April 2010 Medicaid Bulletin

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Attention: All Providers

Medicaid Provider Payment Suspension

DMA shall suspend payment to all N.C. Medicaid providers that currently have outstanding (i.e., thirty days or more past due) balances owed as a result of DMA actions to recoup assessments, overpayments or improper payments until such outstanding balances are either paid in full or the provider enters into an approved payment plan, in accordance with N.C. Session Law 2009-451, Section 10.73A (a) (b) (c), which states:

SECTION 10.73A.(a) The Department of Health and Human Services may suspend payment to any North Carolina Medicaid provider against whom the Division of Medical Assistance has instituted a recoupment action, termination of the N.C. Medicaid Administrative Participation Agreement, or referral to the Medicaid Fraud Investigations Unit of the North Carolina Attorney General's Office. The suspension of payment shall be in the amount under review and shall continue during the pendency of any appeal filed at the Department, the Office of Administrative Hearings, or State or federal courts. If the provider appeals the final agency decision and the decision is in favor of the provider, the Department shall reimburse the provider for payments for all valid claims suspended during the period of appeal.

SECTION 10.73A.(b) Entering into a Medicaid Administrative Participation Agreement with the Department does not give rise to any property or liberty right in continued participation as a provider in the North Carolina Medicaid program.

SECTION 10.73A.(c) The Department shall not make any payment to a provider unless and until all outstanding Medicaid recoupments, assessments, or overpayments have been repaid in full to the Department, together with any applicable penalty and interest charges, or unless and until the provider has entered into an approved payment plan.

For additional information on a repayment plan, please contact DMA Budget Management at 919-855-4140.

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Password Changes for the N.C. Electronic Claims Submission Web Tool

To ensure the privacy and security of protected health information, change your NCECS Web Tool password if your facility has recently terminated an employee. You may contact the ECS Department at 1-800-688-6696, option 1, to obtain a Claims Submission Change Request Form. The ECS Department will fax a Claims Submission Change Request Form to you to be completed and returned via fax (919-859-9703) to facilitate the password change. You may also access the form on DMA's website at http://www.ncdhhs.gov/dma/provider/forms.htm.

HP Enterprise Services
1-800-688-6696 or 919-851-8888

Attention: All Providers

Risperidone, Long Acting, 0.5 mg (Risperdal Consta, HCPCS Code J2794): Additional Coverage Guidelines

Effective with date of service May 15, 2009, the N.C. Medicaid Program added the following ICD-9-CM diagnosis codes to the coverage of risperdone, long acting, to align with the recent FDA approval for the indication of bipolar disease, type 1. Medicaid already covers Risperdal Consta for the indication of schizophrenia. The diagnoses that were added for coverage of bipolar disease are:

- 296.0 (bipolar 1 disorder, single manic episode)
- 296.4 (bipolar 1 disorder, most recent episode [or current] manic)
- 296.5 (bipolar 1 disorder, most recent episode [or current] depressed)
- 296.6 (bipolar 1 disorder, most recent episode [or current] mixed)
- 296.7 (bipolar 1 disorder, most recent episode [or current] unspecified)

Providers who received denials for J2794 on claims submitted with a diagnosis of bipolar disease, type 1, for dates of service on and after May 15, 2009, may file the denied charges as a new claim. Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.

HP Enterprise Services
1-800-688-6696 or 919-851-8888

Attention: All Providers

Updated EOB Code Crosswalk to HIPAA Standard Codes

The list of standard national codes used on the Electronic Remittance Advice (ERA) has been cross-walked to EOB codes as an informational aid to adjudicated claims listed on the Remittance and Status Report (RA). An updated version of the list is available on DMA's website at http://www.ncdhhs.gov/dma/hipaa/.

With the implementation of standards for electronic transactions mandated by HIPAA, providers now have the option to receive an ERA in addition to the paper version of the RA.

The EOB codes that providers currently receive on a paper RA are not used on the ERA. Because the EOB codes on the paper RA provide a greater level of detail on claim denials, all providers will continue to receive the paper version of the RA, even if they choose to receive the ERA transaction. The crosswalk is current as of the date of publication. Providers will be notified of changes to the crosswalk through future general Medicaid bulletins.

HP Enterprise Services
1-800-688-6696 or 919-851-8888

Attention: All Providers

Clinical Coverage Policies

The following new or amended clinical coverage policies are now available on DMA's website at http://www.ncdhhs.gov/dma/mp/:

- 1A-25, *Spinal Cord Stimulation* (posted 2/1/10; effective 1/1/10)
- 3A, *Home Health Services* (posted 12/1/09)
- 3C, *Personal Care Services and PCS-Plus* (effective 4/1/10)
- 3D, *Hospice Services* (posted 12/1/09; effective 12/2/08)
- 4B, *Orthodontics* (effective 4/1/10)
- 8A, *Enhanced Mental Health and Substance Abuse Services* (posted 2/1/10; effective 4/1/10)
- 9, *Outpatient Pharmacy Program* (posted 12/1/09)
- 10A, *Outpatient Specialized Therapies* (posted 12/1/09)
- 10B, *Independent Practitioners* (posted 1/1/10)
- 10C, *Local Education Agencies* (posted 1/1/10)
- 13A, *Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair* (posted 1/1/10)

These policies supersede previously published policies and procedures. Providers may contact HP Enterprise Services at 1-800-688-6696 or 919-851-8888 with billing questions.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

HP Mailing Address Changes

Effective immediately, the following HP Enterprise Services mail box addresses have been changed.

Old Mail Box Address	Current Mail Box Address	City, State, Zip*
300011	30968	Raleigh, NC 27622
300010	30968	
300001	30968	
300012	30968	

*Please note the city, state, and zip code have not changed.

When appropriate, providers are instructed to continue to list any departmental information for routing purposes. For example:

HP Enterprise Services
ATTN: UB04 Claims
PO Box 30968
Raleigh, NC 27622

HP Enterprise Services
1-800-688-6696 or 919-851-8888

Attention: All Providers

New Option for Submitting Recipient Commercial Insurance Information Updates

Federal regulations (42 CFR 433.138 and 139) require Medicaid to be the payer of last resort. For this reason, providers must determine if a recipient has commercial health insurance coverage. If the recipient's eligibility information indicates a commercial health insurance carrier, the provider must bill the carrier before billing Medicaid.

Occasionally, a carrier has terminated coverage but the recipient's eligibility information still indicates commercial health insurance. If the insurance information is not updated, a provider's claim will deny for third party liability when the claim is submitted to Medicaid. To prevent this denial and to allow the claim to be processed, the provider must submit a request for an update to the recipient's health insurance information. The request must be completed and the eligibility information must be updated before the provider's claim can be processed.

Medicaid providers now have the option of submitting requests for updates to a recipient's commercial insurance information electronically via secured Internet connection. The existing paper Health Insurance Information Referral Form (DMA-2057) will continue to be available to providers who choose that process, but electronic submission is preferred by DMA.

The new electronic option expedites the processing of commercial insurance information updates and eliminates the need to attach a paper claim to the referral form. Providers can now submit claims electronically. Because electronic requests are completed within two business days, providers will be able to submit claims immediately upon receipt of the confirmation e-mail from the vendor managing this update process, **hms.**

To submit a request, follow these easy steps:

- Go to http://ncprovider.hms.com

- Complete information in all fields:

Recipient Information

Medicaid ID Number:	* ex: 900123456L
Recipient First Name:	*
Recipient Last Name:	*
Insurance Company Name:	*
Policy ID:	*
Comments:	

Provider Contact Information

First Name:	*
Last Name:	*
Provider Name:	*
Provider Phone Number:	( ) - *
Provider Email Address:	*

Submit Query Reset

- Click Submit Query and the information will be sent over a secure channel to **hms.**

The provider will receive an email from **hms** indicating what action has been taken on the insurance information received.

hms
1-866-263-2227 or 919-424-2800

Attention: All Providers

North Carolina Medicaid Preferred Drug List

DMA established a N.C. Medicaid Preferred Drug List (PDL) on March 15, 2010. The N.C. General Assembly [Session Law 2009-451, Sections 10.66(a)-(d)] authorized DMA to establish the PDL in order to obtain better prices for covered outpatient drugs through supplemental rebates. All therapeutic drug classes for which the drug manufacturer provides a supplemental rebate are considered for inclusion on the list with the exception of medications used for the treatment of human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS).

Initially there will **not** be any changes in the drugs that are currently covered. **In the future,** selected therapeutic drug classes will be reviewed by DMA and the Pharmacy and Therapeutics Committee of the N.C. Physicians Advisory Group. Specific drug products within the selected therapeutic drug classes will be "preferred" based on therapeutic effectiveness, safety and clinical outcomes. Generally, these drugs will not require prior authorization (PA) unless there are other clinical PA requirements such as step therapy or quantity limits.

"Non-preferred" drugs (drug products not included in the therapeutic drug classes listed on the PDL) will be available if prior authorization criteria are met. The prior authorization process will be the same process as it is today. If a prescriber deems that the patient's clinical status necessitates therapy with a "non-preferred" drug, the prescriber will be responsible for initiating a prior authorization request.

For therapeutic drug classes that do not appear on the PDL, nothing has changed. Prescribers can prescribe drugs in these classes as in the past, unless existing prior authorization criteria exists.

The PDL is posted on DMA's Outpatient Pharmacy Program's website (http://www.ncdhhs.gov/dma/pharmacy/).

HP Enterprise Services
1-800-688-6696 or 919-851-8888

Attention: All Providers

Enrollment of Medicare/Medicaid Recipients into Community Care of North Carolina/Carolina ACCESS

The N.C. Medicaid Program is making a targeted effort to enroll recipients who are dually eligible for Medicaid and Medicare into Community Care of North Carolina/Carolina ACCESS (CCNC/CA). Medicaid recipients who are Medicare-eligible are an optional group for enrollment into CCNC/CA and can choose to opt out of enrollment at any time.

During January and February, letters were mailed to all dually eligible recipients seen between January 2009 and December 2009 by a provider who is participating as a CCNC/CA primary care provider. The letter informed these recipients that they were being enrolled as a CCNC/CA member with the last primary care provider that they had seen during this time frame. Recipients were informed to contact their county department of social services if they did not wish to be enrolled with the provider identified in their letter.

If you are a CCNC/CA provider who is interested in enrolling a dually eligible Medicaid/Medicare patient that you are seeing in your practice, complete the CCNC/CA Enrollment Form for Medicaid Recipients found on the DMA website at http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm.

When enrolling recipients, you must inform them of their right to opt out or to choose another provider. They must also be informed of their right to disenroll from the program at any time. Disenrolling from the program does not terminate their Medicaid benefits.

Providers who are not currently participating in CCNC/CA as a primary care provider who would like to have more information about becoming a provider with the program may contact the managed care consultant serving their county. The list of consultants can be found on the DMA website at http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm.

Managed Care
DMA, 919-855-4784

Attention: All Providers

CPT Codes 64490, 64491, 64492, 64493, 64494, and 64495

Claims billed with CPT procedure codes 64490 through 64495, in the office setting, for dates of service January 1, 2010, and after, were incorrectly denied. Changes have been applied to the system and providers who received a denial with EOB 36 may now resubmit the denied charges as new claims (not adjustments) for processing.

HP Enterprise Services
1-800-688-6696 or 919-851-8888

Attention: All Providers

Helpful Hints to Ensure a Provider Enrollment Application is Processed Without Delay

On April 20, 2009, CSC took over the provider enrollment, credentialing, and verification functions from DMA's Provider Services unit. In the past six months, the Provider EVC Center has handled over 12,000 applications from providers who applied for participation in the North Carolina Medicaid Program.

Most applications move quickly through the EVC process but occasionally an application is deemed incomplete and processing is suspended until the issue is resolved with the provider. Our goal is to ensure your application is processed in a timely fashion to allow you to become a participating provider with the N.C. Medicaid Program.

To avoid delays in processing provider applications

1. Complete the W-9 form correctly.
2. Provide all of the ownership and managing employee information in the Managing Relationships section of the application.
3. Complete all of the required fields on the application.
4. Provide all of the titles and signatures where required on the application.
5. Review all of the required supplemental documents before the application is submitted.
6. Verify that the signer is an authorized agent for the provider.
7. Submit the correct type of application.
8 Submit the most recent version of the application. The most current version is located at http://www.nctracks.nc.gov/provider/providerEnrollment/.
9. When submitting a request for a change in provider status, verify that the change should be requested using a Medicaid Provider Change Form. Some changes require the provider to submit a new Provider Enrollment Application but most only require the Medicaid Provider Change Form. Refer to the Report a Change in Provider Status section of the NC Tracks website at http://www.nctracks.nc.gov/provider/cis.html.

To assist providers in preparing their enrollment application, the Provider Qualifications and Requirements Checklist is available at http://www.nctracks.nc.gov/provider/providerEnrollment/.

CSC, 1-866-844-1113

Attention: All Providers

Reporting Fraud, Waste, and Program Abuse

DMA's Program Integrity (PI) Section is devoted to ensuring compliance, efficiency, and accountability within the N.C. Medicaid Program by detecting and preventing fraud, waste and program abuse, thus ensuring that Medicaid dollars are paid appropriately. You are encouraged to report matters involving Medicaid fraud and abuse. If you want to report fraud or abuse, you can remain anonymous; however, sometimes in order to conduct an effective investigation, staff may need to contact you. Your name will not be shared with anyone investigated. (In rare cases involving legal proceedings, we may have to reveal who you are.)

To report suspected Medicaid fraud, waste or program abuse by a medical provider:

- contact DMA by calling the CARE-LINE Information and Referral Service at 1-800-662-7030 (English or Spanish) and ask for the DMA Program Integrity Section; or
- call DMA's Program Integrity Section directly at 1-877-DMA-TIP1 (1-877-362-8471); or
- call the State Auditor's Waste Line at 1-800-730-TIPS (1-800-730-8477); or
- call the Health Care Financing Administration Office of Inspector General's Fraud Line at 1-800-HHS-TIPS (1-800-447-8477); or
- complete and submit a Medicaid fraud and abuse confidential online complaint form on DMA's website at http://www.ncdhhs.gov/dma/fraud/reportfraudform.htm.

Examples of Medicaid Fraud and Abuse by Medical Providers (list is not all-inclusive)

- Medicaid recipient failed to report other insurance when applying for Medicaid
- non-recipient uses a recipient's Medicaid card with or without recipient's knowledge
- provider's credentials/qualifications are not accurate
- provider bills for services that were not rendered
- provider performs and bills for services not medically necessary
- provider alters claim forms and recipient records

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Flu Testing: CPT Code 87804

The December 2009 Medicaid bulletin article titled *Flu Testing: CPT Codes 87400 and 87804* instructed providers to bill two units of CPT code 87804 (infectious agent antigen detection by immunoassay with direct optical observation; influenza) with the QW modifier for flu testing. However, claims have continued to deny. Providers who wish to bill for two influenza tests should now bill CPT code 87804: one unit with the QW modifier and one unit with QW modifier along with 76 modifier.

Providers who have billed more than one flu test on the same day of service and received a denial with EOB 5201 (Diagnostic procedure allowed once per day unless billed with appropriate modifier) or EOB 7701 (Combination of billed modifiers is invalid, please review and resubmit with the correct billing combination) may correct and resubmit the denied claim for payment if they have filed their claims timely.

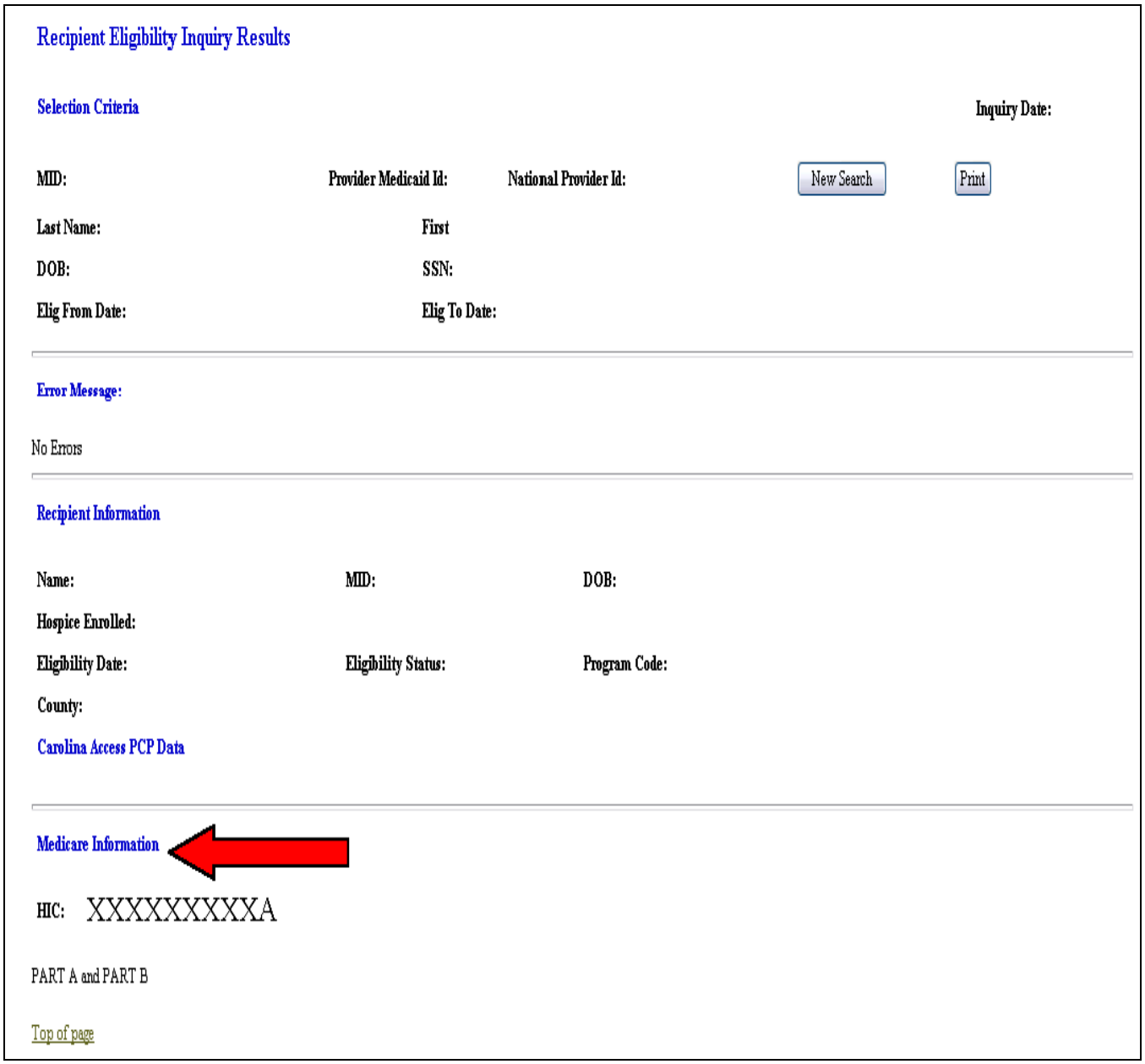
HP Enterprise Services
1-800-688-6696 or 919-851-8888

Attention: All Providers

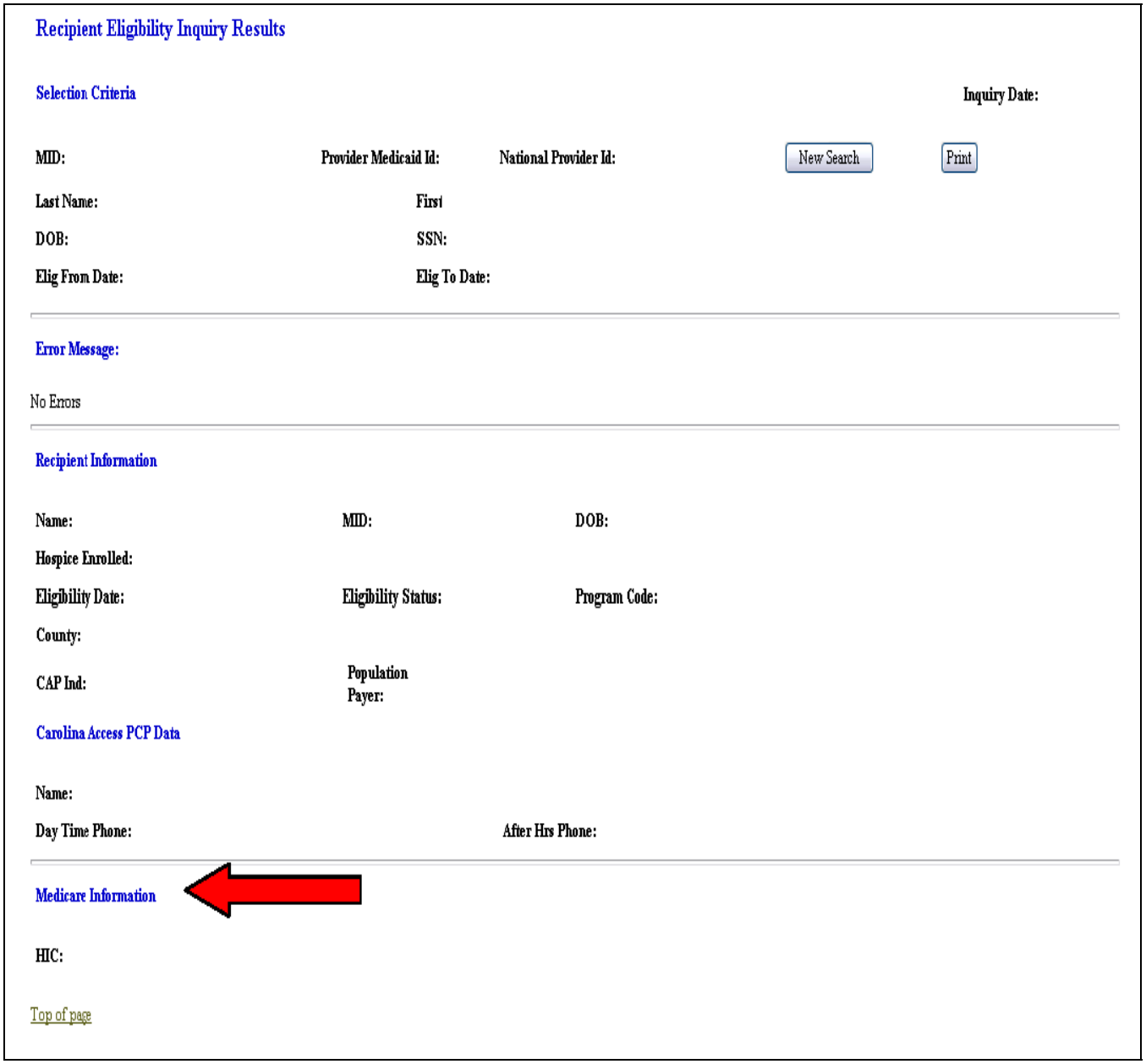
North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool: Medicare Indicators

The NCECS Web Tool provides recipient eligibility information. A recipient's Medicare information, including enrollment for Part A, Part B or both, is available. Refer to the illustrations below for examples of the Medicare information.

Recipient is Eligible for Medicare



Recipient is Not Eligible for Medicare



Recipient Eligibility Inquiry Results

Selection Criteria

Inquiry Date:

MID: Provider Medicaid Id: National Provider Id: New Search Print

Last Name: First

DOB: SSN:

Elig From Date: Elig To Date:

Error Message:

No Errors

Recipient Information

Name: MID: DOB:

Hospice Enrolled:

Eligibility Date: Eligibility Status: Program Code:

County:

CAP Ind: Population
Payer:

Carolina Access PCP Data

Name:

Day Time Phone: After Hrs Phone:

Medicare Information

HIC:

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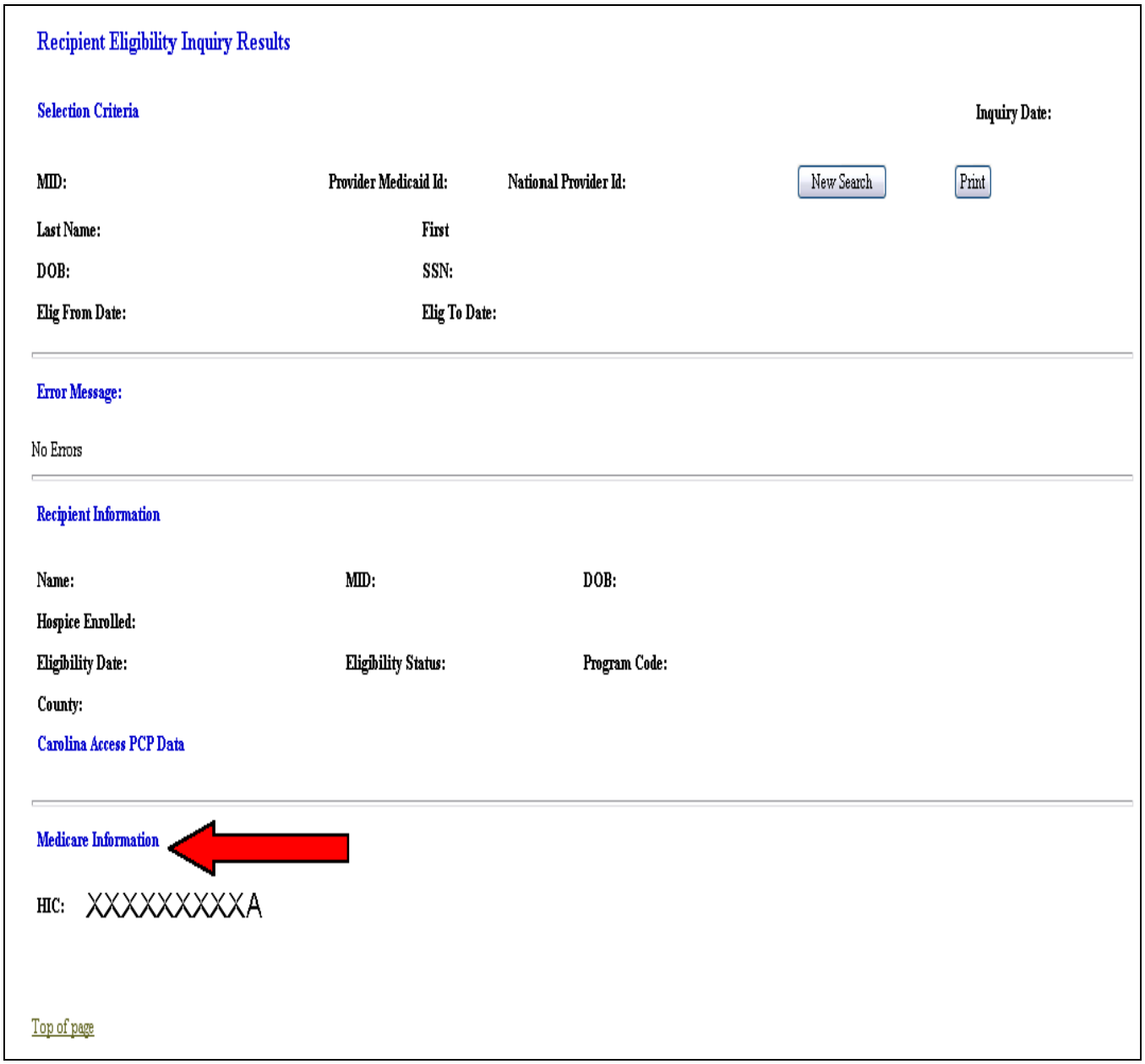
If the health insurance claim (HIC) number is displayed on the screen without showing Part A and/or Part B coverage, it may mean that the recipient is not eligible for Medicare. In this case, providers should use another method to verify Medicare eligibility.

Recipient May Not Be Eligible for Medicare


Recipient Eligibility Inquiry Results

Selection Criteria

Inquiry Date:

MID: Provider Medicaid Id: National Provider Id: New Search Print

Last Name: First

DOB: SSN:

Elig From Date: Elig To Date:

Error Message:

No Errors

Recipient Information

Name: MID: DOB:

Hospice Enrolled:

Eligibility Date: Eligibility Status: Program Code:

County:

Carolina Access PCP Data

Medicare Information

HIC: XXXXXXXXXA

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For additional information on verifying recipient eligibility, refer to the *Basic Medicaid Billing Guide* (http://www.ncdhhs.gov/dma/basicmed/) and the January 2010 Medicaid Bulletin (http://www.ncdhhs.gov/dma/bulletin/0110bulletin.htm). For detailed information on the NCECSWeb Tool, refer to the September 2009 Special Bulletin, *North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool Instruction Guide*, on DMA's website at http://www.ncdhhs.gov/dma/bulletin/.

HP Enterprise Services
1-800-688-6696 or 919-851-8888

Attention: All Providers

Health Check/EPSDT Seminars

Health Check/EPSDT seminars are scheduled for May 2010 at the sites listed below. Information presented at the Health Check/EPSDT seminars is applicable to all providers who provide early and regular medical and dental screenings for Medicaid recipients under the age of 21.

The April 2010 *Health Check Billing Guide* will be used as the primary training document for the seminar. Please print a copy of the *Health Check Billing Guide* for review and bring it to the seminar. If preferred, you may download the *Health Check Billing Guide* to a laptop and bring the laptop to the seminar. Or, you may access the *Health Check Billing Guide* online using your laptop during the seminar. However, please note that HP Enterprise Services cannot guarantee a power source or Internet access for your laptop.

Pre-registration is required. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the seminars by completing and submitting the online registration form, or providers may register by fax using the form below (fax it to the number listed on the form). Please indicate the session you plan to attend on the registration form.

Sessions will begin at 9:00 a.m. and end at 12:00 noon. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided at the seminars. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Date	Location
May 6, 2010	**Asheville** Mountain Area Health Education Center (MAHEC) 501 Biltmore Avenue Asheville NC 28801
May 13, 2010	**Greensboro** Clarion Hotel Airport 415 Swing Road Greensboro NC 27409
May 17, 2010	**Raleigh** The Royal Banquet and Convention Center 3801 Hillsborough Street Raleigh NC 27607
May 20, 2010	**Wilmington** Hampton Inn Medical Park 2320 South 17th Street Wilmington NC 28401

HP Enterprise Services
1-800-688-6696 or 919-851-8888

Health Check/EPSDT Workshops
May 2010 Seminar Registration Form
(No Fee)

Provider Name _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (_____) _____ Fax Number _____

1 or **2** person(s) will attend the seminar at _____ on _____
(circle one) (location) (date)

Please fax completed form to: 919-851-4014
Please mail completed form to:
HP Provider Services
P.O. Box 300009
Raleigh, NC 27622

Attention: All Providers

Coming Soon: Remittance and Status Reports in PDF Format

The N.C. Medicaid Program is in the process of expanding our North Carolina Electronic Claims Submission/Recipient Eligibility Verification (NCECS) Web Tool for providers to download a PDF version on their paper Remittance and Status Report (RA). Once the expansion is complete, paper RAs will no longer be printed and mailed to providers. Providers will be notified of the expansion via the Medicaid Bulletin.

HP Enterprise Services
1-800-688-6696 or 919-851-8888

Attention: All Providers

DMA Prior Approval Information Web Page

DMA has created a new web page with information about prior approval. The page includes contact information, forms, links to best practice guidelines used by DMA and vendor staff, and frequently asked questions as well as general information about the approval process. Providers can access the new page at http://www.ncdhhs.gov/dma/provider/priorapproval.htm.

Provider Services
DMA, 919-855-4050

Attention: HIV Case Management Providers

Transfer of HIV Case Management Operations

Effective April 1, 2010, the Division of Public Health will no longer be the operating agency for HIV Case Management services. A new vendor will be announced soon along with appropriate contact numbers. Please be advised that any existing applications or future applications for new HIV case management providers will be reviewed under the new requirements recently approved by CMS. A new HIV Case Management policy will be posted in an upcoming month. Until then, please direct any questions to Victoria Landes, HIV Program Consultant at DMA, 919 855 4389.

Victoria Landes HIV Program
DMA, 919-855-4389

Attention: Behavioral Health Care Providers

DHHS/DMA Program Integrity Contract with Public Consulting Group

Medicaid services are provided to recipients in all 100 North Carolina counties. In accordance with 42 CFR Part 455, which sets forth requirements for a State fraud detection and investigation program, DMA's Program Integrity Section investigates Medicaid providers when clinically suspect behaviors or administrative billing patterns indicate potentially abusive or fraudulent activity.

The review of providers of community behavioral health services has presented unique challenges. These challenges and the related volume of cases have resulted in a backlog that requires immediate attention. Program Integrity is committed to initiating these reviews and safeguarding against unnecessary or inappropriate use of Medicaid services and against excess payments.

In accordance with 10A NCAC 22F.0202, a Preliminary Investigation shall be conducted on all complaints received or aberrant practices detected, until it is determined that there are sufficient findings to warrant a full investigation; or there is sufficient evidence to warrant referring the case for civil and/or criminal fraud action; or there is insufficient evidence to support the allegation(s) and the case may be closed.

Effective January 28, 2010, Public Consulting Group (PCG), will assist the DMA's Program Integrity Behavioral Health Review Section in eliminating the backlog of cases and prospectively maintaining a steady state of case reviews, preventing a future backlog of cases from accumulating. For assigned cases, PCG will absorb the full scale of operations, beginning with the receipt of a case file, conducting the clinical review, establishing a statistically valid claim review sample for review, and extrapolating these findings to calculate the recoupment.

PCG will initiate contact with the provider, inform the provider of the post payment review process requirements, and work closely with the provider and DMA. PCG will advise the provider where and how to submit records for the review, and will address provider questions regarding the post-payment review process. If the provider is out of compliance, a recoupment letter shall be forwarded to the provider in the amount of the overpayment. The provider will have reconsideration and appeals rights if the provider does not agree with the findings of the review. Reconsideration and appeal rights instructions will be sent out with the recoupment letter.

If the preliminary investigation supports the conclusion of possible fraud, the case shall be referred to the appropriate law enforcement agency for a full investigation.

Program Integrity Behavioral Health Review Section
DMA, 919-647-8000

Attention: Nurse Practitioners

CPT Codes 57452, 57454, and 57505

Effective with date of service March 1, 2010, nurse practitioners can bill and receive reimbursement for CPT procedure codes 57452, 57454, and 57505. To qualify for reimbursement, the nurse practitioner must have formal education and training in the procedure, be validated as competent in performing the procedure, and the procedure must be included in the Collaborative Practice Agreement signed by the nurse practitioner and the primary supervising physician.

HP Enterprise Services
1-800-688-6696 or 919-851-8888

Attention: Nurse Practitioners and Physicians

C1 Esterase Inhibitor (Human) Injectable, 10 Units (Berinert, HCPCS Code J3590): Revised Billing Guidelines

Billing guidelines for the injectable drug C1 esterase inhibitor were published in the February 2010 Medicaid Bulletin and indicated that billing with HCPCS code J0598 applied to both Cinryze and Berinert. The article is being republished to document that the use of HCPCS code J3590 for C1 esterase inhibitor must be used to bill for Berinert. Refer to the article on page 18 for guidelines on billing for Cinryze.

Effective with date of service January 1, 2010, the N.C. Medicaid Program covers C1 esterase inhibitor (human) injectable (Berinert) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologics). Berinert is available as single-use vials for reconstitution containing 500 units of lyophilized concentrate with 10 ml of diluent per vial.

Berinert is a plasma-derived C1 esterase inhibitor (human) indicated for the treatment of acute abdominal or facial attacks of hereditary angioedema (HAE) in **adult and adolescent patients**.

Treatment with Berinert should be through intravenous injections of 20 units per kg of body weight at a rate of 4 ml per minute.

For Medicaid Billing

- The ICD-9-CM diagnosis code required when billing for Berinert is 277.6 (other deficiencies of circulating enzymes – hereditary angioedema).
- Providers must bill Berinert with HCPCS code J3590 (unclassified biologics).
- Providers must indicate the number of HCPCS units used.
- One Medicaid unit of coverage is 10 units. Berinert is supplied as a single-use vial; therefore, billing of a whole vial, including wastage, is permitted. The maximum reimbursement rate, per 10 units, is $35.92. The maximum reimbursement rate, per single-use vial containing 500 units, is $1,795.75.
- Providers must bill with the 11-digit National Drug Code (NDC) and appropriate NDC units. When calculating the NDC units used, the drug in its original state must be considered, NOT the reconstituted amount. The NDC units for Berinert should be reported as "units." If billing for the entire single-dose vial of Berinert, report the NDC units as "UN1." If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for instructions.
- Providers must bill their usual and customary charge.

The new fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

HP Enterprise Services
1-800-688-6696 or 919-851-8888

Attention: Nurse Practitioners and Physicians

C1 Esterase Inhibitor (Human) Injectable, 10 Units (Cinryze HCPCS Code J0598): Revised Billing Guidelines

Billing guidelines for the injectable drug C1 esterase inhibitor were published in the February 2010 Medicaid Bulletin and indicated that billing with HCPCS code J0598 applied to both Cinryze and Berinert. The article is being republished to document that the use of HCPCS code J0598 for C1 esterase inhibitor applies only to Cinryze. Refer to the article on page 17 for guidelines on billing for Berinert.

Effective with date of service January 1, 2010, the N.C. Medicaid Program covers C1 esterase inhibitor (human) (Cinryze), for use in the Physician's Drug Program when billed with HCPCS code J0598. Cinryze is available as 8-ml single-use vials with approximately 500 units of lyophilized powder per vial.

Cinryze is indicated for routine prophylaxis against angioedema attacks in **adolescent and adult patients** with hereditary angioedema (HAE). Cinryze is a replacement product, working on one's own natural C1 inhibitor to regulate clotting and inflammatory reaction that, when impaired, can lead to tissue swelling.

The recommended dosage of Cinryze is 1,000 units (2 vials) of Cinryze administered intravenously every 3 or 4 days. Cinryze is administered at an injection rate of 1 ml per minute.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Cinryze is 277.6 (other deficiencies of circulating enzymes, hereditary angioedema).
- Providers must bill Cinryze with HCPCS code J0598.
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage is 10 units. Providers may bill for an entire single-use vial. The maximum reimbursement rate, per 10 units, is $41.98. The maximum reimbursement rate, per single-use vial containing 500 units, is $2,098.99.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Cinryze should be reported as "units." The drug in its original state must be considered, NOT the reconstituted amount. If billing for the entire single-dose vial, report the NDC units as "UN1." If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Providers must bill their usual and customary charge.

The new fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

HP Enterprise Services
1-800-688-6696 or 919-851-8888

Attention: Community Alternatives Case Managers, Home Health Agencies, and Private Duty Nursing Providers

Additions to the Home Health Medical Supply Fee Schedule

Effective with date of service November 1, 2009, the following codes were added to the Home Health Medical Supply Fee Schedule. Included on the list of codes are the monthly maximum limits for private duty nursing (PDN) providers. The limits apply to only recipients 21 years of age or older regardless of whether they are approved for PDN services or not.

Providers should be cautioned that there is no entitlement to the recipient for receiving the maximum quantity available. The quantity of medical supplies provided should be based solely on medical necessity for the individual recipient. Please refer to the Home Health Fee Schedule on DMA's website (http://www.ncdhhs.gov/dma/fee/) for maximum reimbursement rates.

HCPCS Code	Description	Maximum Monthly Limitations PDN Providers
Ostomy Supplies		
A4361	Ostomy faceplate	3/6 mo
A4368	Ostomy filter	60/mo
A4376	Ostomy pouch, drainable, with faceplate attached, rubber, each.	3/mo
A4378	Ostomy pouch, drainable, for use on faceplate, rubber, each.	3/mo
A4380	Ostomy pouch, urinary, with faceplate attached, rubber, each.	3/mo
A4382	Ostomy pouch, urinary, for use on faceplate, heavy plastic, each	3/mo
A4383	Ostomy pouch, urinary, for use on faceplate, rubber, each	3/mo
A4384	Ostomy faceplate equivalent, silicone ring, each.	3/6 months
A4389	Ostomy pouch, drainable, with barrier attached, with convexity (one-piece), each.	20/month
A4390	Ostomy pouch, drainable, with extended barrier attached, with convexity (one-piece)	60/month
A4391	Ostomy pouch, urinary, with extended wear barrier attached, (one-piece), each	20/month
A4392	Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity, (one-piece), each	20/month
A4393	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, (one-piece), each	20/month
A4395	Ostomy deodorant for use in ostomy pouch, solid, per tablet	100/month
A4396	Ostomy belt with peri-stomal hernia support	1/6 month
A4402	Lubricant, per oz	4/month
A4412	Ostomy pouch, drainable, high output, for use on a barrier with flange (two-piece system), without filter	20/month
A4413	Ostomy pouch, drainable, high output, for use on a barrier with flange (two-piece system)	20/month
A4422	Ostomy absorbent material (sheet, pad, crystal packet) for use in ostomy pouch to thicken liquid stomal output, each	100 per mo
A5093	Ostomy Accessory; convex insert	10/mo
A5102	Bedside drainage bottle with or without tubing, rigid or expandable, each.	1/month
A5131	cleaner, incontinence and ostomy appliances, per 16 oz	1/month

HCPCS Code	Description	Maximum Monthly Limitations PDN Providers
Dressing Supplies		
A6010	Collagen based wound filler, dry form, sterile, per gram of collagen	n/a
A6011	Collagen based wound filler, gel/paste, sterile, per gram of collagen	n/a
A6021	Collagen dressing, sterile, pad size 16 sq. in. or less, each	n/a
A6022	Collagen dressing, sterile, pad size more than 16 sq. in. but less than or equal to 48 in	n/a
A6240	Hydrocolloid dressing, wound filler, paste, sterile, per ounce	n/a
A6241	Hydrocolloid dressing, wound filler, dry form, sterile, per gram	n/a
A6254	Specialty absorptive dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing	n/a
A6255	Specialty absorptive dressing, wound cover, sterile, pad size more than 16 in but less than or equal to 48 sq. in., with any size adhesive border, each dressing	n/a
A6441	Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per yard	n/a
A6442	Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard	n/a
A6448	Light compression bandage, elastic, knitted/woven, width less than three inches, per yard	n/a

HP Enterprise Services
1-800-688-6696 or 919-851-8888

Attention: CAP/C Case Managers, Home Health Agencies, and Private Duty Nursing Providers

Medical Supplies Provision for Recipients Approved for Private Duty Nursing Services

Home health skilled nursing services are not covered on the same day as private duty nursing (PDN) services. The PDN nurse must provide all of the nursing care needed in the home for the PDN recipient. The PDN provider assumes the responsibility for providing medical supplies and billing Medicaid for the supplies as part of the PDN service. This guideline also applies to CAP/C Nursing (HCPCS code T1000) under the CAP/C program.

Specialized therapies may be provided during the same time period that a PDN recipient is receiving PDN services.

Refer to Section 7.3.1 of Clinical Coverage Policy 3A, *Home Health Services*, on DMA's website at http://www.ncdhhs.gov/dma/mp/.

HP Enterprise Services
1-800-688-6696 or 919-851-8888

Attention: Private Duty Nursing Providers

Clarification on Provision of Medical Supplies for Recipients Without Private Duty Nursing Coverage

Effective September 1, 2009, private duty nursing (PDN) providers can provide incontinent, ostomy, and urological (IOU) medical supplies to any eligible Medicaid recipient regardless of whether the recipient has been approved for PDN services. Providers were notified of this provision in an article published in the September 2009 Medicaid Bulletin. This article provides additional information and further clarification of the criteria for providing this service.

The provision of medical supplies to Medicaid recipients without PDN coverage is limited to IOU supplies. Providers must adhere to the criteria outlined in the September 2009 bulletin article. Clarification to the criteria for this provision is as follows.

- The limitations apply to recipients 21 years of age and older. Supplies for recipients under 21 years of age have no monthly maximum limits. The monthly limits on these supplies should be based on medical necessity and physician orders as documented in the plan of care.
- The PDN provider is required to meet all of the home care needs of the PDN-approved recipient when agreeing to provide care for the recipient. The PDN provider musts determine if it can provide all of the skilled nursing care and medical supplies needed by the recipient prior to accepting a recipient for PDN services. Home health skilled nursing visits and provision of supplies are not allowed when the recipient is receiving PDN nursing services (see EPSDT exception below). This provision would include specimen collection for laboratory test (i.e., blood draws).
- The reference in the September bulletin to a referral to a home health agency for medical needs that exceed the quantity limits pertains to only recipients with no PDN approval and cannot be applied to PDN-approved recipients.

Providers are reminded that under EPSDT, the policy limits do not apply to recipients under 21 years of age. Services can be provided to these recipients to the extent of medical necessity, or to correct or ameliorate the recipient's condition as long as all of the EPSDT criteria are met. A request for coverage under EPSDT to exceed the policy limits is required prior to exceeding the limits. The request is submitted to DMA using the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age or a letter of medical necessity from the provider that addresses all of the EPSDT criteria. The EPSDT coverage criteria can be found on the DMA website at http://www.ncdhhs.gov/dma/epsdt/.

The limitations on the IOU supplies listed below have been increased to allow more flexibility in meeting the medical needs of the recipient. These limits apply to only the recipients 21 years of age and older regardless of whether they are PDN-approved or non-PDN-approved recipients.

Providers should be cautioned that there is no entitlement for the recipient to receive the maximum quantity available. The quantity of medical supplies provided should be based solely on medical necessity for each individual recipient.

HCPCS Code	PDN-Provided Medical Supplies Description	Unit	Monthly Maximum Limits
A4554	Disposable underpads, all sizes (e.g. Chux's)	each	200
T4521	Adult sized disposable incontinence product, brief/diaper, small	each	225
T4522	Adult sized disposable incontinence product, brief/diaper, medium	each	225
T4523	Adult sized disposable incontinence product, brief/diaper, large	each	225

HCPCS Code	PDN-Provided Medical Supplies Description	Unit	Monthly Maximum Limits
T4524	Adult sized disposable incontinence product, brief/diaper, extra large	each	225
T4529	Pediatric sized disposable incontinence product, brief/diaper, small/medium size	each	225
T4530	Pediatric sized disposable incontinence product, brief/diaper, large size	each	225
T4533	Youth-sized disposable incontinence product, brief/diaper	each	225
A4927	Non-sterile exam gloves	100/box	2
A4321	Therapeutic agent for urinary catheter irrigation (acetic acid - 250 to 1,000 cc)	1 bottle	3
A6216	Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border	each	400

HP Enterprise Services
1-800-688-6696 or 919-851-8888

Attention: Children's Developmental Service Agencies, Health Departments, Home Health Providers, Hospital Outpatient Clinics, Independent Practitioners, Local Education Agencies, Local Management Entities, and Physicians

Outpatient Specialized Therapies Prior Authorization Process: Post-Payment Validation

Beginning April 2010, The Carolinas Center for Medical Excellence (CCME) will implement post-payment validation on paid therapy claims. Validation will initially occur for service dates July 1, 2009, through November 30, 2009. Providers will be notified of recipients selected in the sample and documentation for those recipients, such as the therapy order, evaluation, and progress notes, will be requested. This documentation will be reviewed for compliance with policy requirements. If documentation for service dates is found to be non-compliant with policy requirements, recoupment of monies paid will be determined and providers will be notified of overpayment.

An informational power point presentation and additional details about the post-payment validation process are posted on CCME's prior authorization website, http://www.medicaidprograms.org/nc/therapyservices. Providers who billed for therapy services between July and November 2009 are encouraged to register for secure web access on CCME's prior authorization website (http://www.medicaidprograms.org/nc/therapyservices) to view information about the post-payment validation process.

CCME, 1-800-228-3365

Attention: TCM/DD Case Managers

Transition to Annual Authorization for Non-Waiver TCM/DD Services

Effective May 1, 2010, all requests for non-waiver targeted case management services for developmental disabilities will be authorized on an annual schedule rather than the current process of quarterly authorizations. The annual schedule is based on the recipient's birth month. The effective date of the annual authorization period will be the first day of the month following the recipient's birth month and the end of the authorization period will be the last day of the recipient's birth month.

Example 1

If the recipient's birthday is in June, the annual authorization period will be July 1, 2010, through June 30, 2011.

Any request submitted to ValueOptions on, or after, May 1, 2010, will be authorized through the last day of the recipient's birth month.

Example 2

A request with a start date of May 1, 2010, with the recipient's birth month of November, will have an authorization period of May 1 through November 30, 2010.

Requests received by ValueOptions prior to May 1, 2010, will be authorized for 90 days. Prior to the end of the 90-day period, the case manager is to submit a request with an end date of the last day of the recipient's birth month.

Example 3

A request with a start date of April 1, 2010, with the recipient's birth month of November will have an authorization period of April 1, 2010, through June 30, 2010. The case manager will then submit a request, prior to June 30, 2010, with a start date of July 1, 2010, and an end date of November 30, 2010.

Behavioral Health Section
DMA, 919-855-4290

Attention: Local Management Entities, Outpatient Behavioral Health Providers, and Provisionally Licensed Providers

Extension of Coverage for Provisionally Licensed Providers Billing Outpatient Behavioral Health Services through the Local Management Entity

The March 2010 Medicaid Bulletin and Implementation Update #70 reported on the extension of coverage of provisionally licensed providers delivering outpatient behavioral health services as a reimbursable service under Medicaid and state funds and billed through the Local Management Entity (LME) to June 30, 2011. This bulletin article listed the HCPCS procedure codes that could be utilized to bill for services delivered by the provisionally licensed individuals. These codes were codes H0001, H0004, and H0005. HCPCS procedure code H0031 was inadvertently omitted and should be added to the above list of procedure codes.

Catharine Goldsmith, Behavioral Health Section
DMA, 919-855-4290

Attention: Adult Care Home Providers, CAP/MR-DD Service Providers, Enhanced Behavioral Health (Community Intervention) Services Providers, Personal Care Services Providers, and Residential Child Care Treatment Facilities

Clarification of Suspension of Mandatory Cost Reporting for Rate Adjustments

Effective January 1, 2010, mandatory Medicaid cost reports for the above mentioned providers are suspended until rescinded by the Secretary of the N.C. Department of Health and Human Services (DHHS). The official DHHS notification can be found on DMA's website at http://www.ncdhhs.gov/dma/cost/reports.htm. Specific questions may be addressed to the contacts identified in the notification.

It is important to note that any outstanding cost reports due prior to December 31, 2009, are due and must be filed with the appropriate DHHS Division. This suspension is for cost reports only; cost settlements will continue on the filed cost reports for those providers that are part of the cost settlement process.

Frequently Asked Questions

1. Should any adult care homes that filed PCS settlement forms due January 31, 2010, ask that these forms be returned and any funds that were paid as a result of the filing of these forms be refunded?

The memo published suspended the cost reports due on or after January 1, 2010; not the settlements associated with cost reports due on or before December 31, 2009. Therefore, DMA shall continue the settlement process for adult care home providers whose cost report was due prior to the suspension. The settlement forms that were due on January 31, 2010, are associated with those cost reports due on or before December 31, 2009, that have not yet been returned. If the settlement form due on January 31, 2010, showed monies due to DMA, those monies are required to be paid if the provider has not already done so. For amounts due to DMA as calculated on the settlement forms due January 31, 2010, and have been paid will not be returned to the provider since it was a settlement for the cost report due on December 31, 2009.

2. For adult care homes that have not filed personal care service settlement forms that were due January 31, 2010, should they file them at this point?

The memo published suspended the cost reports due on or after January 1, 2010; not the settlements associated with cost reports due on or before December 31, 2009. Therefore, DMA shall continue the settlement process for adult care home providers whose cost report was due prior to the suspension. If a provider has not sent DMA the settlement form associated with the cost report due on or before December 31, 2009, they should do so now.

3. How will the State settle future personal care services payments if cost reports are not required; or, will they be settled?
We have several clients whose buildings are heavy Special Care Unit (SCU) buildings. We have been preparing interim payback calculations for these clients. They are asking us if these calculations should be performed. Although it is clear cost reports are not required, most of our heavy SCU clients, due to the size of their paybacks in the past (some over $100,000), are reluctant to accept these paybacks will simply "go away" without further definitive guidance from the State. There is significant planning that occurs relative to these paybacks and our clients are unwilling to just hope there will be no more paybacks. Additional written guidance relative to this matter is appreciated.

DMA will not do cost settlements associated with cost reports that are suspended.

Finance Management
DMA, 919-855-4180

Attention: Personal Care Services Providers

Implementation of Independent Assessment, Prior Authorization, and New Personal Care Services and PCS-Plus Clinical Coverage Policy

Independent assessment of personal care services (PCS) recipients is being implemented in response to Session Law 2009-451 (Senate Bill 202), Section 10.68A.(a)(3) (http://www.ncga.state.nc.us/Sessions/2009/Bills/Senate/PDF/S202v8.pdf). The Carolinas Center for Medical Excellence (CCME) was awarded the contract to conduct PCS independent assessments.

All PACT forms received by CCME on or before March 19, 2010, have been reviewed. Denial of service notifications will be mailed by April 9, 2010, to recipients and providers regarding recipients who do not meet program qualifying criteria. Requests for additional information will be mailed to providers regarding recipients whose PACT forms lack critical information or documentation. The timeline for mailing requests for additional information will be announced on the **Independent Assessment website** (http://www.qireport.net/). Payments for prior services not provided in compliance with program policy are subject to recoupment.

Independent assessment, prior authorization, and the new clinical coverage policy for PCS and PCS-Plus (http://www.ncdhhs.gov/dma/mp/) will be implemented April 1, 2010. Effective April 1, 2010, the following changes will occur:

1. **New Referrals and Admissions**
   All individuals applying for admission to PCS or PCS-Plus must obtain a referral through their primary care or attending physician. New referral forms and instructions may be accessed on the DMA website (http://www.ncdhhs.gov/dma/services/pcs.htm) and the **Independent Assessment website** (http://www.qireport.net/).

   CCME will contact individuals applying for admission to schedule appointments for independent assessments.

   Between April 1 and April 16, 2010, providers may conduct only those new referral assessments that were scheduled before April 1, 2010.

2. **Change of Status Reviews**
   CCME will conduct all change of status reassessments. Referral forms and instructions for requesting change of status reviews may be accessed on the DMA website (http://www.ncdhhs.gov/dma/services/pcs.htm) and the **Independent Assessment website** (http://www.qireport.net/).

3. **Continuing Service (Annual) Reassessments**
   CCME will conduct PCS and PCS-Plus continuing service reassessments. During April 2010, CCME will begin conducting reassessments of recipients whose PACTs will expire in May 2010. CCME will notify providers and contact recipients to schedule these reassessments. CCME may request assistance from providers if recipients cannot be reached.

   During April 2010, providers should conduct reassessments for PCS and PCS-Plus recipients as their assessment dates come due. The last day providers will conduct continuing service reassessments is April 30, 2010. Beginning May 1, 2010, CCME will conduct all reassessments.

4. **Recipient Choice of Provider**
   Individuals approved for PCS may choose any qualified home care agency licensed to provide PCS in the recipient's county. CCME assessors will provide recipients with randomized lists of licensed providers from which to choose. It is the responsibility of the provider agency to ensure that its provider enrollment information is current with DMA.

5. **Prior Authorization**

All assessments and reassessments conducted by CCME will determine recipient eligibility and authorized service levels. Prior approval of these recipients' claims will be required. Claims for services that exceed levels authorized by CCME will be denied.

6. **Claims Processing Requirements**

Implementation of independent assessment will involve additional claims processing requirements. In order to process PCS claims, a complete roster that identifies each provider's Medicaid PCS recipients is required. To ensure prompt claims processing and payment, providers who have not previously submitted PACT forms for all current recipients should submit recipient information immediately. Use one of the following two methods:

a. Submit PACT forms for all current recipients using and following instructions on the PACT Face Sheet (see the **Independent Assessment website**).

b. In lieu of submitting recipient PACT forms, providers may prepare and submit to CCME a summary that includes the following:

   1) Agency name;
   2) Medicaid provider number;
   3) Agency physical address;
   4) Agency contact person, telephone number, and e-mail address; and
   5) A list, alphabetized by recipient last name, of each PCS recipient's Medicaid identification number, date of birth, date of current PACT form, and first and last name.

Beginning April 1, 2010, please allow two weeks after sending recipient information before submitting claims for new recipients, as payments will be delayed until CCME receives and transmits this information to the claims vendor. Once recipient information has been processed by the claims vendor, unprocessed claims may be re-submitted for payment.

7. **Weekly Summaries**

Continue to submit to CCME updates of new recipients you assess and admit through April 16, 2010, and of continuing recipients you reassess through April 30, 2010. Either use and follow instructions in Part 1 of the Weekly Summary Form (see the **Independent Assessment website**), or use the method described in paragraph 6.b., above, to submit information for newly admitted and reassessed recipients.

Until further notice, continue to submit weekly discharge updates to CCME, using and following instructions in Part 2 of the Weekly Summary Form (see the **Independent Assessment website**).

Providers will not be required to submit new admission or reassessment updates for recipients assessed by CCME.

8. **Compliance with New PCS Clinical Coverage Policy**

The new PCS and PCS-Plus Clinical Coverage Policy 3C (http://www.ncdhhs.gov/dma/mp/) is in effect. The policy includes changes required by Session Law 2009-451 (Senate Bill 202), Section 10.68A.(a)(3), including changes in Non-Covered Tasks. Providera must update Plans of Care (POCs) to comply with the new policy and must implement the revised POCs by April 30, 2010. POC revisions made in response to policy changes in Non-Covered Tasks may be signed as RN updates. DMA will not require physician signature or approval of these changes. Further guidance on updating POCs to comply with the new policy will be available on the **Independent Assessment website.**

Refer to the **Independent Assessment website** and future bulletin articles for additional information and updates. Questions also may be directed to the CCME Independent Assessment Help Line at 1-800-228-3365 and by e-mail to PCSAssessment@thecarolinascenter.org.

CCME, 1-800-228-3365

Early and Periodic Screening, Diagnosis and Treatment and Applicability to Medicaid Services and Providers

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria stated in this publication **may be exceeded or may not apply to recipients under 21 years of age** if the provider's documentation shows that

- the requested service is medically necessary to correct or ameliorate a defect, physical or mental illness, or health problem; and
- all other Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) criteria are met.

This applies to both proposed and current limitations. Providers should review any information in this publication that contains limitations in the context of EPSDT and apply that information to their service requests for recipients under 21 years of age. A brief summary of EPSDT follows.

EPSDT is a federal Medicaid requirement (42 U.S.C. § 1396d(r) of the Social Security Act) that requires the coverage of services, products, or procedures for Medicaid recipients under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (including any evaluation by a physician or other licensed clinician).

This means that EPSDT covers most of the medical or remedial care a child needs to

- improve or maintain his or her health in the best condition possible OR
- compensate for a health problem OR
- prevent it from worsening OR
- prevent the development of additional health problems

Medically necessary services will be provided in the most economic mode possible, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure that is unsafe, ineffective, experimental, or investigational; that is not medical in nature; or that is not generally recognized as an accepted method of medical practice or treatment.

If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **not** eliminate the requirement for prior approval.

For important additional information about EPSDT, please visit the following websites:

- *Basic Medicaid Billing Guide* (especially sections 2 and 6): http://www.ncdhhs.gov/dma/basicmed/
- *Health Check Billing Guide:* http://www.ncdhhs.gov/dma/healthcheck/
- EPSDT provider information: http://www.ncdhhs.gov/dma/epsdt/

Proposed Clinical Coverage Policies

In accordance with NCGS §108A-54.2, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's website at http://www.ncdhhs.gov/dma/mpproposed/. To submit a comment related to a policy, refer to the instructions on the website. Providers without Internet access can submit written comments to the address listed below.

Richard K. Davis
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh NC 27699-2501

The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is revised as a result of the initial comment period.

2010 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
April	4/1/10	4/6/10
	4/8/10	4/13/10
	4/15/10	4/22/10
May	4/29/10	5/4/10
	5/6/10	5/11/10
	5/13/10	5/18/10
	5/20/10	5/27/10

Electronic claims must be transmitted and completed by 5:00 p.m. on the cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite following the transmission date.

Craigan L. Gray, MD, MBA, JD
Director
Division of Medical Assistance
Department of Health and Human Services

Melissa Robinson
Executive Director
HP Enterprise Services