January 2011 Medicaid Bulletin

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

Attention: All Providers

No Copayments for Family Planning Recipients

For the past several months, DMA has experienced a significant increase in telephone calls from Family Planning Waiver (FPW) recipients stating they have received bills from their providers for services under the program. As a reminder, under North Carolina Medicaid's FPW Program there is **no copayment for recipients for any covered services** received through the FPW Program. Therefore, providers should refrain from billing recipients for any medical, lab, pharmacy or any other covered services provided under the Waiver program. In addition, providers should not send bills to recipients for unreimbursed claims for any covered services provided under the Family Planning Waiver.

When a **non-covered service** is requested by a recipient, the provider must inform the recipient either orally or in writing that the requested service is not covered under the FPW Program and, therefore, will be the financial responsibility of the recipient. This must be done prior to rendering the service. A provider may refuse to accept an FPW recipient and bill the recipient as private pay only if the provider informs the recipient prior to rendering the service, either orally or in writing, that the service will not be billed to Medicaid and that the recipient will be responsible for the payment.

Questions about FPW claims should be directed to HP Enterprise Services at 1-800-688-6696 or 919-851-8888. When billing for services provided through the Family Planning Waiver, please refer to the North Carolina Medicaid Special Bulletin (Revised May 2006) *Family Planning Waiver "Be Smart,"* which can be found on DMA's website at http://www.ncdhhs.gov/dma/services/familyplanning.htm.

Andrea C. Phillips, FPW Program Manager
DMA 919-855-4260

Attention: All Providers

PDF Format Remittance and Status Reports

In June 2010, the N. C. Medicaid Program implemented an expansion of the N.C. Electronic Claims Submission/Recipient Eligibility Verification (NCECS) Web Tool to allow providers to download a PDF version of their paper Remittance and Status Report (RA). The NCECSWeb Tool retains ten checkwrite versions of the PDF version of the RA. Providers are encouraged to print the RAs or save an electronic copy to assist in keeping all claims and payment records current. Printed RAs should be kept in a notebook or filed in chronological order for easy reference. If a provider needs an RA that is older than ten checkwrites, the provider can follow the current procedure of requesting a copy through HP Enterprise Services Provider Services and will continue to be assessed a fee.

All providers who want to download a PDF version of their RA are required to register for this service regardless if they already have an NCECSWeb logon ID. The Remittance and Status Reports in PDF Format Request form and instructions can be found on DMA's Provider Forms web page at http://www.ncdhhs.gov/dma/provider/forms.htm. Providers are encouraged to complete the form immediately and return it to the HP Enterprise Services Electronic Commerce Services Unit to ensure adequate time for set up. Providers who are new to billing or providers without an RA cover page must submit a letter on company letterhead with the form stating the Medicaid Provider Number, NPI, address, and the reason why an RA has not been received.

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

Attention: All Providers

Medicare Crossover Claims

For crossover claims to process correctly, the National Provider Identifier (NPI) submitted on the Medicare claim must match the NPI on file with N.C. Medicaid. Claims submitted to Medicare with an NPI that is not on file with Medicaid will not cross over to Medicaid and cannot be processed.

Only one NPI number is collected for each Medicaid provider number. If a provider has multiple NPIs, but only one Medicaid provider number, the provider must select the NPI to be reported to Medicaid. All NPI changes must be submitted on the Medicaid Provider Change Form. The form is available online at http://www.nctracks.nc.gov/provider/cis.html.

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

Attention: All Providers

Submitting Claims on Paper: Optical Character Recognition Technology

To meet the budget reductions mandated in SL 2009-451, DMA implemented new requirements for paperless commerce. Beginning October 2, 2009, all providers were required to file claims electronically. Institutional and professional claims that comply with the exceptions listed on DMA's website (http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm) may be submitted on paper.

Paper claims are electronically read using industry standard Optical Character Recognition (OCR) technology. OCR technology requires that paper claims be submitted on standardized red and white claim forms with the appropriate data fields completed. Refer to claim-specific manuals for standardized guidelines. Paper claims submitted on non-standard claim forms **may be denied in processing.** Examples of non-standard claim forms include forms that have been individually created and printed by a provider, fax copies, scan copies, carbon copies or photocopies. When completing the paper claim form, use black ink only. Do not submit scan copies, carbon copies or photocopies, and do not highlight any portion of the claim. For auditing purposes, all claim information must be visible in an archive copy. For information related to claim filing requirements and billing guidelines, refer to N.C. Medicaid program information and policies, found at http://www.ncdhhs.gov/dma/mp/. N.C. Medicaid programs and policies are addressed separately and maintained by authorized sections of DMA.

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

Attention: All Providers

Corrected 1099 Requests for Tax Years 2008, 2009, and 2010: Action Required by March 1, 2011

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, 2011. The 1099 MISC tax form will reflect the tax information on file with N.C. Medicaid as of the last Medicaid checkwrite cycle date, December 22, 2010.

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, 2011, 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., 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 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

Update on the N.C. Health Information Technology Plan and Schedule

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. The Final Rule outlining the provisions of this program was published in the July 28, 2010, Federal Register. A copy of that rule can be found on DMA's EHR web page (http://www.ncdhhs.gov/dma/provider/ehr.htm).

Schedule for EHR Incentive Payments

DMA is creating a system called North Carolina Medicaid Incentive Payment System (NC MIPS) that will accept registration data from providers, perform the processing to verify the eligibility of providers to receive an incentive payment, and calculate the payment amount.

Providers will be able to begin registration with NC MIPS beginning January 3, 2011, via a web page linked from DMA's website. On February 15, 2011, the second phase of NC MIPS processing, called provider attestation, will begin and will be followed by April 1, 2011, when NC MIPS will begin processing the actual payments and funds will be sent to those providers who have met the eligibility requirements of the EHR Incentive payment program.

DMA will be communicating to providers more details of NC MIPS capabilities and the responsibilities for providers to begin enrollment in the EHR Incentive Program. Please refer to DMA's EHR web page (http://www.ncdhhs.gov/dma/ehr.htm) on a routine basis for this information, since this is the fastest way to ensure that providers have the latest information.

Additional Information

Frequently asked questions (FAQs) on the Final Rule are available on DMA's EHR web page. These questions and answers provide an excellent overview of the main provisions of the Medicaid providers EHR Incentive Program. Additional FAQs are also available from CMS (http://questions.cms.hhs.gov/app/answers/list/p/21,26,1058).

DMA Provider Services publishes a special provider newsletter titled *The Provider Insider* to highlight generally known rules and conditions of the EHR incentive program and to guide providers through the process for funding. Refer to the EHR Newsletter web page at http://www.ncdhhs.gov/dma/ehr/EHRNews.htm for a copy of the newsletter.

The CSC EVC Call Center will also answer questions at this toll-free number: 1-866-844-1113. Providers are encouraged to use the following e-mail address as an additional way to ask questions: NCMedicaid.HIT@dhhs.nc.gov.

CSC, 1-866-844-1113
NCMedicaid.HIT@dhhs.nc.gov

Attention: All Providers

CPT Code Update 2011

Effective with date of service January 1, 2011, 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 American Medical Association.) New CPT codes that are covered by the N.C. Medicaid Program are effective with date of service January 1, 2011. Claims submitted with deleted codes will be denied for dates of service on or after January 1, 2011. Previous policy restrictions continue in effect unless otherwise noted.

New Covered CPT Codes (effective January 1, 2011)									
99224	99225	99226	11045	11046	11047	22551	22552	29914	29915
29916	37220	37221	37222	37223	37224	37225	37226	37227	37228
37229	37230	37231	37232	37233	37234	37235	38900	43283	43327
43328	43332	43333	43334	43335	43336	43337	43338	43753	43754
43755	43756	43757	49418	57156	61781	61782	61783	64568	64569
64570	64611	74176	74177	74178	76881	76882	80104	82930	83861
84112	85598	86481	86902	87501	87502	87503	87906	88120	88121
88177	88749	90460	90461	91013	92132	92133	92134	92228	93451
93452	93453	93454	93455	93456	93457	93458	93459	93460	93461
93462	93463	93464	93563	93564	93565	93566	93567	93568	96446

End-Dated CPT Codes (effective December 31, 2010)									
11040	11041	20000	33861	35454	35456	35459	35470	35473	35474
35480	35481	35482	35483	35484	35485	35490	35491	35492	35493
35494	35495	39502	39520	39530	39531	43324	43326	43600	49420
61795	64573	75992	75993	75994	75995	75996	76150	76350	76880
82926	82928	86903	89100	89105	89130	89132	89135	89136	89140
89141	89225	89235	90465	90466	90467	90468	91000	91011	91012
91052	91055	91105	91123	92135	93012	93014	93230	93231	93232
93233	93235	93236	93237	93501	93508	93510	93511	93514	93524
93526	93527	93528	93529	93539	93540	93541	93542	93543	93544
93545	93555	93556	96445						

New CPT Codes Not Covered									
31295	31296	31297	31634	33620	33621	33622	49327	49412	53860
64566	65778	65779	66174	66175	88363	90470	90644	90664	90667
90668	90867	90868	91117	92227	95800	95801	Category II and III Codes		

CPT Codes From Previous CPT Updates That Are Now Covered (effective January 1, 2011)		
75572	75573	75574

Billing Information

CPT Code	Diagnosis Editing
64568	Must be billed with one of the following diagnoses: 332.0, 333.1, 336.6, 333.71, 333.79, 333.83, 333.90, 345.10 through 345.81, or 996.2.
64611	Must be billed with diagnosis 527.7.
75572 75573 75574	These procedures were new CPT codes effective January 1, 2010, but were not covered by N.C. Medicaid at that time. Effective January 1, 2011, these codes are covered by N.C. Medicaid.
80104	HCPCS procedure code G0430 is end-dated – bill with 80104.
90460 90461+	Refer to page 10 for information on these immunization administration procedure codes.

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

Clinical Policy and Programs
DMA, 910-355-1883

Attention: All Providers

Payment Error Rate Measurement in North Carolina

In compliance with the Improper Payments Information Act of 2002, CMS implemented a national Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid Program and the State Children's Health Insurance Program (SCHIP). North Carolina has been selected as 1 of 17 states required to participate in PERM reviews of Medicaid fee-for-service and Medicaid Managed Care claims paid in federal fiscal year 2010 (October 1, 2009, through September 30, 2010). The PERM SCHIP program will not be participating in the 2010 PERM measurement.

CMS is using two national contractors to measure improper payments. The statistical contractor, Livanta, will coordinate efforts with the State regarding the eligibility sample, maintaining the PERM eligibility website, and delivering samples and details to the review contractor. The review contractor, A+ Government Solutions, will be communicating directly with providers and requesting medical record documentation associated with the sampled claims. Providers will be required to furnish the records requested by the review contractor within 75 calendar days from the date of the medical record request letter.

A+ Government Solutions has begun requesting medical records for North Carolina's sampled claims. Providers are urged to respond to these requests promptly with timely submission of the requested documentation. No response or insufficient documentation will count against the State as an error.

Providers are reminded of the requirement listed in Section 1902(a)(27) of the Social Security Act and 42 CFR 431.107 to retain any records necessary to disclose the extent of services provided to individuals and, upon request, to furnish information regarding any payments claimed by the provider rendering services.

For further information or questions regarding PERM, providers can visit the CMS website at http://www.cms.gov/perm/.

Program Integrity
DMA, 919-647-8000

Attention: All Providers

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

Medicaid **Recipient** Appeal Process/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) seminars are scheduled for the month of January and February 2011. Seminars are intended to address the 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. A copy of the *Medicaid Recipient Due Process Rights and Prior Approval Policies and Procedures* is available on DMA's website at http://www.ncdhhs.gov/dma/provider/priorapproval.htm under the heading "Additional Information."

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

Providers may register for the seminars by completing and submitting the online registration form (http://www.ncdhhs.gov/dma/provider/seminars.htm). Please include a valid e-mail address for your return confirmation. Providers may also register by fax using the form below (fax it to the number listed on the form). Please include a fax number or a valid e-mail address for your return confirmation. Please indicate on the registration form the session you plan to attend. Providers will receive a registration confirmation outlining the training materials that each provider should bring to the seminar.

Sessions will begin at 9:00 a.m. and 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. However, there will be a scheduled lunch break. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Seminar Dates and Locations

Date	Location
January 20, 2011	**Wilmington** Hampton Inn – Medical Park 2320 South 17th Street Wilmington NC 28401
January 25, 2011	**Raleigh** The Royal Banquet and Conference Center Room C 3801 Hillsborough Street Raleigh NC 27607
January 27, 2011	**Greenville** Hilton Greenville 207 SW Greenville Boulevard Greenville NC 27834
February 1, 2011	**Greensboro** Clarion Hotel Airport 415 Swing Road Greensboro NC 27409

Date	Location
February 3, 2011	**Charlotte** Crowne Plaza 201 South McDowell Street Charlotte NC 28204 **Note: There is a parking fee of $6.00 per vehicle for parking at this location.**
February 10, 2011	**Asheville** Mountain Area Health Education Center 501 Biltmore Avenue Asheville NC 28801

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

Medicaid Recipient Appeal Process/Early and Periodic Screening, Diagnosis and Treatment
January/February 2011 Seminar Registration Form
(No Fee)

Provider Name and Discipline _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (_____) _____ Fax Number _____

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

Please fax completed form to: 919-851-4014

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

Or register online by utilizing the link available within the bulletin

Attention: All Providers

CPT Codes 90460 and 90461: New Codes for Immunization Administration That Include Physician Counseling for Recipients through 18 Years of Age

Effective with date of service January 1, 2011, the N.C. Medicaid Program covers the **new** CPT codes for immunization administration, 90460 and 90461. These codes **replace** CPT codes 90465 through 90468. CPT codes 90465 through 90468 have been deleted by CPT effective with date of service December 31, 2010, and should not be billed after that date. The code descriptors for CPT codes 90460 and 90461 are as follows:

Procedure Code	Description	Billing Instructions
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; **first vaccine/toxoid component**	No additional instructions.
90461+ (add-on code)	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; **each additional vaccine/toxoid component**	List separately in addition to code for primary procedure, 90460.

A vaccine is a product that contains one or more components. According to CPT 2011, "A component refers to each antigen in a vaccine that prevents disease(s) caused by one organism. Combination vaccines are those vaccines that contain multiple vaccine components." An example of a combination vaccine by this definition is DTaP, a combination of diphtheria, tetanus, and pertussis components. CPT guidance states that codes 90460 and 90461 should be used "only when the physician or qualified health care professional provides face-to-face counseling of the patient and family during the administration of a vaccine."

According to CPT 2011, "For immunization administration of any vaccine that is not accompanied by face-to-face physician or qualified health care professional counseling to the patient/family or for administration of vaccines to patients over 18 years of age, report codes 90471 through 90474."

Codes 90471 through 90474, used for immunization administration, have not changed. Their descriptors are listed in the table below:

Procedure Code	Description	Billing Instructions
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **one vaccine** (single or combination vaccine/toxoid)	No additional instructions.

Procedure Code	Description	Billing Instructions
90472+ (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid); **each additional vaccine** (single or combination vaccine/toxoid)	List separately in addition to code for primary procedure, 90471.
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)	Do not report 90473 in conjunction with 90471.
90474+***** (add-on code)	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid)	List separately in addition to code for primary procedure Use 90474 in conjunction with 90471 or 90473.*

***Note:** Currently, 90474 cannot be billed with 90473 because there are no two oral and/or intranasal vaccines that would be given to a recipient.

The following principles should guide the billing of these **NEW** codes, 90460 and 90461:

1. The recipient must be under 19 years of age on the date of service.
2. Modifier EP must be appended to CPT codes 90460 and 90461.
3. Do **NOT** append the EP modifier to the vaccine CPT codes.
4. The new codes, like the current codes, are immunization administration codes. They are not add-on "counseling" codes. Therefore, a new counseling code plus a current non-counseling code for a single vaccine cannot be mixed. For example, 90460EP (primary code involving counseling for a vaccine **component**) plus 90472EP (add-on code for a **vaccine NOT** involving counseling) cannot be reported for the **SAME** vaccine, such as MMR.
5. The physician or qualified health care professional must perform **face-to-face vaccine counseling** associated with the administration and should document such. If the physician or qualified health care professional provides only a vaccine information statement (VIS), this does not constitute face-to-face counseling for the purposes of billing CPT codes 90460EP and 90461EP. The physician or qualified health care professional is not required to administer the vaccine.
6. A "first" administration is defined as the first vaccine administered to a recipient during a single patient encounter.
7. All of the units billed for CPT codes 90460EP, 90461EP, 90471EP, 90472EP, 90473EP, and 90474EP must be billed on **ONE** detail to avoid duplicate audit denials. Currently, 90474EP cannot be billed with 90473EP because there are no two oral/intranasal vaccines that would be given to a recipient. Only one unit of either 90473EP or 90474EP is allowed.
8. Codes involving counseling (90460EP, 90461EP) can be billed on the same encounter as codes not involving counseling (90471EP through 90474EP) for **separate** vaccines for those recipients through 18 years of age.

Health Check Billing Guideline Examples for Immunization Administrations

In the following examples, two vaccines are administered to a recipient who is four years of age. For purposes of showing how the new codes may be billed, the vaccines are DTaP and PCV13. The table below demonstrates how the immunization administration codes can be billed when **either** counseling **or** non counseling is provided for **all** vaccines administered at that encounter **or** when counseling is provided for **one but not all** vaccines administered at one encounter.

Provider Type: Private Sector Providers and Local Health Departments
Recipient Age: 4 Years of Age
Health Check Screening with Immunization(s), Immunizations Only or Office Visit with Immunizations

	With Counseling for All Vaccines (DTaP and PCV13) for Recipients Through 18 Years of Age	With Counseling for Some Vaccines (DTaP) for Recipients Through 18 Years of Age	With No Counseling for Recipients Through 20 Years of Age
For the first vaccine: DTaP **Report CPT vaccine code 90700** **This vaccine has three components**	For the first vaccine/toxoid **component** (i.e., diphtheria), bill 90460EP.*	For the first vaccine/toxoid **component** (i.e., diphtheria), bill 90460EP.*	For the first vaccine (i.e., DTaP), bill 90471EP.*
	For the second vaccine/toxoid **component** (i.e., tetanus), bill 90461EP.*	For the second vaccine/toxoid **component** (i.e., tetanus), bill 90461EP.*	N/A
	For the third vaccine/toxoid **component** (i.e., pertussis), also bill 90461EP.*	For the third vaccine/toxoid **component** (i.e., pertussis), also bill 90461EP.*	N/A
For the second vaccine: Pneumococcal conjugate, PCV13 **Report CPT vaccine code 90670** **This vaccine has one component**	For the first and only vaccine/toxoid **component** in the second vaccine (i.e., PCV13), bill 90460EP.* ***Note:** On the claim, a total of 4 administration units would be billed. CPT 90460EP would be billed on **ONE** detail with a total of 2 units for the first **components** in DTaP and PCV13. CPT 90461EP would be billed on **ONE** detail with 2 units for the second and third **components** of DTaP.	For the second vaccine (i.e., PCV13), bill 90471EP.* ***Note:** On the claim, a total of 4 administration units would be billed. CPT 90460EP would be billed on **ONE** detail with 1 unit for the first component in DTaP. CPT 90461EP would be billed on **ONE** detail with 2 units for the second and third components in DTaP. CPT 90471EP would be billed on **ONE** detail with 1 unit for the second vaccine (PCV13).	For the second vaccine (i.e., PCV13), bill 90472EP.* ***Note:** On the claim, CPT 90471EP would be billed with 1 unit and CPT 90472EP would be billed with 1 unit.
	Immunization diagnosis code(s) **not** required.	Immunization diagnosis code(s) **not** required.	Immunization diagnosis code(s) **not** required.
	Vaccine CPT codes 90700 and 90670 **are** required to be reported.	Vaccine CPT codes 90700 and 90670 **are** required to be reported.	Vaccine CPT codes 90700 and 90670 **are** required to be reported.

Provider Type: FQHC/RHC
Recipient Age: 4 Years of Age
Health Check Screening with Immunization(s) or Immunizations Only

	With Counseling for All Vaccines (DTaP and PCV13) for Recipients Through 18 Years of Age	With Counseling for Some Vaccines (DTaP) for Recipients Through 18 Years of Age	With No Counseling for Recipients Through 20 Years of Age
For the first vaccine: DTaP **Report CPT vaccine code 90700** **This vaccine has three components**	For the first/toxoid **component** (i.e., diphtheria), bill 90460EP.	For the first/toxoid **component** (i.e., diphtheria), bill 90460EP.	For the first vaccine (i.e., DTaP), bill 90471EP.
	For the second toxoid/**component** (i.e., tetanus), bill 90461EP.	For the second toxoid/**component** (i.e., tetanus), bill 90461EP.	N/A
	For the third vaccine/**component** (i.e., pertussis), bill 90461EP	For the third vaccine/**component** (i.e., pertussis), bill 90461EP	N/A
For the second vaccine: Pneumococcal conjugate, PCV13 **Report CPT vaccine code 90670** **This vaccine has one component**	For the **first and only component in the second vaccine** (i.e., PCV13), bill CPT code 90460EP.* ***Note:** On the claim, a total of 4 administration units would be billed. CPT 90460EP would be billed on **ONE** detail with a total of 2 units for the first **components** in DTaP and PCV13. CPT 90461EP would be billed on **ONE** detail with 2 units for the second and third **components** of DTaP.	For the second vaccine (i.e., PCV13), bill CPT code 90471EP.* ***Note:** On the claim, a total of 4 administration units would be billed. CPT 90460EP would be billed on **ONE** detail with 1 unit for the first **component** in DTaP. CPT 90461EP would be billed on **ONE** detail with 2 units for the second and third **components** in DTaP. CPT 90471EP would be billed on **ONE** detail with 1 unit for the second vaccine (PCV13).	For the second vaccine (i.e., PCV13), bill CPT code 90472EP. **Note:** On the claim, CPT 90471EP would be billed with 1 unit and CPT 90472EP would be billed with 1 unit.
	Immunization diagnosis code(s) **not** required.	Immunization diagnosis code(s) **not** required.	Immunization diagnosis code(s) **not** required.
	Vaccine CPT codes 90700 and 90670 **are** required to be reported.	Vaccine CPT codes 90700 and 90670 **are** required to be reported.	Immunization vaccine codes 90700 and 90670 **are** required to be reported.

Provider Type: FQHC/RHC
Recipient Age: 4 Years of Age
Core Visit with Immunizations

	With Counseling for All Vaccines for Recipients Through 18 Years of Age	With Counseling for Some Vaccines for Recipients Through 18 Years of Age	With No Counseling for Recipients Through 20 Years of Age
For the first and second vaccine:	Cannot bill 90460 or 90461.	Cannot bill 90460 or 90461.	Cannot bill 90471 or 90472.
	Immunization diagnosis code(s) **not** required.	Immunization diagnosis code(s) **not** required.	Immunization diagnosis code(s) **not** required.
	Vaccine CPT codes 90700 and 90734 **are** required to be reported.	Vaccine CPT codes 90700 and 90734 **are** required to be reported.	Vaccine CPT codes 90700 and 90734 **are** required to be reported.

For recipients 21 years of age and older, the immunization administration codes have not changed. Bill the series of CPT codes 90471 through 90474 with **NO** modifier. Refer to individual bulletin articles on specific vaccines for additional billing guidelines.

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

Attention: Optometrists

Cataract Surgery: CPT Procedure Code 66982

It has come to DMA's attention that optometrists are receiving denials when billing CPT procedure code 66982 [extracapsular cataract removal with insertion of intraocular lens prosthesis (one-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental state] with modifier 55 (postoperative management only). System updates have been completed to correct this issue. Optometrists who received denials with EOB 79 (this service is not payable to your provider type or specialty in accordance with Medicaid guidelines) may resubmit claims that meet timely filing criteria for processing (not as an adjustment).

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

Attention: All Providers

Office of Medicaid Management Information System Services Website

The N.C. Office of Medicaid Management Information System Services (OMMISS) provides oversight and manages activities for the procurement and implementation of support systems and services for the Replacement Medicaid Management Information System (MMIS). The OMMISS also coordinates system-critical services for MMIS Reporting and Analytics and the information technology infrastructure and systems for the Division of Health Service Regulation (DHSR).

The Replacement MMIS will expand claims payment functionality to N.C. Department of Health and Human Services' (DHHS') divisions beyond DMA and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) to include the Division of Public Health (DPH) and the Migrant Health Program in the Office of Rural Health and Community Care (ORHCC).

The OMMISS website (http://ncmmis.ncdhhs.gov/) provides information about the Replacement MMIS (called NCTracks) the status of the development project, and information that providers can use to prepare their operations for NCTracks when it goes live in the fall of 2012.

Providers can expect periodic releases of useful information, topics of interest for the provider community related to the Replacement MMIS, and answers to frequently asked questions (FAQs). Providers can also submit questions through the OMMISS website about the new system and receive timely responses from appropriate DHHS personnel. All appropriate questions and responses will be published in the FAQs. All questions regarding current or emerging Medicaid policy or Medicaid claims should be directed to the appropriate DMA staff per the DMA website at http://www.ncdhhs.gov/dma/contactus.htm.

For questions about the Replacement MMIS, contact OMMISS Provider Relations at ommiss.providerrelations@dhhs.nc.gov.

Don Donaldson, Provider Relations
OMMISS, 919-740-3858

Attention: Hospitals

Changes in Specified Time to Request a Reconsideration Review

DMA Program Integrity and its authorized agents conduct announced and unannounced audits and post-payment reviews of Medicaid paid claims to identify program abuse and overpayments. If improper payments are found, a Tentative Notice of Overpayment is sent to the provider by certified mail. Upon notification of a tentative decision, the provider may request a paper, telephone or personal reconsideration review of the overpayment identified. Although hospital providers had been allowed additional time to request a reconsideration, effective November 4, 2010, **all** providers have **fifteen (15) working (business) days** from the receipt of the Tentative Notice of Overpayment to submit in writing the Request for Reconsideration to the DHHS Hearing Office. In accordance with 10A NCAC 22F.0402(b), failure to request a reconsideration review within fifteen (15) working (business) days from the receipt of the notice shall result in the implementation of the tentative decision as DMA's final decision.

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Implementation of the National Correct Coding Initiative

The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), as amended by the Health Care and Education Recovery Act of 2010 (P.L. 111-152), together referred to as the Affordable Care Act (ACA) requires state Medicaid programs to be compliant with the National Correct Coding Initiative (NCCI) in claims processing by March 31, 2011. DMA notified providers of this requirement in the October 2010 Medicaid Bulletin.

NCCI was developed by CMS and used in Medicare Part B claims processing to prevent payment of incorrect code combinations or to avoid payments of units of service that are medically unlikely to be correct (e.g., claims for excision of more than one gallbladder or more than one pancreas). CMS is now requiring that NCCI be implemented for Medicaid.

The two components of NCCI are procedure-to-procedure edits (CCI) and medically unlikely edits (MUE) are required to be implemented by the March 31st deadline. Providers are encouraged to research these edits and be prepared to submit comments upon request.

CCI procedure-to-procedure edits are for practitioners, ambulatory surgical centers, and outpatient hospital services (only for drugs, high-tech images, ultrasounds, and labs as they are billed at a CPT/HCPCS code level) that define pairs of HCPCS/CPT codes that should not be reported together.

Medically unlikely edits (MUE) are units of service edits for practitioners, ambulatory surgical centers, outpatient hospital services (only for drugs, high-tech images, ultrasounds, and labs as they are billed at a CPT/HCPCS code level), and durable medical equipment. This component defines for each HCPCS/CPT code the number of units of service that is unlikely to be correct (e.g. claims for excision of more than one appendix or more than one hysterectomy).

Upon implementation of CCI and MUEs, an explanation and justification for all NCCI edits will be available on a claim and line-level basis through the N.C. Electronic Claims Submission (NCECS) Web Tool. For example, incompatible code pairs will be cited and code lines exceeding MUE limits will be identified.

DMA will notify providers through the Medicaid Bulletin when NCCI system edits are slated for implementation. Additional information is also available on DMA's NCCI web page (http://www.ncdhhs.gov/dma/provider/ncci.htm) and the CMS website at http://www.cms.gov/MedicaidNCCICoding/.

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

Attention: All Providers

Verification of Enrollment in Community Care of North Carolina/Carolina ACCESS

This is a reminder that providers should check for primary care provider (PCP) information every month before rendering services to a Medicaid recipient. This is true even when a Medicaid identification card is presented. New cards are issued when the recipient enrolls in Community Care of North Carolina/Carolina ACCESS (CCNC/CA), when the recipient changes primary care providers or when the recipient is disenrolled from CCNC/CA. Verification is important for proper payment since a recipient may present an outdated card with the incorrect information.

Current PCP information can be verified in the following ways:

- Automated Voice Response System Inquiry, 1-800-723-4337 – Medicaid eligibility verification is available for services provided in the current month as well as for services provided within the past 12 months.
- Recipient Eligibility Verification Tool, https://webclaims.ncmedicaid.com/ncecs/ – The NCECSWeb Tool includes a recipient eligibility verification component that allows providers who have a Web Tool logon ID and password to access current eligibility information.
- Real Time Eligibility Verification (270/271 Transaction) – Providers may choose to process a real-time eligibility inquiry transaction for a single Medicaid recipient through the Eligibility Verification System.
- Batch Eligibility Verification (270/271 Transaction) – The 270/271 transaction set is also available in batch mode, allowing trading partners to submit multiple eligibility requests for multiple recipients.

Refer to Section 10 and Appendix F of the *Basic Medicaid Billing Guide* (http://www.ncdhhs.gov/dma/basicmed/) for additional information on these verification methods.

Managed Care Section
DMA, 919-855-4780

Attention: Community Care of North Carolina/Carolina ACCESS Providers

Provider Satisfaction Survey

DMA's Managed Care Section will be conducting a provider satisfaction survey beginning February 2011. The online survey will be available on DMA's website at http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm. The satisfaction survey is intended only for DMA's Community Care of North Carolina/Carolina ACCESS (CCNC/CA) enrolled providers and will be available during the month of February. All CCNC/CA providers are encouraged to complete the online survey. All of the information provided in the survey will be kept confidential. Results obtained from the survey will assist DMA in its efforts to improve customer service to its providers and their CCNC/CA enrollees.

Jerry Law, Managed Care
DMA, 919-855-4780

Attention: Community Care of North Carolina/Carolina ACCESS Providers

Carolina ACCESS Referral/Authorization Guidelines

Coordination of care for managed care enrollees is a contractual requirement for participation as a primary care provider (PCP) serving as a medical home in the Community Care of North Carolina/Carolina ACCESS (CCNC/CA) program. This includes offering for the patient to be seen at his/her assigned PCP office within the appointment availability standards (refer to the *Basic Medicaid Billing Guide*) or provide a Carolina ACCESS (CA) referral to another provider or facility for the purpose of authorizing medically necessary care for the patient. **The CCNC/CA PCP should consider a CA authorization even when an enrollee has not yet established contact with his/her assigned PCP practice and medically necessary services are needed.** A CA referral/authorization is not the same as prior approval (PA).

All CA referrals and authorizations are at the discretion of the PCP and can be retroactive to the date(s) of service. Appropriate referrals can be made to other providers by telephone or in writing. **Note:** Some services do not require a CA referral from the assigned medical home. Refer to the *Basic Medicaid Billing Guide* for a list of these exemptions. If a recipient wants to change to a different PCP, the PCP's staff should encourage the enrollee to contact the local county department of social services (DSS). The PCP may also contact the local county DSS or the assigned Managed Care Consultant to ensure that the recipient is linked correctly. Until the correction is made, the assigned PCP remains responsible for managing the recipient's care.

It is important that providers verify a Medicaid recipient's eligibility, coverage, and enrollment (via approved verification methods other than the Medicaid identification card) before rendering treatment to ensure that CA referral and authorization guidelines are followed. CCNC/CA providers should also document all approved or denied CA referrals in the enrollee's chart. If the enrollee has not established care at the assigned PCP office, DMA encourages documentation on an internal referral log or spreadsheet. For more information on CCNC/CA guidelines, please refer to the CCNC/CA Provider Agreement or to the *Basic Medicaid Billing Guide* (http://www.ncdhhs.gov/dma/basicmed/).

Managed Care Section
DMA, 919-855-4780

Attention: All Providers

Clinical Coverage Policies

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

- 1A-12, *Breast Surgeries* (posted 12/6/10; eff. 12/1/10)
- 1C-1, *Podiatry Services* (posted 12/6/10; eff. 12/1/10)
- 1C-2, *Medically Necessary Routine Foot Care* (posted 12/6/10; eff. 12/1/10)
- 4A, *Dental Services* (posted 1/1/11; eff.12/1/10)
- 9, *Outpatient Pharmacy Program* (12/15/10)

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

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Dental Providers and Health Department Dental Centers

American Dental Association Code Updates

Effective with date of service January 1, 2011, the following dental procedure codes have been added for the N.C. Medicaid Dental Program. These additions were a result of the Current Dental Terminology (CDT) 2011-2012 American Dental Association (ADA) code updates. Clinical Coverage Policy 4A, *Dental Service*s, has been updated to reflect these changes.

CDT 2011-2012 Code	Description and Limitations
D3354	Pulpal regeneration – (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration * limited to recipients under age 21
D7251	Coronectomy – intentional partial tooth removal
D7295	Harvest of bone for use in autogenous grafting procedure * requires prior approval

The following procedure code descriptions were revised effective with date of service January 1, 2011.

Revised CDT Code	Description and Limitations
D2940	Protective restoration
D3351	Apexification/recalcification/pulpal regeneration – initial visit
D3352	Apexification/recalcification/pulpal regeneration – interim medication replacement
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure
D9230	Inhalation of nitrous oxide/anxiolysis, analgesia
D9420	Hospital or ambulatory surgical center call

Providers are reminded to bill their usual and customary charges rather than the Medicaid rate. For coverage criteria and additional billing guidelines, please refer to Clinical Coverage Policy 4A, *Dental Services*, on DMA's website at http://www.ncdhhs.gov/dma/mp/.

Dental Program
DMA, 919-855-4280

Attention: Pharmacists and Prescribers

Suboxone, Subutex, and Buprenorphine Prior Authorization

Effective with date of service January 3, 2011, prior authorization requests for Suboxone (buprenorphine/naloxone), Subutex (buprenorphine) or generic buprenorphine will not be approved for doses greater than 24 mg (buprenorphine) per day. The maximum FDA-approved dose for buprenorphine is 24 mg per day. Doses higher than this have not been demonstrated to provide any clinical advantage. DMA clinical pharmacists have been working with prescribers to help transition their patients to the FDA approved dose since this prior authorization was implemented on September 15, 2010. The criteria for approval of Suboxone, Subutex or buprenorphine are posted on the following website http://www.ncmedicaidpbm.com.

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

Attention: OB/GYN Providers and Radiology Providers

Obstetrical Due Date for Obstetrical Ultrasounds

It is necessary to indicate the due date of the recipient when requesting prior authorization via the MedSolutions website for obstetrical ultrasounds. This is required to ensure that the study is being performed at the appropriate interval in the pregnancy. If the due date is omitted from the request, auto approval cannot be obtained.

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

Attention: Federally Qualified Health Centers, Health Departments, Nurse Midwives, Nurse Practitioners, OB/GYN Providers, Physicians, and Rural Health Clinics

Pregnancy Medical Home Project Seminars

Pregnancy Medical Home seminars are scheduled for the month of March 2011. Seminars are intended to educate providers on the new Pregnancy Medical Home project. The seminar sites and dates will be announced in the February 2011 Medicaid Bulletin. Pre-registration will be required. Due to limited seating, registration will be limited to two staff members per office. Unregistered providers are welcome to attend if space is available. For more information on the Pregnancy Medical Home project, please visit http://www.ncdhhs.gov/dma/.services/pmh.htm.

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

Attention: Nurse Practitioners and Physicians

Aglucosidase Alfa (Lumizyme, HCPCS Code J3590): Billing Guidelines

Effective with date of service May 25, 2010, the N.C. Medicaid Program covers Lumizyme for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologics). Lumizyme is available in a single-use 20-ml vial containing 50 mg of Lumizyme. Lumizyme is indicated for patients who are 8 years of age and older with late (non-infantile) onset Pompe disease, who do not have evidence of cardiac hypertrophy. It is usually given every two weeks as an intravenous infusion. The infusion dosage is calculated on 20 mg/kg of body weight and should be administered over approximately four hours.

For Medicaid Billing

- ICD-9-CM diagnosis code 271.0 (Pompe disease) is required for billing Lumizyme.
- Providers must bill Lumizyme with HCPCS code J3590 (unclassified biologics).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage is 10 mg. The maximum reimbursement rate per 10 mg is $145.74. An entire 50-mg/20-ml single-dose vial may be billed.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Lumizyme should be reported in "UNs." To bill for the entire 50-mg/20-ml single-dose vial, report the HCPCS units as 5 units and 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 919-851-8888

Attention: Enhanced Behavioral Health (Community Intervention) Services Providers and Local Management Entities

Behavioral Health Mobile Crisis Management

Through correspondence with providers, DMA has been able to identify and remedy an error in the claims payment system for procedure code H2011, Mobile Crisis Management. Since September 1, 2008, an audit has been in place that denied payment of this service when billed on the same date of service as inpatient treatment in an institution of mental disease (IMD) resulting in denials with EOB 9080 (enhanced benefit service not allowed on the same day as inpatient). These claims may now be resubmitted for reimbursement.

For claims that subsequently deny based on EOB 0018 or EOB 8918, the provider may follow the direction provided in Section 8 of the *Basic Medicaid Billing Guide* at http://www.ncdhhs.gov/dma/basicmed/ for time limit override. The Medicaid Resolution Inquiry Form is used to submit these claims for time limit overrides.

Behavioral Health Unit
DMA, 919-855-4290

Attention: CAP/MR-DD Case Managers, CAP/MR-DD Service Providers, and Local Management Entities

CAP/MR-DD Utilization Review by Local Management Entities

Effective January 20, 2011, utilization review (UR) for CAP/MR-DD services will be provided by local management entities (LMEs). The recipient's county determines which LME is responsible for reviewing the CAP/MR-DD request. Effective with date of service January 20, 2011, all CAP/MR-DD requests, including revision requests and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requests for State-plan covered services for CAP/MR-DD recipients, must be sent to the appropriate LME UR vendor as listed below.

Crossroads Behavioral Health Center

Buncombe, Davie, Forsyth, Henderson, Iredell, Madison, Mitchell, Polk, Rockingham, Rutherford, Stokes, Surry, Transylvania, Yadkin, Yancey

Contact Number: 336-835-1000
Fax number: 336-527-8030

Eastpointe LME

Beaufort, Bertie, Bladen, Brunswick, Camden, Carteret, Chowan, Columbus, Craven, Cumberland, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Hertford, Hyde, Johnston, Jones, Lenoir, Martin, Nash, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Robeson, Sampson, Scotland, Tyrrell, Washington, Wayne, Wilson

Contact number: 1-800-913-6109
Fax number: 910-298-7194

The Durham Center

Alamance, Anson, Caswell, Chatham, Durham, Franklin, Granville, Guilford, Halifax, Harnett, Hoke, Lee, Montgomery, Moore, Orange, Person, Randolph, Richmond, Vance, Wake, Warren

Contact number: 919-560-7100
Fax number: 919-560-7377

Pathways LME

Alexander, Alleghany, Ashe, Avery, Burke, Caldwell, Catawba, Cherokee, Clay, Cleveland, Gaston, Graham, Haywood, Jackson, Lincoln, Macon, McDowell, Mecklenburg, Swain, Watauga, Wilkes

Contact number: 704-884-2501
Fax number: 1-855-728-4329 (available beginning January 20, 2011)

As a point of clarification, requests for additional units of CAP/MR-DD services above the current authorized amount are considered "revision requests." When submitting CAP/MR-DD revision requests or provider change requests for continued need reviews (CNRs) that have been approved by ValueOptions (VO), the targeted case managers are required to submit the following documents to the LME:

1. A complete revision request including CAP targeted case management (CTCM) forms, cost summary, and signature page, as well as any other documentation required per service definitions.
2. A complete copy of the last CNR packet including cost summary, signature page, and MR-2.
3. Copies of any revisions that were approved by VO after the last CNR and prior to the revision being requested.

Any request (CNR, plan of care, revision or provider change) received by VO **after January 19, 2011,** will be sent to appropriate LME for processing. Any request (CNR, plan of care, revision or provider change) received by VO **on or before January 19, 2011,** will be processed by VO.

Any denials pending at VO will remain with them until completion. VO will represent these cases in mediation and will enter Maintenance of Service (MOS) authorizations.

Any CAP/MR-DD requests that are still pending with VO for 'more information' will remain with VO until completion. Case managers are to submit any revision or provider change for a POC or CNR that remains pended at VO on or after January 20, 2011, to VO for processing.

Requests for non-waiver Targeted Case Management for Individuals with Intellectual and Developmental Disabilities (I/DD TCM) made by direct enrolled providers for recipients with eligibility in Eastpointe LME counties (Duplin, Lenoir, Sampson, Wayne) or The Durham Center county (Durham) should be sent to Eastpointe LME or The Durham Center respectively. Eastpointe LME and The Durham Center can only authorize the new weekly code (T1017 HE) for direct enrolled providers. All other requests for non-waiver I/DD TCM should be sent to VO.

Behavioral Health Unit
DMA, 919-855-4290

Attention: Personal Care Services Providers

Independent Assessment Updates and Reminders

Provider Interface registration forms are still being accepted. The Provider Interface allows Personal Care Services (PCS) agencies to receive and respond to recipient referrals, view independent assessments and decision notices, update service area information, and perform other reporting functions using a secure internet-based system. If you would like to register to use the Provider Interface, please complete and submit the QiRePort Provider Registration Form available on the **Independent Assessment website** (http://www.qireport.net).

Continue to visit the **Independent Assessment website** (http://www.qireport.net) regularly for PCS forms, reference documents, educational content, announcements, and frequently asked questions.

Questions may be directed to the CCME Independent Assessment Help Line at 1-800-228-3365 and by e-mail to PCSAssessment@thecarolinascenter.org. Please direct questions regarding recipient status or referrals to the Help Line for faster response and to avoid the transmission of protected health information over e-mail.

CCME, 1-800-228-3365

Attention: Critical Access Behavioral Health Agencies, Enhanced Behavioral Health (Community Intervention) Services Providers, and Local Management Entities

Claims for Community Support Team, Intensive In-Home, and Child and Adolescent Day Treatment Services after December 31, 2010

This is a reminder that beginning with dates of service January 1, 2011, only certified Critical Access Behavioral Health Agencies (CABHAs) may deliver Community Support Team (CST), Intensive In-home Services (IIH) and Child and Adolescent Day Treatment Services (DT). On and after that date, only CABHAs are eligible for reimbursement for the provision of CST, IIH and DT. Non-CABHA providers will not be reimbursed for CST, IIH, or DT even if a recipient has an authorization that extends beyond January 1, 2011. Any claims submitted for these services for dates of service on or after January 1, 2011, under NPIs associated with a Community Intervention Services Agency Medicaid Provider Numbers (MPN) will be denied. Therefore, it is very important that CABHAs complete the enrollment process and obtain a CAHBA billing Medicaid Provider Number (MPN) as soon as possible. Please see the complete CABHA billing guidelines in IU #73.

CABHAs that were certified by December 31, 2010, but not yet enrolled with Medicaid, may still receive authorizations for medically necessary CST, IIH, and DT services after January 1, 2011. CABHAs that were certified by December 31, 2010, but not yet enrolled with Medicaid, may also provide medically necessary CST, IIH, and DT services with active authorizations at their own risk. Authorization for services and provision of services does not guarantee reimbursement for services. CABHAs cannot bill for CST, IIH, and DT services until they are enrolled with Medicaid and have a CABHA MPN.

As a reminder, the CABHA should submit authorization requests for enhanced services using the current MPN associated with the enhanced service. The MPN for an enhanced service is identified by the alpha suffix appended to the core MPN (for example "8300005B"). All authorizations will be made to that current MPN. This is the MPN that providers currently list on the ITR as the “Facility ID.”

In instances where Therapeutic Foster Care (Level II–Family Type) is part of the CABHA continuum, CABHAs should submit requests with the LME’s MPN. In instances where Level II–Program Type, III, and IV Residential Child Care Services are part of the CABHA continuum, CABHAs should submit requests with the Level II–Program Type, III, or IV provider’s MPN. In other words, providers should continue to request authorizations in the same way as they do today.

Authorizations will not be made to the CABHA MPN. Providers should not request authorization with the CABHA MPN. Requests submitted with only the CABHA MPN and not the MPN associated with the enhanced service will be returned as “Unable to Process.”

CABHAs are encouraged to review the CABHA Enrollment/Authorization/Billing Training Packet for detailed information on how to complete the enrollment application, how to request authorization, how to submit claims for billing, and who to contact for assistance. CABHAs are also encouraged to review the CABHA frequently asked questions (FAQs). Both the training packet and the FAQs can be accessed from the CABHA service web page at http://www.ncdhhs.gov/dma/services/cabha.htm.

Behavioral Health Unit
DMA, 919-855-4290

Attention: CAP/C Case Managers and CAP/C Service Providers

Video Conference Seminar for CAP/C Case Managers and CAP/C Service Providers

The video conference seminar for CAP/C case managers and CAP/C service providers is scheduled for February 24, 2011. Information presented at this video conference seminar will include a review of CAP/C service authorizations and related processes for CAP/C. This will be an interactive video conference seminar providing virtual training with live video and audio communication.

The video conference seminar is scheduled at the locations listed below. The session 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 seminar. **Because meeting room temperatures vary, dressing in layers is strongly advised.** Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the CAP/C Seminar by completing and submitting the online registration form (http://www.ncdhhs.gov/dma/provider/seminars.htm) or providers may register by fax using the CAP/C Registration Form (fax it to the number listed on the form). **Pre-registration is required.** Providers will receive a registration confirmation outlining the training material(s) each attendee should bring to the seminar. All locations will have live audio and visual feed from the central Raleigh location.

Seminar Schedule – 9:00 a.m. to 12:00 noon, February 24, 2011

City	Address
Asheville	UNC-Asheville Robinson Hall, Room 129 University Heights Asheville NC 28804
Charlotte	Central Piedmont Community College Harris Conference Center, Harris 2 Building Video Conference Room 3216 CPCC Harris Campus Drive Charlotte NC 28208
Greenville	Pitt County Community College Fulford Building, Room 153 1986 Pitt Tech Road Winterville NC 28590
Raleigh	Department of Public Instruction 5th Floor 301 N. Wilmington Street Raleigh NC 27601

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

Video Conference Seminars for CAP/C Case Managers and CAP/C Service Providers
February 24, 2011
Seminar Registration Form
(No Fee)

Provider Name and Discipline _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (_____) _____ Fax Number _____

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

Please fax completed form to: 919-851-4014

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

Or register online by utilizing the link available within the bulletin

Attention: Podiatrists

Podiatrists Billing for CPT Procedure Codes 13160 and 29581

It has come to DMA's attention that podiatrists are receiving denials for CPT procedure codes 13160 (secondary closure of surgical wound or dehiscence, extensive or complicated) and 29581 (application of multi-layer venous wound compression system, below knee).

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

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

Attention: HIV Case Management Providers

Reminders and Updates for HIV Case Management Services

Physician Referral Form

In response to the numerous questions posed on this topic and requests for guidance, DMA and The Carolinas Center for Medical Excellence (CCME) are providing a sample "Physician Referral Form." It is recognized that your agency may already have a form for this purpose; therefore, this serves as a recommendation. The sample form and instructions are available online at http://www.thecarolinascenter.org.

We are pleased to announce registration is now open for the training on the **New Policy Requirements for HIV Case Managers** scheduled for **January 11 and January 12, 2011,** and **January 13, and January 14, 2011** (see schedule below). **These trainings are limited to those HIV case managers who are employed by providers who are currently enrolled with Medicaid to provide HIV Case Management.**

Date	Session Topic	Required Attendees
January 11 and 12, 2011	New Policy Requirements	HIV Case Managers
January 13 and 14, 2011	New Policy Requirements	HIV Case Managers

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

National Accreditation

DMA and CCME have received numerous questions regarding the requirement for national accreditation. We have researched the subject and are offering the following information for your consideration. This information does not constitute an endorsement of any of the agencies listed.

Note: Upon further research we have learned that the Community Health Accreditation Program (CHAP), a national accrediting organization listed in Clinical Coverage Policy 12B, does not accredit non-medical HIV Case Management. However, in the list below we provided information about the other two national accrediting organizations named in Clinical Coverage Policy 12B along with two additional national accrediting organizations that we would consider for approval.

Medicaid HIV Case Management Accreditation Options

***CARF International/Commission on Accreditation and Rehabilitation Facilities**

- **Accreditation length granted:** 3 years
- **Length of accreditation process:** 12 to 18 months
- **Informational/Training on accreditation:** Providers should ask point of contact
- **Point of Contact:** Shanna Lawson
  Resource Specialist
  Behavioral Health/Child and Youth Services
  520-325-1044 ext. 7189
  Slawson@carf.org

***URAC/Utilization Review Accreditation Commission**

- **Accreditation length granted:** 2 and 3 year options
- **Length of accreditation process:** 4 to 13 months
- **Informational/Training on accreditation:** Willing to provide a free 60- to 90-minute webinar of detailed information on the accreditation process for interested providers

- **Point of Contact:** Susan Stern
  Sales Executive
  202-326-3977
  sstern@urac.org

****TJC/The Joint Commission (formerly JCAHO/The Joint Commission on Accreditation of Healthcare Organizations)**

- **Accreditation length granted:** 3 years
- **Length of accreditation process:** 4 to 8 months
- **Informational/Training on accreditation:** Willing to provide a free teleconference for information on the accreditation process. TJC also provides a mentorship option connecting providers new to the accreditation process with a provider in the area that is already accredited by TJC.
- **Point of Contact:** Peggy Lavin
  Senior Associate Director
  Behavioral Health Care Accreditation Program
  630-792-5411
  plavin@jointcommission.org

  Evelyn Choi
  Senior Accreditation Specialist
  Behavioral Health Care Accreditation Program
  630-792-5866
  echoi@thejointcommision.org

****COA/Council on Accreditation**

- **Accreditation length granted:** 4 years
- **Length of accreditation process:** 4 to 14 months
- **Informational/Training on accreditation:** Providers should ask point of contact with COA
- **Point of Contact:** Joseph Seoane
  Director of Client Relations
  212-797-3000 ext 263
  jseoane@coanet.org

  Zoe Hutchinson (Informational/Training Questions)
  Manager, Client and Sponsor Relations
  212-797-3000 ext 242
  zhutchinson@coanet.org

*Accreditation organization designated as an option for accreditation under Clinical Coverage Policy 12B for HIV Case Management

**Accreditation organization that meets Medicaid HIV Case Management standards for accreditation

Note: Length of time given for the accreditation process for all organizations listed is approximate and will vary by organization. Please contact designated contacts above for specific information.

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

Attention: Enhanced Behavioral Health (Community Intervention) Services Providers and Local Management Entities

Critical Access Behavioral Health Agency Certification and Endorsement for Community Support Team, Intensive In-Home, and Child and Adolescent Day Treatment Services after January 1, 2011

Providers who want to become a Critical Access Behavioral Health Agency (CABHA) after January 1, 2011, will follow the steps detailed in 10A NCAC 22P.0101 through .0603 *[*found on the Office of Administrative Hearings (OAH) website at http://www.oah.state.nc.us/rules]. These steps include submitting a letter of attestation (see IU #75 for information on this process), which must include evidence of the three core services (Comprehensive Clinical Assessment, Medication Management, and Outpatient Behavioral Health Therapy), two endorsed enhanced services to create an age and disability specific continuum, key leadership positions (medical director, clinical director, quality management/training director), 3-year national accreditation, etc. If, during a desk review, the attestation packet is found to be complete, the next step is the clinical interview followed by an on-site verification.

Providers may apply for CABHA certification using the CABHA-only services of Community Support Team (CST), Intensive In-Home (IIH) or Child and Adolescent Day Treatment (DT) as one or both of the endorsed services that create their age and disability specific continuum. If they are not already endorsed for the service, they must apply and become endorsed for the service by the local management entity (LME) in whose catchment area the service will be provided. If the provider meets endorsement for the service, the LME will issue a Notification of Endorsement Action (NEA) letter. The NEA will indicate that although the provider is endorsed, they are not eligible for Medicaid enrollment or an IPRS contract for those services until they meet CABHA certification. Upon successfully completing the desk review, clinical interview, and on-site verification to become certified as a CABHA, when they enroll to obtain their CABHA Medicaid Provider Number (MPN), they will also obtain their MPN for the service(s) listed above that is part of their continuum.

Providers that are currently endorsed for CST, IIH, and/or DT will be able to remain endorsed (as long as the NEA doesn't expire). However, they will not be eligible to receive authorizations or bill for services until they are CABHA-certified and enrolled. Providers that are currently endorsed for CST, IIH, and/or DT with an upcoming expiration date, as indicated on the NEA, will need to follow the 3-year re-endorsement process that is already established. If an LME has recently involuntarily withdrawn a provider's endorsement for CST, IIH, and/or DT because the provider was not going to achieve certification as a CABHA, and the expiration date on the NEA has not occurred yet, the LME should reinstate the endorsement. Per the endorsement policy effective January 1, 2011, providers will need to be serving consumers within 60 days of enrollment and if not serving consumers within 60 days of enrollment, endorsement will be withdrawn.

Behavioral Health Unit
DMA, 919-855-4290

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Proposed Clinical Coverage Policies

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

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

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

2011 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
January	1/6/11	1/11/11	1/12/11
	1/13/11	1/19/11	1/20/11
	1/20/11	1/27/11	1/28/11
February	1/27/11	2/1/11	2/2/11
	2/3/11	2/8/11	2/9/11
	2/10/11	2/15/11	2/16/11
	2/17/11	2/24/11	2/25/11

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

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

Melissa Robinson
Executive Director
HP Enterprise Services