Economic Opportunity Act of 1964.

(12) "Medical or surgical emergency" is a situation arising from any disease, defect or condition normally supported by Children's Special Health Services which may be life-threatening, or in which delay of prompt remedial medical care would be detrimental to the future health and well-being of the child.

(13) "Non-sponsored clinic" is a clinic which serves individuals with Children's Special Health Services supported medical conditions but which is not recognized, supported and listed as an official Children's Special Health Services clinic.

(14) "Outpatient" is an individual who receives care without inpatient hospital admission. This includes care provided in emergency rooms, clinics, and physicians' offices, or in other hospital settings, including outpatient surgery.

(15) "Period of validity" is the 30 days following the date approved for admission during which hospitalization for inpatient care or outpatient surgery may begin.

(16) "Rostered orthodontist and prosthodontist" are specialists who meet the stipulations set forth in Section .0700 of this Subchapter and who have made application to and been approved by Children's Special Health Services to request authorizations and provide services for eligible children.

(17) "Rostered physician" is a medical specialist who meets the stipulations set forth in Section .0700 of this Subchapter and who has made application to and been approved by Children's Special Health Services to request authorizations and provide services for eligible children.

(18) "Rostered speech and language pathologist" is a specialist who meets the stipulations set forth in Section .0700 of this Subchapter and has made application to and been approved by Children's Special Health Services to request authorizations and provide services for eligible children.

(19) "Rostered audiologist" is a specialist who meets the stipulations set forth in Section .0700 of this Subchapter and has made application to and been approved by Children's Special Health Services to request authorizations and provide services for eligible children.

(20) "Sponsored clinic" is a clinic that is recognized, supported, and listed as an official Children's Special Health Services.

Authority G.S. 130A-124.

SECTION .0200 - GENERAL POLICIES

10A NCAC 43F .0201 REFERRAL AND FOLLOW-UP

(a) Referrals to Children's Special Health Services will be accepted from individuals and the staff of various agencies, including, but not limited to, the following:

(1) local health departments,
(2) departments of social services,
(3) hospitals,
(4) local physicians,
(5) preschool and school health programs,
(6) developmental evaluation centers,
(7) volunteer agencies,
(8) the patient or his/her family.

(b) Children shall be seen by the child health program of a local health department or by a private physician before referral to a sponsored clinic, when feasible, to ensure the provision of comprehensive care.

(c) Reports of findings and recommendations for each child seen in a clinic or discharged from a hospital shall be furnished to the physician or agency designated by the parent or guardian as the child's primary health care provider. In addition, the patient, parent or guardian shall be asked for permission for such reports to be submitted to other persons or organizations, including the referral source, which may have a continuing professional relationship regarding the patient's medical care and well-being.
(d) When a child under care moves from one county to another within the state, the health department of the child's former county of residence shall advise the health department of current residence by letter with copies of pertinent records. Information will be furnished to out-of-state agencies or physicians upon request.

Authority G.S. 130A-124.

10A NCAC 43F .0202 RELEASE OF MEDICAL INFORMATION
(a) Appropriate consent of the patient, parent, or guardian shall be obtained before any patient information may be transmitted.
(b) Children's Special Health Services shall have the right to review all records of any patient receiving services through the program.
(c) Consent for the disclosure of medical and financial information regarding patients served through the program shall be made on forms as provided in Rule .0603 of this Subchapter.

Authority G.S. 130A-124.

10A NCAC 43F .0203 OUT-OF-STATE CARE
(a) Children's Special Health Services shall not ordinarily support medical or hospital care outside of North Carolina if the needed treatment is available within the state.
(b) In instances where appropriate care cannot be provided, due to problems of access or availability, a request for authorization accompanied by a letter of justification for out-of-state services may be submitted by a rostered physician to the program director for approval, in accordance with this Subchapter.

Authority G.S. 130A-124.

10A NCAC 43F .0204 SPONSORED CLINICS
(a) Various types of sponsored clinics, with the participation of at least one rostered physician, will be conducted periodically throughout the State of North Carolina.
(b) Return visits and cost services that are not available in the clinic (hospitalization, surgery, special therapy, appliances, etc.) shall be provided upon approval of an application and certification of eligibility by Children's Special Health Services. Clinics may require appointments which can be made by telephone or letter to the coordinator of the clinic at the health department or agency in which the clinic is held.

Authority G.S. 130A-124.

10A NCAC 43F .0205 PARTICIPATING PHYSICIANS, ORTHODONTISTS AND PROSTHODONTISTS
(a) Children's Special Health Services shall require physicians, orthodontists and prosthodontists to be rostered, as provided in Section .0700 of this Subchapter.
(b) Rostered physicians, orthodontists and prosthodontists shall be responsible for requesting cost services.
(c) Rostered physicians, orthodontists and prosthodontists may request cost services relating only to their specialty but may refer patients to other specialists or clinics.

Authority G.S. 130A-124.

10A NCAC 43F .0206 NEW CLINIC DIRECTORS AND NEW CLINICS
The director of Children's Special Health Services shall appoint new clinic directors and establish new clinics. In the performance of this task, the Director shall consider the recommendations of the North Carolina Medical Society advisory committee to the program as well as that of the local medical society and the director of the local health department.

Authority G.S. 130A-124.

10A NCAC 43F .0207 SPEECH AND LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS
(a) Children's Special Health Services shall require speech and language pathologists and audiologists who provide evaluation and treatment in sponsored clinics to be rostered, as provided in .0700 of this Subchapter.
(b) Speech and language pathologists providing speech therapy on a fee-for-service basis shall be rostered, as provided in .0700 of this Subchapter.
(c) When there is no rostered speech and language pathologist in the area, exceptions may be made by the Medical Director of Children's Special Health Services on an individual basis for non-rostered specialists to serve eligible children.
(d) Rostered speech and language pathologists and audiologists may request services relating only to their specialty, but may refer patients to other specialists or clinics.

Authority G.S. 130A-124.

SECTION .0300 - ELIGIBILITY

10A NCAC 43F .0301 DETERMINATION

~~Determination of eligibility shall be made by Children's Special Health Services based upon criteria set forth in this Section and based upon rules found in 10A NCAC 45A.~~

Authority G.S. 130A-124.

10A NCAC 43F .0302 AGE

~~The age requirement for receiving services from Children's Special Health Services shall be from date of birth to 21 years of age, except for those conditions mandated by legislative act to be covered at any age (e.g., cystic fibrosis); or as specified in specific agreements as in Rule .1003(2) of this Subchapter; or as provided in 10A NCAC 43F .1100; NORTH CAROLINA HEMOPHILIA ASSISTANCE PLAN.~~

Authority G.S. 130A-124.

10A NCAC 43F .0303 MEDICAL CONDITIONS SUPPORTED BY THE PROGRAM

~~Medical conditions that qualify for program support include, but shall not be limited to, the following:~~

~~(1) certain disabilities requiring orthopedic treatment, e.g., orthopedic birth defects, scoliosis, Perthe's disease, etc.;~~
~~(2) certain disabilities requiring plastic surgery, e.g., repair of cleft lip and cleft palate, burns (rehabilitative stage, for grafting and associated care), facial dysostosis restructure;~~
~~(3) congenital cardiac defects and rheumatic heart disease requiring medical and surgical treatment;~~
~~(4) certain other conditions requiring surgery, e.g., hydrocephalus, bladder tumor, tracheoesophageal fistula, etc.;~~
~~(5) cerebral palsy;~~
~~(6) orthodontics/prosthodontics if incidental to cleft palate, facial dysostosis restructure or scoliosis;~~
~~(7) cystic fibrosis;~~
~~(8) chronic seizure disorders;~~
~~(9) sickle cell anemia and hemophilia;~~
~~(10) nephrotic syndrome;~~
~~(11) speech-language pathology, chronic otological diseases, and hearing impairment;~~
~~(12) malignancies;~~
~~(13) diabetes mellitus;~~
~~(14) immunodeficiency diseases.~~

Authority G.S. 130A-124.

10A NCAC 43F .0304 MEDICAL CONDITIONS OR PROCEDURES NOT SUPPORTED

~~Medical conditions or procedures not supported by Children's Special Health Services shall include at least the following:~~

~~(1) most acute illnesses and accidents, i.e., those which do not usually result in chronic disability;~~
~~(2) appendectomy and inguinal herniorrhaphy;~~
~~(3) allergies;~~
~~(4) respiratory distress syndrome;~~
~~(5) ophthalmological conditions;~~
~~(6) surgery for cosmetic purposes only.~~

Authority G.S. 130A-124.

10A NCAC 43F .0305 APPEALS PROCEDURE CONCERNING ELIGIBILITY

~~Appeals concerning the interpretation and enforcement of the rules in this Section shall be made in accordance with G.S. 150B.~~

Authority G.S. 130A-124.

SECTION .0400 - SERVICES

10A NCAC 43F .0401 CLINIC SERVICES

~~(a) Children's Special Health Services shall sponsor clinics to provide care for children with a number of conditions. To be eligible for diagnostic services provided by Children's Special Health Services contract clinics, a child must meet the eligibility criteria established by the local provider. Financial eligibility requirements may not be more restrictive than the official poverty guidelines issued annually by the United States Department of Health and Human Services. To receive treatment services in program funded~~

clinics, a child must meet the Children's Special Health Services eligibility criteria of age, residence, medical condition, and annual net family income based on the official poverty guidelines issued annually by the United States Department of Health and Human Services. A concerted effort shall be made to coordinate services received in sponsored clinics and in hospitals with primary care providers. There shall be the following kinds of special clinics:

(1) Orthopedic clinics. These clinics shall be located throughout the state, and may be held monthly or more frequently. Arrangements for treatment, such as hospitalization, appliances, or physical therapy, may be made at that time.

(2) Congenital heart and rheumatic fever clinics. These clinics shall provide diagnosis and clinic observation; Children's Special Health Services shall provide prophylactic and condition specific drug therapy and hospitalization. Surgery may be provided for remediable congenital or rheumatic cardiac defects in program approved hospitals.

(3) Speech and hearing clinics. These clinics shall provide diagnostic evaluation and therapy when feasible and shall offer the services of a speech and language pathologist, audiologist, and otolaryngologist with other specialty consultations as indicated. Speech and language therapy provided on a fee for service basis required by patients of these clinics shall be requested through a sponsored speech and hearing clinic.

(4) Cystic fibrosis clinics. These clinics shall provide evaluation, diagnosis and prescriptions for condition specific medication, appliances, and referral for hospitalization for individuals with this condition and certain other chronic lung diseases.

(5) Hematology and oncology clinics. These clinics shall provide services for individuals with malignancy and program supported hematological conditions. Prescriptions for chemotherapy for malignancy shall be provided. Lyophilized anti-hemophilic Factor VIII Concentrate (human) shall be supplied by providers on a replacement basis.

(6) Neurological clinics. These clinics shall provide diagnosis and treatment of chronic seizure and certain other neurological disorders. Prescriptions for condition specific medications for seizure shall be provided also.

(7) Nephrology clinics. These clinics shall provide evaluation, diagnosis, prescriptions for condition specific medication for nephrotic syndrome, and referral for hospitalization for children with certain renal diseases.

(8) Oral and facial clinics. These clinics shall provide multidisciplinary evaluation, diagnosis, treatment, and referral for hospitalization for children with cleft lip, cleft palate, or facial dysostosis. Services to patients with oral and facial problems shall not be supported unless provided under the auspices of a sponsored clinic. Speech and language therapy on a fee for service basis required by patients of these clinics shall be requested through a sponsored oral and facial clinic.

(9) Myelodysplasia clinics. These clinics shall provide multidisciplinary evaluation, diagnosis, treatment, appliances, and referrals for hospitalization.

(10) Pediatric rehabilitation clinic. This clinic shall provide diagnosis, clinical observation, therapy, and referral for hospitalization and surgery for children with supported congenital problems.

(b) Program eligible patients shall be encouraged to utilize the services of sponsored clinics when such clinics provide the type of services needed and are located within 50 miles of the patient's residence. Program support shall not be available for services provided by non sponsored clinics when such services are available through sponsored clinics within 50 miles of the patient's residence, unless a rostered physician submits a written claim that good cause exists for the patient's inability to utilize the sponsored clinic service, due to the cost of transportation in relation to the economic value of services needed or a medical hardship occasioned in relation to the patient's physical condition, and the program director determines that good cause exists.

(c) Rostered clinic physicians, orthodontists or prosthodontists who refer patients for interim follow up care between clinic visits may refer them to a local non rostered physician or dentist and have their care supported by the program, provided the requesting rostered physician, orthodontist or prosthodontist signs the request for care.

(d) Individuals with accepted medical conditions who develop emergency situations related to their disability between regular clinic visits may be authorized by Children's Special Health Services for treatment by a local rostered physician.

(e) Cost services that require equipment or other resources not available in a sponsored clinic may be supported when such services must be obtained elsewhere.

(f) A child eligible to be served in a sponsored speech and hearing clinic may be served in the private office of a rostered otolaryngologist when the patient has a medical problem not usually associated with a chronic speech and hearing disorder.

Authority G.S. 130A-124.

10A NCAC 43F .0402 OTHER OUTPATIENT SERVICES

Certain ambulatory care for which there are no sponsored clinics may be provided in physicians' offices, local health departments, or hospital outpatient facilities. Such care shall be authorized only when requested by a rostered physician.

Authority G.S. 130A-124.

10A NCAC 43F .0403 HOSPITALS

Hospitals receiving payment for services from Children's Special Health Services must meet certification requirements for providers and suppliers of services and must have adequate facilities to provide the type of service requested.

Authority G.S. 130A-124.

10A NCAC 43F .0404 HOSPITALIZATION

~~Children's Special Health Services shall support inpatient hospitalization for children with accepted medical conditions as provided in Rule .0306 of this Subchapter, when authorized in accordance with Rule .0502 of this Subchapter, and with 10A NCAC 45A .0302.~~

Authority G.S. 130A-124.

10A NCAC 43F .0405 SPECIAL THERAPY

~~(a) Special therapy not available through the school system shall be provided by local therapists in accordance with Rules .0501 and .0504 of this Subchapter.~~

~~(b) Physical and occupational therapy shall be provided when requested by rostered physicians.~~

~~(c) Speech and language therapy shall be provided when requested by a rostered speech and language pathologist who is a team member of a sponsored speech and hearing or oral and facial clinic following evaluation in such clinic.~~

~~(d) Unless the program director determines that additional therapy is required, special therapy shall not be approved for more than three times a week.~~

~~(e) Special therapy shall be authorized for a six month period. Requests for additional authorizations shall be made in accordance with all other provisions of this Rule and with Rule .0504 of this Subchapter.~~

Authority G.S. 130A-124.

10A NCAC 43F .0406 ORTHODONTIC AND PROSTHODONTIC DENTAL CARE

~~Orthodontic and prosthodontic care shall be provided only for children with cleft palate, facial dysostosis, or to prevent deformities resulting from treatment of scoliosis. The child must be seen or referred by an appropriate rostered physician, orthodontist or prosthodontist representing a program sponsored oral and facial clinic team. Treatment must be authorized by Children's Special Health Services.~~

Authority G.S. 130A-124.

10A NCAC 43F .0407 APPLIANCES AND EQUIPMENT

~~(a) All unused, re-usable or non-expendable equipment purchased by Children's Special Health Services shall remain the property of the State of North Carolina, and shall revert to the program when no longer needed.~~

~~(b) Appliances and equipment shall be furnished to eligible patients when prescribed by physicians rostered in the appropriate specialty and authorized by Children's Special Health Services. These shall include at least orthotic and prosthetic devices, respiratory equipment, special beds, wheelchairs, lifts, hearing aids, and similar items. Colon bags, cement and sterile equipment may be supported, but expendable supplies shall not be approved.~~

~~(c) The requesting physician must approve all orthotics, prosthetics and adaptive devices for quality and fit; for hearing aids, the audiologist must approve and co-sign the request with the rostered otolaryngologist.~~

~~(d) The vendor shall make such adjustments as are recommended by the requesting physician, and audiologist in the case of hearing aids.~~

~~(e) A licensed hearing aid dealer shall sign the Department of Human Resources Hearing Aid Vendor Agreement in order to be reimbursed for equipment and services provided to Children's Special Health Services eligible patients.~~

Authority G.S. 130A-124.

10A NCAC 43F .0408 DRUGS

~~(a) All hospital inpatient drugs shall be supported by Children's Special Health Services.~~

~~(b) Children's Special Health Services shall support condition-specific drugs and related supplies for outpatient treatment of eligible children with:~~

- ~~(1) cystic fibrosis,~~
- ~~(2) bronchiectasis,~~
- ~~(3) hemophilia,~~
- ~~(4) glycogen storage disease,~~
- ~~(5) vitamin D resistant rickets,~~
- ~~(6) chronic seizure disorder,~~
- ~~(7) congenital and rheumatic heart disease,~~
- ~~(8) nephrotic syndrome,~~
- ~~(9) immunodeficiency disorders,~~
- ~~(10) diabetes mellitus,~~
- ~~(11) malignancies,~~
- ~~(12) sickle cell disease,~~
- ~~(13) myelodysplasia, or~~
- ~~(14) other conditions if the program's medical director determines that drug therapy may improve the patient's condition.~~

(c) Children's Special Health Services shall supply bicillin, penicillin, and oral lanoxin to rheumatic fever clinics and local health departments for distribution to eligible patients. Requests for these drugs shall be made by telephone or letter to the program by the clinic director or director of the local health department. Children with rheumatic fever who are allergic to penicillin may obtain a prescription from a rostered physician for an alternate drug which may be filled by any licensed pharmacist.
(d) Lyophilized antihemophilic Factor VIII Concentrate (human) shall be supplied to providers on a replacement basis.

Authority G.S. 130A-124.

10A NCAC 43F .0409 BLOOD

(a) The cost of processing blood or blood derivatives and administering transfusions shall be supported by the program, but the cost of blood or blood derivatives shall not be supported. The family, guardian or custodian of the child shall be responsible for securing replacement blood.
(b) Notwithstanding the provisions of Paragraph (a) of this Rule, for those individuals supported by the North Carolina Hemophilia Assistance Plan in accordance with rules found in Section .1100 of this Subchapter, the rules of that section shall apply.

Authority G.S. 130A-124.

10A NCAC 43F .0410 STAFF CONSULTANT AND ADVISORY SERVICES

(a) Staff consultants shall be available in the central and regional offices of the Department for special services relating to clinics, in-service and patient education programs, planning and implementation of programs or services to children and their families.
(b) Staff consultant services shall be available in medicine, nursing, social work, physical therapy, speech language pathology and audiology, nutrition, and administration.

Authority G.S. 130A-124.

SECTION .0500 - AUTHORIZATION AND BILLING PROCEDURES

10A NCAC 43F .0501 AUTHORIZATION POLICIES

(a) If an individual is known to be (or appears to be) eligible for program support, it shall be the responsibility of program providers to request support for cost services.
(b) If there is another third party which would normally finance the requested cost services, that source shall be utilized as provided in Section .0300 of this Subchapter.
(c) Requests for cost services shall be submitted on forms described in Rule .0602 of this Subchapter.
(d) Final approval for support of care shall be decided in accordance with Section .0300 of this Subchapter.

Authority G.S. 130A-124.

10A NCAC 43F .0502 SERVICE AUTHORIZATION

(a) Inpatient authorizations are approved when the authorization request form for cost services is returned with the signature of Children's Special Health Services' director or the director's designee.
(b) The date or expected date of hospital admission must be stated on the request for admission. Separate authorizations shall be required for each admission.
(c) Unless the program's medical director determines that additional inpatient hospitalization is necessary, initial inpatient authorization shall not exceed 30 days. When the program's medical director determines that an extension of the authorization is necessary, the extension shall not exceed 30 days. To request an extension, a provider shall:

(1) Submit an authorization request form including the medical justification to the claims processing unit prior to the expiration of the authorization currently in effect; or
(2) Request an extension by telephone to the claims processing unit. All telephone requests must be followed by a submission of the authorization request form including the medical justification to the claims processing unit within 15 days, including the day of telephone request.

(d) A copy of the authorization for hospitalization shall be sent by the claims processing unit to the hospital, the physician, the local health department of residence, and to other appropriate agencies and individuals.
(e) Authorization requests for augmentative communication aids, electronic devices, or electric wheelchairs, shall be approved only when accompanied by acceptable individual justification.
(f) Authorization requests for outpatient drugs shall be approved for a period not to exceed eight months.

Authority G.S. 130A-124.

10A NCAC 43F .0503 CANCELLATIONS

Long term drug authorizations shall be automatically cancelled eight months after the date of approval. The program will not honor bills submitted by providers on the basis of cancelled authorizations.

Authority G.S. 130A-124.

10A NCAC 43F .0504 SPECIAL THERAPY REQUESTS

Requests for speech and language, physical, and occupational therapy shall include:

(1) a statement that the therapy is not available through the school system for children six years of age and over;

(2) a summary of progress for children in continual therapy for whom an authorization is submitted requesting an extension for an additional six-month period;

(3) an annual re-evaluation for children receiving therapy for one or more years with a statement from the appropriate rostered specialist that the child can benefit from additional therapy.

Authority G.S. 130A-124.

10A NCAC 43F .0505 BILLING POLICIES

(a) Claims for payment shall be submitted and payment shall be made in accordance with rules found in 10A NCAC 45A.

(b) If an authorized service is cancelled the claims processing unit must be notified so that the authorization may be cancelled and the encumbered money released for use.

Authority G.S. 130A-124.

10A NCAC 43F .0506 PHYSICIANS' BILLING POLICIES

(a) Physician's bills shall be submitted in accordance with rules found in 10A NCAC 45A.

(b) Physician's services in a clinic may be billed as follows:

(1) Bills may be submitted based on an hourly rate for the period of time in attendance at the clinic;

(2) Bills may be submitted on a per-patient basis or on a negotiated rate agreed upon by the program;

(3) Bills may be submitted by means of an expenditure report according to terms specified by previous agreement.

Authority G.S. 130A-124.

10A NCAC 43F .0507 OTHER PROFESSIONAL SERVICES

(a) Bills for other professional services shall be submitted in accordance with the rules found in 10A NCAC 45A.

(b) When a therapy session or a series of therapy sessions is being billed for, bills shall state the date and length of each session.

Authority G.S. 130A-124.

10A NCAC 43F .0508 CLINIC CHARGES AND OUTPATIENT CHARGES

(a) Bills for ambulatory hospital-based services and emergency care shall be submitted and payment shall be made in accordance with rules found in 10A NCAC 45A.

(b) In non-contract sponsored clinics, Children's Special Health Services shall be billed at a rate previously agreed upon.

(c) In contract sponsored clinics, Children's Special Health Services shall be billed according to the terms specified in a contractual agreement.

Authority G.S. 130A-124.

10A NCAC 43F .0509 CLERICAL CHARGES

(a) Payment for clerical services may be made on a fee-for-service basis. The billing procedure shall indicate whether the clerical service is provided by a local health department employee or by an individual employed only to provide the additional clerical service for the clinic. The bill shall indicate the number of patients seen.

(b) Clerical services provided through a contract shall be billed by means of an expenditure report as specified in the contract.

Authority G.S. 130A-124.

10A NCAC 43F .0510 AUTHORIZED HOSPITALIZATION

All bills for hospitalization shall be submitted in accordance with rules found in 10A NCAC 45A.

Authority G.S. 130A-124.

10A NCAC 43F .0511 AUTHORIZED APPLIANCES

(a) Bills for appliances shall include appropriate charge data and shall be transmitted in triplicate to Children's Special Health Services in accordance with 10A NCAC 45A .0302.

(b) Insurance or any other coverage shall be exhausted before a bill can be paid by the program.

Authority G.S. 130A-124.

10A NCAC 43F .0512 AUTHORIZED DRUGS FOR OUTPATIENTS

(a) Bills for drugs shall be submitted to Children's Special Health Services in accordance with 10A NCAC 45A .0302. Billing forms approved by the program shall be used.

(b) Insurance or any other coverage shall be exhausted before a bill can be paid by the program.

Authority G.S. 130A-124.

10A NCAC 43F .0513 REIMBURSEMENT RATES

Reimbursement rates for Children's Special Health Services are found in 10A NCAC 45A .0400.

Authority G.S. 130A-124.

10A NCAC 43F .0514 APPEALS PROCEDURE

Appeals concerning the interpretation and enforcement of the rules in this Section shall be made in accordance with G.S. 150B.

Authority G.S. 130A-124.

SECTION .0600 - FORMS

10A NCAC 43F .0601 REQUESTS FOR FORMS

All forms for Children's Special Health Services may be obtained from Division of Public Health, 1915 Mail Service Center, Raleigh, North Carolina 27699-1915.

Authority G.S. 130A-124.

10A NCAC 43F .0602 REQUEST FORM FOR COST SERVICES

(a) The purpose of the request form for cost services shall be to:

(1) provide information to establish and justify clinical eligibility;

(2) notify requesting parties that they are authorized to provide a service which may be paid for by Children's Special Health Services.

(b) The request form for cost services shall include at least the following information:

(1) patient identification;

(2) diagnosis;

(3) services requested and anticipated dates of services;

(4) justification when needed;

(5) signature of rostered physician or other appropriate rostered specialist;

(6) date of request.

Authority G.S. 130A-124.

10A NCAC 43F .0603 FINANCIAL ELIGIBILITY FORM

The Financial Eligibility forms shall be submitted in accordance with rules found in 10A NCAC 45A.

Authority G.S. 130A-124.

10A NCAC 43F .0604 FORMS FOR DENIAL OF REQUESTS FOR SERVICE

Forms used to reply to requests for services may serve as a rejection notice. These forms shall indicate the reasons for denial of a request. The forms shall be sent to the requesting party and to the patient, parent or guardian.

Authority G.S. 130A-124.

10A NCAC 43F .0605 CLINIC NOTES FORM

Physicians and other professionals shall record patient information on a clinic notes form. The form shall include notes concerning the patient's complaints, history, physical examination, progress notes, diagnosis, and recommended treatment.

Authority G.S. 130A-124.

10A NCAC 43F .0606 CLINIC RECORD

(a) A medical record shall be maintained for each patient seen in sponsored clinics.

(b) The clinic record shall include at least:

(1) identifying information about the patient;

(2) complaint and history;
(3) physical examination;
(4) diagnosis and treatment;
(5) a copy of the patient's clinic notes.

(c) Children's Special Health Services shall be entitled to review the clinic record of a patient upon request.

Authority G.S. 130A-124.

10A NCAC 43F .0607 CLERICAL SERVICES

(a) Reimbursable clerical services shall be certified as "completed" by the clinic secretary and the local health director, on a form which is acceptable to Children's Special Health Services.

(b) The form shall contain:

(1) name and address of clerk;
(2) date of service;
(3) number of patient records processed;
(4) signature of clerk and local health director.

Authority G.S. 130A-124.

SECTION .0700 - ROSTERS

10A NCAC 43F .0701 QUALIFICATIONS

(a) There shall be two categories of rostered physicians under Children's Special Health Services:

(1) In order to be accorded full rostering status, an applicant must be a resident of North Carolina, licensed to practice medicine in the state, have hospital privileges in the community of his/her practice, and be board certified in pediatrics. Physicians who are not board certified in pediatrics may be fully rostered if they are board certified in a specialty with pediatric training in that specialty, and:
(A) meet the applicable membership criteria of the American Academy of Pediatrics for that specialty, or
(B) meet substantially equivalent credentialing requirements for a pediatric subspecialty in a specialty.

(2) A physician may be conditionally rostered if that physician serves an area not adequately served by a fully rostered physician. A conditionally rostered physician shall meet all of the requirements set forth in Paragraph (a)(1) of this Rule for a fully rostered physician, except for the requirements that a physician be board certified in pediatrics and meet the applicable membership criteria of the American Academy of Pediatrics for that specialty or meet substantially equivalent credentialing requirements for a pediatric subspecialty in a specialty. However, the physician shall possess pediatric experience in a specialty and provide services necessary for the care of children in an area that is not adequately served. The status of the conditionally rostered physician shall be reviewed every three years.

(b) Physicians rostered by the Program prior to September 1, 1989 shall be considered fully rostered.

(c) The orthodontist/prosthodontist applicant for rostering must be a resident of North Carolina, licensed to practice dentistry in the state, board eligible or certified by the American Board of Orthodontics or by the American Board of Prosthodontics, respectively, and a member of a Children's Special Health Services oral/facial clinic team.

(d) The speech/language pathologist or audiologist applicant for rostering must be a resident of North Carolina, licensed to practice in the state in accordance with G.S. Chapter 90, Article 22, and certified by the American Speech and Hearing Association. In addition, the applicant must be practicing 20 hours per week with at least 12 hours in direct patient contact, and within the previous two years, an average of one-half or more of the patients served must have been children.

Authority G.S. 130A-124.

10A NCAC 43F .0702 FURTHER INFORMATION

Children's Special Health Services reserves the right to ask a roster applicant for further information, or credentials, or to determine whether the hospital of affiliation is equipped adequately for the practice of the applicant's specialty.

Authority G.S. 130A-124.

10A NCAC 43F .0703 APPEALS PROCEDURE

Appeals concerning the interpretation and enforcement of the rules in this Section shall be made in accordance with G.S. 150B and 10 NCAC 1B.

Authority G.S. 130A-124.

10A NCAC 43F .0704 ADMINISTRATIVE REQUIREMENTS

Rostered physicians shall:

(1) Encourage insurance clerk and office manager to be properly trained regarding Children's Special Health Services and its forms;
(2) Properly prepare or ensure the completion of forms and paperwork as indicated or needed for services to the family;
(3) Take responsibility for preparing requests for ancillary services such as drugs and supplies; and
(4) Not hold the patient or family responsible for unprocessed or unpaid bills for physician's services which are due to provider error or non-compliance with program guidelines.

Authority G.S. 130A-124.

SECTION .0800 - ADOPTION

10A NCAC 43F .0801 GENERAL PROVISION

(a) If the requirements of this Section are met, a child who has been legally adopted and has no natural parent with legal responsibility for the child, shall, after the final order of adoption, be considered a family of one under 10A NCAC 45 .0204(c) for purposes of determining financial eligibility for program support.
(b) Authorization and payment for services shall be made pursuant to Section .0500 of this Subchapter and 10A NCAC 45A .0302 and .0303.
(c) After the adoption is completed, the agency handling the adoption shall inform the program of the following:
(1) the child's new name and address; and
(2) the adoptive parents' name and address.
If the child was placed independently, the adoptive parents shall provide this information to the program.

Authority G.S. 130A-124.

10A NCAC 43F .0802 REQUIREMENTS FOR THE ADOPTIVE CHILD

To be eligible for program support, the child must meet the following requirements:
(1) The child must have a program supported medical condition as provided in 10A NCAC 43F .0303 which is documented by a physician rostered by the program to be existing prior to the final order of adoption; and
(2) The child must meet the residency requirements of 10A NCAC 45A .0201(b)(1).

Authority G.S. 130A-124.

10A NCAC 43F .0804 APPLICATION FOR COVERAGE AFTER ADOPTION

(a) Application for post-adoption coverage shall be made on a form provided by the Department by the agency having legal responsibility, in the case of a state or private agency placement, or by the adoptive parents, in the case of an independent placement. The application must be received by Children's Special Health Services prior to the final order of adoption.
(b) Applications for state agency placed children shall be submitted to the North Carolina Adoption Resource Exchange, Division of Social Services, Department of Human Resources, for forwarding to Children's Special Health Services. Applications from private adoption agencies and for children adopted independently shall be submitted directly to the medical director of Children's Special Health Services.

Authority G.S. 130A-124.

SECTION .0900 - AGREEMENTS WITH OTHER AGENCIES

10A NCAC 43F .0901 AGREEMENT WITH VOCATIONAL REHABILITATION

Children's Special Health Services maintains an agreement with the division of vocational rehabilitation in order to best utilize the services of both parties:
(1) The division of vocational rehabilitation may utilize sponsored clinics for diagnostic and follow-up care for Children's Special Health Services eligible individuals under 21 years of age.
(2) Sponsored orthopedic clinic services shall be provided to clients of the division of vocational rehabilitation who are over 21 years of age, based on a transfer of line item funds from vocational rehabilitation to Children's Special Health Services.

Authority G.S. 130A-124.

SECTION .1000 - CHILDREN'S SPECIAL HEALTH CONTRACT FUNDS

10A NCAC 43F .1001 OUTPATIENT CLINIC SERVICES

To provide access to outpatient clinic services, the division contracts with appropriate agencies. This Section includes the funding guidelines under which these contracts are let.

Authority G.S. 130A-124.

10A NCAC 43F .1002 DEFINITIONS

The following definitions shall apply throughout this Section:

(1) "Division" means the Division of Public Health.

(2) "Provider" means a county or district health department or other public or private non-profit agency receiving Children's Special Health Services funds. ("Local provider" means a county or district health department; "Non-Local provider" means an educational institution, medical center or other public or private non-profit agency.)

(3) "New state or federal funds" means any funds which are in excess of the amount allocated by the Children's Special Health Services to providers as of July 1, 1984.

Authority G.S. 130A-124.

10A NCAC 43F .1003 PROVIDER ELIGIBILITY

(a) Children's Special Health Services funds may be awarded to any public or private non-profit agency.

(b) An agency to whom funds are awarded must be able to demonstrate capability for provision of Children's Special Health Services as outlined in this Subchapter.

(c) Existing Children's Special Health Services' contractors are eligible to receive priority for program funds based on their continued compliance with Children's Special Health Services' standards and rules, and on demonstration of acceptable service performance.

Authority G.S. 130A-124.

10A NCAC 43F .1004 CLIENT ELIGIBILITY

To be eligible for outpatient clinic services, the client must meet the eligibility criteria of age, residence, medical condition and financial resources established in this Subchapter.

Authority G.S. 130A-124.

10A NCAC 43F .1005 SCOPE OF SERVICES

(a) Outpatient clinics for specific diagnostic categories shall be established based upon needs and the availability of funds.

(b) Outpatient clinic services shall include evaluation, treatment, follow-up and referral. Program eligible children shall be given first priority for clinic services paid through the Children's Special Health Services contract.

(c) Within the service limitations of this Section and commensurate with funds available to pay for those services as specified in the approved contract budget, the number and type of services offered will be negotiated annually with each provider, approved by the program, and detailed in the addendum of the contract.

Authority G.S. 130A-124.

10A NCAC 43F .1006 ALLOCATION OF FUNDS: CONTRACT

(a) Contract funds will be negotiated with the provider. These negotiations will include a consideration of the number of counties or size of area to be serviced, Children's Special Health Services eligible population, existing contracts, new funds, and state equity.

(b) Any new state or federal funds to be distributed statewide to providers shall be allocated based upon the following formula:

(1) Each provider's percentage of total state need for Children's Special Health Services compared to their percentage of total Children's Special Health Services funding for providers.

(2) Service delivery gaps in given catchment areas.

(3) Actual utilization of funds in previous fiscal years, special population groups, and other management considerations that relate to a provider's ability to effectively and efficiently use funds.

(c) Any new state or federal funds that are not distributed to existing contract providers shall be governed by the section entitled "Application for Funds".

(d) In order to maximize the utilization of Children's Special Health Services funds, in the event a local or non-local provider is expending funds at a rate which will, if continued, result in an underexpenditure of funds at the end of the contract period, the Children's Special Health Services may after consulting with the provider reduce the amount of funds budgeted by an amount consistent with the projected level of underexpenditure. Funds projected to be unexpended may be reallocated to other contract providers in accordance with community needs and performance records. Children's Special Health Services shall notify the provider in writing prior to any reduction of funds.

(e) A contract is signed annually with each provider. Contracts for Children's Special Health Services funds are subject to annual renewal and are subject to the availability of funds.

(f) A provider that consistently fails to meet acceptable levels of performance as determined through site reviews by the program or data from the Health Services Information System and has been offered state consultation and technical assistance, may have Children's Special Health Services funds reduced or discontinued. Recommendations to reduce or discontinue must be reviewed and approved by the State Health Director.

Authority G.S. 130A-124.

10A NCAC 43F .1007 REPORTING REQUIREMENTS

~~Providers receiving funds from Children's Special Health Services must report client and service data through the Health Services Information System (HSIS). Data may be submitted on hard copy forms provided by the division, diskette or magnetic tape. Data must be submitted on no less than a monthly basis.~~

Authority G.S. 130A-124.

10A NCAC 43F .1008 CLIENT AND THIRD PARTY FEES

~~(a) If a Children's Special Health Services contract clinic imposes any charges for diagnostic services provided to children, such charges:~~

~~(1) Will be applied according to a public schedule of charges;~~

~~(2) Will not be imposed on low income individuals or their families; and~~

~~(3) Will be adjusted to reflect the income, resources, and family size of the individual receiving the services.~~

~~(b) If client fees are charged, Children's Special Health Services contract clinics must make reasonable efforts to collect from third party payors.~~

~~(c) Client and third party fees collected by Children's Special Health Services contract clinics for the provision of diagnostic services must be used, upon approval of the program, to expand, maintain, or enhance these services. No person shall be denied services because of an inability to pay.~~

Authority G.S. 130A-124.

10A NCAC 43F .1009 APPLICATION FOR FUNDS

~~(a) New grants for provision of services shall be awarded through a request for proposal (RFP) process that includes notification of local providers of the eligibility criteria and requirements for funding.~~

~~(b) Grant proposals for Children's Special Health Services' funds must be sent to the Children and Youth Section, Division of Maternal and Child Health, P.O. Box 27687, Raleigh, NC 27611-7687. The grant proposal shall include at least the following information:~~

~~(1) A Children's Special Health Services annual plan which includes an assessment of the need for the clinic services; measurable project objectives, and strategies for meeting the project objectives.~~

~~(2) A proposed budget.~~

~~(3) The plan will be in accordance with the rules of this Subchapter.~~

~~(c) Technical assistance in preparing a grant proposal shall be available from central and regional office Children's Special Health Services staff.~~

~~(d) Children's Special Health Services shall approve or deny a grant proposal for Children's Special Health Services funds or request additional information within 60 days after receipt of a grant proposal. If additional information is requested, the provider shall have 45 days to submit the information. Failure by the provider to submit the additional information requested within 45 days shall be grounds for denying the grant proposal. Upon receipt of the additional information, the Children's Special Health Services shall approve or deny the application within 45 days.~~

Authority G.S. 130A-124.

10A NCAC 43F .1010 BUDGETING OF GRANT FUNDS

~~Upon approval of an application for grant funds, a budget will be negotiated and a contract will be signed between the grantee and the Children's Special Health Services.~~

Authority G.S. 130A-124.

10A NCAC 43F .1011 ANNUAL PLAN

~~The contractor shall submit an updated annual plan each year to Children's Special Health Services according to program specifications and within the time frame specified each year by the program.~~

Authority G.S. 130A-124.

10A NCAC 43F .1012 RENEWAL OF GRANT FUNDS

~~When considering renewal of funding, the Children and Youth Section shall consider the extent to which:~~

~~(1) objectives are met as described in progress reports or site reviews by the program, and~~

~~(2) contract requirements are met.~~

Authority G.S. 130A-124.