February 2012 Medicaid Bulletin

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Attention: All Providers

NC Medicaid Recovery Audit Contractors (RAC)

On September 16, 2011, the Centers for Medicare and Medicaid Services (CMS) published the Final Rule for Medicaid Recovery Audit Contractors (RAC). Mandated by the Affordable Care Act (ACA), the Medicaid RAC Final Rule required states to implement their Medicaid RAC programs by January 1, 2012, or they would lose federal funding for the program.

Under the Medicaid RAC program, states must contract with a RAC to perform post payment audits in order to identify Medicaid payments that may have been underpaid or overpaid. They must follow federal and state guidelines to recover overpayments or to inform DMA of underpayments.

On February 17, 2011, the Division received approval of Medicaid State Plan Amendment NC 10-037 to establish one or more RACs. Effective January 1, 2012, the Division partnered with its current post payment review vendor, Public Consulting Group (PCG), to be one of the NC Medicaid RACs. In addition, a RAC Request for Proposal (RFP) will be posted soon so that there will be two NC Medicaid RAC after the contract is awarded.

Modeled after the best practices gathered from the Medicare RAC program which has been operational since January of 2010, under Medicaid RAC regulations, the RAC must:

- Have at least one FTE medical director on staff;
- Hire certified coders, unless the state determines that certified coders are not necessary for the effective review of claims;
- Provide a toll-free customer service phone number which is available during normal business hours;
- Limit audits to a three-year look back period;
- Perform audits based on the number of medical records and frequency of reviews determined by the State; and
- Coordinate with other vendors or entities that perform post payment provider audits, including the Medicaid Investigation Unit (MIU) and the CMS Medicaid Integrity Program, to ensure reviews are not duplicative. However, it is possible that entities may review the same claim for different purposes. Additional Information on the Federal Regulations for the Medicaid RAC program can be obtained at http://www.gpo.gov/fdsys/pkg/FR-2011-09-16/pdf/2011-23695.pdf.

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Corrected 1099 Requests for Tax Years 2009, 2010, and 2011 - Action Required by March 1, 2012

Each provider number receiving Medicaid payments of more than $600 annually will receive a 1099 Miscellaneous Income Form (MISC) tax form from HP Enterprise Services. The 1099 MISC tax form generated as required by IRS guidelines will be mailed to each provider no later than January 31, 2012. The 1099 MISC tax form will reflect the tax information on file with NC Medicaid as of the last Medicaid checkwrite cycle date, December 22, 2011.

If the tax name or tax identification number on the annual 1099 MISC you receive is incorrect, a correction to the 1099 MISC must be requested. This ensures that accurate tax information is on file for each provider number with Medicaid and sent to the IRS annually. When the IRS receives incorrect information on your 1099 MISC, it may require backup withholding in the amount of 28 percent for future Medicaid payments. The IRS could require HP Enterprise Services to initiate and continue this withholding to obtain correct tax data. Please note that only the provider name and tax identification number can be changed and must match the W-9 form submitted.

A correction to the original 1099 MISC must be submitted to HP Enterprise Services by March 1, 2012 and must be accompanied by the following documentation:

- Cover page outlining what information needs to be changed and for which tax year(s).
- A copy of the original 1099 MISC form(s) or the last page of the last Remittance and Status Report(s) showing the total YTD for that specific year(s). A current signed and completed IRS W- 9 form clearly indicating the correct tax identification number and tax name. (Additional instructions for completing the W-9 form can be obtained at http://www.irs.gov under the link " Forms and Publications.") The W-9 form cannot be dated prior to one year before submission.

Fax all documents to 919-816-3186, Attention: Corrected 1099 Request – Financial
Or
Mail all documents to:
HP Enterprise Services
Attention: Corrected 1099 Request - Financial
2610 Wycliff Rd. Suite 401
Raleigh, NC 27607-3073

A copy of the corrected 1099 MISC form(s), along with a second copy of the incorrect 1099 MISC form(s) with the "Corrected" box selected, will be mailed to you for your records. All corrected 1099 MISC requests will be reported to the IRS. In some cases, additional information may be required to ensure that tax information on file with Medicaid is accurate. Providers may be notified by phone or mail of any additional action which may be required to complete the correction information.

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

Attention: All Providers

Reporting Managing Relationship Changes

Providers are responsible for notifying the Division of Medical Assistance (DMA) of any change in their disclosed managing relationships. This notification must be made within thirty (30) calendar days of the change. The changes must be reported by submission of a new Provider Enrollment Packet, which can be found on the NCTracks website at https://www.nctracks.nc.gov/provider/providerEnrollment/index.jsp. Providers are encouraged to use the online provider enrollment application. With each submission, the provider must disclose all managing relationships in the Managing Relationship section. The entire Provider Enrollment Packet must be complete and correct upon submission to avoid delays in processing.

Below are two examples of how changes in managing relationships should be reported on the Provider Enrollment Packet:

- **Scenario 1** (**Adding a managing relationship**): Upon enrollment, a provider disclosed that they had four managing relationships. A year later, the provider added one new managing relationship. The provider must complete a new Provider Enrollment Packet. In the Managing Relationship section, the provider must list all five managing relationships.

- **Scenario 2** (**Removing a managing relationship**): Upon enrollment, a provider disclosed that they had 20 managing relationships. Six months later, the provider removed one of their managing relationships. The provider must complete a new Provider Enrollment Packet. In the Managing Relationship section, the provider must list all 19 managing relationships.

By properly notifying DMA of managing relationship changes, the provider will ensure that their Medicaid provider file is always current.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Recredentialing of Medicaid Providers

As the Enrollment, Verification, and Credentialing (EVC) vendor for North Carolina's Medicaid Program, CSC must recredential existing Medicaid providers a minimum of every three years to ensure that all provider information is accurate and current. On November 1, 2011, the EVC Operations Center began recredentialing providers as part of a one month ramp-up project and will recredential 11,000 providers every six months after that. This process includes a thorough examination of a provider's background, credentials, and qualifications to ensure the provider continues to meet North Carolina's Medicaid Program participation guidelines. It will also reduce fraud by ensuring a provider's record is current and that the state is aware of any adverse actions taken against the provider.

Another benefit is the ability to electronically generate and distribute contract renewals for all enrolled Medicaid providers 75 days prior to the 3-year anniversary date of enrollment or the date of the last contract renewal. It also allows providers the chance to complete their renewals electronically. Given the volume of providers that require recredentialing, this feature will reduce processing time for staff, shorten the amount of time a provider spends completing the application, and give providers sufficient notice to remain enrolled in the Medicaid Program.

To make this process simple, CSC has pre-populated a recredentialing application with the information they currently have on file for each provider. Within 30 days of receiving the invitation letter, providers must verify their Medicaid Provider information, provide any additional information requested via the online recredentialing application and follow the instructions in the letter. **CSC will not mail recredentialing applications to providers**.

It is critical that providers verify and/or provide all information required in the recredentialing application. Failure to complete this application and provide all requested information within 30 days from the date of the re-enrollment letter will result in termination from the NC Medicaid Program.

Providers will be required to pay a $100 fee at recredentialing. CSC will notify providers by mail with instructions on how to make payment of the recredentialing fee, if applicable.

EVC Operations Center
CSC, 866-844-1113

Attention: All Providers

Keeping Your Medicaid Provider Record Current

Providers must update the information in your provider file as soon as the change occurs. Having current information allows timely response to request and delivery of correspondence to the appropriate parties and addresses. The Provider Administrative Participation Agreement and the Electronic Claims Submission Agreement outlines your responsibilities for maintaining accurate provider records.

Excerpt from the Provider Administrative Participation Agreement –
Item 6. Disclosure:

a. At any time during the course of this Agreement, the Provider agrees to notify the Department at the North Carolina Department of Health and Human Services, Division of Medical Assistance, and Provider Services Section, of any material and/or substantial change in information contained in the enrollment application given to the Department by the Provider. This notification must be made in writing within thirty (30) calendar days of the event triggering the reporting obligation. Material and/or substantial change includes, but is not limited to, a change in:

i. ownership;
ii. licensure;
iii. federal tax identification number;
iv. bankruptcy;
v. additions, deletions, or replacements in group membership; and
vi. any change in address or telephone number.

b. The Provider agrees to submit to the Department upon request professional, business, and personal information concerning the Provider, any person with an ownership interest in the Provider, and any authorized agent of the Provider in accordance with the disclosure requirements set forth in 42 CFR Chapter IV, part 455, Subpart B. Such submittal shall include:

i. Proof of a valid license, operating certificate, and/or certification if required by controlling Authority or policy, or rule of a local jurisdiction in which the Provider is located and that is consistent with Controlling Authority.
ii. Any prior or current violation, recoupment, fine, suspension, termination, or other administrative action taken relative to medical or behavioral health care benefit programs under (a) federal or State law, policy, or rule; or (b) Department policy(ies) or (c) the laws or rules of any other state, Medicare, or any regulatory body.
iii. Full and accurate disclosure of any financial or ownership interest that the Provider, or a person with an ownership interest in the Provider, may hold in any other medical or behavioral health care provider or medical or behavioral health care related entity or any other entity with whom the Provider conducts business or any other entity that is licensed by the state to provide medical or behavioral health care services.

Excerpt from the Electronic Claims Submission Agreement:
Item 5:

The Provider shall notify the CSC EVC Center in writing of the name, address, and phone number of any entity acting on its behalf for electronic submission of the Provider's claims. The Provider shall execute an agreement with any such entity, which includes all of the provisions of this agreement, and Provider shall provide a copy of said agreement to CSC prior to the submission of any paperless claims by the entity. Prior written notice of any changes regarding the Provider's use of entities acting on its behalf for electronic submission of the Provider's claims shall be provided to CSC. For purposes of compliance with

this agreement and the laws, rules, regulations and policies applicable to Medicaid providers, the acts and/or omissions of Provider's staff or any entity acting on its behalf for electronic submission of the Provider's claims shall be deemed those of the Provider, including any acts and/or omissions in violation of Federal and State criminal and civil false claims statutes.

Item 13:
Any member of a group practice that leaves the group and establishes a solo practice must make a new election for electronic billing under his solo practice provider number.

EVC Operations Center
CSC, 866-844-1113

Attention: All Providers

Changes in Medicaid Prior Approval Policies and Procedures, Recipient Due Process (Appeals), and Early Periodic Screening, Diagnosis and Treatment (EPSDT) Seminars

N.C. Medicaid will hold **Prior Approval, Recipient Due Process, and EPSDT** training for providers during the month of March 2012.

The seminar is intended to address changes in Medicaid's **prior approval policies and procedures** and the Medicaid **recipient appeal process** when a Medicaid service is denied, reduced, terminated, or suspended. The seminar will also provide an overview of **EPSDT-Medicaid for Children**. The seminars are scheduled at the location listed below. The 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 seminars.

Pre-registration is required. Providers may register for the Changes in Medicaid Prior Approval Policies and Procedures, Recipient Due Process, and EPSDT seminars online. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available. Providers will receive a registration confirmation specifying the training material(s) each provider should bring to the seminar. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Date	Location
March 27, 2012	**Raleigh** Wake Tech Community College Student Service Building Conference Center Second Floor, Rooms 213 & 214 9191 Fayetteville Road Raleigh NC 27603

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

Attention: All Providers

Implementation of the Patient Protection and Affordable Care Act Requirements – Credible Allegation of Fraud and Payment Suspension

On February 2, 2011 in the Federal Register Volume 76, Number 22, the Centers for Medicare & Medicaid Services (CMS) clarified new requirements under the Patient Protection and Affordable Care Act (PPACA) regarding Medicaid Program Integrity efforts to combat fraud and abuse. The Social Security Act was amended with requirements that the State Medicaid Agency MUST:

- Suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity.
- Make a fraud referral to the Medicaid Fraud Control Unit (MFCU) whenever the State Medicaid agency investigation leads to the initiation of a payment suspension in whole or part.
- Send notice of its suspension of program payments within the following timeframes:

  a) Five days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold such notice.
  b) Thirty days if requested by law enforcement in writing to delay sending such notice, and in no event may exceed 90 days.

A provider may request, and shall be granted a reconsideration review in accordance with 10A NCAC 22F.0402.

The Social Security Act was also amended to include a definition of credible allegation of fraud. A credible allegation of fraud may be an allegation, which has been verified by the State, from any source and including but not limited to the following:

1. Fraud hotline & online form complaints
2. Claims data mining
3. Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judicially on a case-by-case basis. These new provisions in the Social Security Act were effective on March 25, 2011.

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Medicaid Providers Must Screen for Individual & Entity Exclusion

The HHS Office of Inspector General (HHS-OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all Federal health care programs (as defined in section 1128B(f) of the Social Security Act based on the authority contained in various sections of the Act, including sections 1128, 1128A, and 1156.

When the HHS-OIG has excluded a provider, Federal health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. (Section 1903(i)(2) of the Act; and 42 CFR section 1001.1901(b)). This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity, and extends to:

- all methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system;
- payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and
- payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician/pharmacist or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider/pharmacist, practitioner or supplier that is not excluded. (42 CFR Section 1001.1901(b).

Providers can look for excluded Individuals & Entities on the HHS-OIG List of Excluded Individuals and Entities (LEIE) database, which is accessible to the general public and displays information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. The LEIE website is located at: http://www.oig.hhs.gov/fraud/exclusions.asp.

To further protect against payments for items and services furnished, prescribed or ordered by excluded individuals and/or entities, the Division of Medical Assistance (DMA) is advising all current providers and providers applying to participate in the Medicaid program to take the following steps:

- Provider has an **obligation** and must screen all employees and contractors to determine whether any of them have been excluded.
- DMA will require this obligation as a condition of enrollment into the Medicaid program.
- Search the HHS-OIG website monthly by the names of an individual or entity to capture exclusions and reinstatements that have occurred since the last search.
- Immediately report to the appropriate Regional Office of the OIG Office of Investigations or DMA any exclusion information discovered.

DMA understands that providers share our commitment to combating fraud, waste & abuse. Working together will strengthen efforts to identify excluded parties, improve the integrity and quality of the Medicaid program and benefit the Medicaid recipients and North Carolina taxpayers. This form of defense in combating fraud, waste & abuse must be conducted accurately, thoroughly and routinely.

Program Integrity
DMA, 919-647-8000

Attention: All Providers

DMA Response to CMS OESS Penalty Extension Letter for X12 ASC 5010 Implementation

On January 16, 2009, the US Department of Health and Human Services (DHHS) published two final rules in the Federal Register related to Health Information Portability and Accountability Act (HIPAA) which became effective on March 17, 2009. One was to adopt ASC X 12 versions 5010 and NCPDP version D.0 for HIPAA covered electronic transactions. The other rule was to adopt lCD-10-CM for diagnosis reporting and ICD-10-PCS for inpatient procedures. The compliance date for the implementation of ASC X12 5010 and NCPDP D.0 transactions was January 1, 2012. On November 17, 2011, DHHS' Office of E-Health Standards and Services (OESS) announced a 90 day discretionary enforcement period of compliance with 5010 and NCPDP D.0. This announcement clearly stated that the compliance date was still January 1, 2012.

Given the OESS notice, the North Carolina Division of Medical Assistance (DMA) has decided to continue with the dual processing of 4010A1 and 5010 837 transactions ONLY until March 31, 2012. The ASC X12 4010A1 and 5010 834 and 820 transactions will be processed in dual mode ONLY for the month of January, 2012. The remaining HIPAA covered ASC X12 4010A1 transactions and NCPDP 5.1 transactions will be rejected starting on January 4, 2012 after business hours.

During this extended dual processing period for 4010A1 837 transactions, a new MMIS+ edit will be implemented with effective date February 10, 2012. This edit will suspend adjudication of all claims submitted in the ASC X12 4010A1 format for a two week period and then based on the checkwrite schedule final adjudication will be reported.

Providers who continue to submit 4010A1 837 transactions after the January 1, 2012 date will be required to submit a transition plan documenting their plan to reach 5010 compliance by the March 31, 2012 date. This transition plan must clearly document the steps that have been completed, the steps remaining that need to be completed to become 5010 compliant, the Medicaid provider numbers impacted and contact information to include email address and phone number. The transition plan should be emailed to HPES email address: ecspdf@hp.com. Please note "5010 Transition Plan" in the email subject line.

Providers can contact HPES, ECS unit at 1-800-688-6696 or 919-851-8888; press option 1 for questions or assistance regarding this information about the ASC X12 5010 implementation.

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

Attention: All Providers

NC Medicaid EHR Incentive Program Path to Payment

The NC Medicaid Electronic Health Record (EHR) Incentive Program provides the opportunity for eligible professionals (EPs) to receive up to $63,750 in incentive payments over six years for participating in the program. The payment for Year One is $21,250 and requires EPs to adopt, implement or upgrade to a certified EHR technology. Subsequent years address meaningful use standards and participants receive payments of $8,500 per year for up to five years.

The process for EPs to receive a Year One incentive payment includes the following steps:

1. **Requirements.** Review requirements at NC Medicaid EHR Incentive Program website www.ncdhhs.gov/dma/provider/ehr.htm.
2. **Eligibility**. Determine eligibility for the program using the eligibility wizard located at http://www.cms.gov/EHRIncentivePrograms/15_Eligibility.asp.
3. **CMS Registration.** Register with the Centers for Medicare and Medicaid Services (CMS) at http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp.
4. **A/I/U.** Adopt, implement, or upgrade to a certified EHR system. The Office of the National Coordinator for Health Information Technology (ONC) maintains a comprehensive listing of all certified technologies that are currently available at http://onc-chpl.force.com/ehrcert. New vendors and products are certified and added to the list as they become available.
5. **Confirmation.** NC Medicaid will verify information provided from CMS and send a welcome email to providers with an invitation to begin the attestation.
6. **Attestation.** Once a provider receives a welcome email inviting them to begin the attestation process with the NC Medicaid Incentive Payment System (NC-MIPS), the provider can log onto the NC-MIPS portal, located at https://ncmips.nctracks.nc.gov and complete the attestation process.
7. **EP Attestation.** EPs attest to information about their practice, patient encounters and certified EHR system. Attestation guides are available at https://ncmips.nctracks.nc.gov/ to assist in the process. Additional assistance is available from the call center at 1-866-844-1113. Do not forget to print and sign a copy; then mail, fax or email it to the NC-MIPS Center at one of the following:

   NC-MIPS CSC EVC Center
   PO Box 300020
   Raleigh, NC 27622-8020
   Fax: 866-844-1382
   Scan & Email: ncmips@csc.com

8. **Verification.** Once attestations are completed, they are verified by NC Medicaid. If **any** problems are found, providers are notified with instructions on how to address any issue. The verification process consists of multiple internal checks at NC Medicaid and can take as long as 4-10 weeks. This estimate is based on a fully implemented and operational system. **There may be delays as NC Medicaid continues to operationalize the system.**
9. **Notification.** Providers will be notified once the verification process has been **completed** along with when to expect an incentive payment. Payments are made according to the established Medicaid payment schedule.

10. **Future Payments.** EPs are eligible for five additional incentive payments based upon the Meaningful Use of their certified EHR technology (as defined by CMS). The first year of Meaningful Use will be based upon a 90-day reporting period. Additional years of Meaningful Use will have a reporting period of 365 days. The program runs through 2021 and program years do not have to be consecutive.

Additional information about Meaningful Use and the measures associated with it can be found on the CMS website located at http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp.

Additional resources can be found at the NC Medicaid EHR Incentive Program website www.ncdhhs.gov/dma/provider/ehr.htm.

For technical issues or to inquire about the status of your attestation, please contact 1-866-844-1113 or ncmips@csc.com.

Contact Medicaid about this program at NCMedicaid.HIT@dhhs.nc.gov or 919-855-4200.

NC Medicaid Health Information Technology (HIT)
DMA, 919-855-4200

Attention: All Providers

EHR Incentive Program Attestation Tail Period

North Carolina has created a 60-day "attestation tail period," or an extension beyond the year-end deadline to attest for a NC Medicaid EHR Incentive Payment. Now and in future payment years this will allow eligible professionals additional time to attest for a payment beyond the year during which requirements are met.

This means that the last day for eligible professionals to register and attest to receive an incentive payment for calendar year 2011 will be **February 29, 2012**.

NC Medicaid Health Information Technology (HIT)
DMA, 919-855-4200

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/:

- A6, Off Label Antipsychotic Safety Monitoring in Children through Age 17 (posted 1/1/12; eff. 12/1/11)
- 1A-15, Surgery for Clinically Severe Obesity (1/1/12)
- 1A-31, Wireless Capsule Endoscopy (1/1/12)
- 1A-32, Tympanometry and Acoustic Reflex Testing (1/1/12)
- 3K-1, Community Alternatives Program for Children (CAP/C) (1/1/12)
- 9, Outpatient Pharmacy Program (1/1/12)
- 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers (1/1/12)
- 10D, Independent Practitioners Respiratory Therapy Services (1/1/12)
- 11A-1-Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL)
- 11A-2- Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia
- 11A-3- Hematopoietic Stem-Cell & Bone Marrow Transplantation for Chronic Myelogenous Leukemia
- 11A-4 - Donor Leukocyte, Donor Lymphocyte or Buffy Coat Infusion for Hematologic Malignancies that Relapse or at a High Risk for Relapse after Allogeneic Stem Cell Transplantation (Date of termination 12/31/11)
- 11A-5 - Allogeneic Hematopoietic & Bone Marrow Transplant for Genetic Diseases and Acquired Anemias
- 11A-6 - Hematopoietic Stem-Cell & Bone Marrow Transplantation in the Treatment of Germ Cell Tumors
- 11A-7 - Hematopoietic Stem-Cell & Bone Marrow Transplantation for Hodgkin Lymphoma

The following new or amended NC Health Choice policies are now available on DMA's website at http://www.ncdhhs.gov/dma/hcmp/:

- Abatacept (Date of termination 9/30/2011) Acquired Anemias
- Alefacept Injection (Date of termination 9/30/2011)
- Allogeneic Hematopoietic & Bone Marrow Transplant for Genetic Diseases and
- Capsule Endoscopy, Wireless Cell Tumors
- Endovascular Stent Graft for Aortic Aneurysm (Date of termination 9/30/2011)
- Hematopoietic Stem-Cell & Bone Marrow Transplantation for Chronic Myelogenous
- Hematopoietic Stem-Cell & Bone Marrow Transplantation for Hodgkin Lymphoma
- Hematopoietic Stem-Cell & Bone Marrow Transplantation in the Treatment of Germ
- Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia
- Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic
- Independent Practitioners Infliximab (Date of termination 9/30/2011) Leukemia Leukemia (ALL)
- Surgery for Morbid Obesity
- Tympanometry and Acoustic Reflex Testing

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

Outpatient Specialized Therapies

The Division of Medical Assistance (DMA) Outpatient Specialized Therapies Policy has been amended effective January 1, 2012. Please read the posted policy located at http://www.ncdhhs.gov/dma/mp/8f.pdf for changes.

As a budget initiative under the Appropriations Act of 2011 (House Bill 200) DMA will limit **adult** therapy services. A recipient 21 years of age or older may have:

- up to 3 treatment visits and
- 1 evaluation visit of all Physical Therapy (PT), Occupational Therapy (OT), Speech Language/ Audiology (SLP/Aud) therapy services combined per calendar year from all therapy providers in any outpatient setting including Home Health. Treatment by multiple disciplines in the same visit will each count separately toward the total visit limit.

A recipient 21 years of age or older who has had an amputation, hip fracture or joint replacement and is within 3 months post surgery or discharge from inpatient services may have;

- 1 PT evaluation and/or
- 1 OT evaluation visit and up to 10 therapy treatment visits combined (PT, OT, SLP/Aud) per calendar year from all outpatient therapy providers in all outpatient settings including office, home, and hospital. Treatment by multiple disciplines in the same visit will each count separately toward the total visit limit. A different amputation, hip fracture or joint replacement would trigger a new 10 visit limit segment along with 2 evaluations.

A recipient 21 years of age or older who has had a stroke, traumatic brain injury or spinal cord injury and is within 6 months post discharge from inpatient services may have;

- 1 physical therapy evaluation and/or
- 1 Occupational therapy evaluation and/or 1 Speech therapy evaluation and up to 30 therapy treatment combined visits (PT, OT, SLP) per calendar year, from all therapy providers, in any outpatient setting including Home Health.

Treatment by multiple disciplines in the same visit will each count separately toward the total visit limit. If a recipient receiving these services experiences a documented occurrence of a new stroke, a new cycle of 30 visits may start. A new stroke, TBI or spinal cord injury would trigger a new 30 visit segment along with 3 evaluations.

In order for a recipient to have either 2 evaluations or 3 evaluations as outlined above the following diagnosis codes must be billed on claim form with other diagnoses. Remember there is a time element involved in qualifying for additional evaluations and visits.

Diagnosis List for 2 Evaluations:

V43.60	V43.61	V43.62	V43.64	V43.65	V43.66	V43.66	V49.60
V49.61	V49.62	V49.63	V49.64	V49.65	V49.66	V49.67	V49.70
V49.71	V49.72	V49.73	V49.74	V49.75	V49.76	V49.77	V54.13

Diagnosis List for 3 Evaluations:

Category 800	Category 801	Category 803
Category 804	Category 850	Category 851
Category 852	Category 853	Category 854

952.00	952.01	952.02	952.03	952.04	952.05	952.06	952.07	952.08	952.09
952.10	952.11	952.13	952.14	952.15	952.16	952.17	952.18	952.19	952.2
952.3	952.4	952.8	952.9	953.0	953.1	953.2	953.3	953.4	953.5
953.8	953.9								

430	431	433.01	433.11	433.21	433.31	433.81	433.91	434.01
434.11	434.91	435.0	435.1	435.2	435.3	435.8	435.9	

All limits are hard limits. Prior approval is required for all treatment visits. As is currently done, adult prior approvals will not span two calendar years. A new prior approval will be required for each calendar year.

When completing the PA request, providers should submit sufficient medical history to support an exception to the 3 visit limit, including, but not limited to appropriate medical or surgical diagnosis and discharge date from inpatient services. Relevant qualifying information can be added in the designated diagnosis fields or in the Additional Medical History or other text fields.

Pharmacy and Ancillary Services
DMA, 919-855-4310

Attention: All Providers
Implementation of Additional Correct Coding Edits: Facility Duplicates

As announced in previous Medicaid bulletins, the Division of Medical Assistance (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). These edits identify any inconsistencies with CPT, AMA, CMS and/or DMA policies and deny at the claim detail level. Additional correct coding edits for Facility Duplicates will be implemented in the second quarter of 2012. DMA will notify providers of the implementation date in a future Medicaid bulletin article.

Duplicates – Outpatient Facility Claims

For Hospital Outpatient services, DMA will only edit claim details related to drug, radiology, and laboratory services. Edits will reject only the claim line when all criteria match at the line and header level. If all other criteria match, but the two lines have different CPT/HCPCS codes, or one line has a CPT/HCPCS code and the other line has no CPT/HCPCS code, the two lines do not meet the criteria for line level Duplicate Outpatient Facility editing. If both lines have NO CPT/HCPCS codes, the line will not be considered for duplicate matching. The criteria for line level outpatient facility duplicate matching are as follows:

- Recipient/Patient
- Billing provider identification number
- Bill type
- Service date (line level)
- Charge amount (line level)
- HCPCS or CPT code

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

Attention: All Providers

Implementation of Additional Correct Coding Edits: Professional Duplicates

As announced in previous Medicaid bulletins, the Division of Medical Assistance (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). These edits identify any inconsistencies with CPT, AMA, CMS and/or DMA policies and deny at the claim detail level. Additional correct coding edits for Professional Duplicates will not be implemented on February 1, 2012 as previously published. DMA will implement these edits on March 1, 2012 for dates of service on or after March 1, 2012.

Duplicates – Professional Claims

North Carolina Medicaid and Health Choice will be implementing edits that detect duplicate submissions of a service on separate claims. The analytics examine codes that, by definition, cannot be billed more than once on the same date of service, within a defined date range, or over the lifetime of the patient for CPT and HCPCS codes. The following are examples of Professional Duplicate edits:

- Same Day Duplicate edits occur when the same provider submits a procedure on separate claims for the same date of service, and the procedure code description does not support multiple submissions.

Procedure	Claim	Description	Analysis
11200	XX159	Removal of skin tags, up to 15	Allow
11200	XX256	Removal of skin tags, up to 15	Deny

- Date Range Duplicate edits occur when the same provider submits the same procedure more than once on separate claims within a defined time period.

Procedure	Claim	Description	Analysis
94774	XX622	Pediatric home apnea monitoring per 30 days	Allow
94774	XX489	Pediatric home apnea monitoring, performed within 30 days of previous monitoring	Deny

- Lifetime Duplicate edits occur when a procedure is billed more than once in a patient's lifetime on separate claims (e.g. appendectomy, autopsy).

Procedure	Claim	Description	Analysis
58200	XX115	Total abdominal hysterectomy	Allow
58200	XX419	Total abdominal hysterectomy (billed two years later)	Deny

When clinically appropriate, a modifier may be appended to the claim detail to override the edit.

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

Attention: Pharmacy Providers

Pharmacy Generic Dispensing Fee Change

The Medicaid and Health Choice dispensing fee for generic drugs will change February 1, 2012 to four tiers based on a pharmacy's quarterly generic dispensing rate. The dispensing fee for brand drugs will remain $4.00. The dispensing fee for generic drugs will be determined according to the following tiers:

Generic Dispensing Rate	Generic Dispensing Fee
80% +	$9.00
75% - 79.9%	$6.50
70% - 74.9%	$4.40
69.9% -	$4.00

Pharmacy providers' generic dispensing rates will be posted on the Division of Medical Assistance (DMA) website at http://www.ncdhhs.gov/dma/pharmacy/index.htm. Changes to providers' generic dispensing fees during calendar year 2012 will occur on the first day of February 2012, May 2012, August 2012 and November 2012 based on the previous three month period.

The first reporting of generic dispensing rates is available on the DMA website for the February 1, 2012 change and is based on a provider's average generic dispensing rate for time period October 1, 2011 – December 31, 2011.

Reporting of generic dispensing rates during the remainder of calendar year 2012 will be made available in April 2012, July 2012 and October 2012 approximately two weeks prior to changes made in May 2012, August 2012 and November 2012.

Pharmacy Program
DMA, 919-855-4305

Attention: Nurse Practitioners and Physicians

Brentuximab Vedotin (Adcetris™, HCPCS code J9999): Billing Guidelines Correction

There is one correction to the article for Adcetris published in the December 2011 general Medicaid bulletin page 22. The recommended infusion **time is 30 minutes, not 1 hour, as previously published**.

Effective with date of service September 26, 2011, the North Carolina Medicaid Program covers brentuximab vedotin injection (Adcetris) for use in the Physician's Drug Program when billed with HCPCS code J9999 (not otherwise classified, antineoplastic drugs). Adcetris is available in 50 mg single-use vials.

Adcetris is a CD30-directed antibody-drug conjugate indicated for the treatment of Hodgkin's lymphoma after failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multi-agent chemotherapy regimens in patients who are not ASCT candidates, and systemic anaplastic large cell lymphoma after failure of at least one prior multi-agent chemotherapy regimen. The recommended dose of brentuximab is 1.8 mg/kg delivered by intravenous infusion over 30 minutes. Treatment is to be repeated every 3 weeks for a maximum of 16 cycles, or until there is disease progression or unacceptable toxicity.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Adcetris is:
  - 201.00–201.98 Hodgkin disease
  - 200.60–200.68 Anaplastic large cell lymphoma
- Providers must bill Adcetris with HCPCS code J9999 (not otherwise classified, antineoplastic drugs).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage is 50 mg. The maximum reimbursement rate per unit is $4,684.55.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Adcetris should be reported as "UN." To bill for the entire 50 mg vial of Adcetris, report the NDC units as "UN1."
- If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Providers must bill their usual and customary charge.
- The 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 1-919-851-8888

Attention: Nurse Practitioners and Physicians

Aflibercept (Eylea™, HCPCS code J3590): Billing Guidelines

Effective with date of service November 22, 2011, the North Carolina Medicaid Program covers aflibercept injections (Eylea™) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologics). Eylea is available in 2 mg/0.05 mL single use vials. Each vial should be used for the treatment of a single eye.

Eylea is indicated for the treatment of Neovascular (Wet) Age-Related Macular Degeneration (AMD). Eylea (aflibercept) is a recombinant fusion protein consisting of portions of human VEGF receptors 1 and 2 extracellular domains fused to the Fc portion of human IgG1 formulated as an iso-osmotic solution for intravitreal administration.

The recommended dose for Eylea is 2 mg (0.05 mL or 50 microliters) administered by intravitreal injection every 4 weeks (monthly) for the first 12 weeks (3 months), followed by 2 mg (0.05 mL) via intravitreal injection once every 8 weeks (2 months).

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Eylea is:
  - 362.52 – Exudative senile macular degeneration
- Providers may bill for the administration of Eylea with CPT procedure code 67028 [intravitreal injection of a pharmacologic agent (separate procedure)]. Indicate modifiers for left or right eye or for bilateral procedure, as appropriate.
- Providers must bill Eylea with HCPCS code J3590 (unclassified biologics).
- Providers must indicate the number of HCPCS units. One single-use vial may be billed for the treatment of one eye, or two single-use vials may be billed for the treatment of both eyes.
- One Medicaid unit of coverage is 2 mg (0.05 ml). The maximum reimbursement rate per unit is $1998.00.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. NDC units for Eylea should be reported as "ML" To bill for the entire 2 mg/0.05 mL vial of Eylea, report the NDC units as "ML.05." To bill for two vials, report the NDC units as "ML.10."
- 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 1-919-851-8888

Attention: North Carolina Health Choice Providers

Co-payments

When providers collect the co-payment from a North Carolina Health Choice (NCHC) member and the reimbursement amount reflected on your Remittance Advice is less than the co-payment amount collected in advance, providers should credit the difference to the NCHC member's account or reimburse the difference.

For further assistance, providers may contact HP Enterprise Services Provider Services Department at 1-800-688-6696, menu option 3, Monday through Friday from 8:00 a.m. to 4:30 p.m.

NC Health Choice
DMA, 919-855-4100

Attention: North Carolina Health Choice Providers

Wellness Exams

Providers who have received EOB 1058 ("The only well child exam billable through the Medicaid program is a health check screen), should resubmit the claim with the appropriate preventive medicine code (99383-99385; 99393-99395) and diagnosis code.

E/M CPT codes in the 99201 - 99215 series should not be billed in conjunction with the preventive medicine diagnosis or CPT codes listed above. The preventive medicine codes appropriate for NC Health Choice (NCHC) are listed below with their descriptions.

Age	New Patient	Established Patient
6 through 11 years	99383	99393
12 through 17 years	99384	99394
18 years	99385	99395

For further assistance, providers may contact HP Enterprise Services Provider Services Department at 1-800-688-6696, menu option 3, Monday through Friday from 8:00 a.m. to 4:30 p.m.

NC Health Choice and Well Visits and Vaccines

For wellness exams under the NCHC program provided on/or after 10/01/2011, providers have received denials when billing the preventive medicine Evaluation and Management (E/M) codes and vaccine administration codes on the same day of service. The Division of Medical Assista-nce is in the process of making system changes to correct this issue. Until these changes are complete, providers may bill the E/M code and hold claims for the vaccines and vaccine administration. Providers will be notified when the system update is complete and at that time can bill for the vaccines. Claims that have been denied can be voided and replaced with a claim for the E/M code only.

In addition, for NCHC children, providers may bill the individual services that are part of the wellness package for Medicaid recipients.

NC Health Choice
DMA, 919-855-4100

Attention: Durable Medical Equipment and Pharmacy Providers

Roche ACCU-CHEK Diabetic Supplies Under the DME and Pharmacy Programs

Effective November 15, 2011, Roche Diagnostics Corporation Diabetes Care is N.C. Medicaid's designated preferred manufacturer for blood glucose monitors, diabetic test strips, control solutions, lancets, and lancing devices. These products are covered under the Durable Medical Equipment and Outpatient Pharmacy Programs and will be reimbursed under the pharmacy point-of-sale system with a prescription.

The transition period has been extended from November 15, 2011 through March 14, 2012. During this period, both Roche and Prodigy diabetic supplies will be covered. Beginning on March 15, 2012, the second phase of the transition will take effect where both Roche and Prodigy diabetic supplies will be covered; however, a one-time override will be required for continued use of Prodigy products through April 14, 2012. As of April 15, 2012, only Roche diabetic supplies will be covered.

Prior authorization will be allowed for insulin-pump dependent recipients who cannot use Roche products. Pharmacy and DME providers need to ensure that invoices are easily retrievable in case documentation is needed to support the billing of these products. This could be requested to support the quantities being invoiced to Roche for the rebates due back to N.C. Medicaid and N.C. Health Choice.

Insulin Pump Users
Prior authorization will be allowed for insulin-pump dependent recipients who cannot use Roche products due to a dedicated glucometer communicating with their insulin pump. In these instances the provider must be a durable medical equipment (DME) provider or a pharmacy/DME provider. Prior authorization requests should be submitted to HP at P.O.Box 31188, Raleigh, NC 27622. Effective November 15, 2011, there are no designated preferred manufacturers of insulin syringes. The following are the list of NDC's that will be covered:

Covered Products	Package Size	Unit Type	NDC - 11
ACCU-CHEK Aviva Plus Care Kit *(Available on or after March 1, 2012. Contains the FastClix lancing device.)*	1 Meter Kit	1 Meter	65702-0101-10
ACCU-CHEK Aviva Care Kit	1 Meter Kit	1 Meter	65702-0101-10
ACCU-CHEK Compact Plus Care Kit	1 Meter Kit	1 Meter	50924-0019-01
ACCU-CHEK Aviva Test Strips	50 count	1 bottle	65702-0103-10
ACCU-CHEK Compact Test Strips	51 count	1 bottle	50924-0988-50
ACCU-CHEK Aviva Plus Test Strips	50 count	1 bottle	65702-0407-10
ACCU-CHEK Aviva Control Solution (2 levels)	1 bottle	1 bottle	65702-0107-10

ACCU-CHEK Compact Control Solution (2 levels)	1 bottle	1 bottle	65702-0369-10
ACCU-CHEK FastClix Lancets *(available on or after January 3, 2012)*	102 count	1 box	65702-0288-10
ACCU-CHEK Multiclix Lancets	102 count	1 box	50924-0450-01
ACCU-CHEK Softclix Lancets	100 count	1 box	50924-0971-10
ACCU-CHEK Softclix Lancing Device (Blue)	1 count	1	50924-0957-01
ACCU-CHEK Softclix Lancing Device (Black)	1 count	1	65702-0400-10
ACCU-CHEK FastClix Lancing Device Kit *(available on or after March 1, 2012)*	1 count	1	65702-0481-10
ACCU-CHEK Multiclix Lancing Device Kit	1 count	1	50924-0446-01

Billing Instructions for Submitting Diabetic Supplies under DME

Claims for diabetic test strips, control solution, lancets and lancing devices submitted under the DME program must be billed using the NDC in addition to the HCPCS code. The NDC will be entered in the shaded area of block 24A of the CMS-1500 claim form. During the time period March 15, 2012 through April 14, 2012 when the one-time override is available for Prodigy products, DME providers will need to place the SC modifier in block 24D of the CMS-1500 claim form to bypass the requirement to bill for Roche NDCs listed in the chart above. As of April 15, 2012, this modifier will no longer be accepted. These requirements will not apply to private duty nursing and home health providers until April 15, 2012. HCPCS codes and supply limits for diabetic supplies are the same as outlined in Clinical Coverage Policy 5A, Durable Medical Equipment, as indicated below:

HCPCS Code	Product Description	Quantity Limit
A4253	Blood glucose test or reagent strips (1 unit = 50 strips)	4/month – age ≥21
A4253	Blood glucose test or reagent strips (1 unit = 50 strips)	6/month – age ‹ 21
A4259	Lancets (1 unit = 100 lancets)	2/month
A4258	Lancing device	2/year
A4256	Normal, high, low calibrator solution	4/year

Prior Authorization Instructions for Insulin Pump Users

With an effective date based on date of service of January 15, 2012 prior authorization will be required for insulin-pump dependent recipients who cannot use Roche products due to a dedicated glucometer communicating with their insulin pump. In these instances the provider must be a durable medical equipment (DME) provider or a pharmacy/DME provider. Claims with a prior authorization on file will need to be submitted with a NU and U9 modifier. Claims for test strips not supplied by Roche that do not have a Prior authorization on file for A4253 NU, U9 will be denied for lack of authorization. The U9 modifier will indicate that test strips **not** supplied by Roche have been authorized for payment. Prior authorization requests should be submitted to HP at the following addresses:

NC Medicaid
P.O.Box 31188
Raleigh, NC 27622

NC Health Choice
P.O.Box 322490
Raleigh, NC 27622

Billing Instructions for Submitting Diabetic Supplies under Pharmacy Point-of-Sale System
Claims for diabetic test strips, control solution, lancets and lancing devices submitted at point-of-sale must be billed using the NDC. Test strips must be billed in multiples of 50 and lancets must be billed in multiples of 100 except for the ACCU-CHEK Compact Test Strips, 51 count package size, the ACCU-CHEK Multiclix Lancets, 102 count package size and the ACCU-CHEK Fastclix Lancets, 102 count package size. In order to accommodate the unbreakable package sizes under the pharmacy point-of-sale system, the ACCU-CHEK Compact Test Strips (NDC 50924-0988-50) can be billed up to 204 test strips per month for recipients 21 years of age and older and up to 306 test strips per month for recipients under 21 years of age will be allowed. **Point-of-sale system changes have been completed to accommodate the higher quantity limits for test strips for pediatric recipients less than 21 years of age.** ACCU-CHEK Multiclix Lancets (NDC 50924-0450-01) and ACCU-CHEK Fastclix Lancets (NDC 65702-0288-10) can be billed up to 204 lancets per month. For Medicaid billing, 1 lancing device = 1 unit. Rates apply to these diabetic supplies; therefore, no copayments and no dispensing fees apply.

During the time period March 15, 2012 through April 14, 2012 when the one-time override is available for Prodigy products, pharmacy providers can place a "1" in the prior authorization type code field (461-EU) or a "2" in the submission clarification field (420-DK) to override the requirement to bill for Roche NDCs. As of April 15, 2012, this override will no longer be available and only the Roche NDCs referenced above will be covered. Diabetic supply limits will be the same as under the DME program. Prior authorization requests for additional quantities or for non-Roche diabetic supplies must go through the DME program.

Blood Glucose Monitors
ACCU-CHEK Aviva and Compact Plus blood glucose monitors are free to N.C. Medicaid and N.C. Health Choice recipients through the DME and Outpatient Pharmacy Programs. DME providers will have access to free blood glucose monitors to supply to recipients. Pharmacy providers can dispense free blood glucose monitors to recipients by submitting the following information to Roche Diagnostics:

Rx GRP (Carrier Group): MAX26266
ID#: 1ACCUCHEK
Suffix (Dependent) Code: 01
Rx BIN#: 610415
PCN: PCS
COB: Primary
Other Coverage Code: Blank

For additional information, providers may call ACCU-CHEK Customer Care, 1-877-906-8969 or DMA Clinical Policies and Programs at 919-855-4310 (DME) or 919-855-4300 (Pharmacy).

Clinical Policies and Programs
DMA, 919-855-4310

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://agency.governmentjobs.com/northcarolina/default.cfm. To view the vacancy postings for DMA, click on "Agency," then click on "Department of Health and Human Services". If you identify a position for which you are both interested and qualified, complete a **state application form online** 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.

2012 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
February	2/2/12	2/7/12	2/8/12
	2/9/12	2/14/12	2/15/12
	2/16/12	2/22/12	2/23/12
	2/23/12	2/29/12	3/1/12
March	3/1/12	3/6/12	3/7/12
	3/8/12	3/13/12	3/14/12
	3/15/12	3/20/12	3/21/12
	3/22/12	3/29/12	3/30/12

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