January 2013 Medicaid Bulletin

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Attention: All Providers

Termination of Inactive N.C. Medicaid and N.C. Health Choice Provider Numbers

Note to Providers: This article was originally published in September 2011.

The N.C. Division of Medical Assistance (DMA) wants to remind all providers of its policy for terminating inactive providers to reduce the risk of fraudulent and unscrupulous claims billing practices. DMA's updated policy was announced in the *July 2011 Medicaid Bulletin*.

N.C. Medicaid and N.C. Health Choice (NCHC) provider numbers that do not reflect any billing activity within the previous 12 months will be terminated. Unless providers can attest that they have provided services to N.C. Medicaid or NCHC recipients in the previous 12-month period, their provider numbers will be terminated. A new enrollment application and agreement to re-enroll must be submitted to CSC for any provider who is terminated. As a result, a lapse in the provider's eligibility may occur.

Termination activity occurs on a quarterly basis, with provider notices being mailed out on April 1, July 1, October 1, and January 1 of each year with termination dates of May 1, August 1, November 1, and February 1, respectively. These notices are sent to the current mailing address listed in the provider's file. Providers are reminded to update their contact and ownership information in a timely manner.

Terminated providers who wish to re-enroll can reach CSC by phone at 1-866-844-1113 or by email at NCMedicaid@csc.comail.

Provider Services
DMA, 919-855-4050

Attention: All Providers

NC Medicaid Provider Direct Enrollment and Screening – UPDATE

Note to Providers: This article was originally published in December 2012.

Beginning October 1, 2012, the N.C. Division of Medical Assistance (DMA) implemented Federal regulations 42 CFR 455.410 and 455.450 – requiring all participating providers to be screened according to their categorical risk level. These screenings will take place both upon initial enrollment and re-enrollment.

42 CFR 455.450 establishes the following three categorical risk levels for N.C. Medicaid and N.C. Health Choice (NCHC) providers to assess the risk of fraud, waste, and abuse:

- Low
- Moderate
- High

Provider types and specialties that fall into the moderate- and high-risk categories are subject to a pre-enrollment site visit, unless a screening and site visit has been successfully completed by Medicare or another state agency within the previous 12 months. Senate Bill 496 §108C-3 further defines provider types that fall into each category.

The Centers for Medicare & Medicaid Services (CMS) sets the application fee, which may be adjusted annually. The application fee amount for enrollment in 2012 was set at $523. **The application fee for enrollment in 2013 is set at $532.** The purpose of the fee is to cover the cost of screening and other program integrity efforts. The application fee will be collected per site location prior to executing a provider agreement from a prospective or re-enrolling provider.

This requirement does **not** apply to the following:

(1) Individual physicians or non physician practitioners.

(2) (i) Providers who are enrolled in either of the following:
(A) Title XVIII of the Act.
(B) Another State's Medicaid or CHIP plan.

(ii) Providers that have paid the applicable application fee to—
(A) A Medicare contractor; or
(B) Another State.

Providers who are required to pay this fee will be sent an invoice via mail. States must collect the applicable fee for any newly enrolling, reenrolling or reactivating institutional provider.

North Carolina Senate Bill 496 108C-9.c, also requires that – prior to initial enrollment in the N.C. Medicaid or NCHC programs – an applicant's representative shall attend trainings as designated by DMA, including, but not limited to, the following:

- The *N.C. Basic Medicaid and N.C. Health Choice Billing Guide*, common billing errors, and how to avoid them.
- Audit procedures, including explanation of the process by which the DMA extrapolates audit results.
- Identifying Medicaid recipient fraud.
- Reporting suspected fraud or abuse.
- Medicaid recipient due process and appeal rights.

This training is completely web-based and will be made available to online.

It is imperative for providers to submit their application with a valid e-mail address that is frequently checked. Providers will be notified via e-mail when it is time to complete the training and the steps necessary to complete the training.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Enrollment and Application Fees - UPDATE

Note to Providers: This article was originally published in December 2012, but the ACA application fee was updated for 2013.

Affordable Care Act (ACA) Application Fee

As of October 1, 2012 the N.C. Division of Medical Assistance (DMA) began collecting the federal application fee required under Section 1866 (j) (2) (C) (i) (l) of the Affordable Care Act (ACA) from certain Medicaid and N.C. Health Choice (NCHC) providers.

The Centers for Medicare & Medicaid Services (CMS) sets the application fee, which may be adjusted annually. The application fee for enrollment in 2013 is set at $532. The purpose of the fee is to cover the cost of screening and other program integrity efforts. The application fee will be collected **per site location** prior to executing a provider agreement from a prospective or reenrolling provider.

This requirement does not apply to the following:

(1) Individual physicians or non-physician practitioners.
(2) (i) Providers who are enrolled in either of the following:
    (A) Title XVIII of the Act.
    (B) Another state's Medicaid or CHIP plan.
  (ii) Providers who have paid the applicable application fee to:
    (A) A Medicare contractor; or
    (B) Another state.

Providers who are required to pay this fee will be sent an invoice via mail. States must collect the applicable fee for any initially enrolling, reenrolling or reactivating institutional provider.

North Carolina Enrollment Fee

Session Law 2011-145 Section 10.31(f) (3) mandated that DMA collect a $100 enrollment fee from providers upon initial enrollment with the Medicaid/Health Choice programs and at three-year intervals when the provider is re-credentialed.

Initial enrollment is defined as an in-state or border-area provider who has never enrolled to participate in the N.C. Medicaid/Health Choice programs. The provider's tax identification number is used to determine if the provider is currently enrolled or was previously enrolled.

Applicants should not submit payment with their application. Upon receipt of the enrollment application, an invoice will be mailed to the applicant if either fee is owed.

An invoice will only be issued if the tax identification number in the enrollment application does not identify the applicant as a currently enrolled Medicaid and N.C. Health Choice provider.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Provider Affiliation Information is Needed for NCTracks

Before NCTracks – the multi-payer replacement Medicaid Management Information System (MMIS) which goes live on July 1, 2013 – there is information that needs to be obtained and/or confirmed from participating healthcare providers. Among this information is provider affiliation.

Provider affiliation determines on behalf of which individual providers a group can bill and receive payment. Missing and or/inaccurate provider affiliation information in the current and new NCTracks system can result in claims processing delays, misdirected payments, or claims denials. Therefore, it is important that the information is captured/updated as soon as possible.

According to the current provider database, there are more than 11,500 provider groups enrolled in the Medicaid program. More than 3,000 of those groups do not currently have any rendering/servicing providers affiliated with them.

Affiliation information is gathered as part of the new provider enrollment, re-enrollment, and provider re-credentialing processes. Groups who have already re-credentialed with the Enrollment, Verification, and Credentialing (EVC) system should have designated their affiliated rendering/servicing providers, and no further action is required.

Groups that need to update their provider affiliations can do so by using the Medicaid Provider Change Form on the EVC website at www.nctracks.nc.gov/provider/cis.html.

If you have questions regarding provider affiliation, the provider recredentialing process, or other mechanisms to update provider affiliation information, call the EVC Help Desk at 866-844-1113.

Provider Services
DMA, 919-844-4050

Attention: All Providers

Corrected 1099 Requests for Tax Years 2010, 2011, and 2012: Action Required by March 1, 2013

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, 2013. 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 20, 2012.

If the tax name or tax identification number on the annual 1099 MISC is incorrect, a correction to the 1099 MISC must be requested. This ensures that accurate tax information is sent to the IRS annually, and is on file with Medicaid for each provider number. When the IRS receives incorrect information on a 1099 MISC, it may require backup withholding from future Medicaid payments. The IRS could require HP Enterprise Services to initiate and continue this withholding until it obtains correct tax data. 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, 2013 and each year requested must be accompanied by ONLY the following documentation for that year:

- Cover page from outlining the information that 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 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 providers for

their 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

National Correct Coding Initiative: Billing Guidance – UPDATE

Note to Providers: This is an updated version of an article which was originally published in October 2012.

The Centers for Medicare & Medicaid Services (CMS) has decided that the edits that deny **Alcohol and/or substance (other than tobacco) abuse structured screening, and brief intervention (SBIRT) services (99408 and 99409) on the same day as the Smoking and tobacco use cessation counseling codes (99406 and 99407) are not appropriate for the Medicaid program.**

CMS originally intended for these edits to be deleted in the Medicaid National Correct Coding Initiative (NCCI) fourth-quarter edits retroactive to April 1, 2011. However, these changes were not implemented by CMS and therefore the original implementation date of October 1, 2012 is inaccurate. Now the changes are complete and any claims denied for dates of service on or after April 1, 2011, that were filed in a timely manner, can be re-filed as a new claim beginning January 1, 2013.

Providers with claims that would be denied due to the 18 month time limit should complete the Medicaid Resolution Inquiry Form for these claims.

For more information, providers can contact the Provider Services unit of HP Enterprise Services (HPES), at 1-800-688-6696 or 919-851-8888 and press option 3 for assistance.

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

Attention: All Providers

National Correct Coding Initiative: Additional Procedure-to-Procedure (PTP) Modifiers

The claim adjudication rules for Procedure-to-Procedure (PTP) edits specify that the edit should be bypassed if:

a) an edit pair has a Correct Coding Modifier Indicator (CCMI) of 1, and,
b) if a designated PTP-associated modifier is used correctly on either code of the PTP edit pair.

A list of the current PTP-associated modifiers is found in the *Medicaid NCCI Edit Design Manual.*

There are two existing CPT modifiers that will be added on January 1, 2013 to the list of designated PTP-associated modifiers for Medicaid fee-for-service claims subject to PRA edits, but not for claims subject to OPH edits:

24 Unrelated evaluation and management service by the same physician during a postoperative period

57 Decision for surgery

There are also two new HCPCS modifiers that will be added on January 1, 2013 to the list of designated PTP-associated modifiers for Medicaid fee-for-service claims subject to the Practitioner (PRA) and Outpatient Hospital (OPH) edits:

LM Left main coronary artery
RI Ramus intermedius coronary artery

The N.C. Division of Medical Assistance (DMA) is in the process of implementing the LM and RI modifiers in the new CSC MMIS system. Until this is complete, providers are advised to submit claims using these modifiers in order to establish timely filing, even though the claims will deny. DMA will notify providers when the system changes are complete after the new system is operational so that they can refile the claims for payment.

For more information, providers can contact the Provider Services unit of HP Enterprise Services, at 1-800-688-6696 or 919-851-8888; press option 3 for assistance.

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

Attention: All Providers

Implementation of Additional Correct Coding Edits: Facility Duplicates - UPDATE

Note to Providers: This is an updated version of an article which was originally published in January 2012.

As announced in previous N.C. Medicaid bulletins, the N.C. Division of Medical Assistance (DMA) is implementing additional correct coding guidelines. These new correct coding guidelines and edits are nationally sourced by organizations such as the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA). These edits identify any inconsistencies with CPT, AMA, CMS, and/or DMA policies and generate denials at the claim-detail level. Additional correct coding edits for Facility Duplicates will be implemented on January 1, 2013 for dates of service on or after January 1, 2013.

Duplicates – Outpatient Facility Claims

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

Beneficiary/Patient

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

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

Attention: All Providers

CPT Code Update 2013

Note to Providers: CPT Code Updates are published in the Medicaid Bulletin in January of every year.

Effective with date of service January 1, 2013, 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 2013 edition of *Current Procedural Terminology*, published by the American Medical Association.) New CPT codes that are covered by the N.C. Medicaid and N.C. Health Choice (NCHC) programs are effective with date of service January 1, 2013.

Claims submitted with deleted codes will be denied for dates of service on or after January 1, 2013. Previous policy restrictions continue in effect unless otherwise noted. This includes restrictions that may be on a deleted code that are continued with the replacement code(s).

New Covered CPT Codes (effective 01/01/2013)									
22586	23473	23474	24370	24371	32554	32555	32556	32557	32701
33361	33362	33363	33364	33365	33367	33368	33369	33990	33991
33992	33993	36221	36222	36223	36224	36225	36226	36227	36228
37197	37211	37212	37213	37214	38243	52287	64615	78012	78013
78014	78071	86711	86828	86829	86830	86831	86832	86833	86834
86835	87631	87632	87633	87910	87912	90785	90791	90792	90832
90833	90834	90836	90837	90838	90839	90840	92920	92924	92928
92933	92937	92941	92943	92944	93653	93654	93655	93656	93657
95017	95018	95076	95079	95782	95783	95907	95908	95909	95910
95911	95912	95913	95924	95940	95941	G0455			

End-Dated CPT Codes (effective 12/31/2012)									
29590	31656	31715	32520	32421	32422	37201	37203	37209	43234
65805	71040	71060	75650	75660	75662	75665	75671	75676	75680
75685	75900	75961	78000	78001	78003	78006	78007	78010	78010
86890	83891	83892	83893	83894	83896	83897	83898	83900	83901
83902	83903	83904	83905	83906	83907	83908	83909	83912	83913
83914	88394	88385	88386	90665	90701	90718	90801	90802	90804
90805	90806	90807	90808	90809	90810	90811	90812	90813	90814
90815	90816	90817	90818	90819	90821	90822	90823	90824	90826
90827	90828	90829	90857	90862	92980	92981	92982	92984	92995
92996	93651	93652	95010	95015	95075	95900	95903	95904	95920
95934	95936								

New CPT Codes Not Covered by Medicaid or NCHC									
31647	31648	31649	31651	31660	31661	43206	43252	44705	78072
82777	86152	86153	88375	90653	90672	90739	90863	91112	92921
92925	92929	92934	92938	95943	99485	99486	99487	99488	99489
99495	99496								
New molecular pathology procedures 81201-81203, 81235, 81252-81254, 81321-81326, 81479									
New multianalyte assay procedures 81500, 81503, 81506, 81508-81512, 81599									
All Category II and III Codes are not covered									

Billing Information

CPT CODE	BILLING INFORMATION	DIAGNOSIS EDITING	PRIOR APPROVAL
33361 33362 33363 33364 33365	According to *CPT Professional Edition 2013*, codes 33361-33365 are used to report transcatheter aortic valve replacement (TAVR)/transcatheter aortic valve implantation (TAVI). TAVR/TAVI requires two physician operators and all components of the procedure are reported using modifier 62.	N/A	N/A
90833+ 90836+ 90838+	The evaluation and management codes used in conjunction with the add-on psychiatric codes are managed by the LME/MCO.	N/A	N/A
95017 95018	When billing multiple units for the same procedure code, for the same date of service, combine all units and bill on a single detail. Use one line for each HCPCS procedure code that was billed on a given date.	N/A	N/A

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

Clinical Policy and Programs
DMA, 910-581-9876

Attention: All Providers and N.C. Health Choice Providers

Correct Coding Edits – CPT Code 29806

The N.C. Division of Medical Assistance (DMA) was informed that claims for CPT code 29806 adjudicated from September 4, 2012 through November 19, 2012 were inappropriately denied by the Correct Coding Edits.

Claims previously filed with CPT code 29806 that denied with EOB 9974, "PAYMENT OF PROCEDURE CODE IS DENIED BASED ON CORRECT CODING STANDARDS ADD-ON EDITING" can be resubmitted electronically. Do **not** submit as an Adjustment Request.

For additional billing guidance, contact HP Enterprise Services Provider Services at 1-800-688-6696, menu option 3.

Provider Services,
DMA, 919-855-4050

Attention: All Providers

Clinical Coverage Policies

The following new or amended combined N.C. Medicaid and N.C. Health Choice (NCHC) clinical coverage policies are available on the N.C. Division of Medical Assistance (DMA) website at www.ncdhhs.gov/dma/mp/:

- *8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers (12/1/12)*
- *2A-1, Acute Inpatient Hospital Services (12/1/12)*
- *3G, Private Duty Nursing (12/1/12)*
- *NCHC Inpatient Rehabilitation Facility Benefits (Date of termination 11/30/2012)*
- *NCHC Private Duty Nursing (Date of termination 11/30/2012)*

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

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers and N.C. Health Choice Providers

Subscribe & Receive Email Alerts on Important N.C. Medicaid and N.C. Health Choice Updates - UPDATE

Note to providers: This article was originally published on November 2011, but the web address for subscriptions has been changed.

N.C. Division of Medical Assistance (DMA) allows all providers the opportunity to sign up for N.C. Medicaid/N.C. Health Choice (NCHC) email alerts. Providers will receive email alerts on behalf of all Medicaid and NCHC programs. Email alerts are sent to providers when there is important information to share outside of the general Medicaid Provider Bulletins. To receive email alerts subscribe at www.seeuthere.com/hp/medicaidalert.

Providers and their staff members may subscribe to the email alerts. Contact information including an email address, provider type and specialty is essential for the subscription process. You may unsubscribe at any time. **Email addresses are never shared, sold or used for any purpose other than Medicaid and NCHC email alerts.**

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

Attention: All Providers

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

N.C. Medicaid will hold a **Prior Approval, Recipient Due Process, and EPSDT** training for providers in March 2013.

This webinar is intended to address changes in Medicaid's **prior approval policies and procedures** and the Medicaid **recipient appeal process** when a Medicaid service is denied, reduced, terminated, or suspended. The webinar will also focus on an overview of **EPSDT-Medicaid for Children**.

Pre-registration will be required for the webinar and registration will be limited to 50 participants per session.

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

Attention: All Providers

Payment Error Rate Measurement (PERM)

The Payment Error Rate Measurement (PERM) is an audit program that was developed and implemented by the Centers for Medicare & Medicaid Services (CMS) to comply with the Improper Payments Information Act (IPIA) of 2002. It is used nationwide to review eligibility determinations and claims payment made by Medicaid and Children's Health Insurance Programs (CHIP) to ensure that States only pay for appropriate claims. Comparisons are made among staff and a national report is distributed outlining the various error rates among states.

Note: N.C. Health Choice (NCHC) is North Carolina's CHIP program.

PERM is required every three years; North Carolina participated in PERM in 2007 and 2010. North Carolina will participate in federal fiscal year 2013 (October 2012 – September 2013) PERM reviews of Medicaid fee-for-service, Medicaid Managed Care and CHIP program claims starting in a few months.

North Carolina	FFS	Managed Care	Eligibility	Overall
FY 2007 Rate	**3.1%**	**0.3%**	**1.0%**	**4.0%**
FY 2010 Rate	**3.4%**	**0.0%**	**8.9%**	**11.9%**

Our goal is to decrease the error rate for 2013, but we need providers to participate and commit to quality improvement to be successful.

How PERM is implemented

Claims Review - A claim is reviewed to determine if it was correctly processed, and the services declared were provided, medically necessary, correctly coded, and properly paid or denied.

For the PERM cycle, CMS uses two contractors to perform claims reviews:

A Statistical Contractor (SC) that collects universe claims data quarterly from states and uses a stratified random sampling design to draw the sample for review.

A Review Contractor (RC) that uses the sample list to request copies of medical records from providers and reviews for medical necessity, correct coding, correct payment or denial of claims, and that services declared were provided.

The Lewin Group is the Statistical Contractor and A+ Government Solutions is the Review Contractor for the FY 2013 PERM cycle. A+ served as the Review Contractor

for the FY 2010 through FY 2012 PERM cycles, so many of the processes states are accustomed to will continue into FY 2013. Throughout the cycle, A+ will be responsible for collecting Medicaid and CHIP state policies; conducting data processing reviews; requesting medical records from providers; conducting medical reviews; and playing host to the State Medicaid Error Rate Findings (SMERF) website – where states can track medical records requests, view review findings and request difference resolutions/appeals on identified errors, among other things.

As a reminder, providers are required to furnish the records requested by A+ within the timeframe specified in the medical record request letter. Do not delay locating and sending medical records to A+. North Carolina's highest error amount recorded in 2010 was for no documentation provided for review. To avoid errors, ensure that all requested documents are sent and the documentation meets program requirements for the service under review. DMA Program Integrity staff will assist A+ when necessary to improve compliance.

Where providers can find more information:

- CMS website at www.cms.gov/PERM/.
- CMS PERM "Providers" web page: www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Providers.html
- Central PERM email address for Providers**:** PERMProviders@cms.hhs.gov
- Providers can also participate in "Provider Education Calls" to learn more about the PERM process and provider responsibility: www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Provider_Education_Calls.html

Dates for the FY 2013 PERM provider education webinar/conference calls are:

Tuesday, May 21, 2013, 3:00 - 4:00 p.m. EST
Wednesday, June 5, 2013, 3:00 - 4:00 p.m. EST
Tuesday, June 18, 2013, 3:00 - 4:00 p.m. EST
Tuesday, July 2, 2013, 3:00 - 4:00 p.m. EST

Program Integrity,
DMA, 919-814-0000

Attention: All Providers

NC Medicaid EHR Incentive Program Webinar Series

Scheduled to begin in mid-January, the N.C. Medicaid Electronic Health Record (EHR) Incentive Program will be holding a weekly webinar series for the provider community. Whether you are participating in the N.C. Medicaid EHR Incentive Program for the first time or are coming back to attest to meaningful use, you will not want to miss out on this informative webinar series.

The 30-minute webinars will cover important aspects of the program and allow providers the opportunity to ask questions. Open and transparent conversation will be encouraged with the hope that providers will deliver candid feedback that can be used to improve the program.

Topics for the webinar series include, but are not limited to:

- An Introduction to the N.C. Medicaid EHR Incentive Program
- Patient Volume: What You Need to Know
- NC-MIPS Deep Dive
- Tips for a Successful Attestation
- Audits and Appeals: What to Expect
- Meaningful Use 101
- Meaningful Use 102
- Targeted webinars for select stakeholder groups

For a more detailed schedule of the webinar series, visit the EHR website at www.ncdhhs.gov/dma/provider/ehr.htm.

Yearly N.C. Medicaid EHR Incentive Program Update

As of December 20, 2012, a total of $87.72 million has been paid out through the EHR program, including 2,211 payments to professionals and 55 payments to hospitals.

Thank you to all participants, partners and advocates who have helped make 2012 such a successful year. We look forward to working with you in the coming year.

N.C. Medicaid Health Information Technology (HIT)
DMA, 919-855-4200

Attention: Adult Care Home Providers

Preadmission Screening and Review (PASRR) Process for Adult Care Homes licensed under G.S. § 131D, Article 1 and defined in G.S. § 131D-2.1

Preadmission Screening

The Preadmission Screening (PASRR) Program is a review of any individual who is being considered for admission into a Medicaid Certified Adult Care Home regardless of the source of payment.

Who Is Subject to PASRR Screens

All applicants for Medicaid Certified Adult Care Homes licensed under G.S. 131D; Article 1 must be screened through the PASRR Level I Process.

Level I Screens

The North Carolina Department of Health and Human Services (DHHS) provides a Level I screening, by an independent screener for all applicants to Adult Care Homes licensed under G.S. 131D, Article 1 to identify beneficiaries with serious mental illness (SMI). For individuals with no evidence or diagnosis of SMI, the initial Level I screen remains valid unless there is a significant change in status. A PASRR number will be generated automatically by the Medicaid Uniform Screening Tool (MUST) for admission to the Adult Care Home.

FL2/MR-2 Process

The admission process into an Adult Care Home requires a FL-2/MR-2 to be accepted for the living or group home care which is equivalent to domiciliary or adult care home level of care. The completed FL-2/MR-2 form must be signed and dated by a licensed physician, physician assistant, or nurse practitioner.

The PASRR Process

Before an adult care home can accept any individual seeking admission, a PASRR must be conducted and a PASRR number must be obtained for all new admissions. The referring agency's (e.g., primary physician or hospital) appropriate staff must complete the North Carolina Medicaid Uniform Screening Tool (MUST) for the adult care home.

Completing the North Carolina Level I Screening Form

The primary physician or referring agency's appropriate clinical staff completes the MUST, and the family is provided with the opportunity to provide input. The individual completing the MUST form must be familiar enough with the beneficiary's mental health

status and history to provide accurate information required by the screening form. If there is clearly no evidence of SMI, a PASRR number will be generated automatically by the MUST. If the individual meets the criteria and the individual chooses to reside in adult care home, the admission process can begin. All individuals with no evidence or suspicion of SMI who have completed the level one process can proceed with admission into an adult care home if they desire by obtaining an N.C. Medicaid long-term care service form (FL-2 form) at their local county DSS.

If there is evidence or suspicion of SMI, additional information will be required through a manual review process, in which the applicant will be referred for a level II face-to-face evaluation.

Completing the Level II Screening Form

Individuals requiring further assessment, will be referred for a Level II evaluation, and the referral source will be notified via the MUST web portal email notification system. If a Level II evaluation is needed, the PASRR contractor notifies the referral source that a Level II PASRR evaluation is required and requests, if applicable, that medical records be available for the on-site evaluation by a qualified mental health professional (QMHP).

The process is as follows:

- A face-to-face, in-depth assessment is performed by the QMHP
- The completed Level II evaluation with recommendations is then forwarded to DHHS
- After the completion of the Level II evaluation, DHHS makes the final determination for placement and services. A PASRR number is assigned, and if an adult care home is determined to be the appropriate Level of Care, copies are sent to appropriate sources.

A certified notification of the determination and other available options are mailed by the PASRR contractor to the beneficiary/responsible party.

The North Carolina Adult Care Home Tracking Form

A North Carolina Adult Care Home Tracking form will be sent with the final determination to be completed by the adult care home **within five (5) business working days**. The completed adult care home tracking form must be returned within the required time period to the address indicated on the tracking form.

Transfers

Level I and Level II determinations shall be maintained in the individual's file and transferred with the individual to another facility. Unless there is a change in mental status, no further contact with MUST is required for beneficiaries who are **not** subject to the MUST Level II Process.

Facilities that accept an individual in transfer who has been evaluated through the level II process must submit the adult care home tracking form which can be obtained from **DMH website**.

The Adult Care Home Tracking form is the mechanism used to monitor the individual's place of residence and must be submitted for these Level II beneficiaries if:

- A Level II individual transfers to a Medicaid-Certified Facility
- A Level II individual expires
- A Level II individual is permanently discharged from the adult care home facility

Status Change (New Level I Required)

If there is a status change, a request for a new MUST screening should be submitted to the contractor.

Home and Community Care
DMA, 919-855-4340

Attention: Personal Care Service Providers (formerly ACH-PCS and In-Home Care Services Providers) and CAP Providers

Personal Care Services Rate Effective January 1, 2013

On November 30, 2012, the Centers for Medicare & Medicaid Services (CMS) approved the Personal Care Services (PCS) State Plan Amendment with an effective date of January 1, 2013. The new PCS rate will be $3.88 per 15-minute unit. The below referenced fee schedule is posted on the DMA website at http://www.ncdhhs.gov/dma/fee/. The current codes for Adult Care Home-Personal Care Services (ACH-PCS) and In-Home Care (ICH) providers will be end-dated effective December 31, 2012.

Procedure Code	Modifier	Description	Program Description	Billing Unit	Maximum Allowable
99509	HA	ATTENDANT CARE SERVICES	Personal Care Services, Private Residences, Beneficiaries Under 21 Years	15 min.	$3.88
99509	HB	ATTENDANT CARE SERVICES	Personal Care Services, Private Residences, Beneficiaries 21 Years and Older	15 min.	$3.88
99509	HC	ATTENDANT CARE SERVICES	Personal Care Services, Adult Care Homes	15 min.	$3.88
99509	HH	ATTENDANT CARE SERVICES	Personal Care Services, Supervised Living Facilities, Adults With MI / SA	15 min.	$3.88
99509	HI	ATTENDANT CARE SERVICES	Personal Care Services, Supervised Living Facilities, Adults With MR / DD	15 min.	$3.88
99509	HQ	ATTENDANT CARE SERVICES	Personal Care Services, Family Care Homes	15 min.	$3.88
99509	SC	ATTENDANT CARE SERVICES	Personal Care Services, Adult Care Homes Special Care Units	15 min.	$3.88

Procedure Code	Modifier	Description	Program Description	Billing Unit	Maximum Allowable
99509	TT	ATTENDANT CARE SERVICES	Personal Care Services, Adult Care Homes Combination Homes	15 min.	$3.88

Providers are reminded to bill their usual and customary charges.

CAP Personal Care Services Rates

CAP providers will continue to bill CAP PCS using the current codes and will be reimbursed at the current rate of $3.47 per 15-minute unit. Please reference the chart below.

Procedure Code	Program Description	CAP Program	Billing Unit	Maximum Allowable
S5125	In-Home Aide II and III-PC	CAP Children CAP Choice CAP DA CAP IDD	15 min.	$3.47
S5135	Companion Care	CAP Choice	15 min.	$3.47
S5150	Respite Care In-Home	CAP Children CAP Choice CAP DA CAP IDD	15 min.	$3.47

Providers are reminded to bill their usual and customary charges.

Finance Management
DMA, 919-814-0053

Attention: Adult Care Home Providers, Family Care Home Providers, and Supervised Living Homes Billing PCS Services

Transition and Implementation Update, Personal Care Services

This article does not apply to providers billing for Personal Care Services (PCS) under the CAP program.

Consolidated Personal Care Services Policy and State Plan Amendment

Effective January 1, 2013, Medicaid PCS for recipients in all settings – including private residences and licensed adult care homes, family care homes, 5600a and 5600c supervised living homes, and combination homes with adult care home (ACH) beds – will be provided under a consolidated PCS benefit. On November 30, 2012, the Centers for Medicare & Medicaid Services (CMS) approved the N.C. Medicaid State Plan Amendment (SPA) 12-013. Clinical Coverage Policy 3L, Personal Care Services, is effective January 1, 2013 and is posted in final version on DMA's Medicaid Clinical Coverage Policy webpage.

New Admission Reporting and Independent Assessments of ACH/PCS Beneficiaries Admitted On or Before December 31, 2012

Independent assessments of Medicaid ACH/PCS beneficiaries newly admitted through December 31, 2012 to licensed adult care homes (ACH, family care homes, 5600a and 5600c supervised living homes, and combination homes with ACH beds) are ongoing. Providers may report new admissions of Medicaid residents who began receiving ACH/PCS on or before December 31, 2012 and who require independent assessments to determine eligibility for PCS effective January 1, 2013.

Complete the Independent Assessment Request for New Admissions (Form DMA-3066) **immediately** and submit by fax to The Carolinas Center for Medical Excellence (CCME) at 877-272-1942. **To be processed as a continuing request for services, new admission requests must be received no later than January 11, 2013.** After January 11, 2013, all service requests must follow Clinical Coverage Policy 3L procedures.

After receipt of a completed Independent Assessment Request for New Admissions (Form DMA-3066), CCME will contact your facility to schedule a return visit to assess beneficiaries who have not previously been assessed for PCS eligibility. Independent assessments of beneficiaries admitted through December 31, 2012 will be scheduled into January 2013 until all are complete.

Current beneficiaries with PCS assessment requests not yet processed to notification by December 21, 2012 will be transitioned to the new PCS program at current service levels, effective January 1, 2013, pending the outcome of the independent assessment. CCME will begin issuing transition-pending-assessment notices to beneficiaries with requests in process on December 27, 2012. Providers will receive notice copies.

Medical Attestation Forms for New Admissions Through December 31, 2012

A completed PCS Medical Attestation (Form DMA-3065) is also required to determine PCS eligibility for all licensed facility residents admitted through December 31, 2012. Initiate completion of the PCS Medical Attestation immediately for all new admissions to ensure that a completed form is available for presentation to the assessor at the time of the resident's scheduled assessment. **Failure to complete and submit the medical attestation will result in a denial of services.**

Beneficiary Decision Notices on Continuing Requests for Services

The N.C. Division of Medical Assistance (DMA) began issuing beneficiary decision notices for current licensed facility residence on December 3, 2012. Adverse decision notices include an appeal request form and instructions and deadlines for filing an appeal. **In accordance with federal regulations, maintenance of service (MOS) will be available for a current ACH/PCS beneficiary whose request for continuation of PCS has been denied or reduced, and who has filed an appeal in a timely manner.** As a reminder, providers may not file appeals on behalf of beneficiaries unless the beneficiary lists the provider as the representative on the appeal request form and the beneficiary signs the appeal form. Notices indicating the effective date and service level will be issued to beneficiaries and providers as MOS is authorized.

Beneficiary Decision Notices on New Requests for Services

Completed independent assessments for licensed facility residents with no calendar year 2012 ACH/PCS claims are processed as new requests for services. MOS is not available in the event of an appeal of an adverse decision on a new request for services. If, due to claims lag, a current ACH/PCS beneficiary's assessment is processed as a new request, providers may contact the CCME Independent Assessment Help Line at 1-800-228-336. Upon Medicaid payment of ACH/PCS claims for dates of service December 31, 2012 or earlier, a new notice of decision on a continuing request will be issued. In the event of a timely appeal of an adverse decision, MOS at the previous service level will be authorized with an effective date of January 1, 2013.

Personal Care Services Billing Code and Rate Change

Effective for dates of service beginning January 1, 2013, PCS claims for beneficiaries in all settings must be submitted using the billing code and modifiers indicated in Clinical Coverage Policy 3L. The billing code modifier that is associated with each beneficiary's prior approval – which should be used for claims submission – can be found on the beneficiary Notice of Decision. Refer to the new Personal Care Services fee schedule for the new PCS rate.

Reimbursement for previous ACH/PCS billing codes will no longer be available for dates of service after December 31, 2012. Prior approval requests for Special Care Unit or Enhanced ACH/PCS postmarked later than December 31, 2012 will not be processed.

Provider Interface

Licensed facility provider registration for the PCS Provider Interface began on November 29, 2012. To register to use the Provider Interface, complete the Provider Registration For Licensed Facility PCS Provider Use of QiRePort form and it send to CCME via fax at 877-272-1942 or by mail to: CCME, ATTN: PCS Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary, NC 27518-8598.

When the Provider Interface is available, registered users will receive an email notification from *support@QiRePort.net* which includes the QiRePort website link, a login I.D. and temporary password. To ensure that the registration email is properly delivered to your account inbox, add *support@QiRePort.net* to your email account contacts list.

PCS providers registered to use the Provider Interface may log into QiRePort to view and download beneficiary assessments for beneficiaries assessed during the transition period. Providers not registered to use the Provider Interface may request faxed copies of independent assessments beginning January 2, 2013. Refer to the DMA Consolidated PCS webpage beginning January 2, 2013 for the independent assessment copy request form and instructions.

Policy 3L Plan of Care Requirements

Pursuant to Clinical Coverage Policy 3L, for each beneficiary transitioning to the new PCS program with an effective date of January 1, 2013, an individualized, person-centered plan of care which addresses all unmet needs identified in the independent assessment must be implemented within 30 days of the effective date of Clinical Coverage Policy 3L. Each beneficiary approved for PCS services effective after the January 1, 2013 program implementation date must have a policy compliant plan of care implemented within 72 hours of initiating services or within 30 days of implementation of Clinical Coverage Policy 3L, whichever is later.

PCS New Referrals Beginning January 1, 2013

Beneficiaries who seek admission, are admitted, or first receive services in licensed homes on January 1, 2013 and after may request new referral assessments through their primary care or attending physicians, nurse practitioners, or physician assistants. The new referral form is available on the DMA Consolidated PCS webpage. **PCS reimbursement will not be available for a beneficiary admitted to a licensed facility on or after January 1, 2013, unless and until the beneficiary has received an independent assessment and Policy 3L qualifying criteria are met.**

Change of Status Request Process

Effective January 1, 2013, providers may report status changes for beneficiaries approved for PCS services. A Change of Status reassessment should be requested for a beneficiary who, since the previous assessment, has experienced a change in condition that affects the needs for hands-on assistance with Activities of Daily Living (ADLs) or other services covered under Clinical Coverage Policy 3L. **Note: Change of Status requests cannot be processed for beneficiaries who have not been approved for PCS.**

The Change of Status request form is available on the DMA Consolidated PCS webpage. The form may be completed by the licensed home provider and should be submitted by fax to CCME at 877-272-1942. After receipt, CCME will contact facilities to schedule return visits to assess beneficiaries whose Change of Status requests support the need for reassessment. The form must be complete and include a description of the status change causing the modification in PCS assistance.

Beneficiary Annual Reassessment

Annual reassessments of approved PCS beneficiaries will begin the week of January 21, 2013. Annual reassessment dates for current beneficiaries approved to transition effective January 1, 2013 are determined by the date on the beneficiary's FL-2 documented on the medical attestations form and independent assessment.

Upcoming Provider Trainings

Plans for upcoming provider trainings will be announced on the DMA Consolidated PCS webpage. For additional information about the new PCS program, refer to the DMA Consolidated PCS webpage and to previous and future Medicaid Bulletins for licensed ACH providers.

Questions regarding eligibility assessments for the consolidated PCS program may be directed to the CCME Independent Assessment Help Line at 1-800-228-3365, or to PCSAssessment@thecarolinascenter.org.

Home and Community Care Section
DMA, 919-855-4340

Attention: In-Home Care Providers

Consolidated Personal Care Services Implementation Update

This article does not apply to providers billing for Personal Care Services (PCS) under the CAP program.

Consolidated Personal Care Services Policy

Effective January 1, 2013, Medicaid PCS for recipients in all settings – including private residences and licensed adult care homes (ACH), family care homes, 5600a and 5600c supervised living homes, and combination homes with ACH beds – will be provided under a consolidated PCS benefit. On November 30, 2012, the Centers for Medicare & Medicaid Services (CMS) approved N.C. Medicaid State Plan Amendment (SPA) 12-013. Clinical Coverage Policy 3L, Personal Care Services, is effective January 1, 2013 and is posted in final version on DMA's Medicaid Clinical Coverage Policy webpage.

Change in Covered Services

Pursuant to N.C. Session Law 2012-142, Sections 10.9F.(b) and 10.9F.(c), **the new PCS program will not cover errands**. Effective on January 1, 2013, beneficiary plans of care should be updated to reflect this service exclusion. Providers may use one of two methods to update plans of care for beneficiaries previously authorized for errands assistance:

1) Reduce the beneficiary's total monthly service hours by the number of hours previously authorized for errands (1 hour for medication pick-up, 4 hours for off-site laundry, 4 hours for grocery assistance), or

2) Re-assign the hours previously authorized for errands to other tasks identified as unmet needs on the most recent independent assessment, and document the reason for allocating additional time to those tasks.

Continue to request Change of Status reassessments for beneficiaries whose assistance needs have changed as a result of a change in medical condition, informal caregiver status, or environmental conditions.

Beneficiary Transition Notices

All beneficiaries authorized for In-Home Care (ICH) services on December 31, 2012 were transitioned at their December 31, 2012 authorized service levels to the new PCS program, with an effective date of January 1, 2013. Decision notices were mailed to all authorized IHC beneficiaries and their providers in December 2012.

PCS New Referrals Beginning January 1, 2013

Beneficiaries seeking PCS services to begin January 1, 2013 and after may request new referral assessments through their primary care or attending physicians, nurse practitioners, or physician assistants. Home care agency providers and referring practitioners may continue to use the previous IHC program forms available on the CCME Independent Assessment website for new referrals and change of status requests.

Upcoming Provider Trainings

Plans for provider trainings will be announced on the N.C Division of Medical Assistance (DMA) Consolidated PCS webpage. For additional information about the new PCS program, refer to the DMA Consolidated PCS webpage and to previous and future Medicaid Bulletins for licensed Adult Care Home providers.

Questions regarding eligibility assessments for the consolidated PCS program may be directed to the CCME Independent Assessment Help Line at 1-800-228-3365, or to PCSAssessment@thecarolinascenter.org.

Home and Community Care Section
DMA, 919-855-4340

Attention: All Dental Providers and Health Department Dental Centers

American Dental Association Code Updates

Note to Providers: The last ADA coding update was posted in the *January 2011 Medicaid Bulletin.* ADA coding updates occur every two years, but the ADA is working on a system to update them more frequently.

Effective with date of service January 1, 2013, the following dental procedure code has been added for the N.C. Medicaid Dental Program. This addition is a result of the Current Dental Terminology (CDT) 2013 American Dental Association (ADA) code updates. Clinical Coverage Policy 4A, Dental Services will be updated to reflect these changes.

CDT 2013 Code	Description and Limitations
D1208	Topical application of fluoride • limited to recipients under age 21 • allowed once per recipient per six (6) calendar month period for the same provider

The following procedure codes were end-dated effective with date of service December 31, 2012.

End-Dated CDT Code	Description
D1203	Topical application of fluoride (including prophylaxis) – child
D1204	Topical application of fluoride (including prophylaxis) – adult

The following procedure code descriptions were revised effective with date of service January 1, 2013.

Revised CDT Code	Description
D0210	Intraoral – complete series of radiographic images
D0220	Intraoral – periapical first radiographic image
D0230	Intraoral – periapical each additional radiographic image
D0240	Intraoral – occlusal radiographic image
D0250	Extraoral – first radiographic image
D0260	Extraoral – each additional radiographic image
D0270	Bitewing – single radiographic image
D0272	Bitewings – two radiographic images
D0273	Bitewings – three radiographic images
D0274	Bitewings – four radiographic images

Revised CDT Code	Description
D0290	Posterior–anterior or lateral skull and facial bone survey radiographic image
D0330	Panoramic radiographic image
D0340	Cephalometric radiographic image
D1206	Topical application of fluoride varnish

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 at www.ncdhhs.gov/dma/mp/

Dental Program,
DMA, 919-855-4280

Attention: HIV Case Management Providers

Contact Hours for Continuing Education

Providers must obtain 20 contact hours of continuing educational annually as detailed in Sub-section 6.1.7.2 in Clinical Coverage Policy 12B. Ten hours of the 20 hour annual requirement must include clinically-oriented training. **Continuing education opportunities outside those provided by The Carolinas' Center for Medical Excellence require prior approval by Victoria Landes, DMA's HIV Case Management Consultant.** Trainings approved by the N.C. Division of Medical Assistance (DMA) include a statement indicating approval for clinical hours where appropriate**.**

During the transition time, DMA has been flexible regarding the deadline for submission of requests for continuing education credits. **Beginning January 2013, case managers must make a request to obtain continuing education credits three weeks prior to the event.** Information regarding prior approval is located at http://www.ncdhhs.gov/dma/services/hivcm.htm

Webinars and Online training programs are acceptable methods for obtaining continuing education hours. Participation must be validated by documentation. Information regarding training may be obtained at: www.thecarolinascenter.org/HIVCM.

HIV Case Management Program
DMA, 919-855-4389

Attention: Pharmacists

Hemophilia Specialty Pharmacy Program

The specialty pharmacy program for hemophilia drugs mandated by the General Assembly [Session Law 2012-142, Section 10.48 (a2)] will be implemented on **January 31, 2013**. Pharmacy providers furnishing hemophilia drugs and services to Medicaid and N.C. Health Choice (NCHC) beneficiaries should follow the clinically appropriate standards of care outlined in Clinical Coverage Policy No. 9B, *Hemophilia Specialty Pharmacy Program*. The related hemophilia maximum allowable costs for 340B and non-340B pharmacy providers will also be implemented on January 31, 2013. Policy and reimbursement information will be posted on the DMA Outpatient Pharmacy Program website at www.ncdhhs.gov/dma/pharmacy/index.htm.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Pharmacists

Pharmacy Dispensing Fee Changes

The Medicaid and N.C. Health Choice (NCHC) dispensing fees for generic and brand drugs will be changing effective February 1, 2013. The dispensing fee for brand drugs will change to $3.00.

The dispensing fee for generic drugs will be determined according to the following revised tiers:

- Greater than 82% claims per quarter = $7.75
- Between 77.1% and 82% claims per quarter = $6.50
- Between 72.1% and 77% claims per quarter = $4.00
- Less than or equal to 72% claims per quarter = $3.00

The dispensing fees for generic drugs will change again effective July 1, 2013 and will be determined according to the following revised tiers:

- 80% or more claims per quarter = $7.75
- Between 75% and 79.9 % claims per quarter = $6.50
- Between 70% and 74.9% claims per quarter = $4.00
- Less than or equal to 69.9% claims per quarter = $3.00

It is important for pharmacy providers to check their generic dispensing rate and make sure that they make appropriate system changes in order to submit the appropriate

dispensing fees for reimbursement. Pharmacies should continue to submit the gross amount due and their usual and customary amount.

The gross amount due (field 430-DU) should include the Medicaid allowable for the drug plus the applicable dispensing fee. The pharmacy point-of-sale system will know what each provider's generic dispensing fee is for the quarter and will not pay more than what the system will allow for the cost of the drug plus the dispensing fee. There is not a separate field for the dispensing fee – it must be included in the gross amount due as it is today.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Pharmacists and Prescribers

Prescribers not Enrolled in Medicaid

Note to Providers: The article was previously published in December 2012.

The Affordable Care Act established a new rule that prohibits Medicaid and Children's Health Insurance Programs [such as N.C. Health Choice (NCHC)] from paying for prescriptions written by prescribers who are not enrolled in Medicaid and NCHC programs.

On January 1, 2013, pharmacy providers will begin to receive a message at point-of-sale for prescriptions written by prescribers not enrolled in the Medicaid and/or NCHC program. This message will notify pharmacy providers that pharmacy claims written by non-enrolled prescribers will begin denying on April 1, 2013.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Pharmacists and Prescribers

Benzodiazepines and Barbiturates No Longer Covered for Dual Eligible Beneficiaries

The Medicare Improvement for Patients and Providers Act (MIPPA) Section 175 requires Medicare Part D prescription drug plans to cover benzodiazepines for any condition and barbiturates used for seizures, cancer, or chronic mental health conditions. Because Medicare will begin coverage for these drugs effective January 1, 2013, N.C. Medicaid will no longer provide coverage for these medications for dual eligibles except for barbiturates when used for conditions not listed above.

Pharmacies should submit these claims to the beneficiary's Medicare Part D prescription drug plan beginning on January 1, 2013. Providers must follow the manual claims submission process to submit barbiturate drug claims to Medicaid for diagnoses not listed. If a pharmacy receives a not covered message from a Medicare Part D Plan for a barbiturate due to a diagnosis not indicated above, the pharmacy may bill Medicaid for the claim via a paper claim. The claim can be found at www.ncdhhs.gov/dma/forms/pharmclaim.pdf. Include a copy of the NCPDP denial with your paper claim.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Pharmacists

New BIN instructions for the free ACCU-CHEK Free Meter program

Pharmacy providers can dispense an ACCU-CHEK meter to N.C. Medicaid and N.C. Health Choice (NCHC) beneficiaries (one meter per Medicaid recipient) by submitting the following information at the pharmacy terminal:

BIN#: 015251
PCN#: PRX2000
Group#: AC01
ID#: AC018641687

For assistance in filing this claim, call the OptumRx Helpdesk at 1-800-510-4836

Outpatient Pharmacy
DMA, 919-855-4300

Employment Opportunities with the N.C. Division of Medical Assistance (DMA)

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." If you identify a position for which you are both interested and qualified, complete a state application form online and submit it. 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/general.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. To submit a comment related to a policy, refer to the instructions on the Proposed Clinical Coverage Policies Web page at http://www.ncdhhs.gov/dma/mpproposed/. 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.

2013 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
January	01/03/13	01/08/13	01/09/13
	01/10/13	01/15/13	01/16/13
	01/17/13	01/23/13	01/24/13
	01/24/13	01/31/13	02/01/13
February	02/07/13	02/12/13	02/13/13
	02/14/13	02/20/13	02/21/13
	02/21/13	02/28/13	03/01/13
	02/28/13	03/05/13	03/06/13

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.

Michael Watson
Director
Division of Medical Assistance
Department of Health and Human Services

Melissa Robinson
Executive Director
HP Enterprise Services