April 2011 Medicaid Bulletin

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Attention: All Providers

School Based Health Center

The Provider Type section of the downloadable version (PDF) and the online version of the **Organization In-State/Border** application (with and without CCNC/CA) has been updated to include school based health center (SBHC) (sponsored by a federally qualified health center, physician group, nurse practitioner group or health department) as an option in the **Outpatient Clinic/Facility** category.

The Provider Qualification and Requirements Checklist has been revised to delete the requirement that a SBHC (sponsored by a federally qualified health center, physician group, nurse practitioner group or health department) applicant must provide a letter of approval from the N.C. Division of Public Health. The checklist has also been revised to add the requirement for the applicant to provide a copy of the completed N.C. Credentialing Assessment Tool from the N.C. Division of Public Health.

The revised enrollment applications will accommodate:

- the name of the SBHC and their sponsoring organization
- the National Provider Identifier for the SBHC and their sponsoring organization
- the Employer Identification Number (EIN) and name for the SBHC and their sponsoring organization

Applicants will be required to attach a fully completed N.C. School Based Health Center Verification of Credentialed Status form with the two signatures required. SBHCs sponsored by a federally qualified health center will need to submit a Health Resources and Services Administration (HRSA) Notice of Grant Award, including Form 5 – Part B/Services Sites.

Applicants will have a 60-day grace period to begin using the updated enrollment applications. If you have questions regarding the application, please contact the CSC EVC Center. Customer service representatives are available Monday through Friday, 8:00 a.m. through 5:00 p.m. Eastern Time, at 1-866-844-1113.

CSC, 1-866-866-1113

Attention: All Providers

HIPAA 5010 Implementation

In accordance with 45 CFR Part 162 – Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA); Final Rule, HIPAA-covered entities, which include state Medicaid agencies, must adopt modifications to the HIPAA required standard transactions by January 1, 2012. The modifications are to the HIPAA named transactions to adopt and implement ASC X12 version 5010 and NCPDP Telecommunication version D.0.

N.C. Medicaid will be implementing the HIPAA requirements for the 5010 transactions within the MMIS+ claims processing system. DMA will notify providers through upcoming Medicaid bulletins as the HIPAA 5010 implementation efforts progress.

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

Attention: All 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 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.

Program Integrity is charged with initiating these reviews to safeguard against unnecessary or inappropriate use of Medicaid services and 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 June 2010, Public Consulting Group (PCG), contracted with DMA's Program Integrity to conduct post payment reviews for all Medicaid provider types. Program Integrity identifies provider claims for review and assigns cases to PCG, which handles the full scale of operations including

- the receipt of a case file
- conducting the clinical review
- establishing a statistically valid claim review sample
- extrapolating these findings to calculate the recoupment

PCG responsibilities include:

- initiating contact with the provider
- informing the provider of the post payment review process requirements
- working closely with the provider and DMA
- advising the provider where and how to submit records for the review
- addressing provider questions regarding the post payment review process

If the provider's claims are determined to be out of compliance, a Tentative Notice of Overpayment letter will be sent to the provider in the amount of the overpayment. In accordance with 10A NCAC 22F.0402, reconsideration and appeal rights will be offered to the provider if the provider does not agree with the findings of the review. Instructions for the reconsideration review and appeal rights are included with the Tentative Notice of Overpayment letter.

If the preliminary investigation supports the conclusion of possible fraud, as defined in NCGS 108A-63, the case shall be referred to the appropriate law enforcement agency for a full investigation, in accordance with 10A NCAC 22F.0203.

Program Integrity
DMA, 919-647-8000

Attention: All Providers

You Can Avoid Delays with the Enrollment Process!

A provider of clinical services who wants to be eligible for Medicaid reimbursement must complete the required Medicaid provider enrollment application and enter into a provider agreement with DMA.

Individuals interested in becoming a N.C. Medicaid provider have the ability to enroll via the web. The web application ensures all required fields are completed before the application is submitted for processing. By enrolling on the web, one can dramatically reduce the potential for further follow-up work that occurs frequently with paper applications, which delays the issuance of the Medicaid provider number. Currently, complete applications for individuals are finalized in 27 business days or fewer. You can complete your provider application on the secure portal at http://www.nctracks.nc.gov/provider/providerEnrollment/LoginAction?SessionIndex=begin.

Below are some reasons why you should complete your application on the web!

1. Required fields are marked with an asterisk (*) and messages indicate if an applicant has failed to complete a required field.
2. Check marks inform applicants that they have completed all of the required fields.
3. Online help is available for every question on the application.
4. Costs are lower because of reduced printed materials and postage.
5. The online application is available 24 hours a day, 7 days a week.
6. There is no installation and maintenance required for the online application.
7. Using the online application ensures that applicants are using the most current version of the application.
8. The application is stored until the applicant submits it to CSC.

Completing the provider enrollment application online eliminates the delay associated with incomplete paper applications. Listed below are examples of issues with paper applications that cause a delay in completing the enrollment process. During the follow-up process, an application is put on hold by CSC, while a letter requesting the missing information is mailed to the provider. Once all information is received, the application can then continue through the remaining enrollment process. The follow-up process can delay an application up to 60 days or more.

Currently, CSC has identified the "Top 10" reasons that applicants are experiencing delays related to the processing of paper enrollment applications:

1. The W-9 form is not completed correctly.
2. Portions of the ownership and managing employees section are not provided.
3. Consent to Release Information is omitted.
4. Titles and dates are not provided.
5. Required documents are not provided.
6. Documents that have been returned are incorrect.
7. Strikethroughs and correction fluid have been used on the application.
8. The address on the application does not match the supporting documents.
9. Incorrect answer for Doing Business As (DBA) information.
10. The signer is not an authorized agent for the applicant.

CSC, 1-866-844-1113

Attention: All Providers

National Correct Coding Initiative Update: Laboratory Services

As communicated in the October, December, January, February, and March Medicaid bulletins, the National Correct Coding Initiative (NCCI) will become operational with date of service March 31, 2011. Providers will not be able to bill certain pairs of codes for an individual recipient on the same date of service.

In general, individual component codes 83721, 80061, 80076, 82310, 81002, 81003, 88143, 87591, and 87491 cannot be billed by the same attending provider for the same recipient on the same date of service as 80061, 83704, 80069, 80053, 81003, 81000, 81001, 81005, 88175, and 87149.

In preparation for this implementation, testing of NCCI edits was performed to determine the scope and volume of resulting denials. In a 6-week period during the months of February through March, the most common laboratory claim denials for CCI edits were identified as follows:

Rejected Code		Paid Code	
83721	ASSAY OF BLOOD LIPOPROTEIN	80061	LIPID PANEL
80061	LIPID PANEL	83704	LIPOPROTEIN BLD BY NMR
80076	HEPATIC FUNCTION PANEL	80069	RENAL FUNCTION PANEL
82310	ASSAY OF CALCIUM	80053	COMPREHSIVE METABOLIC PANEL
82310	ASSAY OF CALCIUM	80069	RENAL FUNCTION PANEL
81002	URINALYSIS NONAUTO W/O SCOPE	81003	URINALYSIS AUTO W/O SCOPE
81002	URINALYSIS NONAUTO W/O SCOPE	81000	URINALYSIS NONAUTO W/SCOPE
81002	URINALYSIS NONAUTO W/O SCOPE	81001	URINALYSIS AUTO W/SCOPE
81003	URINALYSIS AUTO W/O SCOPE	81005	URINALYSIS
88143	CYTOPATH C/V THIN LAYER REDO	88175	CYTOPATH C/V AUTO FLUID REDO
87591	N. GONORRHOEAE DNA AMP PROB	87149	DNA/RNA DIRECT PROBE
87491	CHYLMD TRACH DNA PROBE	87149	DNA/RNA DIRECT PROBE

Providers will need to revise the schedule and delivery of laboratory services to ensure that similar laboratory services are not provided on the same date of service. For additional information on NCCI, please visit http://wwww.ncdhhs.gov/dma/provider/ncci.htm or contact HP Enterprise Services at 1-800-688-6696 or 919-851-8888, option 3.

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

Attention: All Providers

Enactment of the Affordable Care Act

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively known as the Affordable Care Act) makes a number of changes to the Medicare and Medicaid programs and to the Children's Health Insurance Program. These changes will enhance the provider enrollment process to improve the integrity of the services through the reduction of fraud, waste, and abuse. A full copy of the final rule is available in the Federal Register, Vol 76, No. 22, page 5862, online at http://www.gpoaccess.gov/fr/.

Craig Umstead, Provider Services
DMA, 919-855-4050

Attention: All Providers

National Correct Coding Initiative Update: Modifiers

As communicated in prior bulletins (October 2010, December, 2010, January 2011, February 2011, and March 2011), N.C. Medicaid will be implementing the National Correct Coding Initiative (NCCI) effective with dates of service on or after March 31, 2011. In some instances, it may be appropriate to append a modifier to a code to indicate the services were performed at a different anatomical site or in a different session.

Information about NCCI modifiers can be found on the CMS website at http://www.cms.gov/NationalCorrectCodInitEd/. (Click on NCCI Policy Manual for Medicare Services. The modifier explanations will be found on page 13 in Chapter 1, General Coding Policies.)

In preparation for implementation of the NCCI edits, N.C. Medicaid began reviewing current policies and procedures, including the April 1999 Medicaid Special Bulletin, *Modifiers* (http://www.ncdhhs.gov/dma/bulletin/), to ensure compliance with the NCCI mandate. Several issues have been identified:

- Modifiers LT and RT are recognized with a limited number of procedures. Other CCI anatomical modifiers are currently accepted by N.C. Medicaid.
- In cases where another anatomical modifier is not appropriate, modifier 59 may be used to identify a different anatomical site of service.
- Modifier 91 (Repeat Clinical Diagnostic Laboratory Test) is only recognized as a crossover modifier at this time. In cases where the laboratory procedure was supplied in a different session, the use of modifier 59 may be appropriate.

Hospital providers of laboratory, radiology, and pharmaceuticals in the outpatient setting do not currently use the NCCI modifiers; however, the use of one of these modifiers may be necessary to appropriately bypass NCCI edits. The use of modifiers by these providers to bypass NCCI edits will not impact other claims processing.

DMA will continue to review policies and procedures related to modifiers. Providers will be notified of any changes to the guidelines for the use of modifiers through the Medicaid Bulletin.

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

Attention: N.C. Health Choice Providers

Prior Approval Criteria Added to N.C. Health Choice Policies

On March 2, 2011, the following N.C. Health Choice policies were removed from public comment. These policies had prior approval criteria added to them.

1. Anterior Cruciate Ligament Allograft
2. Targeted Phototherapy for Psoriasis
3. Arthroscopic Surgery for Femoroacetabular Impingement
4. Cryoablation or Radiofrequency Ablation of Renal Cell Cancer
5. Surgery for Morbid Obesity
6. Monoclonal Antibody Imaging
7. Meniscal Allograft Transplantation
8. Continuous Local Delivery of Anesthesia to Operative Site
9. Reconstructive Eyelid Surgery and Brow Lift

For a complete list of policies that are covered by N.C. Health Choice, refer to the N.C. Health Choice Policies web page at http://www.ncdhhs.gov/dma/hcmp/.

Margaret Watts, N.C. Health Choice
DMA, 919-855-4104

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/:

- 1K-7, *Prior Approval for Imaging Services*

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

Quality Assurance Questionnaire

Last month, DMA Provider Services published the first in a series of quality assurance (QA) questionnaires to assist DMA in its efforts to improve customer service to enrolled providers and Medicaid recipients. The QA questionnaires are intended only for DMA's enrolled Medicaid providers. All enrolled providers are encouraged to complete the April 2011 QA questionnaire. Results obtained from the questionnaire will be kept confidential. Completed questionnaires may be submitted by e-mail to ncdma.providerqasurvey@lists.ncmail.net or by fax to 919-715-8548.

Craig L. Umstead, Provider Services
DMA, 919-855-4050

April 2011 Medicaid Provider Quality Assurance Questionnaire			
	Question	**Response**	
		YES	**NO**
1	Does the annual Medicaid identification card and web-portal eligibility verification greatly improve your way of doing business?	☐	☐
2	Do you regard your experience as a N.C. Medicaid provider overall to be a positive experience?	☐	☐
3	Do you and your fellow colleagues enrolled in the Medicaid program view Medicaid as a value added health plan that improves the lives of citizens?	☐	☐
4	Do you find the administrative services and education information provided by DMA through its website, bulletins, and customer service to be adequate in supporting a high level of health care for Medicaid recipients?	☐	☐
5	Do you or your staff ask all Medicaid recipients to present their identification as well their Medicaid identification card prior to receiving services?	☐	☐
6	Would a more electronically managed Medicaid program improve your ability to provide services (i.e., electronic health records, electronic billing, prior approvals, enrollment applications, etc.) to recipients	☐	☐
7	Does the Medicaid Bulletin adequately inform you of important Medicaid recipient, provider, and program issues in a timely fashion?	☐	☐
8	Do you believe that the clinical coverage policies addressing Medicaid patients are fair and meet the needs of a majority of the patients?	☐	☐
9	Are patients always notified in writing of a non-covered Medicaid service?	☐	☐
10	Do you find your experience in using the provider services phone line to be timely and at a high professional level?	☐	☐
11	Do you have a formal process to measure Medicaid patient customer satisfaction in your practice?	☐	☐
12	Has your business relationship (i.e., billing, payment, clinical policy, and enrollment) experience with N.C. Medicaid been at a high professional level?	☐	☐
13	Do you or your staff need more training and direction (i.e., billing, payment, clinical policy, and enrollment) from DMA?	☐	☐
14	Would you prefer to handle all enrollment and recertification and other communication with the Medicaid program electronically?	☐	☐
15	Have you supported the development of electronic health record (EHR) and electronic billing with your practice?	☐	☐
16	Is contacting HP (fiscal agent) the first resource you use when you encounter an EOB that you need assistance in finding a resolution?	☐	☐

Please submit your completed questionnaire to DMA Provider Services by e-mail at ncdma.providerqasurvey@lists.ncmail.net or by fax to 919-715-8548.

All responses will be kept confidential.

Attention: All Providers

Correction to Carolina ACCESS Editing for Anesthesiology Services

Effective September 1, 2003, Carolina ACCESS (CA) editing was modified to allow payment for anesthesiology services that are not authorized by the primary care provider (PCP) if **either** the NPI associated with the **group provider number** or the NPI associated with the **attending provider number** listed on the claim identifies the provider as an anesthesiologist. DMA is aware that multi-specialty billing providers have been receiving denials with EOB 270 (billing provider is not the recipient's Carolina ACCESS PCP. Authorization is missing or unresolved.) when the attending provider is a certified registered nurse anesthetist (CRNA) or an anesthesia assistant.

System updates have been completed to correct this issue. Multi-specialty billing providers who received claim denials with EOB 270 for anesthesia services provided by CRNAs or anesthesia assistants may submit new claims (not adjustments) that meet timely filing criteria for processing.

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

Attention: All Providers

Basic Medicaid Seminars

Basic Medicaid seminars are scheduled for the month of April 2011. These seminars are intended to educate all types of providers on the basics of billing for N.C. Medicaid, recent updates and changes, and the latest budget initiatives. The focus of the morning session will be the first seven sections of the revised April 2011 Basic Medicaid Billing Guide, which is the primary document that will be referenced during the seminar. The afternoon sessions will be broken out by claim type: Professional, Institutional, and Dental ADA/Pharmacy. The remaining sections of the April 2011 Billing Guide will be reviewed during these breakout sessions focusing on claims submission, National Correct Coding Initiative, resolving denied claims and the uses of N.C. Electronic Claims Submission/Recipient Eligibility Verification Web Tool.

Providers are encouraged to print the Billing Guide and/or the slide presentation, which will be posted on the DMA seminar webpage prior to the first scheduled session. This material will assist providers in following along with the presenters. Please note that the seminar slide presentation addresses the topics to be discussed and does not represent all of the information being presented. If preferred, you may download the Billing Guide and/or the slide presentation to a laptop and bring the laptop to the seminar. Or, you may access the Billing Guide and presentation online using your laptop during the seminar. **However, HP Enterprise Services cannot guarantee a power source or Internet access for your laptop.** Copies of these documents will not be provided.

Pre-registration is required for both the morning session and the afternoon session of your choice. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend, if space is available. Please bring your seminar confirmation with you to the morning and afternoon sessions of the seminar.

Providers may register for the seminars by completing and submitting the online registration form. Please include a valid e-mail address for your return confirmation. Providers may also register by fax (fax it to the number listed on the form). Please include a fax number or a valid e-mail address for your return confirmation. Confirmations will be sent within two business days of receiving the registration form. Please remember to register for the afternoon session you wish to attend.

The morning session 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; however, there will be a lunch break. The afternoon sessions will begin at 1:00 p.m. and end at 4:00 p.m. Providers are encouraged to arrive at 12:45 p.m. to complete registration. **Because meeting room temperatures vary, dressing in layers is advised.**

Seminar Dates and Locations

Date	Location
April 6, 2011	**Asheville** Crown Plaza Tennis & Gold Resort One Resort Drive Asheville NC 28806
April 12, 2011	**Greensboro** Clarion Hotel Airport 415 Swing Road Greensboro NC 27409
April 14, 2011	**New Bern** New Bern Convention Center 203 South Front Street New Bern NC 28563
April 19, 2011	**Raleigh** Wake Tech Community College Student Service Building Conference Center Second Floor, Rooms 212-215 9191 Fayetteville Road Raleigh NC 27603
April 27, 2011	**Charlotte** Crowne Plaza 201 South McDowell Street Charlotte NC 28204 **Note: Parking fee of $6.00 per vehicle for parking at this location.**

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

Basic Medicaid Billing
April 2011 Seminar Registration Form
(No Fee)

Provider Name and Discipline _____

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 **morning** session:
(circle one)

☐ General Session, 9:00 a.m. to 12:00 a.m.

1 or **2** person (s) will attend the **afternoon** session **(select only one session):**
(circle one)

☐ Professional Billing, 1:00 p.m. to 4:00 p.m.
☐ Institutional Billing, 1:00 p.m. to 4:00 p.m.
☐ Dental/Pharmacy Billing, 1:00 p.m. to 4:00 p.m.

Please indicate seminar location and date:

☐ Asheville, April 6, 2011
☐ Greensboro, April 12, 2011
☐ New Bern, April 14, 2011
☐ Raleigh, April 19, 2011
☐ Charlotte, April 27, 2011

Please fax completed form to: 919-851-4014

Please mail completed form to:
HP Provider Services
P.O. Box 300009
Raleigh, NC 27622

Or register online by utilizing the link available within the bulletin

Attention: All Providers

HCPCS Code Changes for the Physician's Drug Program

The following HCPCS code changes were made to comply with CMS HCPCS code changes for January 1, 2011.

End dated Codes with No Replacement Code

The following HCPCS codes were deleted by CMS effective with date of service December 31, 2010. There are no replacement codes.

HCPCS Code	Definition
J0128	Injection, abarelix (Planaxis), 10 mg
J0704	Injection, betamethasone sodium phosphate, per 4 mg
J0970	Injection, estradiol valerate, up to 40 mg
J1390	Injection, estradiol valerate, up to 20 mg
J1470	Injection, gamma globulin, intramuscular, 2 cc
J1480	Injection, gamma globulin, intramuscular, 3 cc
J1490	Injection, gamma globulin, intramuscular, 4 cc
J1500	Injection, gamma globulin, intramuscular, 5 cc
J1510	Injection, gamma globulin, intramuscular, 6 cc
J1520	Injection, gamma globulin, intramuscular, 7 cc
J1530	Injection, gamma globulin, intramuscular, 8 cc
J1540	Injection, gamma globulin, intramuscular, 9 cc
J1550	Injection, gamma globulin, intramuscular, 10 cc
J2321	Injection, nandrolone decanoate, up to 100 mg
J2322	Injection, nandrolone decanoate, up to 200 mg
J9062	Cisplatin, 50 mg
J9080	Cyclophosphamide, 200 mg
J9090	Cyclophosphamide, 500 mg
J9091	Cyclophosphamide, 1.0 g
J9092	Cyclophosphamide, 2.0 g
J9093	Cyclophosphamide, lyophilized, 100 mg
J9094	Cyclophosphamide, lyophilized, 200 mg
J9095	Cyclophosphamide, lyophilized, 500 mg
J9096	Cyclophosphamide, lyophilized, 1 g
J9097	Cyclophosphamide, lyophilized, 2 g
J9110	Cytarabine, 500 mg
J9140	Dacarbazine, 200 mg
J9290	Mitomycin, 20 mg
J9291	Mitomycin, 40 mg
J9375	Vincristine sulfate, 2 mg
J9380	Vincristine sulfate, 5 mg

New HCPCS Procedure Codes

The following HCPCS codes were added to the list of covered codes for the Physician's Drug Program effective with date of service January 1, 2011. These codes do not replace other codes.

New HCPCS Code	Description	Unit
J2426	Paliperidone palmitate extended release (Invega Sustenna)	1 mg
J7309	Methyl aminolevulinate (MAL) for topical administration, 16.8% (Metvixia)	1 g
J7335	Capsaicin 8% patch (Qutenza)	Per 10 square centimeters
J9315	Romidepsin (Istodax)	1 mg
J3243	Tigecycline (Tygacil)	1 mg

Refer to the additional articles beginning on page 15 for the specific billing guidelines for these drugs.

End-Dated Codes with Replacement Codes

The following HCPCS codes were end-dated effective with date of service December 31, 2010, and replaced with new codes effective with date of service January 1, 2011. Claims submitted for dates of service on or after January 1, 2011, using the end-dated codes will be denied.

End-Dated HCPCS Code	Description	Unit	New HCPCS Code	Description	Unit
J0170	Adrenalin, epinephrine	Up to 1 ml ampule	J0171	Adrenalin, epinephrine	0.1 mg
J0559	Penicillin G benzathine and penicillin G procaine	2500 units	J0558	Penicillin G benzathine and penicillin G procaine	Per 100,000 units
J0560 J0570 J0580	Penicillin G benzathine	Varying units	J0561	Penicillin G benzathine	Per 100,000 units
J1785	Imiglucerase (Cerezyme)	1 unit	J1786	Imiglucerase (Cerezyme)	10 units
J9350	Topotecan (Hycamtin)	4 mg	J9351	Topotecan (Hycamtin)	0.1 mg
J1825	Interferon beta-1a (Avonex) End-dated in 1998	33 mcg	J1826	Interferon beta-1A (Avonex)	30 mcg

New Codes That Were Previously Billed with the Miscellaneous Drug Codes J3490, J3590, and J9999

Effective with date of service January 1, 2011, the N.C. Medicaid Program covers specific HCPCS codes for the drugs listed in the following table. Claims submitted for these drugs for dates of service on or after January 1, 2011, using the unlisted drug codes J3490, J3590 or J9999 will be denied. An invoice is not required.

Old HCPCS Code	Description	Old Unit	New HCPCS Code	Description	New Unit
J3590	C-1 esterase inhibitor (Human) Berinert	10 units	J0597	C-1 esterase inhibitor (Human) Berinert	10 units
J3590	Canakinumab (Ilaris)	180 mg vial	J0638	Canakinumab (Ilaris)	1 mg
J3590	Collagenase, clostridium histolyticum, (Xiaflex)	0.9 mg vial	J0775	Collagenase, clostridium histolyticum, (Xiaflex)	0.1 mg
J3490	Ecallantide (Kalbitor)	10 mg	J1290	Ecallantide (Kalbitor)	1 mg
J3590	Immune globulin (Hizentra)	100 mg	J1559	Immune globulin (Hizentra)	100 mg
J3490	Olanzapine, long acting (Zyprexa Relprevv)	1 mg	J2358	Olanzapine, long acting (Zyprexa Relprevv)	1 mg
J3490	Telavancin	250 mg	J3095	Telavancin (Vibativ)	10 mg
J3590	Tocilizumab	10 mg	J3262	Tocilizumab (Actemra)	1 mg
J3590	Ustekinumab (Stelara)	45 mg vial	J3357	Ustekinumab (Stelara)	1 mg
J3590	Velaglucerase alra	1 unit	J3385	Velaglucerase alra (VPriv)	100 units
J3590	Coagulation factor VIII complex/Von Willebrand factor complex (Wilate)	1 I.U.	J7184	Von Willebrand factor complex (Wilate)	100 units
J3590	Antithrombin recombinant (ATryn)	1 I.U.	J7196	Antithrombin recombinant	50 I.U.
J3490	Dexamethasone, intravitreal implant (Ozurdex)	1 pouch (0.7 mg)	J7312	Dexamethasone, intravitreal implant (Ozurdex)	0.1 mg
J9999	Ofatumumab (Arzerra)	100 mg	J9302	Ofatumumab (Arzerra)	10 mg
J9999	Pralatrexate (Folotyn)	20 mg	J9307	Pralatrexate (Folotyn)	1 mg

Refer to the fee schedule for the Physician's Drug Program on DMA's website at http://www.ncdhhs.gov/dma/fee/fee.htm for the current reimbursement rates. Providers must bill their usual and customary charges.

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

Attention: Nurse Practitioners and Physicians

Capsaicin 8% Patch (Qutenza, HCPCS Code J7335): Billing Guidelines

Effective with date of service January 1, 2011, the N.C. Medicaid Program covers Qutenza for use in the Physician's Drug Program when billed with HCPCS code J7309. Qutenza is a TRPV I channel agonist indicated for the management of neuropathic pain associated with postherpetic neuralgia (PHN).

The Qutenza (capsaicin) 8% patch contains capsaicin in a localized dermal delivery system. The capsaicin in Qutenza is a synthetic equivalent of the naturally occurring compound found in chili peppers. Capsaicin is soluble in alcohol, acetone, and ethyl acetate and very slightly soluble in water. Qutenza is a single-use patch stored in a foil pouch. Each Qutenza patch is 14 cm x 20 cm (280 cm2) and consists of a polyester backing film coated with a drug-containing silicone adhesive mixture and covered with a removable polyester release liner. The backing film is imprinted with "capsaicin 8%." Each Qutenza patch contains a total of 179 mg of capsaicin (8% in adhesive, 80 mg per gram of adhesive) or 640 mcg of capsaicin per square cm. Cleansing gel is provided in a 50 gram tube. Qutenza is available in a carton containing one patch and a 50-gram tube of cleansing gel or a carton of two patches and a 50-gram tube of cleansing gel.

The packaging information indicates that Qutenza should be applied to the most painful skin areas using up to four patches but should not be used on broken skin or the face or scalp. A topical anesthetic is applied prior to applying Qutenza. Qutenza is applied for 60 minutes, and repeated every three months or as warranted by the return of pain (not more frequently than every three months). Only physicians or a health care professional under the close supervision of a physician are to administer Qutenza.

For Medicaid Billing

- One of the following ICD-9-CM diagnosis codes must be billed with Qutenza:
  - 053.10 (herpes zoster with unspecified nervous system complication)
  - 053.12 (postherpetic trigeminal neuralgia)
  - 053.13 (postherpetic polyneuropathy)
  - 053.19 (herpes zoster with nervous system complications, other)
- Diagnosis codes must be supported with adequate documentation in the medical record.
- Providers must bill Qutenza with HCPCS code J7335.
- Providers must indicate the number of HCPCS unit in field 24G on the CMS-1500 claim form or in the appropriate field on the 837P, 837I or the NCECSWeb Tool. Claims must be filed electronically unless they meet one of the ECS-mandated exceptions (http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm).
- One Medicaid unit of coverage is 10 square centimeters. The maximum reimbursement rate per unit is $24.63.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Qutenza should be reported as "UN." One "UN" equals one kit. To bill for one Qutenza patch (a total of 280 centimeters square), report the HCPCS units as 28 and the NDC units as "UN1" for each patch. If Qutenza 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.
- CPT code 64999 may be used for billing the administration of Qutenza.

The 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: Health Departments, Local Management Entities, Nurse Practitioners, Physicians, and Psychiatric Nurse Practitioners

Paliperidone Palmitate Extended Release, 1 mg (Invega Sustenna, HCPCS Code J2426): Billing Guidelines

Effective with date of service January 1, 2011, the N.C. Medicaid Program covers paliperidone palmitate extended release (Invega Sustenna) for use in the Physician's Drug Program when billed with HCPCS code J2426. Invega Sustenna is available in prefilled disposable syringes containing 39 mg, 78 mg, 117 mg, 156 mg or 234 mg of paliperidone palmitate.

Invega Sustenna is indicated for the acute and maintenance treatment of schizophrenia in adults. For patients who have never taken oral paliperidone or oral or injectable risperidone, tolerability should be established with oral paliperidone or oral risperidone prior to initiating treatment with Invega Sustenna. According to the label, Invega Sustenna should be initiated with a dose of 234 mg on treatment day one and 156 mg one week later; both administered in the deltoid muscle. The recommended monthly maintenance dose is 117 mg. Some patients may benefit from lower or higher maintenance doses within the recommended range of 39 mg to 234 mg based on individual patient tolerability and/or efficacy. Following the second dose, monthly maintenance doses can be administered in either the deltoid or gluteal muscle. It is to be administered by intramuscular injection only.

For Medicaid Billing

- One of the ICD-9-CM diagnosis codes in the ranges listed below must be billed with Invega Sustenna.
  - 295.00 through 295.05
  - 295.10 through 295.15
  - 295.20 through 295.25
  - 295.20 through 295.25
  - 295.30 through 295.35
  - 295.40 through 295.45
  - 295.50 through 295.55
  - 295.60 through 295.65
  - 295.80 through 295.85
  - 295.90 through 295.95
- Diagnosis codes must be supported with adequate documentation in the medical record.
- Providers must bill Invega Sustenna with HCPCS code J2426. The amount of drug in an entire prefilled disposable syringe may be billed.
- Providers must indicate the number of HCPCS units in field 24G on the CMS-1500 claim form or in the appropriate field on the 837P, 837I or the NCECSWeb Tool. Claims must be filed electronically unless they meet one of the ECS-mandated exceptions (http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm).
- One Medicaid unit of coverage is 1 mg. The maximum reimbursement rate per unit is $6.27.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Invega Sustenna should be reported as "ML." To bill for an entire single-dose prefilled disposable syringe of Invega Sustenna, report the NDC units as "ML0.25 through ML1.5" depending on the syringe used. 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 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

Romidepsin, 1 mg (Istodax, HCPCS Code J9315): Billing Guidelines

Effective with date of service January 1, 2011, the N.C. Medicaid Program covers Istodax for use in the Physician's Drug Program when billed with HCPCS code J9335. Istodax is a histone deacetylase (HDAC) inhibitor indicated for treatment of cutaneous T-cell lymphoma (CTCL) in patients who have received at least one prior systemic therapy. The safety and effectiveness of Istodax in pediatric patients has not been established; therefore, coverage is limited to those recipients 18 years of age and older.

The recommended dosing schedule for Istodax is 14 mg/m^2 administered intravenously (IV) over a 4-hour period on days 1, 8, and 15 of a 28-day cycle. Cycles should be repeated every 28 days provided that the patient continues to benefit from and tolerates the drug. Treatment discontinuation or interruption with or without dose reduction to 10 mg/m^2 may be needed to manage adverse drug reactions. Istodax is supplied as a kit that includes a sterile, lyophilized powder in a single-use vial containing 10 mg of romidepsin and 20 mg of the bulking agent, povidone, USP. In addition, each kit includes one sterile vial containing 2 ml (deliverable volume) of the diluent composed of 80% propylene glycol, USP, and 20% dehydrated alcohol, USP.

For Medicaid Billing

- One of the following ICD-9-CM diagnosis codes must be billed with Istodax for CTCL:
  - ♦ 202.10 through 202.18 (mycosis fungoides)

  OR

  - ♦ 202.20 through 202.28 (Sezary's disease)
- Diagnosis codes must be supported with adequate documentation in the medical record.
- Providers must bill Istodax with HCPCS code J9315.
- Recipients must be 18 years of age or older.
- Providers must indicate the number of HCPCS units in field 24G on the CMS-1500 claim form or in the appropriate field on the 837P, 837I or the NCECSWeb Tool. Claims must be filed electronically unless they meet one of the ECS-mandated exceptions (http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm).
- One Medicaid unit of coverage is 1mg. The maximum reimbursement rate per unit is $211.38. The entire single-use vial may be billed.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Istodax should be reported as "UN." To bill for one single use vial, report the NDC units as "UN1." If the Istodax 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 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: Dialysis Facilities, Nurse Practitioners, and Physicians

Tigecycline, 1 mg (Tygacil, HCPCS Code J3243): Billing Guidelines

Effective with date of service July 1, 2010, the N.C. Medicaid Program covers Tygacil for use in the Physician's Drug Program when billed with HCPCS code J3243. Tygacil is a tetracycline-class antibacterial indicated for patients 18 years of age or older for complicated skin and skin structure infections; complicated intra-abdominal infections; and community-acquired bacterial pneumonia. The safety and effectiveness of Tygacil in pediatric patients has not been established; therefore, coverage is limited to those recipients 18 years of age or older.

Tygacil is to be administered intravenously (IV) with an initial dose of 100 mg, followed by 50 mg every 12 hours. The infusions should be administered over approximately 30 to 60 minutes. In severe hepatic impairment (Child Pugh C) the initial recommended dose is 100 mg followed by 25 mg every 12 hours. Tygacil is available in a single-dose 5-ml vial containing 50 mg of lyophilized powder for reconstitution.

For Medicaid Billing

- Providers should select the most appropriate ICD-9-CM diagnosis code with the highest level of specificity to describe the patient's condition.
- Diagnosis codes must be supported with adequate documentation in the medical record.
- Providers must bill Tygacil with HCPCS code J3243.
- Recipients must be 18 years of age or older.
- Providers must indicate the number of HCPCS units in field 24G on the CMS-1500 claim form or in the appropriate field on the 837P, 837I or the NCECSWeb Tool. Claims must be filed electronically unless they meet one of the ECS-mandated exceptions (http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm).
- One Medicaid unit of coverage is 1mg. The maximum reimbursement rate per unit is $1.20. An entire single-use vial may be billed.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Tygacil should be reported as "UN." To bill for one single use vial, report the NDC units as "UN1." If the Tygacil 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 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

Methyl Aminolevulinate (MAL) for Topical Administration, 16.8%, 1 Gram (Metvixia, HCPCS Code J7309): Billing Guidelines

Effective with date of service January 1, 2011, the N.C. Medicaid Program covers Metvixia for use in the Physician's Drug Program when billed with HCPCS code J7309. Metvixia is available in a 2-gram multi-dose tube.

Metvixia cream, a porphyrin precursor, in combination with the Aktilite CL128 lamp, a narrowband, red-light illumination source, is indicated for treatment of thin and moderately thick, non-hyperkeratotic, non-pigmented actinic keratoses of the face and scalp in immunocompetent patients when used in conjunction with lesion preparation in the physician's office when other therapies are considered medically less appropriate.

Photodynamic therapy with Metvixia cream is a multi-stage process comprised of:

- lesion preparation
- application of Metvixia cream occlusion for 3 hours
- removal of excess cream with saline
- illumination with the Aktilite CL128 lamp emitting a narrow output spectrum red light with a peak at 630 nm and a spectral half-width of approximately 20 nm at a light dose of 37 J/cm^2 using the Aktilite CL128 lamp.

Two treatment sessions should be administered one week apart. Multiple lesions may be treated during the same treatment session using a total of not more than 1 gram (half tube) of Metvixia cream. Nitrile gloves should be worn at all times during this procedure. Metvixia cream is not for ophthalmic, oral or intravaginal use.

For Medicaid Billing

- ICD-9-CM diagnosis code 702.0 (actinic keratosis) must be billed with J7309.
- Diagnosis codes must be supported with adequate documentation in the medical record.
- Providers must bill Metvixia with HCPCS code J7309.
- Providers must indicate the number of HCPCS units in field 24G on the CMS-1500 claim form or in the appropriate field on the 837P, 837I or the NCECSWeb Tool. Claims must be filed electronically unless they meet one of the ECS-mandated exceptions (http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm).
- The amount of cream for one 1-gram treatment should not exceed one-half tube. The HCPCS code unit for one weekly treatment would be 1.
- The recipient must be 18 years of age or older.
- One Medicaid unit of coverage is 1 gram (one-half tube). The maximum reimbursement rate per unit is $74.59.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Metvixia should be reported as "GM." To bill for one 1-gram treatment of Metvixia, report the NDC units as "GM1." 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.

- CPT code 96567 [photodynamic therapy by external application of light to destroy pre-malignant and/or malignant lesions of the skin and adjacent mucosa by activation of photosensitive drug(s), each phototherapy exposure session] may be billed for treatment with the Aktilite CL128 lamp. Report 96567 once per light exposure session regardless of how many lesions are treated or how long the light exposure session lasts *(CPT Changes: An Insider's View 2002, American Medical Association).*

The 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: Health Departments, Nurse Practitioners, and Physicians

Omalizumab, 5 mg (Xolair, HCPCS Code J2357): Change in Coverage

Effective with date of service, May 16, 2011, the N.C. Medicaid Program will cover Xolair ONLY through the Outpatient Pharmacy Program. Xolair will no longer be covered when billed through the Physician's Drug Program with HCPCS code J2357. **Claims submitted for Xolair with HCPCS code J2357 for dates of service on and after May 16, 2011, will be denied.** This does not include outpatient hospital pharmacy billing through point-of-sale.

Prior authorization (PA) through the Outpatient Pharmacy Program is required for coverage of Xolair for dates of service on and after May 16, 2011. If PA is granted, the length of authorization is 12 months.

The Outpatient Pharmacy Program PA criteria are as follows:

1. Recipient must be six years of age or older.
2. Recipient must have a diagnosis of asthma.
3. Recipient must have inadequately controlled asthma defined as:
   a. Use of inhaled corticosteroids in the past 45 days and excessive use of short-acting beta agonists in the past 60 days;

      OR

   b. Use of inhaled corticosteroids in the past 45 days and short-term steroid use in the past 45 days;

      OR

   c. Use of inhaled corticosteroids in the past 45 days and an emergency room visit in the past 45 days.
4. Recipient must have had a percutaneous skin test or RAST allergy test performed in the past three months indicating reactivity to at least one perennial aeroallergen.
5. Recipient must have an IgE level greater than 30.

Prescribers can request PA by contacting ACS at 1-866-246-8505 (telephone) or 1-866-246-8507 (fax). The criteria and PA request form will be available by May 9, 2011, the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com.

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

Attention: Health Departments, Nurse Midwives, Nurse Practitioners, and Physicians

Hydroxyprogesterone Caproate (Makena, HCPCS Code J3490): Billing Guidelines

Effective with date of service March 14, 2011, the N.C. Medicaid Program covers hydroxyprogesterone caproate (Makena) for use in the Physician's Drug Program when billed with HCPCS code J3490 (unclassified drugs). Makena is available in a 5-ml multi-dose vial containing 250 mg/ml (five doses).

The Food and Drug Administration (FDA) has approved hydroxyprogesterone caproate (Makena) injections to reduce the risk of preterm delivery before 37 weeks of pregnancy for women with a history of one spontaneous preterm birth. The drug's approval was based on a 463-patient, randomized, double-blind clinical trial of women 16 to 43 years old, pregnant with a single fetus, and with a history of spontaneous preterm birth (defined as delivery at less than 37 weeks of gestation following spontaneous preterm labor or premature rupture of membranes). The drug was approved through the FDA's accelerated approval program, which approves a drug based on a surrogate endpoint benefit that is likely to predict clinical outcome.

The drug is designed to be given once a week by injection into the hip, beginning at the 16th week and no later than the 21st week of pregnancy, according to the FDA. The recommended dose of Makena is a 250-mg weekly intramuscular injection administered from gestational weeks 16 through 36 or until delivery, whichever comes first.

Progesterone therapy as a technique to prevent preterm labor is considered investigational/not medically necessary for pregnant women who do **not** meet the above criteria or for those with other risk factors for preterm delivery including, but not limited to, multiple gestations, short cervical length or positive tests for cervicovaginal fetal fibronectin. N.C. Medicaid does not cover services that are considered investigational or not medically necessary.

The N.C. Division of Medical Assistance supports the efforts to reduce premature birth and will continue to seek evidence-based, cost-effective alternatives that support the prevention of preterm labor.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Makena is V23.41 (supervision of pregnancy with history of pre-term labor).
- Providers must verify that the recipient's history includes a singleton preterm birth (prior to 37 weeks gestation). The recipient must be pregnant with a single fetus. Treatment should begin between 16 weeks, 0 days and 20 weeks, 6 days of gestation. Treatment must end before week 37 (through 36 weeks, 6 days). It may be appropriate to start a recipient at a later gestational age if she presented for prenatal care at that time.
- Diagnosis codes must be supported with adequate documentation in the medical record. Documentation must also follow the criteria indicated above.
- Providers must bill Makena with HCPCS code J3490 (unclassified drugs).
- One Medicaid unit of coverage is 250 mg (one dose). The maximum reimbursement rate per unit (one dose) is $1,561.52. Coverage is limited to one unit (one 250-mg dose) per week.
- Providers should indicate the HCPCS unit as 1. Providers must indicate the number of HCPCS units in field 24G on the CMS-1500 claim form, or in the appropriate field on the 837P, 837I or the NCECSWeb Tool. Claims must be filed electronically unless they meet one of the ECS-mandated exceptions (http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm).

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Makena should be reported as "ML." Providers must bill for only the dose administered from the multi-dose vial and report the NDC units as "ML1." 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 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 Midwives, Nurse Practitioners, and OB/GYN Providers

Clarification for Billing Multiple Births

DMA is changing its billing guidance for billing multiple births effective with the March 31, 2011, implementation of the National Correct Coding Initiative edits. Effective with date service March 31, 2011, and after, providers should bill as directed in the following table.

Type of Delivery	CPT Code for First Birth No Modifier	CPT Code for Consecutive Births	Modifier Applied to Each Consecutive Birth Charge Line
All vaginal	59400 or 59409 or 59410	59409 one line for each additional birth	59, 51
All Cesarean	59510 or 59514 or 59515	59514 one line for each additional birth	59, 51
Mixed delivery	59400 or 59409 or 59410	59409 one line for each additional vaginal birth 59514 one line for each additional Cesarean birth	59, 51

The claims-related information in Attachment A of Clinical Coverage Policy 1E-5, *Obstetrics* (http://www.ncdhhs.gov/dma/mp/), will be updated to reflect this change.

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

Attention: Critical Access Behavioral Health Agencies and Outpatient Behavioral Health Providers

Clarification of Outpatient Behavioral Health CPT Codes, E/M Codes, Annual Limits, Referrals, and Prior Authorization

Several questions have recently come to DMA regarding outpatient behavioral health CPT codes, E/M codes, annual limits, referrals, and prior authorization. The intent of this article is to offer clarification.

Children

For children (under the age of 21 years), outpatient behavioral health services require a referral from a Community Care of North Carolina/Carolina ACCESS (CCNC/CA) primary care provider (PCP), a Medicaid-enrolled psychiatrist, or the local management entity (LME) prior to beginning outpatient behavioral health services. Prior authorization from the utilization review (UR) vendor (ValueOptions, Eastpointe LME or The Durham Center) is required for any visits beyond the initial 16 unmanaged visits. Please see the March 2011 Medicaid Bulletin (http://www.ncdhhs.gov/dma/bulletin/0311bulletin.htm) for guidance on counting unmanaged visits for children. The unmanaged visits are per the individual recipient per calendar year, January 1 through December 31. There is no annual visit limit for children. Enrolled licensed clinicians may bill the codes listed in DMA Clinical Coverage Policy 8C (http://www.ncdhhs.gov/dma/mp/). Provisionally licensed clinicians may provide services 'incident to' the physician or may provide services and bill through the LME. Please see the March 2009 Medicaid Bulletin (http://www.ncdhhs.gov/dma/bulletin/0309bulletin.htm) and DHHS Implementation Update #70 (http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/) for additional information.

Adults

For adults (ages 21 years and older), no referral is needed for outpatient behavioral health services if only the behavioral health codes listed in Clinical Coverage Policy 8C (http://www.ncdhhs.gov/dma/mp/) are billed (i.e., 90806 and 90853). Prior authorization from the UR vendor (ValueOptions, Eastpointe LME or The Durham Center) is required for any visits beyond the initial eight unmanaged visits. Please see the March 2011 Medicaid Bulletin (http://www.ncdhhs.gov/dma/bulletin/0311bulletin.htm) for guidance on counting unmanaged visits for adults. The unmanaged visits are per the individual recipient per calendar year, January 1 through December 31. The behavioral health CPT codes listed in Clinical Coverage Policy 8C do not count towards the 22 annual visit (per State fiscal year July 1 through June 30) limit for adults. Information on the annual visit limit for adults is found at http://www.ncdhhs.gov/dma/provider/AnnualVisitLimit.htm.

Critical Access Behavioral Health Providers

All billable CABHA codes, including E/M codes, are listed in DHHS Implementation Update #73 (http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/). All of the E/M codes (i.e., 99213 and 99201) billed by a psychiatrist, CABHA physician/psychiatrist, nurse practitioner or physician assistant billing 'incident to' the physician, count against the 22 annual visit limit for adults (per State fiscal year July 1 through June 30). Only CPT code 90862 does not count toward the annual visit limit. All of the codes that count towards the annual visit limit for adults can be found at http://www.ncdhhs.gov/dma/provider/AnnualVisitLimit.htm.

Because these E/M codes count towards the 22 annual visit limit, psychiatrists, CABHA physicians/psychiatrists, nurse practitioners, and physician assistants, must obtain a referral from the CCNC/CA PCP to bill for these codes. Some recipients with specific mental health diagnoses are exempt from the annual visit limit. The list of excluded diagnoses can be found at http://www.ncdhhs.gov/dma/provider/AnnualVisitLimit.htm and include schizophrenia and bipolar disorder. These E/M codes (99213, 99201, etc.), which are not specific to mental health, do not require prior authorization from the UR vendors (ValueOptions, Eastpointe LME, and The Durham Center) because they are not behavioral health-specific codes.

More information, including frequently asked questions (FAQs) about CCNC/CA, can be found at http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm. Additional information can also be found in the managed care section of the *Basic Medicaid Billing Guide* at http://www.ncdhhs.gov/dma/basicmed/.

Providers must verify a recipient's participation with CCNC/CA and the recipient's PCP using one of the following methods:

1. Real Time Eligibility Verification (270/271 Transaction) – $0.08 per transaction charge from HP Enterprise Services
2. Batch Eligibility Verification (270/271 Transaction) – no charge
3. Automated Voice Response (AVR) System – no charge
4. N.C. Electronic Claims Submission/Recipient Eligibility Verification Web Tool – no charge

For additional information on recipient eligibility verification, refer to DMA's web page at http://www.ncdhhs.gov/dma/provider/RecipEligVerify.htm.

Behavioral Health Section
DMA, 919-855-4290

Attention: Enhanced Behavioral Health (Community Intervention Services) Providers

Medicare and Third Party Liability Bypass for Diagnostic Assessment and Partial Hospitalization

DMA has evaluated the data processing requirements for dually eligible (Medicare/Medicaid) recipients and for those recipients with private insurance who receive enhanced behavioral health services. The majority of all enhanced services bypass the requirement for first billing to Medicare and Third Party Liability (TPL) payors as these services and associated procedure codes are not covered under Medicare Part B and through private carriers.

It was intended that claims for HCPCS code T1023 (diagnostic assessment) and H0035 (partial hospitalization) be submitted to Medicare and private insurance as unbundled CPT codes. DMA has made the decision to retract this requirement. Therefore, denied claims for these two services may be resubmitted for payment if the reason for the denial is based on the recipient's dual eligibility for dates of service on March 20, 2004, and after. For claims that subsequently deny based on EOB 0018 or EOB 8918, the provider may follow the direction provided in Section 11 of the *Basic Medicaid Billing Guide* (http://www.ncdhhs.gov/dma/basicmed/) for time limit override. The Medicaid Resolution Inquiry Form is used to submit these claims for time limit overrides. No further retroactive reviews will be allowed, except based upon recipient eligibility.

Behavioral Health Section
DMA, 919-855-4290

Attention: Outpatient Behavioral Health Providers

National Correct Coding Initiative Update: Behavioral Health Services

As communicated in the October, December, January, February, and March Medicaid bulletins and Implementation Update #85, the National Correct Coding Initiative (NCCI) will become operational with date of service March 31, 2011. Attending (rendering) providers will not be able to bill certain pairs of codes for an individual recipient on the same date of service.

In general, assessment codes (for example, 90801, 90802, H0001, and H0031) cannot be billed by the same attending provider on the same date of service as individual, group, and family therapy codes (for example, 90804 through 90808, 90847, 90849, and H0004) or other assessment or psychological or developmental testing codes (for example, 96101 and 96111).

Individual, group, and family therapy codes (90804, 90806, 90847, 90853, H0004, and H0005) cannot be billed by the same attending provider for the same recipient for the same date of service as other individual, group, and family therapy codes (90804, 90806, 90847, 90853, H0004, and H0005) or psychological or developmental testing codes (for example, 96101 and 96111).

Psychological and developmental testing (for example, 96111 and 96101) cannot be billed by the same attending provider for the same recipient for the same date of services as other psychological and developmental testing codes (for example, 96111 and 96101).

In preparation for this implementation, testing of the NCCI edits was performed to determine the scope and volume of resulting denials. In a 1-week period during the month of February, the most common behavioral health claim denials for CCI edits were identified as follows:

Rejected Code		Paid Code	
90801	PSY DX INTERVIEW	90808	PSYTX OFFICE 75-80 MIN
90801	PSY DX INTERVIEW	90847	FAMILY PSYTX W/PATIENT
90801	PSY DX INTERVIEW	96111	DEVELOPMENTAL TEST EXTEND
90804	PSYTX OFFICE 20-30 MIN	90846	FAMILY PSYTX W/O PATIENT
90804	PSYTX OFFICE 20-30 MIN	90847	FAMILY PSYTX W/PATIENT
90806	PSYTX OFF 45-50 MIN	90846	FAMILY PSYTX W/O PATIENT
90806	PSYTX OFF 45-50 MIN	90847	FAMILY PSYTX W/PATIENT
90806	PSYTX OFF 45-50 MIN	90853	GROUP PSYCHOTHERAPY
90808	PSYTX OFFICE 75-80 MIN	90846	FAMILY PSYTX W/O PATIENT
90808	PSYTX OFFICE 75-80 MIN	90847	FAMILY PSYTX W/PATIENT
90808	PSYTX OFFICE 75-80 MIN	90853	GROUP PSYCHOTHERAPY
90812	INTAC PSYTX OFF 45-50 MIN	90846	FAMILY PSYTX W/O PATIENT
90812	INTAC PSYTX OFF 45-50 MIN	90847	FAMILY PSYTX W/PATIENT
90814	INTAC PSYTX OFF 75-80 MIN	90810	INTAC PSYTX OFF 20-30 MIN
90814	INTAC PSYTX OFF 75-80 MIN	90846	FAMILY PSYTX W/O PATIENT
90814	INTAC PSYTX OFF 75-80 MIN	90847	FAMILY PSYTX W/PATIENT
90814	INTAC PSYTX OFF 75-80 MIN	90857	INTAC GROUP PSYTX
90847	FAMILY PSYTX W/PATIENT	90846	FAMILY PSYTX W/O PATIENT
90862	MEDICATION MANAGEMENT	90806	PSYTX OFF 45-50 MIN

As indicated above, many practitioners will need to revise the schedule and delivery of authorized services to ensure that differing treatments are not provided on the same date of service.

For additional information, please see DMA's NCCI web page at http://www.ncdhhs.gov/dma/provider/ncci.htm or contact HP Enterprise Services at 1-800-688-6696 or 919-851-8888, option 3.

Behavioral Health Section
DMA, 919-855-4290

Attention: HIV Case Management Providers

Reminders and Updates for HIV Case Management Services

The Carolinas Center for Medical Excellence (CCME) and DMA wish to remind currently certified providers that they are required to have their staff trained on the new policy requirements documented in Clinical Coverage Policy 12B.

Training

This training is mandatory for HIV case managers and supervisors who have not previously attended training on the new clinical coverage policy requirements. This training is limited to those individuals who are currently employed by an agency that is currently certified as an HIV Case Management agency. Individuals completing both days of the training will be eligible to receive 12 Contact Hours credit to apply to their 20-hour annual requirement.

Date	Session Topic	Required Attendees
April 20 and 21, 2011	New Policy Requirements	HIV Case Managers and HIV Case Manager Program Supervisors

All of the trainings will be located at the McKimmon Center in Raleigh, North Carolina. Information for the April 2011 training is available on CCME's website at http://www.thecarolinascenter.org/hivcm.

Updates

- Beginning May 16, 2011, CCME and DMA will offer Basic HIV Case Management Training. This training will be mandatory for HIV case managers and supervisors who are hired on or after May 1, 2011. Those individuals who were hired since this training was last offered by the AIDS Care Unit and who have attended the training on the new policy by May 1, 2011, are encouraged to attend this 4-day basic training. The training is limited to individuals who are currently employed by a certified HIV Case Management program. Watch for registration details on CCME's website and the May 2011 Medicaid Bulletin.
- Effective March 1, 2011, the main phone number for CCME has changed. The new number is **919-461-5500.**

Reminders

A list of frequently asked questions (FAQs) is now available on CCME's website at http://www.thecarolinascenter.org/hivcm.

Victoria Landes, HIV Case Management Program
DMA, 919-855-4389

Attention: Podiatrists

Podiatrists Billing for CPT Procedure Code 15740

DMA is aware that podiatrists are receiving denials for CPT procedure code 15740 (flap; island pedicle).

System updates have been completed to correct this issue. Podiatrists who received denials with EOB 79 (this service is not payable to your provider type or specialty in accordance with Medicaid guidelines) may resubmit claims (not as an adjustment) that meet timely filing criteria for processing.

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

Attention: Podiatrists

Podiatrists Billing for CPT Procedure Code 27618

DMA is aware that podiatrists are receiving denials for CPT procedure code 27618 (excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3cm).

System updates have been completed to correct this issue. Podiatrists who received denials with EOB 79 (this service is not payable to your provider type or specialty in accordance with Medicaid guidelines) may resubmit claims (not as an adjustment) that meet timely filing criteria for processing.

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

Attention: Pharmacists and Prescribers

Coverage of Prescription Vitamins and Mineral Products for N.C. Medicaid Recipients

Effective April 13, 2011, N.C. Medicaid will discontinue coverage of all legend vitamins and mineral products with the exception of prenatal vitamins and fluoride. N.C. Medicaid will continue to cover legend prenatal vitamins and fluoride products for Medicaid recipients. Vitamins and minerals, including prenatal vitamins and fluoride products, will no longer be covered for dual-eligible recipients.

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

Attention: Pharmacists and Prescribers

Policy Implementation: Off Label Antipsychotic Monitoring in Children through Age 17

Phase One Implementation: Children 0 through 12 Years of Age – Start Date April 12, 2011

The use of antipsychotic medications by children is an issue confronting parents, other caregivers, health care professionals, and related organized health care agencies across the United States. It is recognized that many antipsychotic medications do not have Food and Drug Administration (FDA) approved labeling for use in children. The risk for a variety of significant side effects related to the use of antipsychotic medications appears to be significant for children and adolescents. Due to well documented safety considerations and limited efficacy information on the use of antipsychotic agents in children, DMA will implement a policy titled *Off Label Antipsychotic Monitoring in Children through Age 17.* The policy creates an opportunity to gather information about antipsychotic prescribing trends within the child and adolescent Medicaid population of North Carolina.

In accordance with the policy, DMA, in partnership with Community Care of North Carolina (CCNC) will maintain a registry for providers to document the use of antipsychotic therapy in Medicaid-eligible children age 17 and under. This registry is supported by an advisory panel consisting of child psychiatrists from North Carolina's four medical universities. The registry, named **A+KIDS** (Antipsychotics-Keeping It Documented for Safety), encourages the use of appropriate baseline and follow-up monitoring parameters to facilitate the safe and effective use of antipsychotics in this population. The registry requirement will be implemented in phases according to the age of the child for whom the antipsychotic is prescribed. Phase one for Medicaid eligible children 12 years of age or younger will begin April 12, 2011. The subsequent phase for the 13- through 17-age group will occur under the same guidelines at a later date. Providers will receive notification of the start date for phase two.

Objectives of the **A+KIDS** registry include improvement in the use of evidence-based safety monitoring for patients for whom an antipsychotic agent is prescribed; reduction of antipsychotic polypharmacy; and reduction of cases in which the FDA maximum dose is exceeded. Data elements collected within the registry reflect a generally accepted monitoring profile for the safety and efficacy follow-up of the prescribed antipsychotic pharmacotherapy. The requirement of safety monitoring documentation in the registry by the prescriber occurs when:

- The antipsychotic is prescribed for an indication that is not approved by the FDA.
- The antipsychotic is prescribed at a higher dosage than approved for a specific indication by the FDA.
- The prescribed antipsychotic will result in the concomitant use of two or more antipsychotic agents.

About the A+KIDS Registry

Prescribers are directed to the **A+KIDS** website (http://www.documentforsafety.org) to register as an **A+KIDS** provider to enable access to the online registry or to learn more about this initiative. Pharmacy providers are encouraged to visit the website to understand how the policy may impact pharmacy claims processing for antipsychotic medications.

Phase one of the registry process will capture demographics and brief clinical information. The information can be submitted electronically through the **A+KIDS** website (http://www.documentforsafety.org) or by completing a form to submit by fax to ACS at 866-246-8507. The form will be available on the DMA Outpatient Pharmacy web page (http://www.ncdhhs.gov/dma/pharmacy/) and the **A+KIDS** website (http://www.documentforsafety.org). Using the fax method to provide information will result in a 3-month-approval period. Faxed forms missing essential information cannot be processed and will be returned to the

prescriber. When information is provided electronically through the registry, approval periods from 3 to 12 months are possible depending on case-specific clinical variables.

Providers can complete registry information in advance for patients. In late March, staff from CCNC began contacting prescribers to educate them about the registry and to inform them about the preregistration process. Technical support is available for providers Monday through Friday from 8:00 a.m. to 5:00 p.m. by calling the registry toll-free number, 1-855-272-6576.

Many resources are available to assist providers with understanding the policy and registry. Technical support is available to assist providers with registration and questions and can be accessed by calling the toll free number, 1-855-272-6576, found on the website. CCNC network psychiatrists and pharmacists are available to educate you about the registry. Additionally, help may be obtained by calling the ACS helpline at 866-246-8505. DMA assistance with understanding the policy and registry is available by contacting the Outpatient Pharmacy Program at 919-855-4300.

Charlene Sampson, Pharmacy Program
DMA, 919-855-4300

Attention: Independent Practitioner and Local Education Agencies

National Correct Coding Initiative Update

As communicated in the October, December, January, February, and March Medicaid bulletins, the National Correct Coding Initiative (NCCI) will become operational with date of service March 31, 2011. Attending (rendering) providers will not be able to bill certain pairs of codes for an individual recipient on the same date of service.

Independent practitioners and local education agencies (LEAs) do not normally bill with modifiers. However, a modifier may be needed to bypass an NCCI edit. CPT procedure codes, such as 92507 and 97530, that cannot be billed on the same day by the same provider for the same recipient will be denied unless modifier 59 is appended to the procedure code to identify that they are two distinct services (for example, speech therapy and physical therapy). For LEAs, this is important since they do not bill with an attending (rendering) number that identifies the service as speech, physical therapy or occupational therapy. It must be clinically appropriate to append a modifier to the procedure code and the documentation must support the use of a modifier. Information about modifiers can be found at http://www.cms.gov/NationalCorrectCodInitEd.

Many practitioners will need to revise the schedule and delivery of authorized services to ensure that treatments are not provided on the same date of service.

For additional information, please see DMA's NCCI web page at http://www.ncdhhs.gov/dma/provider/ncci.htm.

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

Attention: Ambulatory Surgical Centers, Hospital Outpatient Clinics, Hospitals, and Physicians

Reporting of Never Events and Hospital-Acquired Conditions

In compliance with CMS billing guidelines and N.C. legislative mandates, requests for claims payment for dates of service on or after October 1, 2010, that are processed beginning on May 1, 2011, using diagnostic related groupings (DRGs) that are attributed to the list that Medicare maintains related to hospital-acquired conditions (HACs) or never events will not be approved by the Peer Review Organization (PRO) and are not reimbursable. This policy refers to all reimbursement provisions documented in Section 4.19A of the Medicaid State Plan including Medicaid supplemental or enhanced payments and Medicaid disproportionate share hospital payments to **in-state** as well as **out-of-state** providers and complies with Medicare billing guidelines for HACs, never events, and present on admission (POA).

Procedures to Follow for Reporting Avoidable Errors (Never Events)

Avoidable errors that fall under this policy include:

1. Wrong surgical or other invasive procedure performed on a patient
2. Surgery or other invasive procedure on the wrong body part
3. Surgical or other invasive procedure performed on the wrong patient

Effective with date of processing May 1, 2011, any claim for dates of service October 1, 2010, and after, submitted by inpatient hospital claims for avoidable errors should be submitted on a UB-04 claim form or the 837I claim transaction with type of bill (TOB) 110 indicated on the claim. Outpatient hospital claims for avoidable errors should use TOB 130.

The non-covered claim must have one of the following ICD-9-CM diagnosis codes reported in diagnosis position 2-9:

- E876.5 – Performance of wrong operation (procedure) on correct patient (existing code)
- E876.6 – Performance of operation (procedure) on patient not scheduled for surgery
- E876.7 – Performance of correct operation (procedure) on wrong side or body part

Note: The above code shall not be reported in the External Cause of Injury (E-Code) field.

Effective with date of processing May 1, 2011, any claim for dates of service October 1, 2010, and after, submitted by ambulatory surgical centers and practitioners using the CMS-1500 claim form or 837P claim transaction must include the appropriate modifier appended to all lines that relate to the erroneous surgery(ies) or procedure(s) using one of the following applicable National Coverage Determination modifiers:

- **PA –** Surgery wrong body part
- **PB –** Surgery wrong patient
- **PC –** Wrong surgery on patient

Procedures to Follow for Reporting POA and HAC Indicators

Effective with date of processing May 1, 2011, any claim for dates of service October 1, 2010, and after, involving inpatient admissions to general acute care hospitals using the UB-04 claim form or 837I claim transaction must file their discharge claims with POA/HAC indicators for all primary and secondary diagnoses.

The POA/HAC indicator is placed adjacent to the principle and secondary diagnoses as the 6th character after the ICD-9-CM diagnosis code. The codes that are acceptable as POA/HAC indicators are:

- Y = Yes – Present at the time of inpatient admission.
- N = No – Not present at the time of inpatient admission.
- U = Unknown – The documentation is insufficient to determine if the condition was present at the time of inpatient admission.
- W = Clinically Undetermined – The provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not.
- 1 = Unreported/Not Used/Exempt from POA reporting – This code is the equivalent code of a blank on the UB-04; however, it was determined that blanks were undesirable when submitting this data via the 4010A1.

  Note: When the 5010 Inpatient Prospective Payment System (IPPS) is implemented, hospitals will no long report the PA indicator of "1."

For discharges occurring on or after May 1, 2011, hospitals will not receive additional payment for cases in which the selected condition was not present on admission. In other words, the DRG will be paid excluding any code that has a 6th character of N or U. An indicator of "1" will be paid as though the secondary diagnosis were not present. Only diagnoses codes with a 6th character of Y will be considered in the DRG calculations.

At this time the following types of providers are **EXEMPT** from POA/HAC indicator reporting:

- Critical access hospitals
- Long-term care hospitals
- Rural health clinics
- Federally qualified health centers
- Indian health centers
- Inpatient psychiatric hospitals

Note: New pending legislation may change these current exemptions.

Clinical Policy Section
DMA, 919-855-4360

Attention: Community Care of North Carolina/Carolina ACCESS Providers

Provider Satisfaction Survey

In order to allow all Community Care of North Carolina/Carolina ACCESS (CCNC/CA) providers an opportunity to participate in DMA Managed Care's provider satisfaction survey, the timeframe for completing the survey has been extended through April 2011. The online survey is located on DMA's CCNC/CA web page at http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm. The satisfaction survey is intended solely for CCNC/CA providers. All providers participating in the survey are strongly encouraged to complete the survey online. All information provided in the survey will be kept confidential. Results obtained from the survey will assist DMA in its efforts to improve customer service to its providers and their CCNC/CA enrollees.

Managed Care Section
DMA, 919-855-4780

Attention: Pregnancy Medical Home Providers

Registering for Obstetrical Ultrasounds

The **ordering** provider must have signed a contract with the local Community Care of N.C. network to be a Pregnancy Medical Home (PMH) provider with N.C. Medicaid in order for OB ultrasounds to bypass the prior approval requirement and only require registration. The **ordering** provider is responsible for registering the ultrasound with MedSolutions. The PMH provider is allowed up to five business days after the date of service to register the ultrasound with MedSolutions. The registration can be made with MedSolutions via the web (http://www.medsolutionsonline.com), telephone (1-888-693-3211) or fax (1-888-693-3210).

The **rendering** facility does not have to be a PMH provider for the claim to bypass prior approval and pay. However, the ultrasound must be registered with MedSolutions and uploaded to Medicaid before the **rendering** facility's claim can be processed for payment.

The **ordering** provider and the **rendering** facility must be enrolled in N.C. Medicaid and follow the provider requirements found in Clinical Coverage Policy 1K-7, *Prior Approval for Imaging Procedures*, available on DMA's website at http://www.ncdhhs.gov/dma/mp/.

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

Attention: Community Alternatives Program Providers, Durable Medical Equipment Providers, Home Health Agencies, and Private Duty Nursing Providers

Preferred Supplier for Select Incontinence Products and Non-Sterile Gloves

Effective with date of service, May 1 2011, Neil Medical Group from Kinston, N.C., will be the designated as the preferred supplier for select incontinence supplies and non-sterile gloves. N.C. Medicaid recipients will be free to choose to obtain incontinence supplies from any Medicaid-enrolled durable medical equipment (DME) provider, home health agency or private duty nursing (PDN) provider. Case managers for the CAP/CH, CAP/CO, and CAP/DA programs still have the option to provide incontinence supplies to CAP-approved recipients. There has been no change in the types of providers eligible to provide and receive Medicaid reimbursement for these incontinence items and gloves. There has been no change in Medicaid policy for the provision of these items.

Neil Medical Group will provide select incontinence supply items and non-sterile gloves at a guaranteed per-unit price. A selection of quality brands and sizes designed to meet the needs of N.C. Medicaid recipients will be available. Eligible N.C. Medicaid providers may contact Neil Medical Group at 1-800-735-9111 for additional information.

Rates will be posted to the appropriate fee schedules for applicable programs, on or before the effective date. Please refer to DMA's Fee Schedule web page at http://www.ncdhhs.gov/dma/fee/ for the maximum allowable rates for incontinence supply codes. An announcement will be published on or before mid-April to the DMA website at http://www.ncdhhs.gov/dma/provider/ when the rates have been established for these supplies.

The chart below lists the incontinence products and non-sterile gloves that will be covered.

***Note:** Additional codes (indicated by an asterisk after the codes in the table below) are being added to the fee schedules to accommodate billing for pull-up diapers.

HCPCS Code	Code Description
A4554	Disposable under pads, all sizes
T4521	Adult size disposable incontinence product, brief/diaper, small, each
T4522	Adult sized disposable incontinence product, brief/diaper, medium, each
T4523	Adult sized disposable incontinence product, brief/diaper, large, each
T4524	Adult sized disposable incontinence product, brief /diaper, extra large, each
T4525*	Adult sized disposable incontinence product, protective underwear/pull on, small size, each
T4526*	Adult sized disposable incontinence product, protective underwear/pull on, medium size, each
T4527*	Adult sized disposable incontinence product, protective underwear/pull on, large size, each
T4528*	Adult sized disposable incontinence product, protective underwear/pull on, extra large size, each
T4529	Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each
T4530	Pediatric sized disposable incontinence product, brief/diaper, large size, each
T4531*	Pediatric sized disposable incontinence product, protective underwear/pull on, small/medium size, each
T4532*	Pediatric sized disposable incontinence product, protective underwear/pull on, large size, each
T4533	Youth-sized disposable incontinence product, brief/ diaper, each
T4534*	Youth-sized disposable incontinence product, protective underwear/pull on, each
T4535 *Only available to CAP recipients when billed under a CAP provider number.*	Disposable liner/shield/guard/pad/undergarment, for incontinence, each
T4543*	Disposable incontinence product, brief/diaper, bariatric, XXL, each
A4927	Gloves, non sterile , per 100

Please refer to individual N.C. Medicaid program policies (http://www.ncdhhs.gov/dma/mp/) for details on product coverage and limitations.

Durable Medical Equipment Program
DMA, 919-855-4310

Neil Medical Group, 1-800-735-9111

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/

Employment Opportunities with the N.C. Division of Medical Assistance

Employment opportunities with DMA are advertised on the Office of State Personnel's website at http://www.osp.state.nc.us/jobs/. To view the vacancy postings for DMA, click on "Agency," then click on "Department of Health and Human Services," and then click on "HHS Medical Assistance." If you identify a position for which you are both interested and qualified, complete a **state application form** (http://www.osp.state.nc.us/jobs/applications.htm) and submit it to the contact person listed for the vacancy. If you need additional information regarding a posted vacancy, call the contact person at the telephone number given in the vacancy posting. General information about employment with North Carolina State Government is also available online at http://www.osp.state.nc.us/jobs/gnrlinfo.htm.

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.

2011 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
April	3/31/11	4/5/11	4/6/11
	4/7/11	4/12/11	4/13/11
	4/14/11	4/21/11	4/22/11
May	4/28/11	5/3/11	5/4/11
	5/5/11	5/10/11	5/11/11
	5/12/11	5/17/11	5/18/11
	5/19/11	5/26/11	5/27/11

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