January 2010 Medicaid Bulletin

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Providers are responsible for informing their billing agency of information in this bulletin.

Attention: All Providers

Updated EOB Code Crosswalk to HIPAA Standard Codes

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

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

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

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

Attention: All Providers

Electronic Funds Transfer

The N.C. Medicaid Program will no longer issue paper checks for claims payments. All payments will be made electronically by automatic deposit to the account specified in the provider's Electronic Funds Transfer (EFT) Authorization Agreement for Automatic Deposits.

Providers must complete and submit an EFT Authorization Agreement for Automatic Deposits (http://www.ncdhhs.gov/dma/provider/forms.htm) immediately to ensure that there is no disruption to payments. Claims will suspend for 45 days if an EFT Authorization Agreement has not been submitted to and processed by the N.C. Medicaid Program. After 45 days, the claim will deny with EOB 2901 (Denied due to inactive EFT status). Providers must complete and submit an EFT Authorization Agreement prior to resubmitting a new claim (not an adjustment).

Below are fax numbers available for providers to send EFT Authorization Agreements to HP Enterprise Services (EDS):

- 919-816-3186
- 919-816-4399

The e-mail address for submitting EFT Authorization Agreements to HP Enterprise Services is NCXIXEFT@hp.com.

Notice of the requirement for electronic payments was first published in the June 2009 Medicaid Bulletin with additional articles published in July, September, October, November, and December. The Medicaid Bulletin is available on DMA's website at http://www.ncdhhs.nc.gov/dma/bulletin/.

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

Attention: All Providers

North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool

In September 2009, the N.C. Medicaid Program implemented the North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool. This tool allows providers to access electronic recipient eligibility information via the North Carolina Electronic Claims Submission (NCECS) Web Tool at https://webclaims.ncmedicaid.com/ncecs/.

Use of this tool allows providers to immediately verify recipient information such as

- Current eligibility
- Medicaid program (benefit category)
- Medicare participation
- CCNC/CA (Carolina ACCESS) participation
- Transfer of asset information
- Other insurance information

This is the same information that providers receive today through the Automated Voice Response (AVR) system but the tool is quicker and easier to use. In order to use this tool, providers must have access to the NCECSWeb Tool. DMA encourages you to begin immediately the process of obtaining this access.

Providers who currently have an NCECSWeb logon ID and password can utilize this same logon information to access recipient eligibility verification. You do not need to take any further action.

Providers who do not currently have access to the NCECSWeb must take the following action.

Step One:

Submit a completed and signed Electronic Claims Submission (ECS) Agreement to CSC. (Refer to the NC Tracks website at http://www.nctracks.nc.gov/provider/forms for a copy of the form and instructions.)

Note: Providers who have previously submitted the ECS Agreement do not need to resubmit the form.

Step Two:

Contact the HP Enterprise Services Electronic Commerce Services Unit (1-800-688-6696 or 919-851-8888, option 1) to obtain instructions and a logon ID and password for the NCECSWeb Tool.

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

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

Attention: All Providers

Corrected 1099 Requests for Tax Years 2007, 2008, and 2009: Action Required by March 1, 2010

Each provider number receiving Medicaid payments of more than $600 annually will receive a 1099 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, 2010.** The 1099 MISC tax form will reflect the tax information on file with NC Medicaid as of the last Medicaid checkwrite cycle date, December 23, 2009.

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 of 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, 2010** and must be accompanied by the following documentation:

- Cover page from you 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 a 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.
Raleigh, NC 27607-3073

A copy of the corrected 1099 MISC form(s), along with a 2nd 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 the tax information on file with Medicaid is accurate. Providers may be notified by phone or mail of any additional action that may be required to complete the correction information.

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

Attention: All Providers

Copayments and Copayment Exemptions

Providers are reminded that the following copayments apply to all Medicaid recipients except those specifically exempted by law from copayments.

Service	Copayment
Chiropractic	$2.00 per visit
Dental	$3.00 per visit
Prescription drugs, insulin, and OTCs	$3.00 per prescription
Ophthalmologist	$3.00 per visit
Optical supplies and services	$2.00 per visit
Optometrist	$3.00 per visit
Outpatient	$3.00 per visit
Physician	$3.00 per visit
Podiatrist	$3.00 per visit

Providers may not charge copayments for the following services:

- Ambulance services
- Auditory implant external parts and accessories
- Dental services provided in a health department
- Diagnostic X-ray
- Durable medical equipment
- Family planning services
- Federally Qualified Health Center (FQHC) core services
- Health Check (EPSDT)-–related services
- Hearing aid services
- HIV case management
- Home health services
- Home infusion therapy
- Hospice services
- Hospital emergency department services, including physician services delivered in the emergency department
- Hospital inpatient services (inpatient physician services may be charged a copay)
- Laboratory services performed in the hospital
- Non-hospital dialysis facility services
- Personal care services (PCS) or PCS-Plus
- Private duty nursing services
- Rural Health Clinic (RHC) core services
- Services covered by both Medicare and Medicaid
- Services in State-owned psychiatric hospitals
- Services provided to Community Alternatives Program participants
- Services provided to residents of nursing facilities, ICF/MRs, and psychiatric hospitals
- Services related to pregnancy
- Services to individuals under the age of 21

Additional information can be found in the *Basic Medicaid Billing Guide* at http://www.ncdhhs.gov/dma/basicmed/.

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

Attention: All Providers

CPT Code Update 2010

Effective with date of service January 1, 2010, the American Medical Association (AMA) has added new CPT codes, deleted others, and changed the descriptions of some existing codes. (For complete information regarding all CPT codes and descriptions, refer to the 2010 edition of *Current Procedural Terminology*, published by the AMA.) New CPT codes that are covered by the N.C. Medicaid Program are effective with date of service January 1, 2010. Claims submitted with deleted codes will be denied for dates of service on or after January 1, 2010. Previous policy restrictions continue in effect unless otherwise noted.

New Covered CPT Codes (Effective January 1, 2010)									
14301	14302	21011	21012	21013	21014	21016	21552	21554	21558
21931	21932	21933	21936	22901	22902	22903	22904	22905	23071
23073	23078	24071	24073	24079	25071	25073	25078	26111	26113
26118	27043	27045	27059	27337	27339	27364	27616	27632	27634
28039	28041	28047	29581	32552	32561	32562	33782	33783	33981
33982	33983	36147	36148	37761	43281	43282	45171	45172	46707
51727	51728	51729	53855	57426	63661	63662	63663	63664	64490
64491	64492	64493	64494	64495	75791	77338	78451	78452	78453
78454	84145*	84431*	86780*	86825*	86826*	87150*	87153*	87493*	88387*
88388*	88738*	92540	92550	92570	93750	94011	94012	94013	95905

Note: Claims for the new laboratory codes identified by an asterisk in the above table cannot be reimbursed until CMS provides the laboratory fee schedule. Providers will be notified in a future Medicaid bulletin when to begin submitting claims.

End-Dated CPT Codes (Effective December 31, 2009)									
01632	14300	23221	23222	24151	24153	26255	26261	27079	29220
36145	36834	45170	46210	46211	46937	46938	51772	51795	63660
64470	64472	64475	64476	75558	75560	75562	75564	75790	78460
78461	78464	78465	78478	78480	82307	86781	90379	92569	99185
99186									

New CPT Codes Not Covered									
31626	31627	32553	49411	74261	74262	74263	75565	75571	75572
75573	75574	83987	86305	86352	89398	90670	A4264		
Category II and III Codes									

CPT Codes Not Covered Pending Further Research
43775

CPT Codes From Previous CPT Updates that Are Now Covered (Effective January 1, 2010)
65756

Billing Information

CPT Code	Billing Information	Diagnosis Editing	Prior Approval
14301 14302	Do not report 14301 with 14000-14061 for the same body site. Append modifier 59 if 14301 is billed for a different body site but on the same date of service as 14000-14601.	N/A	N/A
33981 33982 33983	N/A	N/A	PA required – see Clinical Coverage Policy 11C on the DMA website.
63661 63662 63663 63664	Do not report 63663 or 63664 with 63661 or 63662 for the same spinal level.	N/A	N/A
64490 64491 64492 64493 64494 64495	Do not report these codes more than once per day.	N/A	N/A

Additional information will be published in future general Medicaid bulletins as necessary.

Clinical Policy and Programs
DMA, 910-355-1883

Attention: All Providers

Paper Claim Submissions

If a claim meets one of the exceptions to the electronic claims submission requirement (see http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm), providers should submit the original claim and not a carbon copy or photocopy of the claim. Because paper claims are manually keyed into the system, submitting the original will decrease the number of denials that providers receive due to keying errors.

When completing the paper claim form, use **black ink only.** Do not submit carbon copies or photocopies. HP Enterprise Services uses optical scanning technology to store an electronic image of the claim and the scanners cannot detect carbon copies, photocopies, highlighted data or any color of ink other than black. For auditing purposes, all claim information must be visible in an archive copy. Carbon copies, photocopies, and claims containing a color of ink other than black will not be processed and will be returned to the provider.

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

Attention: All Providers

Who's Who in North Carolina Medicaid

CSC is the agent contracted by DMA to perform Medicaid provider enrollment, verification, and credentialing (EVC) activities previously performed by DMA Provider Services.

- **EVC Call Center, 1-866-844-1113**
- **Fax Number, 1-866-844-1382**
- **E-mail Address, NCMedicaid@csc.com**
- **CSC NC Tracks Website, http://www.nctracks.nc.gov/**

The **Carolinas Center for Medical Excellence (CCME)** has been contracted by DMA to review prior authorizations and to conduct post-payment validation review for outpatient specialized therapies (OST) and to be the independent assessment entity (IAE) to conduct personal care service (PCS) assessments, which include new referrals, continuation of service reviews, and change of status reviews.

- **CCME, 1-800-228-3365**
- **CCME OST Prior Authorization Website, http://www.medicaidprograms.org/nc/therapyservices/**
- **PACT PCS Review Call Center 1-800-228-3365**
- **PACT Review E-mail Address, PACTreview@thecarolinascenter.org**
- **PACT (Physician Authorization for Certification and Treatment) Review Website for PCS Prior Authorization Information and Forms), http://www.qireport.net/**

MedSolutions has been contracted by DMA to review prior authorizations for certain radiology procedures including CT, MR, PET scans, and ultrasounds.

- **MedSolutions, 1-888-693-3211**
- **Fax Number, 1-888-693-3210**
- **MedSolutions Website, http://www.medsolutionsonline.com/**

Prodigy Diabetes Care, LLC, has been designated by DMA to be N.C. Medicaid's preferred manufacturer for glucose meters, diabetic test strips, control solutions, lancets, lancing devices, and syringes.

- **Prodigy Diabetic Care, LLC, 1-866-540-4816**

ValueOptions, Inc. has been contracted by DMA to provide utilization review of acute inpatient/substance abuse treatment hospital care, psychiatric residential treatment facilities (PRTFs), Levels II through IV residential treatment facilities, outpatient psychiatric, enhanced benefits, and Criterion 5 services. ValueOptions reviews and approves the requests based on medical necessity according to established criteria.

- **ValueOptions, Inc., 1-888-510-1150**
- **Fax Numbers**
  - **For Mental Health/Substance Abuse Services, 919-461-0599**
  - **For Developmental Disability Services, 919-461-0669**
- **ValueOptions Website, http://www.valueoptions.com/**

ACS State Healthcare has been contracted by DMA to manage the prior approval process for certain drugs prescribed to N.C. Medicaid recipients.

- **ACS Clinical Call Center, 1-866-246-8505**
- **Fax Number, 1-866-246-8507**
- **ACS Enhanced Pharmacy Program Website, http://www.ncmedicaidpbm.com/**

HP Enterprise Services, formerly EDS, is the fiscal agent contracted by DMA to process claims and prior authorization requests for certain medical and surgical procedures according to DMA's policies and guidelines for enrolled Medicaid providers. In addition to processing claims and prior authorization requests, HP Enterprise Services will also process Preadmission Screening and Resident Reviews (PASRR) for individuals before admission to North Carolina's nursing facilities.

- **HP Enterprise Services, 1-800-688-6696 or 919-851-8888**
- **NC PASRR Website, http://www.ncmust.com**

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

Attention: All Providers

Medicare and Medicaid Health Information Technology: Title IV of the American Recovery and Reinvestment Act

Background

On February 17, 2009, President Obama signed the American Recovery and Reinvestment Act of 2009 (Recovery Act), a critical measure to stimulate the economy. Among other provisions, the new law provides major opportunities for the Department of Health and Human Services (DHHS), its partner agencies, and the States to improve the nation's health care through health information technology (HIT) by promoting the meaningful use of electronic health records (EHR) via incentives. For a copy of the full bill, go to http://www.hhs.gov/recovery/overview/index.html.

The HIT provisions of the Recovery Act are found primarily in Title XIII, Division A, Health Information Technology, and in Title IV of Division B, Medicare and Medicaid Health Information Technology. These titles together are cited as the Health Information Technology for Economic and Clinical Health Act or the HITECH Act. This article focuses on the provisions of Title IV only.

Funding

Under Title IV, funding is available to certain eligible professionals (EPs) and hospitals, as described below. Funds will be distributed through Medicare and Medicaid incentive payments to EPs, physicians, and hospitals who are "meaningful EHR users." In addition, with regard to the Medicaid program, federal matching funds are also available to States to support their administrative costs associated with these provisions.

Criteria for Qualifying for an Incentive

The qualification criteria for incentives (i.e., meeting specified HIT standards, policies, implementation specifications, timeframes, and certification requirements) are still in development, and will be defined through regulation and additional guidance materials. However, CMS generally expects that under Medicare, "meaningful EHR users" would demonstrate each of the following: meaningful use of a certified EHR, the electronic exchange of health information to improve the quality of health care, and reporting on clinical quality and other measures using certified EHR technology. Medicaid programs will determine their own requirements in line with the Medicaid-related provisions of the Recovery Act. Funds will be distributed through Medicare and Medicaid incentive payments to EPs and hospitals who are "meaningful EHR users." CMS intends to publish a proposed rule in late 2009 to propose a definition of meaningful use of certified EHR technology and establish criteria for the incentives programs. CMS is working extensively with the Office of the National Coordinator for Health Information Technology (ONC) to identify the proposed criteria.

Medicare Payment Incentives for Eligible Professionals

- The Recovery Act establishes financial incentives beginning in January 2011 for EPs (EPs) who are meaningful EHR users. Beginning in 2015, payment adjustments will be imposed on EPs who are not meaningful EHR users.
- Hospital-based physicians who substantially furnish their services in a hospital setting are not eligible.
- Incentive Payments
    - ♦ The incentive payment is equal to 75 percent of Medicare allowable charges for covered services furnished by the EP in a year, subject to a maximum payment in the first, second, third, fourth, and fifth years of $15,000; $12,000; $8,000; $4,000; and $2,000, respectively. For early adopters whose first payment year is 2011 or 2012, the maximum payment is $18,000 in the first year.
    - ♦ There will be no payments for meaningful EHR use after 2016.
    - ♦ There would be no payments to EPs who first become meaningful EHR users in 2015 or thereafter.
    - ♦ For EPs who predominantly furnish services in a health professional shortage area (HPSA), incentive payments would be increased by 10 percent.
- Payment Adjustments
    - ♦ The Medicare fee schedule amount for professional services provided by an EP who was not a meaningful EHR user for the year would be reduced by 1 percent in 2015, by 2 percent in 2016, by 3 percent for 2017, and by between 3 to 5 percent in subsequent years.
    - ♦ For 2018 and thereafter, if the Secretary of the U.S. Department of Health and Human Services (HHS) finds that the proportion of EPs who are meaningful EHR users is less than 75 percent, then the reductions will be increased by 1 percentage point each year, but by not more than 5 percent overall.

Medicare Payment Incentives for Hospitals

- Incentive payments are provided, beginning with October 2010, for eligible subsection (d) hospitals and critical access hospitals (CAHs) that are meaningful EHR users. Reduced payment updates beginning in FY 2015 will apply to eligible hospitals that are not meaningful EHR users.
- An eligible hospital that is a meaningful EHR user could receive up to four years of financial incentives payments, beginning with fiscal year 2011. There will be no payments to hospitals that become meaningful EHR users after 2015.

- Incentive Payments for Hospitals
  - ♦ The incentive payment for each eligible hospital would be calculated based on the product of (1) an initial amount, (2) the Medicare share, and (3) a transition factor.
    - (a) The initial amount is the sum of a $2 million base year amount plus a dollar amount based on the number of discharges for each eligible hospital.
    - (b) The Medicare share is a fraction based on estimated Medicare fee-for-service and managed care inpatient bed days divided by estimated total inpatient bed-days and modified by charges for charity care.
    - (c) The transition factor phases down the incentive payments over the 4-year period. The factor equals 1 for the first payment year, ¾ for the second payment year, ½ for the third payment year, and ¼ for the fourth payment year, and zero thereafter.

The Secretary has discretion to use other data if the required data to calculate the incentive payment formula does not exist.

- The transition factor is modified for those eligible hospitals that first become meaningful EHR users beginning in 2014. Such hospitals would receive payments as if they became meaningful EHR users beginning in 2013 (i.e., if a hospital were to begin EHR meaningful use in 2014, the transition factor used for the year would be ¾ instead of 1, ½ for the second year, ¼ for the third year, and zero thereafter).
  - ♦ For CAHs that are meaningful EHR users, reasonable costs for the purchase of certified EHR technology would be computed by expensing such costs in a single payment year, rather than depreciating them over time. In addition, incentive payments for CAHs would be based on the Medicare share formula used for subsection (d) hospitals, plus 20 percentage points (not to exceed a total of 100 percent). CAHs would receive a prompt interim payment for the Medicare share of such costs (subject to reconciliation). Payments would not be made with respect to a cost reporting period beginning during a payment year after 2015, and in no case would a CAH receive payment with respect to more than four consecutive payment years.
- Market Basket Adjustments for Hospitals that are not Meaningful Users
  - ♦ Eligible subsection (d) hospitals that are not meaningful users for a fiscal year would receive a net reduction of ¼, ½, and ¾ of the market basket update that would apply in 2015, 2016, 2017, and thereafter, respectively.
  - ♦ The Secretary may, on a case-by-case basis, exempt a hospital if requiring the hospital to be a meaningful EHR user would result in a significant hardship.
  - ♦ Eligible CAHs that are not meaningful EHR users for a fiscal year and otherwise would be paid at 101 percent of reasonable costs are subject to the following payment adjustments: in FY2015, reimbursement for inpatient services at 100.66 percent of reasonable costs; in FY2016, reimbursement for inpatient services at 100.33 percent of reasonable costs; and in FY2017 and each subsequent year, 100 percent of reasonable costs.

Medicaid Payment Incentives

The Recovery Act establishes 100 percent Federal Financial Participation (FFP) for States to provide incentive payments to eligible Medicaid providers to purchase, implement, and operate (including support services and training for staff) certified EHR technology. It also establishes 90 percent FFP for State administrative expenses related to carrying out this provision.

Incentive Payments to Providers

- Certain classes of Medicaid professionals and hospitals are eligible for incentive payments to encourage the adoption and use of certified EHR technology. EPs include physicians, dentists, certified nurse midwives, nurse practitioners, and physician assistants who are practicing in Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) led by a physician assistant.

- EPs must meet minimum Medicaid patient volume percentages, and must waive rights to duplicative Medicare EHR incentive payments. EPs may receive up to 85 percent of the net average allowable costs for certified EHR technology, including support and training (determined on the basis of studies that the Secretary will undertake), up to a maximum level, and incentive payments are available for no more than a 6-year period.
- Acute care hospitals with at least 10 percent Medicaid patient volume would also be eligible for payments, as would children's hospitals of any patient volume. Entities that promote the adoption of certified EHR technology, as designated by the State, are also eligible to receive incentive payments through arrangements with EPs under certain conditions.

Medicaid Incentive Program Qualifications

To be eligible for incentive payments not associated with the initial adoption/implementation/upgrade of EHR technology, the provider must demonstrate meaningful use of the EHR technology through a means approved by the State and acceptable to the Secretary. In determining what is "meaningful use," a State must ensure that populations with unique needs, such as children, are addressed. A State may also require providers to report clinical quality measures as part of the meaningful use demonstration. In addition, to the extent specified by the Secretary, the EHR technology must be compatible with State or Federal administrative management systems.

EPs may not receive an incentive under both Medicare and Medicaid in a given year. CMS and the States will develop means to prevent such duplicate payments. CMS expects that the prevention of duplicative payments will be addressed more fully through notice and comment rulemaking.

Frequently Asked Questions (FAQs)

1. When will CMS publish regulations to define certified Electronic Health Records (EHR) and "meaningful use?"

CMS intends to publish a proposed rule in late 2009 to define meaningful use of certified EHR technology and establish criteria for the incentives programs. We are working extensively with the Office of the National Coordinator for Health Information Technology (ONC) to identify the proposed criteria.

2. What is CMS' overall time frame for actions and activities related to the incentive program?

Although further details will be developed, CMS can provide the following timeline based on the current implementation plan:

Date	Milestone
2009	• Coordinate with ONC to develop policies such as the definition of meaningful use • Develop proposed rules to allow public input to the incentive program policies • Plan systems and other requirements needed to support the incentives programs • Plan national outreach program
2010	• Conduct outreach to eligible professionals and providers and to State Medicaid Agencies • Develop systems to support the payment of incentives • Develop final rules to establish policies needed to pay incentives • Develop systems to monitor and evaluate incentive payments
No sooner than October 2010	• Start to pay hospital incentives for Medicare and monitor payments

No sooner than January 2011	• Start to pay eligible professionals for Medicare and monitor payments • Begin and monitor Medicaid incentive payments to eligible professionals and hospitals
2011 to 2016	• Continue paying hospital incentives for Medicare and monitor payments • Continue paying eligible professionals for Medicare and monitor payments
2011 to 2021	• Continue paying Medicaid incentives to eligible professionals and hospitals and monitor payments
2015 and thereafter	• Initiate payment reductions to Medicare hospitals and eligible professionals that fail to adopt EHRs

3. When will CMS begin to pay incentives to eligible professionals (EPs) and hospitals for using certified Electronic Health Records (EHRs)?

By statute, the earliest dates that CMS will be able to pay an incentive under Medicare is October 1, 2010, for hospitals and January 1, 2011, for eligible professionals.

The statute does not define a date for the Medicaid incentives program. Given the range of regulatory and planning activities that must precede States being able to make provider incentive payments, as well as the importance of coordinating Medicaid and Medicare payments to prevent duplication, CMS does not expect that States will be able to make such payments until 2011.

Work is underway to define the meaningful EHR user criteria, as well as the requirements for applying for and receiving the EHR payment incentives, CMS expects to issue a proposed rule in late 2009.

4. If an eligible professional (EP) uses a certified Electronic Health Record (EHR) in a meaningful way in accordance with the adopted regulations, and meets the requirements established by CMS, could that professional receive both the Medicare EHR payment incentive as well as the Medicaid EHR payment incentive?

No, an EP may only receive an EHR payment under either Medicare or Medicaid. CMS expects to more fully address the issue of duplicative payments under Medicare and Medicaid through rulemaking.

5. If I already have an Electronic Health Record (EHR) that has been certified by the Certification Commission for Healthcare Information Technology (CCHIT), will I have to buy a new system if the government mandates that only EHRs that meet a higher certification level are considered certified EHRs?

Decisions about EHR standards, implementation specifications and certification criteria have not been made yet, and are under development. Policies will be proposed in the regulation to be published in late 2009.

6. What is the maximum incentive an eligible professional (EP) can earn for using an Electronic Health Record under Medicaid?

The statute does not define fixed amounts for the incentive payments, only ceilings that cannot be exceeded. CMS expects that the actual payment amounts will be more fully addressed through notice and comment rulemaking.

7. What is the maximum Electronic Health Record (EHR) incentive an eligible professional (EP) can earn under Medicare?

EPs who adopt EHRs as early as 2011 or 2012 may be eligible for up to $44,000 in Medicare incentive payments spread out over five years (increased by 10 percent for EPs who predominantly furnish services in a health professional shortage area).

8. What if my Electronic Health Record (EHR) system costs much more than the incentive the government will pay? May I request additional funds?

The Recovery Act does not provide for incentive payments under Medicare or Medicaid beyond the limits established by the legislation, regardless of the cost of the EHR system chosen by eligible professionals (EPs) or hospitals. With regard to Medicaid, the purpose of the 100 percent federal financial participation (FFP) provider incentive payments to certain eligible Medicaid providers is to encourage the adoption and meaningful use of certified EHR technology. While the incentive payments are expected to be used for certified EHR technology and support services, including maintenance and training necessary for the adoption and operation of such technology, the incentive payments are not direct reimbursement for such activities, but rather are intended to serve as an incentive for EPs and hospitals to adopt and meaningfully use certified EHR technology.

9. What is the earliest date the payment adjustments will start to be imposed for eligible professionals (EPs) and hospitals that are not meaningful Electronic Health Record (EHR) users under the Health Information Technology for Economic and Clinical Health Act (HITECH) provisions of the Recovery Act?

The HITECH provisions of the Recovery Act establish 2015 as the first year that payment adjustments will start to be imposed on Medicare EPs and hospitals that are not meaningful EHR users. There are no payment adjustments associated with the Medicaid provisions under Section 4201.

10. How will eligible providers (EPs) and hospitals apply for incentives if they are using certified Electronic Health Records (EHRs) in accordance with the standards established by the U.S. Department of Health and Human Services (HHS) under the Health Information Technology for Economic and Clinical Health Act (HITECH) portion of the Recovery Act?

The U.S. Department of Health and Human Services (HHS) will publish a rule establishing the criteria which EPs and hospitals must meet in order to qualify for the EHR incentive payments, including defining meaningful EHR users. The rule will also explain how to apply for those incentives.

11. How will the public know who has received incentive payments under the Recovery Act?

CMS will post the names of those receiving Medicare incentives online. The list will include the elements identified in the Recovery Act: name, business addresses, and business phone number of all Medicare eligible professionals and hospitals who received incentive payments under the Recovery Act. There is no such requirement for CMS to publish the names of those receiving Medicaid incentive payments under Section 4201 though States may opt do so.

12. What will be done to help prepare providers to take advantage of the incentive payments for the meaningful use of an Electronic Health Record (EHR)?

A set of supportive programs will be announced after CMS publishes a proposed rule in late 2009, that is, regarding a definition of meaningful use of certified EHR technology and criteria for the incentives programs. These programs are intended to educate and support providers, enable health information exchange, and build the workforce that will be needed for success. Information about these supportive efforts will be communicated to eligible providers through many channels.

Please check the N.C. Medicaid provider web page (http://www.ncdhhs.gov/dma/provider/) periodically for updates about the EHR program and other issues concerning providers and the Recovery Act legislation.

James Hazelrigs, MITA Manager
DMA, 919-855-4100

Attention: All Providers

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

Medicaid **Recipient** Appeal Process and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) seminars are scheduled for the months of February and March 2010. 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 EPDST – Medicaid for Children.

The seminars are scheduled at the locations listed below. Sessions 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. **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 at http://www.ncdhhs.gov/dma/provider/seminars.htm. **Pre-registration is required.** Providers will receive a registration confirmation outlining the training material(s) each provider should bring to the seminar.

Date	Location
February 16, 2010	Greensboro Clarion Hotel Airport 415 Swing Road Greensboro NC 27409
February 18, 2010	Fayetteville Holiday Inn Bordeaux 1707 Owen Drive Fayetteville NC 28304
February 23, 2010	Greenville Greenville Hilton 207 SW Greenville Boulevard Greenville NC 27834
February 25, 2010	Raleigh The Royal Banquet and Convention Center 3801 Hillsborough Street Raleigh NC 27607
March 2, 2010	Concord Embassy Suites Charlotte-Concord and Concord Convention Center 5400 John Q. Hammons Drive Concord NC 28027
March 3, 2010	Asheville Mountain Area Health Education Center 501 Biltmore Avenue Asheville NC 28801

Directions to the Medicaid Recipient Appeal Process and EPSDT Seminars

ASHEVILLE

Mountain Area Health and Education Center

Traveling East on I-40: Take I-40 East to Exit 50. Turn onto Hendersonville Road. Stay in the right-hand lane through five traffic lights. At the 6th traffic light, turn left onto the Mission Hospitals emergency entrance. Take the first right and then another immediate right into the parking deck.

Traveling West on I-40: Take I-40 West to Exit 50B onto Hendersonville Road. Stay in the right-hand lane through five traffic lights. At the 6th traffic light, turn left into the Mission Hospitals emergency entrance. Take the first right and then another immediate right into the parking deck.

Traveling East on I-26: Take I-26 to I-240 East to Exit 5B for Charlotte Street. Exit right onto Charlotte Street. At the 4th traffic light, turn left onto Biltmore Avenue. Proceed through three traffic lights. At the 4th light, turn right into the Mission Hospitals emergency entrance. Take the first right and then another immediate right into the parking deck.

CONCORD

Embassy Suites Concord-Charlotte and Concord Convention Center

Traveling North on I-85: Take Exit 49 (Bruton Smith/Speedway Boulevard). Turn right at the end of exit ramp. Travel approximately 0.25 miles. Turn left onto John Q. Hammons Drive NW.

Traveling South on I-85: Take Exit 49 (Bruton Smith/Speedway Boulevard). Turn left at the end of exit ramp. Travel approximately 0.25 miles. Turn left onto John Q. Hammons Drive NW.

Traveling North on I-77: Take I-**77** North to I-85 North. Take Exit 49 (Bruton Smith/Speedway Boulevard). Turn right at the end of exit ramp. Travel approximately 0.25 miles. Turn left onto John Q. Hammons Drive NW.

Traveling South on I-77: Take I-**77** South to I-85 North. Take Exit 49 (Bruton Smith/Speedway Boulevard). Turn left at the end of exit ramp. Travel approximately 0.25 miles. Turn left onto John Q. Hammons Drive NW.

GREENSBORO

Clarion Hotel Airport

Traveling on I-40 West/I-85 South: Take I-40 West/I-85 South to Exit 131 (I-40 West/Business I-85 South). Follow I-40 Business West through Greensboro to Exit 213 (Guilford College Road).

Traveling North on I-85: Take I-85 North to Exit 120B (PTI Airport/I-40 West/Winston Salem). Avoid Exit 214 (Wendover Boulevard to Guilford College Road. Follow to the second Exit 212B, I-40 East and take Exit 213, Guilford College Road.

Traveling from the Piedmont Triad International Airport: Turn right onto Bryan Boulevard. Take the second exit to I-40 (towards Winston Salem). Take Exit 1 (Greensboro/421 South). Stay in the left-hand lane to avoid going west on I-40. Take Exit 213 (Guilford College Road).

Traveling North on Highway 220/1-73: Take Exit 81 (PTI Airport/ 421 North). Stay in the left-hand lane of the exit to avoid going east on I-40. Take Exit 213 (Guilford College Road).

FAYETTEVILLE

Holiday Inn Bordeaux

Take I-95 to Exit 56 to US 301 to the traffic light at Owen Drive. Turn west* onto Owen Drive and continue for 2.3 miles to the Holiday Inn.

*If you are driving south on US 301 (from I-95 South), this is a right turn. If you are driving north on US 301 (from I-95 North), this is a left turn.

GREENVILLE

Hilton Greenville

Take US 64 East to US 264 East to Greenville. Turn right at the 2nd traffic light as you come into the city onto Allen Road/US Alternate 264. Travel approximately 2 miles. Allen Road becomes Greenville Boulevard/Alternate 264. Follow Greenville Boulevard for 2.5 miles. The Hilton Greenville is located on the right.

RALEIGH

The Royal Banquet and Convention Center

Traveling East on I-40: Take I-40 East towards Raleigh. Take Exit 289 for Wade Avenue. Pass the exits for Edwards Mill Road and Blue Ridge Road, then merge right onto I-440 S/US 1 South toward I-40 East/Hillsborough Street/Sanford (the Outer Beltline). Take Exit 3 for NC 54/Hillsborough Street. Turn left at the bottom of the exit ramp onto Hillsborough Street. Turn right at the 3rd stoplight at Meredith College and Playmakers (the turn is located in front of Quizno's and Ben & Jerry's). Go to the end of the parking lot and turn left to park BEHIND the building or in the covered parking area.

Traveling West on I-40: Take I-40 West towards Raleigh. Take Exit 293 for I-440/US 1/US 64/Raleigh/Wake Forest. The exit will split into two lanes. Stay in the right-hand lane to merge onto I-440/Inner Beltline/Raleigh. Take Exit 3 for NC 54/Hillsborough Street. Turn left at the bottom of the exit ramp onto Hillsborough Street. Turn right at the 3rd traffic light at Meredith College and Playmakers (the turn is located in front of Quizno's and Ben & Jerry's). Go to the end of the parking lot and turn left to park BEHIND the building or in the covered parking area.

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

Medicaid Recipient Appeal Process and EPSDT Workshops
February 2010 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
Please mail completed form to:
HP Provider Services
P.O. Box 300009
Raleigh, NC 27622

Attention: All Providers

North Carolina Electronic Claim Submission and Electronic Initiatives Seminars

North Carolina Electronic Claim Submission (NCECS) and Electronic Initiatives seminars are scheduled for the month of February 2010. Information presented at these seminars will provide an overview of the NCECSWeb Tool functions, including electronic claim submissions and recipient eligibility inquiries. Electronic initiatives within N.C. Medicaid will also be reviewed including electronic requirements, exceptions, HIPAA transactions, and electronic adjustments.

The seminars are scheduled at the locations listed below. Sessions will begin at 9:00 a.m. and will end at 12:00 noon. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided at the seminars. **Because meeting room temperatures vary, dressing in layers is strongly advised.** 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 NCECS and Electronic Initiatives seminars online at http://www.ncdhhs.gov/dma/provider/seminars.htm. **Pre-registration is required.** Providers will receive a registration confirmation outlining the training material(s) each attendee should bring to the seminar.

Date	Location
February 2, 2010	New Bern New Bern Convention Center 203 South Front Street New Bern NC 28563
February 3, 2010	Raleigh The Royal Banquet and Convention Center 3801 Hillsborough Street Raleigh NC 27607
February 9, 2010	Salisbury Holiday Inn Salisbury 530 Jake Alexander Boulevard South Salisbury NC 28147
February 10, 2010	Asheville Mountain Area Health Education Center 501 Biltmore Avenue Asheville NC 28801

Directions to the NCECS and Electronic Initiatives Seminars

ASHEVILLE
Mountain Area Health and Education Center
Traveling East on I-40: Take I-40 East to Exit 50. Turn onto Hendersonville Road. Stay in the right-hand lane through five traffic lights. At the 6th traffic light, turn left onto the Mission Hospitals emergency entrance. Take the first right and then another immediate right into the parking deck.

Traveling West on I-40: Take I-40 West to Exit 50B onto Hendersonville Road. Stay in the right-hand lane through five traffic lights. At the 6th traffic light, turn left into the Mission Hospitals emergency entrance. Take the first right and then another immediate right into the parking deck.

Traveling East on I-26: Take I-26 to I-240 East to Exit 5B for Charlotte Street. Exit right onto Charlotte Street. At the 4th traffic light, turn left onto Biltmore Avenue. Proceed through three traffic lights. At the 4th light, turn right into the Mission Hospitals emergency entrance. Take the first right and then another immediate right into the parking deck.

NEW BERN

New Bern Riverfront Convention Center

Traveling East on I-40: Take exit 309 for US 70 East towards Goldsboro/Smithfield. Continue on US-70 East towards Goldsboro/US 70 East. Merge onto US 117 North/US 13North/US 70 East via the ramp to US 117 Bypass/Kinston/US 70 Bypass/Wilson. Take the US 70/US 17 exit toward Jacksonville/New Bern. Turn left at US 70/Dr. Martin Luther King Jr. Boulevard/US 17 and continue to follow UD 70/US 17. Turn right at Craven Street. Turn right at S. Front Street. The Convention Center is on the left.

Traveling North on US 17: Follow US 17 North through Jacksonville. Continue to follow US 17/NC 58. Continue on Main Street/US 17. Turn right on Craven Street. Turn right at S. Front Street. The Convention Center is on the left.

RALEIGH

The Royal Banquet and Convention Center

Traveling East on I-40: Take I-40 East towards Raleigh. Take Exit 289 for Wade Avenue. Pass the exits for Edwards Mill Road and Blue Ridge Road, then merge right onto I-440 S/US 1 South toward I-40 East/Hillsborough Street/Sanford (the Outer Beltline). Take Exit 3 for NC 54/Hillsborough Street. Turn left at the bottom of the exit ramp onto Hillsborough Street. Turn right at the 3rd stoplight at Meredith College and Playmakers (the turn is located in front of Quizno's and Ben & Jerry's). Go to the end of the parking lot and turn left to park BEHIND the building or in the covered parking area.

Traveling West on I-40: Take I-40 West towards Raleigh. Take Exit 293 for I-440/US 1/US 64/Raleigh/Wake Forest. The exit will split into two lanes. Stay in the right-hand lane to merge onto I-440/Inner Beltline/Raleigh. Take Exit 3 for NC 54/Hillsborough Street. Turn left at the bottom of the exit ramp onto Hillsborough Street. Turn right at the 3rd traffic light at Meredith College and Playmakers (the turn is located in front of Quizno's and Ben & Jerry's). Go to the end of the parking lot and turn left to park BEHIND the building or in the covered parking area.

SALISBURY

Holiday Inn Salisbury

Traveling South on I-85: Take I-85 to Exit 75. At the end of the exit ramp, turn right onto Jake Alexander Boulevard. Travel approximately 0.5 mile. The Holiday Inn is located on the right.

Traveling North on I-85: Take I-85 to Exit 75. At the end of the exit ramp, turn left onto Jake Alexander Boulevard. Travel approximately 0.5 mile. The Holiday Inn is located on the right.

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

NCECS and Electronic Initiatives Workshops
February 2010 Seminar Registration Form
(No Fee)

Provider Name _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (_____) _____ Fax Number _____

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

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

Attention: All Providers

Clarification on Procedures for Reviewing Prior Approval Requests and for Obtaining Additional Information

In an effort to improve the recipient due process procedure, DMA periodically publishes information to clarify or emphasize procedures related to due process. This article provides information about how the N.C. Medicaid Program and its vendors (such as ValueOptions, MedSolutions, CCME, HP Enterprise Services, etc.) review a prior approval request and how additional information about a prior approval request is obtained from the submitting provider or recipient.

Reviewing a Prior Approval Request

When a request is submitted to DMA or one of its vendors, it is reviewed to determine if it is a proper request. If the request is found to be improper, it cannot be processed by DMA or the vendor and it is returned to the sender.

A proper request must include the information specified below. Additionally, a request may be returned to the provider as unable to process when another provider other than the requesting provider is currently authorized to provide the requested service. Written notice and appeal rights are not required.

A proper request must include the following information:

- recipient's name, Medicaid identification number (MID), date of birth
- provider contact information, including signatures
- date of request
- service requested
- the required service order, if applicable
- completed checkboxes that designate whether or not the clinician completed a face-to-face interview and reviewed the assessment (required for behavioral health prior approval requests)

When it is determined that a request is proper, it is reviewed by DMA or one of its vendors, as appropriate. The only actions that DMA or the vendor can take are to approve, deny, reduce, or terminate. In the past, if the provider submitted a request for a service that was not clinically indicated for the recipient, DMA or vendor staff shared with the provider the reasons why the request was not appropriate and suggested alternative services. The provider was allowed to change or withdraw the request. Medicaid has determined that this is a practice that should be changed to ensure that the recipient is involved in the decision to change or withdraw the request. Therefore, providers will no longer be able to change or withdraw the request once it has been submitted. The request will be considered as presented. As a result, it is imperative that the request contain all **recipient-specific** current clinical information that documents events, impairments, symptoms, and patterns that support satisfaction of the clinical coverage criteria for the requested service. If DMA or the vendor denies, reduces, or terminates, written notice with appeal rights will be issued to the recipient or the legal representative.

DMA and its vendors will continue to discuss and educate providers about alternative services that may be more appropriate clinically as well as to discuss/educate the provider about the policy. This discussion should not be construed as an attempt to have the provider change or withdraw the prior approval request. It is an effort to provide educational/collegial information to the provider.

Requesting Additional Information

From time to time, a provider may submit a request without sufficient information for DMA or the vendor to make a decision on the request. Medicaid's policy is that DMA or the vendor must request the specific information needed in writing. The provider must respond to this request by submitting the needed information or requesting a time extension within 15 business days of the date of the notice. If the provider does not submit the information or request a time extension, the request is denied, and a written notice with appeal rights is generated. Even if the recipient appeals, a new request with the needed information may be submitted at any time.

From time to time, information may be needed emergently or to clarify the request. It is acceptable for DMA or the vendor to contact the provider or the recipient by telephone to request the needed information. During the course of the conversation, DMA or the vendor will read a prepared statement indicating the purpose of the call and that the intent of the call is not to ask the provider or recipient to change or withdraw the request.

If you have questions about these procedures, please contact the Medicaid Appeals Unit at 919-855-4260.

Medicaid Appeals Unit
919-855-4260

Attention: All Providers

Electronic Claim Submission EOB Code

The following article was originally published in the October, November, and December 2009 Medicaid bulletins (http://www.ncdhhs.nc.gov/dma/bulletin/).

Effective with date of processing October 2, 2009, the N.C. Medicaid Program requires all providers to file claims electronically. Claims received on or after October 2, 2009, are subject to denial if the claim is not in compliance with the electronic claim mandate. Information on the electronic claim mandate, originally published in the July 2009 Medicaid Bulletin, is available on DMA's budget initiatives web page at http://www.ncdhhs.gov/dma/provider/budgetinitiatives.htm.

Prior to submitting electronic claims, providers must have an Electronic Claim Submission (ECS) Agreement on file with N.C. Medicaid. If an ECS Agreement is not on file, providers may obtain the form on the NC Tracks website at http://www.nctracks.nc.gov/provider/forms/.

To prepare for the electronic claim submission requirement, providers should familiarize themselves with the following EOB code.

EOB 8700 – Per legislative mandate this Medicaid claim must be filed electronically for adjudication.

If a paper claim is submitted and is not included on the list of ECS exceptions, the claim will be denied. The list of exceptions to the requirement for electronic claim submissions has been revised and is available on DMA's website at http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm. Only claims that comply with these exceptions may be submitted on paper. All other claims are required to be submitted electronically.

Notice of the requirement for electronic claims submission was first published in the June 2009 Medicaid Bulletin with additional articles published in July, August, September, and October. The Medicaid Bulletin is available on DMA's website at http://www.ncdhhs.nc.gov/dma/bulletin/.

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

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

Update to Coding on Home Health Fee Schedule

Effective with date of service January 31, 2010, HCPCS code A4365 (adhesive remover, wipes, any type, per box) can no longer be used to bill for this supply. The code will be replaced with HCPCS code A4456 (adhesive remover, wipes, each). The code is being changed to comply with CMS HCPCS code changes for 2010. Providers should note the unit change from one box to each wipe. This supply is included in the items that can be billed by private duty nursing (PDN) providers for both PDN-approved and non-approved recipients and will have a 150 unit maximum monthly limit. Providers are reminded that the quantity of the supplies provided must be individualized to each recipient, based on medical necessity, and ordered by the physician. Providers should always bill their usual and customary charges.

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

Attention: Independent Practitioners and Local Education Agencies

Code Addition

Effective with date of service January 1, 2010, the following new CPT procedure codes were to the list of appropriate codes that independent practitioner and local education agency speech/language pathologists and audiologists may now bill. As stated in the code descriptions below, these codes may not be billed for the same recipient on the same day by the same or different provider. These are evaluation/assessment codes and, therefore, are not subject to prior approval.

New CPT Code	Description
92550	Tympanometry and reflex threshold measurements. (Do not report 92550 in conjunction with 92567, 92568)
92570	Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing. (Do not report 92570 in conjunction with 92567, 92568)

Clinical Coverage Policies 10B, *Independent Practitioners*, and 10C, *Local Education Agencies*, have been updated to reflect this code addition. The policies are available on DMA's website at http://www.ncdhhs.gov/dma/mp/.

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

Attention: Case Management Providers

Limits for Medicaid Case Management Services

Beginning March 1, 2010, there will be a monthly limit on the number of hours allowed for case management service. Providers will be paid for a maximum of three hours of case management each month.

These case management limits apply to CAP/C, CAP/DA, CAP/MR-DD, Targeted Case Management for Persons with Developmental Disabilities, and Early Intervention. Case management limits for the following programs remain unchanged: At Risk, Maternity Child Coordination, Child Service Coordination, Maternity Outreach, and HIV.

These limits may not apply to recipients under the age of 21 years as long as all criteria for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Medicaid for Children, are met. For further information about EPSDT, visit DMA's EPSDT web page (http://www.ncdhhs.gov/dma/epsdt/).

Additional information and instructions will be published in the February 2009 Medicaid Bulletin.

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

Attention: Nurse Practitioners and Physicians

Apoetin Alfa (Epogen/Procrit, HCPCS Code J0885) and Darbepoetin Alfa (Aranesp, HCPCS Code J0881) for Non-ESRD Use: New Billing Guidelines

Effective with date of processing January 1, 2010, claims billed for Epogen/Procrit (J0885) and Aranesp (J0881) will be edited for appropriate diagnosis codes in accordance with the Food and Drug Administration guidelines. The N.C. Medicaid Program cannot reimburse for drugs or services considered to be investigational or experimental.

Epogen/Procrit or Aranesp

One of the following ICD-9-CM diagnosis codes is required when billing for J0885 (injection, epoetin alfa, [for **non-ESRD use**], 1000 units) or J0881 (injection, darbepoetin alfa, 1 mcg [**non-ESRD use**]):

- 042 (human immunodeficiency virus [HIV] disease); **or**
- 238.72 (low grade myelodysplastic syndrome lesions); **or**
- 238.73 (high grade myelodysplastic syndrome lesions); **or**
- 238.74 (myelodysplastic syndrome with 5q deletion); **or**
- 238.75 (myelodysplastic syndrome, unspecified); **or**
- 238.76 (myelofibrosis with myeloid metaplasia); **or**
- 238.79 (other lymphatic and hematopoietic tissues); **or**
- 285.0 (sideroblastic anemia); **or**
- 285.21 (anemia in chronic kidney disease)*; **or**
- 285.29 (anemia of other chronic disease)*; **or**
- 585.2 (chronic kidney disease, stage II [mild]); **or**
- 585.3 (chronic kidney disease, stage III [moderate]); **or**
- 585.4 (chronic kidney disease, stage IV [severe]); **or**
- 585.5 (chronic kidney disease, stage V); **or**
- 585.9 (chronic kidney disease, unspecified); **or**
- 795.71 (nonspecific serologic evidence of HIV); **or**
- V08 (asymptomatic HIV infection status); **or**
- V58.11 (encounter for antineoplastic chemotherapy)*

Note: The ICD-9 CM diagnosis codes listed above with an asterisk after the definition indicate that the code must be billed with a secondary diagnosis:

- **285.21** must be billed with an appropriate chronic kidney disease diagnosis code indicative of the patient's condition:
  - 585.2
  - 585.3
  - 585.4
  - 585.5
  - 585.9
- **V58.11** must be billed with an appropriate diagnosis code indicative of the specific malignancy for which the patient is undergoing treatment:
  - 140.0 through 239.9 **except for** 205.00 through 205.91 (myeloid malignancies).
- When billing **285.29,** also bill with the diagnosis code indicative of the chronic disease causing the anemia.

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

Attention: Pharmacists and Prescribers

Prior Authorization Requirements for Fibrates and Lovaza: Clarification

Effective with date of service of November 17, 2009, the N.C. Medicaid Outpatient Pharmacy Program began requiring prior authorization (PA) for brand name fibrates and Lovaza. This PA includes step therapy.

- **Step 1**

  Coverage for generic gemfibrozil does not require PA.

- **Step 2**

  Coverage for generic fenofibrate requires documented failure with at least a 60-day trial of generic gemfibrozil within the last 12 months.

- **Step 3**

  Coverage for all other fibrates requires a documented failure with at least a 60-day trial of generic gemfibrozil and at least a 60-day trial of generic fenofibrate within the last 12 months.

Exemptions from the PA requirements include

- patients with a documented contraindication to, allergy to, intolerable side effect from, or drug interaction with generic gemfibrozil or generic fenofibrate
- patients who require Trilipix because they are on a statin medication
- patients who require Lovaza because they have high triglyceride levels (> 500mg/dl)

Prescribers can request PA by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax). The criteria and PA request form for these medications are available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com. Medications that require PA include generic fenofibrates (see Step 2), Antara, Fenoglide, Lipofen, Lofibra, Lopid, Tricor, Triglide, Trilipix, and Lovaza.

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

Attention: Pharmacists and Prescribers

New Prior Authorization Requirements for Topical Anti-inflammatory Medications

Effective with date of service of December 8, 2009, the N.C. Medicaid Outpatient Pharmacy Program began requiring prior authorization (PA) for certain topical anti-inflammatory medications. Prescribers can request PA by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax). The criteria and PA request form for these medications are available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com. Medications that now require PA include Elidel, Locoid, and Protopic.

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

Attention: Pharmacists and Prescribers

New Prior Authorization Requirements for Brand-Name Anticonvulsants

Effective with date of service of December 8, 2009, the N.C. Medicaid Outpatient Pharmacy Program began requiring prior authorization (PA) for certain brand-name anticonvulsants. Prescribers can request PA by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax). The criteria and PA request form for these medications are available on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com. Medications that now require PA include Lamictal, Lamictal ODT, Lamictal XR, Lyrica, Topamax, and Trileptal.

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

Attention: Federally Qualified Health Centers and Rural Health Clinics

HCPCS Procedure Code T1015 and Modifier HI

In the October 2009 Medicaid Bulletin article titled *Core Services Policy* and in Clinical Coverage Policy 1D-4, *Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics*, effective October 1, 2009, providers were instructed to bill T1015 with the HI modifier for behavioral health visits.

DMA has become aware that some federally qualified health centers (FQHCs) and rural health clinics (RHCs) have had problems billing HCPCS procedure code T1015 with the HI modifier and have received a denial with EOB 7704 (Provider type and specialty combination is not allowed to bill the modifier submitted. Correct and resubmit denied detail if necessary.). System changes have been made to correct this issue. Providers who received denials with EOB 7704 when billing HCPCS procedure code T1015 for dates of service on October 1, 2009, and after may resubmit the denied charges as a new claim (not adjustments) for processing.

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

Attention: Adult Care Home Providers, Durable Medical Equipment Providers, and Home Health Agencies

Items Billed to Medicaid on Behalf of Residents

Items billed to Medicaid on behalf of residents living in an adult care or in a family care home belong to the resident and must be sent with that resident when they are discharged to another home or a private home. Upon discharge, the home must send the wheelchair, walker, diabetic supplies, incontinent supplies, and medication with the resident. These items are the property of the resident and they are not to be stock piled for other residents, returned to a home health agency or durable medical equipment provider or "donated."

Julie Budzinski, MA
Clinical Policy and Programs
DMA, 919-855-4368

Attention: Personal Care Services Providers

Implementation of PCS PACT Reviews and Independent Assessments

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

A. Stage I, PACT Review of PACT Forms Submitted in Response to November 3 DMA Notice

Date	Action	Instructions for Providers
November 3, 2009	DMA notice (see http://www.qireport.net) was mailed to site addresses of all active enrolled PCS providers with instructions to submit PACT forms to CCME	The postmark deadline for all materials requested in the notice was November 23, 2009. **If you have not responded to the November 3 notice, refer to the PACT Review website (http://www.qireport.net) for instructions and forms, and submit the required materials to CCME immediately.** Include PACT forms for **all** PCS and PCS-Plus recipients.
December 29, 2009, through January 29, 2010	Notices of PACT review results for adult recipients 21 years of age and older will be mailed to recipients and to providers' site addresses	Notices will indicate if recipients qualify for PCS and, if so, for how many hours per month. Claims for PCS services after the dates indicated in the notices will be subject to recoupment. (Notices for PCS-Plus recipients and recipients under the age of 21 years will not be mailed at this time, but their PACT forms must be submitted to CCME.)
January 8, 2010	Final postmark deadline for providers to submit requested PACT materials and prevent interruption in payment of claims	**If you have not responded to the November 3 notice, refer to the PACT Review website (http://www.qireport.net) for instructions and forms, and submit the required materials to CCME immediately.** Include PACT forms for **all** PCS and PCS-Plus recipients.
January 29, 2010	PCS claims submitted for dates of service January 15, 2010, and later will require prior authorization based on PACT review	PCS claims that exceed service levels authorized by CCME will be denied. Claims for recipients whose PACT forms were not submitted to CCME by January 8, 2010, will be denied until CCME has received and reviewed PACT forms and authorized services. (Prior authorization for Basic PCS recipients under the age of 21 years will not be required until Stage II, Independent Assessments, but their PACT forms must be submitted to CCME or claims will be denied.)

B. Stage I, PACT Review of PACT Forms Submitted with Provider Weekly Updates

Date	Action	Instructions for Providers
November 23, 2009, until further notice	Provider submission of weekly assessment and discharge updates	After you have responded to the initial PACT Review notice, continue to conduct new referral assessments, annual reassessments, and change of status reviews. **Each week, complete and submit to CCME assessment and discharge updates using and following instructions in the Weekly Summary Form (see http://www.qireport.net).** Include PACT forms for all newly admitted and reassessed PCS and PCS-Plus recipients.
Beginning January 29, 2010, until further notice	Notices of PACT review results for new admissions, annual reassessments, and change of status reviews will be mailed, and prior authorization of services will be required	Providers must submit PACT forms for new admissions and reassessments, or claims will be denied. Complete and submit the Weekly Summary Form (see http://www.qireport.net) each week you have new admissions or discharges or conduct annual reassessments or change of status reviews of PCS or PCS-Plus recipients.

C. Stage II, Independent Assessments

Date	Action	Instructions for Providers
Dates to be announced	Independent assessments of all individuals applying for PCS and PCS-Plus and all reassessments and change of status reviews	CCME will conduct in-person assessments of all recipients, including PCS-Plus recipients and recipients younger than 21 years of age. Prior authorization will be required for all recipients. Watch the PACT Review website (http://www.qireport.net) and future bulletin articles for important announcements and updates.

The approval processes for PCS-Plus and EPSDT will not change until Stage II, Independent Assessments, is implemented. Continue to obtain approval for PCS-Plus and EPSDT through DMA.

Refer to the PACT Review website (http://www.qireport.net) for additional information, updates, and forms. Questions may be directed to the CCME PACT Help Line at 1-800-228-3365 and by e-mail to PACTreview@thecarolinascenter.org.

CCME, 1-800-228-3365

Attention: Intermediate Care Facilities for Individuals with Mental Retardation

ICF/MR Provider Assessment Fee Increase

Effective November 1, 2009, DMA increased the ICF/MR provider assessment by $2.99 over the assessment amount previously in effect. This assessment increase is consistent with federal law and regulations for provider assessments. Therefore, the assessment is increased from $9.33 to $12.32.

Rate Setting
DMA, 919-855-4200

Attention: Nursing Facilities

Nursing Facility Provider Assessment Fee Increase

Effective November 1, 2009, DMA increased the skilled nursing facility provider assessment by $1.25 over the assessment amount previously in effect. This assessment increase is consistent with federal law and regulations for provider assessments. Therefore, providers with assessments that were previously $5.00 will be increased to $6.25 and providers with assessments that were previously $11.50 will be increased to $12.75. Rates effective for November 1, 2009, reflect this assessment fee increase.

Rate Setting
DMA, 919-855-4200

Attention: Hospitals

Grouper 26 Implementation

On the Remittance and Status Reports (RAs) for the December 1, 2009, and December 8, 2009, checkwrites, hospitals will notice that claims were paid using a combination of weights and rates from Grouper versions 25 and 26.

In moving files into production, the weight table for the Grouper 26 was inadvertently missed. This resulted in claims with Julian dates of 324 through 344 (i.e., November 24, 2009, through December 10, 2009) being paid using Grouper 26 rates and Grouper 25 weights.

This oversight has been corrected. The Grouper 26 weights were loaded into the system on December 8, 2009. All claims received on and after December 4, 2009, for processing on the December 15, 2009, checkwrite and after will process utilizing Grouper 26 weights and rates.

A recoup and repay will be systematically coordinated through the fiscal agent for all previously paid claims with discharge dates of service on or after October 1, 2009, through date of processing December 10, 2009. The recoup and repay is scheduled for January 2010.

Bill Connelly
DMA, 919-855-4193

Attention: Children's Developmental Services Agencies and Early Intervention Services Providers

Community Based Rehabilitative Services

Recently, providers of community based rehabilitative services (CBRS) received notification through the Division of Public Health (DPH) that CBRS would no longer be a Medicaid-billable service as of June 30, 2010. This article serves as a clarification to that notice. DMA needs to make changes in the way CBRS is reimbursed under the North Carolina Medicaid State Plan. DMA is working with DPH and CMS to consider alternative methods of paying for this service. Further updates will be published in future Medicaid bulletins. Providers should continue to provide and deliver the service as approved until further notice. It is important to note that this change is not a result of budget reductions in the Medicaid Program.

Behavioral Health Section
DMA, 919-855-4290

Attention: Ambulatory Surgical Centers

Reimbursement Rate Update

Effective with date of service October 1, 2009, rates will be reduced 5.46% for ambulatory surgical centers. The claims system effective date of this reduction has not been determined; however, published fee schedules were updated on September 29, 2009.

Systematic adjustments will be made to previously paid claims for dates of service on or after October 1, 2009. Providers are reminded to bill their usual and customary rates when submitting claims to N.C. Medicaid.

Fee schedules are available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Durable Medical Equipment Providers and Pharmacists

Additional Information on Prodigy Diabetic Supplies

The following additional information is provided regarding the Prodigy Diabetic Supply program:

Meters

- A CMN/PA is required for the voice meter and can only be provided through a durable medical equipment (DME) provider or a pharmacy/DME provider. The approved CMN/PA must be kept on file for a period of five years as stated in Section 7 of Clinical Coverage Policy 5A, *Durable Medical Equipment* (http://www.ncdhhs.gov/dma/mp/). With the completed CMN/PA for the voice meter on file, the provider can pursue reimbursement for the meter.
- Providers may contact Prodigy directly at 1-866-540-4816 to replace a broken meter. All meters carry a lifetime replacement warranty.
- For a lost or stolen meter or a meter destroyed by fire, providers may contact DMA Clinical Policy at 919-855-4310 for verification requirements and approval for a replacement meter.
- For pediatric patients whose doctor(s) require two meters for optimum patient care, providers should include a copy of the patient's prescription with the rebate form submitted to Prodigy.

Insulin Pump Users

There is an **override** process available for recipients who, for clinical reasons, cannot use Prodigy products. In these instances, the provider must be a DME provider or a pharmacy/DME provider. The following protocol documented in Section 5.5 of in Clinical Coverage Policy 5A, *Durable Medical Equipment* (http://www.ncdhhs.gov/dma/mp/), should be followed: fax the denial to DMA at the designated diabetic supply override fax number, 919-715-3166, along with the required medical necessity forms. Consideration will be given to the request and a written decision will be returned to the provider.

No Preferred Providers for Diabetic Supplies

DMA would like to clarify that Prodigy Diabetes Care, LLC, is the preferred designated manufacturer for diabetic supplies. There are no preferred providers (pharmacies, DME providers) for diabetic supplies. N.C. Medicaid recipients may go to any N.C. Medicaid DME or pharmacy provider to obtain Prodigy diabetic supplies.

Durable Medical Equipment Program
DMA, 919-855-4310

Outpatient Pharmacy Program
DMA, 919-855-4300

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

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

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

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

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

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

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

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

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

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

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

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

Proposed Clinical Coverage Policies

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

Lorie Williams
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh NC 27699-2501

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

2010 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
January	1/7/10	1/12/10
	1/14/10	1/20/10
	1/21/10	1/28/10
	1/28/10	2/2/10
February	2/4/10	2/9/10
	2/11/10	2/17/10
	2/18/10	2/25/10

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

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

Melissa Robinson
Executive Director
HP Enterprise Services