August 2011 Medicaid Bulletin

In This Issue …….....Page

In This Issue……...Page

Attention: All Providers

Basic Medicaid Seminars

Basic Medicaid seminars are scheduled for the month of October 2011. Seminars are intended to educate providers on the basics of Medicaid billing as well as to provide an overview of Medicaid updates and resources. The seminar sites and dates will be announced in the September 2011 Medicaid Bulletin. The October 2011 Basic Medicaid Billing Guide will be used as the training document for the seminars and will be available prior to the seminars on DMA's Basic Medicaid Billing Guide web page at http://www.ncdhhs.gov/dma/basicmed/index.htm.

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

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

Attention: All Providers

CPT Procedure Code 38724 with Modifier 50

It has come to the attention of N.C. Medicaid that claims billed for CPT procedure code 38724 [Cervical lymphadenectomy (modified radical neck dissection)] when billed with modifier 50 (bilateral procedure) for dates of service on or after 06/25/1999, have denied. Effective immediately, providers who have had claims denied and have kept the claims timely, please resubmit the denied charge as a new claim (not as an adjustment request) for processing.

Clinical Policy
DMA, 252-208-1950

Attention: All Providers

CPT Procedure Code 52351 with Modifier 51

It has come to the attention of N.C. Medicaid that claims billed for CPT procedure code 52351 (Cystourethroscopy with urethroscopy and/or pyeloscopy; diagnostic) when billed with modifier 51 (multiple procedures) for dates of service on or after 01/01/2001, have denied. Effective immediately, providers who have had claims denied and have kept the claims timely, please resubmit the denied charge as a new claim (not as an adjustment request) for processing.

Clinical Policy
DMA, 252-208-1950

Attention: All Providers

Drug Screening

In response to CMS Change Request 7266, effective with date of service **April 1, 2011**, DMA end-dated HCPCS code G0430 and replaced it with HCPCS code G0434 (Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter). HCPCS code G0434 should be billed per patient encounter regardless of the number of drug classes testing and irrespective of the use or presence of the QW modifier on the claim.

DMA recognizes that most providers will only have one patient encounter per day. If a second encounter occurs, providers should bill repeat testing with an appropriate modifier. HCPCS code G0431 QW has been end-dated with an effective date of service April 1, 2011 and all other modifier combinations for G0431 are currently active. Please note that the description for G0431 has been changed to (Drug screen, qualitative; multiple drug classed by high complexity test method [e.g., immunoassay; enzyme assay], per patient encounter). CPT code 80100 (Drug screen, qualitative; multiple drug classes chromatographic method, each procedure) has also been end-dated with an effective date of service April 1, 2011. Providers who received claim denials for HCPCS codes G0431 or G0431 QW with EOB 7747 (Exceeds one procedure per day limitation) for dates of service prior to 04/01/2010 will need to resubmit new claims for processing.

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

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.

In preparation for 5010 testing and implementation, HP Enterprise Services began receiving updated Trading Partner Agreement-Appendix A effective July 1, 2011 which was published in the July 2011 Medicaid Bulletin. Follow the attached link to the 5010 version of Appendix A. Complete and mail, with original signature, to HP Enterprise Services. You will be e-mailed a letter with instructions on how to proceed with 5010 transaction testing after your Trading Partner Agreement-Appendix A has been processed.

Trading Partners/Vendors will be notified about testing timelines through upcoming Medicaid bulletins as HIPAA 5010 efforts progress.

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

Attention: All Providers

HIPAA 5010 Implementation – ASC X12 Version

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 implement the HIPAA requirements for the 5010 transactions within the legacy MMIS+ claims processing system. HPES is anticipating beginning Trading Partner testing of the 837 transactions in October, 2011. HPES is anticipating publishing the 837 and 835 companion guides in early September 2011. HPES is also anticipating dual processing beginning in November, 2011. In addition, if your Trading Partner Agreement has been updated, you will receive both the ASC X12 versions 4010 and ASC 5010 of the 835 transaction beginning in November. 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

Implementation of Additional Correct Coding Edits: New Visit and Obstetric Care

As previously announced in the May 2011 bulletin, DMA began implementing additional correct coding guidelines. These new correct coding guidelines and edits are nationally sourced by organizations such as the Centers for Medicare and Medicaid Services (CMS) and The American Medical Association (AMA). They will identify any inconsistencies with CPT, HCPCS, AMA, CMS and/or DMA policies and will deny the claim line.

Additional correct coding edits "New Visit" and "Obstetrics Care" will be implemented on September 1, 2011 for dates of service September 1, 2011 and greater.

New Visit
New Visit edits are defined by the AMA and CMS. A new patient is defined as a patient, "who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within 3 years." The term "professional services" applies to any face-to-face visit with a provider. This includes surgical procedures as well as Evaluation and Management (E/M) visits. An analysis will be performed on a patient's historical claims data to determine whether a New Visit E/M or another professional service has been paid within a three-year period.

Obstetric Care
Obstetric Care edits are based on guidance per the AMA. Per AMA, the total obstetric package includes the provision of antepartum care, delivery, and postpartum care. The Obstetric Care edits apply acceptable methods of billing obstetric services, and identify duplicate or conflicting methods of billing obstetric services and/or their components, as well as appropriate and/or inappropriate use of modifiers. The following are examples of Obstetric Care Edits:

Procedure	Description	Date of Service	Analysis
59510	Routine global care, including antepartum, cesarean delivery, and postpartum care	04/19/2011	Allow
59425	Antepartum care, 4-6 visits	03/29/2011	Deny (included in global care)
59510	Routine global care, including antepartum, cesarean delivery, and postpartum care	04/29/2011	Deny (time-window edit)

DMA will notify providers through the Medicaid Bulletin as new additional correct coding edits are being implemented.

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

Attention: All Providers

Medicaid Recipient Appeal Process (Due Process) and Early Periodic Screening, Diagnosis and Treatment Seminars

Medicaid **Recipient** Appeal Process and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) seminar is scheduled for the month of August, 2011. Seminars are intended to address Medicaid **recipient** appeal process when a Medicaid service is denied, reduced or terminated. The seminar will also focus on an overview of EPSDT-Medicaid for Children. Billing will not be addressed during the presentation.

The seminar is scheduled at the location listed below. This session will begin at 9:00 a.m. and will end at 4:00 p.m. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided at the seminar. **Because meeting room temperatures vary, dressing in layers is strongly advised.** 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 Medicaid Recipient Appeal Process and EPSDT seminars online **or** by fax. **Pre-registration is required.** Providers will receive a registration confirmation outlining the training material(s) each provider should bring to the seminar.

Date	Location
August 23, 2011	Raleigh The Royal Banquet and Conference Center Room C 3801 Hillsborough Street Raleigh, NC 27607

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

Attention: All Providers

NC Health Choice Claims Processing Transition

Effective with date of service on and after October 1, 2011, NC Health Choice (NCHC) claims will be processed by DMA's fiscal agent, HP Enterprise Services. For questions regarding claims processing, with dates of service of 10/1/2011 and after, providers may contact the HP Provider Services Department at 1-800-688-6696, menu option 3. For dates of service prior to the transition date of October 1, 2011, providers will continue to submit claims to BCBS.

Active N.C. Medicaid providers that want to participate in NCHC will not need to take any action for NCHC enrollment. Any provider that is not currently enrolled in the N.C. Medicaid program that wants to provide care to NCHC members will need to complete the Medicaid provider enrollment application on www.nctracks.nc.gov. CSC, DMA's Enrollment, Verification & Credentialing vendor, is available to assist providers who want to enroll in NC Medicaid/Health Choice. CSC contact information is provided below.

Additional information will be available to providers in the general N.C. Medicaid bulletin and on the NCHC webpage found on DMA's website.

EVC Call Center Contact Information

Enrollment, Verification, and Credentialing Call Center Toll-Free Number	866-844-1113
EVC Call Center Fax Number	866-844-1382
EVC Call Center E-Mail Address	NCMedicaid@csc.com
CSC Mailing Address	N.C. Medicaid Provider Enrollment CSC PO Box 300020 Raleigh NC 27622-8020
CSC Site Address	N.C. Medicaid Provider Enrollment CSC 2610 Wycliff Road, Suite 102 Raleigh NC 27607-3073
CSC Website Address	http://www.nctracks.nc.gov

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

Attention: All Providers

Option for Submitting Recipient Insurance Information Updates

This is a reminder that Medicaid providers have the option of submitting recipient commercial insurance information update requests electronically via secured internet connection. The existing paper Health Insurance Referral Form (Form DMA 2057) will continue to be available to providers who wish to continue using that process, but electronic submission is preferred and results in several benefits to providers.

This option results in expedited processing of commercial insurance information updates and eliminates the need to attach a paper claim to the referral form. Electronic requests will be completed within 48 business hours, and providers may submit electronic claims to the Medicaid fiscal agent as soon as the provider receives a confirmation email from HMS, the vendor managing this process.

Providers will need to follow these easy steps:

- Go to: www.ncproviders.hms.com
- Complete the electronic form.
- Submit the electronic form by selecting the Submit Query button.

A copy of the electronic NC Provider Referral Form 2057 follows:

NC Provider 2057 Referral Form

Please use this form to submit changes to recipient information. All requests will be completed within 48 business hours.

* Indicates Required Field

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

Program Integrity
DMA, 647-8136

Attention: All Providers

Termination of Inactive Medicaid Provider Notices

An announcement was made in the July general bulletin regarding the termination of inactive Medicaid providers. The article stated, effective July 1, 2011, once a provider is terminated due to billing inactivity within the previous 12 months, a new application and agreement to re-enroll must be submitted. A letter dated July 1, 2011, was mailed to providers notifying them of the August 1, 2011 termination date. Providers should disregard this letter because providers will not be terminated on August 1st and do not need to re-enroll in the Medicaid Program.

Provider Services
DMA, 919-855-4050

Attention: All Providers

1915 b/c Waiver

The Department of Health and Human Services (DHHS) is pleased to announce Eastpointe, Pathways, and Smoky Mountain Center *****have been selected to be the next Local Management Entities (LME) to move forward to participate in the State's 1915 b/c Medicaid Waiver for mental health, developmental disabilities and substance abuse services. The above LME's were selected through a formal procurement process. The other LME programs that applied will have several options to consider if the wish to remain in the RFA process.

Based upon either the RFA Minimum Requirements and/or RFA Desk Review Requirements CenterPoint, Southeastern Center, and Wake County will need to resubmit their RFA Application to the state by October 1, 2011 if they wish to remain in the RFA process.

Based upon the requirements of the RFA On-Site Review process The Durham Center will need to submit a Plan of Correction within 45 days to DHHS in order to receive second on-site review.

Existing LME - MCO and previous selected LME's proceeding forward based upon the 2010 RFA Application process:

- (existing MCO) PBH partnering with OPC, Alamance Caswell, and Five County
- Western Highland Network
- Mecklenburg County
- East Carolina Behavioral Health
- Sandhills Center

***** 87 Counties out of 100 counties in North Carolina are now part of helping the State move forward with the LME MCO implementation process as DHHS steps into Statewide 1915 b/c Medicaid Waivers.

Behavioral Health Section
DMA, 919-855-4290

Attention: All Providers

Recipient Notices

During the month of July, Division of Medical Assistance (DMA) mailed notices to all eligible Medicaid recipients to inform them of the important changes in the Medicaid and Health Choice programs. Some of the changes were due to recent legislation passed through the North Carolina General Assembly. The changes impacted all Medicaid recipients, Medicaid recipients only and Health Choice recipients only. The changes are as follows:

Optical Services
Recent legislation has eliminated the coverage of eye exams and optical supplies for adults in the coming months. You will receive more information about when this change when it goes into effect in October.

Durable Medical Equipment
Due to the need for cost savings, Medicaid is examining ways to provide incontinence supplies more efficiently. We will provide information about any changes as they are developed.

Outpatient Specialized Therapies
Outpatient specialized therapies are provided in outpatient settings, such as the Health Department. Recent legislation requires that outpatient physical therapy, occupational therapy, and speech therapy visits for adults be limited to three (3) per year. Your provider will be able to tell you more about this change when it is made.

Bariatric Surgery
In the coming months, Medicaid will cover bariatric surgery provided in approved centers. Your provider will be able to tell you of this change when it is made.

Dental Services – Child and Adult
Recent changes to dental policy will affect the way that oral health care services are provided. Medicaid will no longer pay for the following services for all recipients:

- Cast metal partial dentures. Medicaid will continue to cover acrylic partial dentures and allow replacement of acrylic partials every 8 years.

Medicaid will implement the following changes for scaling and root planning (deep cleaning) services for recipients of all ages:

- Providers will be reimbursed for this service no more than once every 24 months rather than the current allowance of once every 12 months.
- There will be an additional prior approval requirement before this service can be approved.

Please discuss these changes with your child's dentist or your dentist to determine if the revised policy will affect dental treatment for either you or your family.

Carolina ACCESS
Carolina ACCESS wants to know how you feel about your health care or the health care of your child. Beginning in September 2011, you may be called and asked to answer some questions about your child's health care. Beginning in October 2011, you may be called and asked about your health care. This will not take too much of your time. If you are called, the person will give you their name and tell you they are calling from the University of North Carolina at Charlotte on behalf of North Carolina Medicaid. They will give you some information about the study. By answering the questions, you will be a part of an effort to improve your health care services. Your answers will be kept confidential. No one at the doctor's office or Medicaid will see any names or know how you answered the questions. We appreciate your participation to help us provide you with better services.

"Be Smart" Family Planning Program
Are you ready to be a parent? Are you ready for another child? Do you think you might want more children? If you answered no to any of these questions, you may want to take advantage of the opportunity to receive birth control

supplies and health care services that are covered under the Medicaid "Be Smart" Family Planning program. The program is designed to reduce unplanned pregnancies and improve the lives of children and families in North Carolina, and there is no co-pay for the services. To start receiving family planning services if you are enrolled in the "Be Smart" Family Planning program, you will need to schedule an appointment for a yearly family planning exam. You can make an appointment for the exam at your local health department, health center/clinic or a doctor's office that participates in the "Be Smart" program. If you have any questions about the services that are covered by the "Be Smart" program, please go to the Division of Medical Assistance website at: http://www.ncdhhs.gov/dma/medicaid/familyplanning.htm

Changes for Medicaid and Health Choice for Children Recipients were:

CARE-LINE Service Change
Effective July 1, 2011, CARE-LINE services will be discontinued. For questions or concerns after July 1, 2011, you can use the current CARE-LINE number (1-800-662-7030; TTY: 1-877-452-2514) to reach the DHHS Customer Service Center. The DHHS Customer Service Center is available Monday – Friday 8 am to 5 pm.

Changes for North Carolina Health Choice for Children Recipients were:

New NC Health Choice (NCHC) ID cards will be mailed beginning September 15, 2011. The new cards are effective October 1, 2011. These new cards are gray in color with the NCHC logo at the top.

Medicaid Eligibility Unit
DMA, 919-855-4000

Attention: All Providers

Update on NC Tracks; the Replacement MMIS

The Centers for Medicare and Medicaid Services (CMS) and the NC Department of Health and Human Services (DHHS) have approved an extension of the schedule to design, develop and implement NCTracks, the Replacement MMIS that will be operated by CSC. The amended schedule moves the NCTracks operational start date to 2013 and includes a four-month period for providers to participate in Provider Operational Preparedness (POP) activities beginning on the Operational Readiness Date, March 1, 2013. More information and a schedule of activities to be included in the POP period will be provided at a later date.

The NCTracks Operational Start Date for claim adjudication is July 1, 2013. DHHS has the option to initiate operations earlier than July 1, 2013, based on feedback from the POP activities and with 30 days notice to CSC.

Replacement MMIS Project Manager
DMA, 919-855-4106

Attention: All Providers

Notice of Rate Reductions

The Department of Health and Human Services, Division of Medical Assistance (DMA) hereby provides notice of its intent to amend the Reimbursement sections of Medicaid State Plan. To comply with SL 2011 - 145, section 10.37.(a) (6), DMA will be submitting State Plan Amendments for the purpose of revising rate methodology language to reflect for SFY 2011 – 2012 effective October 1, 2011 rates paid to North Carolina Medicaid services providers will be reduced by 2.67%. Nursing Homes will have their rate reductions effective July 1, 2011.

More detailed information will be posted on the DMA website at http://www.ncdhhs.gov/dma/provider/index.htm.

For questions concerning the reductions please call DMA Finance Management at 919-855-4180.

Finance Management
DMA, 919-855-4180

Attention: All Providers

Requirements of Medicaid and Health Choice Providers

In accordance with Senate Bill 496 which was signed into law on July 25, 2011, Division of Medical Assistance (DMA) will make changes to the requirements for Medicaid and Health Choice providers. DMA is required by law to:

- Assess providers and assign them to a categorical risk level of "limited," "moderate," or "high." If a provider could fit within more than one risk level described, the highest level of screening is applicable.
- Conduct criminal history record checks for certain providers.
- Suspend payments to providers and audits utilizing extrapolation.
- Establish a registry of billing agents, clearinghouses, and/or alternate payees that submit claims on behalf of providers.
- Require a provider to undergo prepayment claims review.
- Not pursue recovery of Medicaid or Health Choice overpayments owed to the State for any total amount less than one hundred fifty dollars ($150.00).
- Require all applicants who submit an initial application for enrollment in North Carolina Medicaid or North Carolina Health Choice to submit an attestation and complete trainings prior to being enrolled.

For a complete listing of the bill, the website at:
http://www.ncga.state.nc.us/Sessions/2011/Bills/Senate/PDF/S496v5.pdf

Provider Services
DMA, 919-855-4050

Attention: Dental Providers

Dental Seminars

Dental seminars are scheduled for the month of September, 2011. Information presented at these seminars will include a review of clinical coverage guidelines including prior approval and billing procedures, uses of the N.C. Electronic Claims Submission/Recipient Eligibility Verification Tool, and a review of common problems from provider enrollment to unintended billing errors to fraud, waste, and abuse. The seminars are scheduled at the locations listed below. Clinical Coverage Policy 4A, *Dental Services*, (January 1, 2011 revision) will be used as the primary training document for the seminar. Please review and print the Policy (on DMA's Clinical Coverage Policy and Provider Manuals web page) and bring it to the seminar. If preferred, you may download the Clinical Coverage Policy to a laptop and bring the laptop to the seminar or you may access the Clinical Coverage Policy 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 dental seminars by completing and submitting the online registration form. Or, providers may register by fax using the Dental Services Seminar Registration Form (fax it to the number listed on the form). Sessions will begin at 10:00 a.m. and end at 1:00 p.m. Providers are encouraged to arrive by 9:45 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
September 8, 2011	**New Bern** New Bern Convention Center Ballroom C 203 South Front Street New Bern NC 28563 get directions
September 13, 2011	**Asheville** Crowne Plaza Tennis & Gold Resort One Resort Drive Asheville NC 28806 get directions
September 14, 2011	**Charlotte** Crowne Plaza 201 South McDowell Street Charlotte, NC 28204 **Note: Parking fee of $6.00 per vehicle for parking at this location.** get directions

Date	Location
September 21, 2011	**Raleigh** Wake Tech Community College Student Service Building Conference Center Second Floor, Rooms 212-215 9191 Fayetteville Road Raleigh NC 27603 get directions
September 27, 2011	**Greensboro** Clarion Hotel Airport 415 Swing Road Greensboro NC 27409 get directions

Dental Seminars
September 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 seminar at _____ on _____
(circle one) (location) (date)

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

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

Attention: Dental Providers and Health Department Dental Centers

Revised Orthodontic Services Clinical Coverage Policy/New Covered Service D8070 for Recipients under the Age of 21 with Craniofacial Anomalies

A revised version of the DMA Clinical Coverage No. 4B: *Orthodontic Services* will be implemented effective with date of service August 1, 2011. The approved changes to the policy include clarification of existing prior approval (PA) criteria and the addition of other PA criteria. Other language in the revised policy: 1) clarifies what orthodontic treatment is covered and non-covered; 2) adds additional guidance under the "Description" section about existing covered service procedure codes; and 3) gives guidance regarding how to handle orthodontic transfer cases, terminated cases, and completed cases.

In addition, effective with date of service August 1, 2011, the following dental procedure code has been added for the N.C. Medicaid Dental Program.

CDT 2011/2001 2 Code	Description	PA Needed	Reimbursement Rate
D8070	Comprehensive orthodontic treatment of the transitional dentition * limited to recipients under age 21 * limited to functionally impairing malocclusions caused by cleft lip/palate or other severe craniofacial developmental anomalies or traumatic injuries which effect the function of speech, chewing, and/or swallowing * includes placement of fixed or removable appliances (such as an activator) necessary to initiate active treatment * once in a lifetime service unless special approval is granted for services deemed medically necessary for a Medicaid recipient under age 21	Yes	

Providers are reminded that when requesting prior approval of D8070 the same records should be submitted as for D8080—comprehensive orthodontic services of the adolescent dentition—, panoramic radiograph (D0330), cephalometric radiograph (D0340) and tracing with analysis, diagnostic casts (D0470), and treatment narrative. Providers are also reminded to bill their usual and customary charges rather than the Medicaid rate. For complete coverage criteria and additional billing guidelines, please refer to Clinical Coverage Policy 4B, *Orthodontic Services*, on the DMA website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

Dental Program
DMA, 919-855-4280

Attention: HIV Case Management Providers

HIV Case Management Services Training

The Carolinas Center for Medical Excellence (CCME) and The Division of Medical Assistance are pleased to announce that in August 2011 we are offering two Resource Day trainings. The first is for new providers who are interested in becoming certified as HIV Case Management agencies. The intended audience is for agency owners and administrators. The second Resource Day topic is **Understanding and Measuring Health Outcomes: Methods for HIV Case Management Providers** and is intended for case managers and supervisors. See the information listed below under training.

Training:
Registration is now open for the following trainings: New Certification/Application Process. (see schedule below). **This training is an opportunity for potential new providers to learn more about the program and certification requirements. Attendance is mandatory in order to obtain an application for certification.**

Date	Session Topic	Required Attendees
August 17 , 2011	**New Certification/Application Process**	The official agency/program administrator (i.e., the agency owner or director)
August 18, 2011	**Understanding and Measuring Health Outcomes: Methods for HIV Case Management Providers**	HIV Case Managers and Supervisors

All of the trainings will be located at the McKimmon Center in Raleigh, North Carolina (get directions). Information for the August 2011 training is available on CCMEs' HIV Case Management web page.

Updates:
An FAQ document is available at CCMEs' web page (http://www.thecarolinascenter.org/HIVCM).

HIV Case Management Program
DMA, 919-855-4389

Attention: Hospice Agency Providers

Physician Face to Face Encounter Requirement

Effective October 1, 2011 a physician face to face encounter is required for all Medicaid hospice admissions on or after that date. The encounter must occur prior to the 3rd benefit period and prior to all subsequent benefit periods. This applies to admissions on or after that date as well as those previously admitted that will reach the 3rd benefit period on or after October 1, 2011. The contact must be made prior to recertification of terminal illness and is used as a tool to determine the recipient's appropriateness to continue with hospice care. This provision is required in order to be in compliance with the Patient Protection and Affordable Care Act, Section 3132. **Hospice Reform.** This provision would require the Secretary to update Medicare hospice claims forms and cost reports by 2011. Based on this information, the Secretary would be required to implement changes to the hospice payment system to improve payment accuracy in FY2013. The Secretary would also impose certain requirements on hospice providers designed to increase accountability in the Medicare hospice program."

The hospice physician or Nurse Practitioner (NP) must perform the face to face contact and must provide a written attestation that the encounter occurred. The physician must be employed by or under contract to the hospice and the NP providing the face to face encounter must be employed by the hospice agency. The encounter must occur no more than 30 calendar days prior to the start of the hospice recipient's third benefit period. Failure to meet the face-to-face encounter requirements results in a failure by the hospice to meet the patient's recertification of terminal illness eligibility requirement and the patient would cease to be eligible for the benefit.

Clinical Policy
DMA, 919-855-4380

Attention: Hospice Agency Providers

Provision of Hospice Care for Children Under 21 Years Old

Under the Concurrent Care provision of the Patient Protection and Affordable Care Act hospice services are available to Medicaid eligible children under 21 years old, without requiring the waiver of curative treatment of the terminal condition. Concurrent care is considered curative care that can be provided in addition to the services covered by the hospice benefit. The hospice provider must provide the complete package of services covered under the hospice benefit. This provision is in accordance with Sections 1905(o)(1) and 2110(a)(23) of the Social Security Act, and Section 2302 of The Patient.

The Patient Protection and Affordable Care Act do not change the criteria for hospice participation. The Concurrent Care provision only removes the prohibition of receiving curative treatment upon the election of the hospice benefit. Concurrent care does not duplicate the services covered as a part of the hospice benefit. Refer to the Hospice Clinical Coverage Policy, #3D that can be found on the DMA website http://www.ncdhhs.gov/dma/mp/index.htm for services included in the hospice benefit.

Clinical Policy
DMA, 919-855-4380

Attention: Mental Health, Developmental Disability, and/or Substance Abuse Providers, Critical Access Behavioral Health Agencies, Local Management Entities, Community Care of North Carolina/Carolina Access Networks and Primary Care Providers

MH/DD/SA Integrated Care Toolkit

Purpose:

This toolkit was created to assist MH/DD/SA Providers in collaborating with Community Care of North Carolina and Primary Care Providers. (For the purpose of the documents in the toolkit, PCP refers to Primary Care Provider and Provider refers to MH/DD/SA providers.) Please refer to the toolkit documents on the DMA website at http://www.ncdhhs.gov/dma/services/behavhealth.htm.

Overview of the Toolkit:

1) **MH/DD/SA Integrated Care Flowchart** – this document details for MH/DD/SA Providers how to determine if a Medicaid recipient entering services has a CCNC medical home or other primary care provider and how to gather physical health information (through the Provider Portal/Informatics Center and from the primary care provider) to incorporate into the recipient's Assessment and Person-Centered Plan of Care. It also offers guidance on when to contact the Primary Care Providers.

2) **Four Quadrant Care Management Model Responsibilities** – using the Four Quadrant Model framework, this document defines the expectations for collaboration between MH/DD/SA providers and Primary Care Providers in conjunction with Local Management Entities/Managed Care Organizations and Community Care of North Carolina networks.

3) **Sample questions** – this document offers sample questions for MH/DD/SA Providers to ask recipients to determine their level of involvement with primary care and potential physical health needs.

4) **Benefits of CCNC** – this document, from the DSS manual, explains the benefits of a CCNC medical home. This form, along with a Spanish version can be found on the DMA website http://info.dhhs.state.nc.us/olm/forms/forms.aspx?dc=dma
They are forms DMA-9016 and DMA-9016sp. Only DSS can enroll Medicaid recipients into CCNC medical homes.

5) **Information from the Provider Portal/Informatics Center** – this document is an example of information that can be accessed (via CCNC or the LME's) from the Provider Portal/Informatics Center – this includes a Patient Care Team Summary, Visit History, Medication Regimen, and any applicable care alerts.

Behavioral Health Section
DMA, 919-855-4294

Attention: NC Health Choice Providers

Legislative Update

Session Law 2011-145 became law on June 16th. It mandates that "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under the North Carolina Medicaid Program except for the following:
1) No services for long-term care;
2) No non-emergency medical transportation;
3) No EPSDT; and
4) Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

The new law also repealed N.C. GEN. STAT. § 108A-70.23, which addressed services for children with special health care needs under the Health Choice Program. Prior to the passage of the new law, Health Choice children with special health care needs were screened for service eligibility and then received the same level of services available under the Medicaid State Plan. Health Choice recipients will no longer be screened for special needs, because the Health Choice Program will already be benchmarked to the Medicaid State Plan's.. The North Carolina Commission on Children with Special Health Care Needs will continue to monitor and evaluate the availability and provision of health services for special needs children in the State overall and under the North Carolina Health Choice Program.

To help ensure that each Health Choice Program recipient has a medical home, Session Law 2011-145 requires the provision of services to children enrolled in the NC Health Choice Program through Community Care of North Carolina (CCNC). Effective October 1, 2011, NC Health Choice (NCHC) enrollees will be mandated to select a CCNC primary care provider (PCP) practice to serve as their medical home for sick and well-child visits. CCNC PCP practices are required to provide direct care and care coordination including authorizing and documenting medically necessary referrals to specialty care for its NCHC panel members. In addition to fee-for-service reimbursement, CCNC PCP practices will be paid a per member, per month fee for coordinating the care of their NCHC panel members. New NCHC ID cards will have the CCNC PCP practice's name, address and telephone number printed on the front of the card. For primary care providers who are interested in enrolling in CCNC, please visit the following web address: http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm.

In addition to the benefit changes in Health Choice, Session Law 2011-145 amended the procedures for changing medical policy and expanded DMA's rule making authority for the program. The law became effective as of July 1, 2011, but DMA has from October 1, 2011 to March 12, 2012 to fully implement the transition to a Medicaid look-alike program.

In addition to the four benefits exceptions outlined in the new law, several prior approval exceptions and service limitations will distinguish NC Health Choice clinical coverage policies from Medicaid clinical coverage policies. For example:

- Under EPSDT, children enrolled in Medicaid may get replacement eyeglass frames every 12 months. In Health Choice, eyeglass frame replacement will be covered every 24 months.
- Health Choice will also retain some unique prior approval requirements that have been recommended by the Physician Advisory Group.

Such exceptions and service limitations stem from the fact that Health Choice is not an entitlement program, and the State has enrollment and service limitations within the Health Choice budget.

The NC Health Choice Program is undergoing a transition both administratively and programmatically, the following projects are underway:

1. Revision of the NC Health Choice recipient Handbook and ID cards;
2. Development of an NC Health Choice Billing Guide chapter to be incorporated into the Medicaid Billing Guide;
3. Promulgation of new or amendment of existing NC Health Choice Clinical Coverage Policies;
4. Development of Rules for the NC Administrative Code in collaboration with the NC Attorney General's Office;
5. Signing of new contractor agreements with medical and pharmacy claims processing fiscal agents; and
6. Submission of a revised State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS).

NCHC families are receiving notices informing them of these upcoming changes. You can read more detail about some of these projects below.

NEW HEALTH CHOICE HANDBOOK COMING SOON

The NCHC Handbook is currently undergoing revisions to reflect the program benefit changes required by Session Law 2011-145. The revised version will soon be published as a combined Handbook with information for both the NC Health Choice Program *and* the Medicaid Program for Families and Children (Health Check). The Division of Medical Assistance has targeted mailings of the new handbooks to all current and new NCHC and Medicaid Health Check recipients in September 2011. An electronic copy of the revised Handbook will also be posted on the Division of Medical Assistance Web site. Both the paper and electronic versions will be available in English and Spanish.

NEW HEALTH CHOICE ID CARDS COMING SOON

Beginning October 1, 2011, there will be a new NCHC Identification card. The card will be gray with an NCHC logo on it , but it will resemble the Medicaid ID card. The card will list the NCHC recipient and his or her identification number and the Community Care of North Carolina/Carolina ACCESS (CCNC/CA) medical home/Primary Care Provider (PCP) information. As a function of CCNC/CA, all NCHC recipients **must** be referred by their PCP for all services not performed at their medical home. Contact the PCP located on the card if there is any doubt of the referral.

The Division of Medical Assistance will mail the new ID card to all current NCHC recipients during the month of September for use with services from October 1, 2011, and after. NCHC recipients approved after October 1, 2011 will also receive the new card. If someone is approved after October 1 for a time period prior to October 1, he or she will receive the old Blue Cross/Blue Shield NCHC card which should be used for billing for all services received prior to October 1, 2011.

The NCHC card is not proof of eligibility. The provider must verify eligibility by using one of the following:

- Recipient Eligibility Verification Web Tool
- Real Time Eligibility Verification (270/271 Transaction)
- Batch Eligibility Verification (270/271 Transaction)
- Automated Voice Response (AVR) System – 1-800-723-4337, Option 6

You can find additional information about the verification process in Appendix F of the Medicaid Billing Guide.

NEW HEALTH CHOICE BILLING GUIDE COMING SOON

The NCHC Billing Guide is currently undergoing revisions to reflect the program benefit changes required by Session Law 2011-145. The fall 2011 Medicaid Billing Guide update will include a new chapter insert specific to the Health Choice Program.

CLINICAL COVERAGE POLICY UPDATE

The following N.C. Health Choice policies were removed from public comment on June 4, 2011 after being amended:

1. Total Hip Resurfacing
2. Electrodiagnostic Studies

The following N.C. Health Choice policy was removed from public comment on June 18, 2011 after being newly promulgated:

1. Genetic testing for Long QT Syndrome

The following N.C. Health Choice policies were removed from public comment on July 22, 2011 after being scheduled for termination:

1. Minimally Invasive Hip and Knee Arthroplasty
2. Gait Analysis
3. Sacral Nerve Neuromodulation Stimulation for Pelvic Floor Dysfunction

The following N.C. Health Choice policy was removed from public comment on July 31, 2011 after being newly promulgated:

1. Intravenous Iron Therapy

For a complete list of N.C. Health Choice clinical coverage policies, please refer to the N.C. Health Choice Policies web page at http://www.ncdhhs.gov/dma/hcmp/.

NC Health Choice
DMA, 919-855-4104

Attention: All Behavioral Health Providers

Electronic Prior Approval Requests

Mandatory electronic submission of authorization requests

Effective October 1, 2011, the Appropriations Act of 2011 (House Bill 200) mandates that providers submit authorization requests electronically via the vendor's website. For purposes of submitting mental health, substance abuses, and developmental disability requests to the appropriate Utilization Review vendors, please note the following information for submission:

ValueOptions

ValueOptions continues to offer live webinar training on ProviderConnect submission. Providers unable to participate in live webinar training can access pre-recorded webinars for self-paced training. Navigate to the link below and scroll to the *Provider Training Opportunities* section to view webinar details and access additional ProviderConnect resource documents such as the ProviderConnect User Guide, Quick Reference Guide, and Frequently Asked Questions (FAQ) document: http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm

Eastpointe Human Services Providers

For purposes of submitting mental health, substance abuse, intellectual and other developmental disability requests to Eastpointe Human Services, providers should utilize the LME ProviderConnect web portal at https://carelink.carenetasp.com/EastpointePC/.

Eastpointe providers can access pre-recorded webinars for self-paced training. Navigate to the link below and scroll to the bottom of the page and see the section labeled *Webinars*. Providers can also view additional Medicaid utilization review materials from this page. http://www.eastpointe.net/providers/MedicaidUR/mur.aspx

The Durham Center Providers

For purposes of submitting mental health, substance abuse, IDD and CAP I/DD requests to The Durham Center, providers should utilize the ProviderConnect web portal:
https://carelink.carenetasp.com/DurhamPC/

The Durham Center will be providing several live webinars in the coming months. Please visit the Durham Center's training/events calendar located on their website or use the following link to get directly to the calendar: http://www.durhamcenter.org/index.php/provider/calendar. Providers unable to participate in live webinar training can access pre-recorded webinars for self-paced training. Navigate to the link below and scroll to the *ProviderConnect* section to access a recorded webinar and to access the Durham Center ProviderConnect User Manual. The webinar and user manual will provide information regarding obtaining a ProviderConnect user name and password. http://www.durhamcenter.org/index.php/provider/docs/service

Pathways LME Providers

For the Purpose of submitting CAP I/DD requests to Pathways LME, providers should utilize the following link and select "CAP MR/DD Authorization Request": http://www.pathwayslme.org/capur/

The "CAP MR/DD Authorization Request" link is under construction at this time. Please visit Pathways LME website for updates on electronic submissions and trainings they will be providing.

Crossroads Behavioral Healthcare Providers

For the Purpose of submitting CAP I/DD requests to Crossroads Behavioral Healthcare, providers should utilize the following ProviderConnect web portal:https://carelink.carenetasp.com/crossroadspc/login.asp

Crossroads providers can access a ProviderConnect presentation at the link below and select "CAP MR/DD UR" and scroll down to Provider Training Presentations: http://crossroadsbhc.org/. To obtain a login and/or individualized training on Provider Connect, you can contact Pat Draughn at pdraughn@crossroadsbhc.org

Behavioral Health Section
DMA, 919-855-4290

Attention: All Podiatrists and Podiatry Groups

Claims for CPT Codes 29904, 29905, 29906 and 29907

It has come to DMA's attention that individual podiatrists and podiatry groups have had claims denied for CPT codes 29904 (Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body), 29905 (Arthroscopy, subtalar joint, surgical; with synovectomy), 29906 (Arthroscopy, subtalar joint, surgical; with debridement) and 29907 (Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis). System changes have been made to correct this issue.

Providers with denied claims related to EOB 79 (this service is not payable to your provider type or specialty in accordance with Medicaid guidelines) that have been timely filed may resubmit the denied charges as a new claim (not as an adjustment request) for processing.

HP Enterprise Services
1-800-688-6696 or 919-855-8888

Attention: Nurse Practitioners and Physicians

Dexamethasone Implant, Intravitreal, 0.1 mg (Ozurdex, HCPCS Code J7312): Updated Billing Guidelines

Effective for dates of service October 1, 2009 through December 31, 2010, the N.C. Medicaid Program covers dexamethasone implant, intravitreal (Ozurdex) for use in the Physician's Drug Program when billed with HCPCS code J3490 (unclassified drugs). Refer to the bulletin article in February 2010.

Effective with date of service January 1, 2011, Medicaid covers Ozurdex when billed with HCPCS code J7312 (Injection, dexamethasone, intravitreal implant, 0.1 mg) only for the indications noted below.

Ozurdex is a biodegradable implant indicated for the treatment of macular edema following branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO) and for the newer indication, treatment of non-infectious uveitis affecting the posterior segment of the eye. Dexamethasone, a potent corticosteroid, has been shown to suppress inflammation by inhibiting multiple inflammatory cytokines resulting in decreased edema, fibrin deposition, capillary leakage, and migration of inflammatory cells.

Treatment with Ozurdex is for ophthalmic intravitreal injection only. Treatment of both eyes may be performed on the same day. Ozurdex is available as a 0.7-mg pouch with a single-use, specially designed drug delivery system (DDS) applicator.

For Medicaid Billing

For macular edema:

- One of the following ICD-9-CM diagnosis codes is required when billing Ozurdex for the treatment of **macular edema following BRVO or CRVO**:
    - 362.30 (retinal vascular occlusion, unspecified)
    - 362.35 (central retinal vein occlusion)
    - 362.36 (venous tributary [branch] occlusion)

    OR
    - 362.37 (venous engorgement)

    PLUS

- One of the following codes must be billed in addition to one of the codes listed above:
    - 362.53 (cystoid macular degeneration, cystoid edema)

      OR
    - 362.83 (retinal edema)

For uveitis:

- One of the following ICD-9-CM diagnosis codes is required when billing Ozurdex for the treatment of **non-infectious uveitis** affecting the posterior segment of the eye:

    - 363.00 through 363.08 (Focal choroiditis and chorioretinitis)

  - 363.10 through 363.15 (Disseminated choroiditis and chorioretinitis)
  - 363.20 (Chorioretinitis, unspecified)
  - 363.21 (Pars planitis)
  - 363.22 (Harada's disease)

- Providers must bill Ozurdex with HCPCS code J7312 (Injection, dexamethasone, intravitreal implant, 0.1 mg) for dates of service on and after January 1, 2011.
- Providers must bill Ozurdex with HCPCS code J3490 (Medicaid unit = 1 pouch) for dates of service October 1, 2009 through December 31, 2010.
- Providers must indicate the number of HCPCS units billed. For J7312, one Medicaid unit of coverage is 0.1 mg. To bill a complete pouch (treatment for one eye), bill 7 units. The maximum number of billable units is 14, if treatment of both eyes is performed on the same day. For J3490, one Medicaid unit of coverage is one pouch. One unit of J3490 should be billed if one eye was treated. Two units of J3490 should be billed if both eyes were treated on the same day.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Ozurdex should be reported as "UN." To bill for the implant, report the NDC units as "UN1" for administration to 1 eye or "UN2" for administration to both eyes. If the implant 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 the DMA website for additional instructions.
- Medicaid covers only rebatable NDCs.
- Providers must bill their usual and customary charge.
- Providers may bill CPT procedure code 67028 with the appropriate modifier for the administration of the implant.

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

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

Attention: Nurse Practitioners and Physicians

Injection, Von Willebrand Factor Complex (Human), Wilate: Updated Billing Guidelines

Effective with date of service July 1, 2011, the N.C. Medicaid program covers the coagulation factor Wilate when billed with HCPCS code Q2041 – Injection, Von Willebrand Factor Complex (Human), Wilate, **1 I.U**. VWF:RCO. HCPCS code J7184 – Injection, Von Willebrand Factor Complex (Human), Wilate, **100 I.U.** VWF:RCO - is no longer covered for dates of service on and after July 1, 2011.

The ICD-9-CM diagnosis code required for billing Wilate is 286.4 (von Willebrand's disease).

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

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

Attention: Optical Providers

Elimination of Adult Routine Eye Exams, Refractions, and Visual Aids Services

In accordance with House Bill 200, Section 10.37.(a), effective with date of service October 1, 2011, all routine eye exams, refractions, and visual aids for adult Medicaid recipients 21 years of age and older will no longer be covered.

Watch for the comprehensive Routine Eye Exam and Visual Aids for Recipients under Age 21 Policy at http://www.ncdhhs.gov/dma/provider/index.htm.

Clinical Policy and Programs
DMA, 929-855-4310

Attention: Pharmacists and Prescribers

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

Phase Two Implementation: Children 13 through 17 Years of Age – Start Date August 24, 2011. Effective April 12, 2011, DMA implemented a policy titled *Off Label Antipsychotic Monitoring in Children through Age 17.* Phase one was the 0 – 12 age group. Implementation of the second phase for ages 13 – 17 is August 24, 2011. The policy requests the prescriber of any antipsychotic medication to a Medicaid recipient in these age groups to document monitoring parameters done that support safe use of the antipsychotic agent. Antipsychotic choices are not limited by the policy.

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) is maintaining a registry for providers to document the use of antipsychotic therapy. The registry called A+KIDS (Antipsychotics-Keeping It Documented forSafety) is supported by an advisory panel consisting of child psychiatrists from North Carolina's four medical universities. The registry encourages the use of appropriate baseline and follow-up monitoring parameters to facilitate the safe and effective use of antipsychotics in this population.

Objectives of the **A+KIDS** registry include improvement in the use of evidence-based safety monitoring for antipsychotics; reduction of antipsychotic polypharmacy; and reduction of cases with the prescribed dose differing from the FDA approved dosage for an indication. 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 different 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.

The registry process captures 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 is 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 always 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 6 to 12 months are possible depending on case-specific clinical variables. Providers can complete registry information in advance for patients.

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 found on the website. The technical support staff will assist providers with registration and questions. Other resources are available to assist providers with understanding the policy and registry. CCNC network psychiatrists and pharmacists are available to provide education and training. 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.

Pharmacy Program
DMA, 919-855-4300

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

Proposed Changes to Medicaid Clinical Coverage Policy 8C

Outpatient Behavioral Health Services Provided by Direct-Enrolled Provider, have been posted for 45 days of public comment. The policy with proposed changes can be found on the DMA website at http://www.ncdhhs.gov/dma/mpproposed/index.htm.

Behavioral Health Section
DMA, 919-855-4294

Attention: Outpatient Behavioral Health Service Providers

Payment of Psychiatric Reduction on Professional Crossover Claims

Payment of Psychiatric Reduction on crossover claims is a percentage based on the Billing provider type and specialty (PT/PS). Professional crossover claims include details for deductible, coinsurance and psychiatric reduction amounts. The Medicaid payment for these claims is the sum of the Medicare Crossover percentage times the deductible and coinsurance amounts and the psychiatric reduction percentage times the psychiatric reduction.

For previous announcements on this policy change, refer to the October 2008 general Medicaid Bulletin, *Medicaid Reimbursement for the Psychiatric Reduction* and the March 2009 general Medicaid Bulletin, *Payment of Psychiatric Reduction on Professional Crossover Claim*. Below is a summary of the effective dates and percentage changes for each PT/PS grouping:

Provider Specialty	Percent Payment on Psychiatric Reduction				
	3/1/09 – 10/31/09	**11/1/09 – 12/31/09**	**1/1/10 – 12/31/11**	**1/1/12 – 12/31/12**	**1/1/13 – 12/31/13**
Psychiatrist Licensed Psychologist Multi-Specialty Physician Group	95%	86%	86%	86%	86%
Certified Nurse Practitioner Mental Health Nurse Practitioner	80.75%	61.60%	57.92%	52.40%	43.20%
Local Management Entities Licensed Clinical Social Worker (LCSW) Licensed Professional Counselor (LPC) Licensed Marriage and Family Therapist (LMFT) Certified Clinical Nurse Specialist (CCNS) Licensed Psychological Associate (LPA) Certified Clinical Supervisor (CCS) Certified Clinical Addictions Specialist (CCAS) Independent Mental Health Practitioner Group	56.67%	38.67%	30.40%	18%	0%

Effective January 1, 2014 and subsequent calendar years, there will be 0% payment on the Psychiatric Reduction. Please refer to future bulletin articles for additional updates.

Rate Setting Section
DMA, 919-647-8177

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
August	7/28/11	8/2/11	8/3/11
	8/4/11	8/9/11	8/10/11
	8/11/11	8/16/11	8/17/11
	8/18/11	8/25/11	8/26/11
September	9/1/11	9/7/11	9/8/11
	9/8/11	9/13/11	9/14/11
	9/15/11	9/22/11	9/23/11
	9/29/11	10/4/11	10/5/11

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