July 2010 Medicaid Bulletin

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

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Attention: All Providers

Medicaid Integrity Contractors Audit

The Deficit Reduction Act of 2005 created the Medicaid Integrity Program (MIP) and dramatically increased the federal government's role and responsibility in combating Medicaid fraud, waste, and abuse. Section 1936 of the Social Security Act (the Act) requires CMS to contract with eligible entities to review and audit Medicaid claims, to identify overpayments, and to provide education on program integrity issues. Additionally, the Act requires CMS to provide effective support and assistance to states to combat Medicaid provider fraud and abuse.

CMS created the Medicaid Integrity Group (MIG) in July 2006 to implement the MIP. As a result of this action, the Medicaid Integrity Contractors (MIC) audit was developed. Section 1936 of the Act requires CMS to enter into contracts to perform four key program integrity activities:

- review provider actions;
- audit claims;
- identify overpayments; and
- educate providers, managed care entities, beneficiaries, and others with respect to payment integrity and quality of care.

CMS has awarded contracts to several contractors to perform the functions outlined above. The contractors are known as the MICs. There are three types of MICs:

- **The Review MIC.** The Review MIC analyzes Medicaid claims data to identify aberrant claims and potential billing vulnerabilities, and provides referrals to the Audit MIC. Thomson Reuters is the Review MIC for North Carolina.
- **The Audit MIC.** The Audit MIC conducts post-payment audits of all types of Medicaid providers and identifies improperly paid claims. The Audit MIC for North Carolina is Health Integrity.
- **The Education MIC.** Education MICs work with the Review and Audit MICs to educate health care providers, State Medicaid officials, and others about a variety of Medicaid program integrity issues. There are two Education MICs:
  - Information Experts
  - Strategic Health Solutions

The objectives of the MIC audit are to ensure that claims are paid

- for services provided and properly documented;
- for services billed using the appropriate procedure codes;
- for covered services; and
- in accordance with federal and state laws, regulations, and policies.

MIC Audit Process

1. **Identification of potential audits through data analysis.** The MIG and the Review MICs examine all paid Medicaid claims using the Medicaid Statistical Information System. Using advanced data mining techniques, MIG identifies potential areas that are at risk for overpayments that require additional review by the Review MICs. The Review MICs, in turn, identify specific potential provider audits for the Audit MICs on which to focus their efforts. This data-driven approach to identifying potential overpayments helps ensure that efforts are focused on providers with truly aberrant billing practices.
2. **Vetting potential audits with the state and law enforcement.** Prior to providing an Audit MIC with an audit assignment, CMS vets the providers identified for audit with state Medicaid agencies, state and federal law enforcement agencies, and Medicare contractors. Vetting is the process whereby CMS provides a list of potential audits generated by the data analysis mentioned above. If any of these agencies are conducting audits or investigations of the same provider for similar billing issues, CMS may elect to cancel or postpone the MIC audit to avoid duplicating efforts.

3. **Audit MIC receives audit assignment.** CMS forwards the list of providers to be reviewed to the Audit MIC after the vetting process is completed. The Audit MIC immediately begins the audit process. CMS policy is that the audit period, also known as the "look back" period, should mirror that of the state that paid the provider's claims.

4. **Audit MIC contacts provider and schedules entrance conference.** The Audit MIC mails a notification letter to the provider. The notification letter
   - identifies a point of contact within the Audit MIC;
   - gives at least two-weeks' notice before the audit is to begin;
   - includes a records request outlining the specific records that the Audit MIC will be auditing; and
   - asks the provider to send the records to the Audit MIC for a desk audit. For a field audit, the provider must have the records available in time for the Audit MIC's arrival at the provider's office.

   The Audit MIC schedules an entrance conference to communicate all relevant information to the provider. The entrance conference includes a description of the audit scope and objectives.

5. **Audit MIC performs audit.** Most of the audits conducted by the Audit MIC are desk audits; however, the Audit MIC also conducts field audits in which the auditors conduct the audit on-site at the provider's location. Providers are given specific timelines in which to produce records. Because some audits will be larger in scope than others, provider requests for time extensions are seriously considered on a case-by-case basis. The audits are being conducted according to Generally Accepted Government Auditing Standards (http://www.gao.gov/govaud/ybk01.htm).

6. **Exit conference held and draft audit report is prepared.** At the conclusion of the audit, the Audit MIC will coordinate with the provider to schedule an exit conference. The preliminary audit findings are reviewed at this meeting. The provider has an opportunity to comment on the preliminary audit findings and to provide additional information if necessary. If the Audit MIC concludes, based on the evidence, that there is a potential overpayment, the Audit MIC prepares a draft report.

7. **Review of draft audit report.** The draft audit report is shared with CMS for approval and is provided to the state for review and comments. The report is then given to the provider for review and comment. The draft report may be subject to revision based on additional information and shared again with the state.

8. **Draft audit report is finalized.** Upon completion of this review process, the findings may be adjusted, either up or down, as appropriate based on the information provided by the provider and the state. The state's comments and concerns will also be given full consideration. CMS has the final responsibility for determining the final amount of any identified overpayment in any audit. At this point, the audit report is finalized.

9. **CMS issues final audit report to the state, triggering the "60-day" rule.** CMS sends the final audit report to the state. Pursuant to 42 CFR 433.316 (a) and (e), this action serves as CMS' official notice to the state of the discovery and identification of an overpayment. Under federal law, 42 CFR 433.12 (2), the state must repay the federal share of the overpayment to CMS within 60 calendar days, regardless of whether the state recovers or seeks to recover the overpayment from the provider.

10. **The state issues final audit report to provider and begins overpayment recovery process.** The state is responsible for issuing the final audit report to the provider. Each state must follow its respective administrative process in this endeavor. At this point, the provider may exercise whatever appeal or adjudication rights are available under state law when the state seeks to collect the overpayment amount identified in the final audit report.

Ten providers have completed MIC audits in North Carolina. To date, no errors have been reported.

Program Integrity
DMA, 919-647-8000

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 a timeframe specified in the medical record request letter.

It is anticipated that A+ Government Solutions will begin requesting medical records for North Carolina's sampled claims in June 2010. Providers are urged to respond to these requests promptly with timely submission of the requested documentation.

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.

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Optical Character Recognition for Paper Claims

Paper claims that meet one of the exceptions to the electronic claims submission requirement (see http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm) are submitted to HP Enterprise Services, N.C. Medicaid's fiscal agent for claims processing. Paper claims are now being electronically read using Optical Character Recognition (OCR) equipment. This OCR technology requires that paper claims be submitted on standardized claim forms with the appropriate data fields completed. Examples of non-standard claim forms include forms that have been individually created and printed by a provider, fax copies, carbon copies or photocopies. Non-standard paper claims will be returned to the provider or may be denied in processing.

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

Attention: All Providers

Medicaid Provider Administrative Participation Agreement

The N.C. Department of Health and Human Services Medicaid Provider Administrative Participation Agreement has been revised. Those providers who deferred the completion of the Agreement that was included in the verification packet mailed out as part of the 12-month verification project may now access the revised Agreement on the NC Tracks website at http://www.nctracks.nc.gov/provider/forms/.

Providers who included a completed Agreement with the verification packet and providers who have enrolled for participation with N.C. Medicaid within the last 12 months do not need to resubmit an Agreement. CSC, N.C. Medicaid's contractor for provider enrollment, verification, and credentialing, will contact you when a new Agreement is required.

The completed N.C. Department of Health and Human Services Medicaid Provider Administrative Participation Agreement should be submitted by mail, fax, or by e-mail to CSC by September 1, 2010.

N.C. Medicaid Provider Enrollment
CSC
PO Box 300020
Raleigh NC 27622-8020

Fax: 1-866-844-1382
E-mail: NCMedicaid@csc.com

CSC, 1-866-844-1113

Attention: All Providers

PDF Format Remittance and Status Reports Changes Implemented

Effective with the June 8, 2010, checkwrite, 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). There was a transition period for the month of June, 2010, where the paper RA was printed and mailed to providers. Beginning with the July 7, 2010, checkwrite, RAs will only be available through the NCECS Web Tool. As a part of this effort, minor changes were made to the layout of the RA as described in the June 2010 Medicaid bulletin (http://www.ncdhhs.gov/dma/bulletin/).

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.

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

Attention: All Providers

State Medicaid Health Information Technology Plan

The Office of Medicaid Management Information Systems Services (OMMISS) is leading an effort to develop the State Medicaid Health Information Technology (HIT) Plan (SMHP), in collaboration with DMA, the Health and Wellness Trust Fund (HWTF), the N.C. Health Information Exchange (NCHIE), the Regional Extension Center (REC), and other stakeholders. The SMHP, along with an Implementation Advanced Planning Document (I-APD), will outline the State's plans to administer the Medicare and Medicaid Electronic Health Record (EHR) Incentive Payments for North Carolina's eligible providers and hospitals.

CMS must approve the SMHP before the I-APD will be approved. CMS has advised that two separate I-APDs may be created to secure funding for administering the Incentive Payment program; one for MMIS-related costs and one for HITECH costs. The Incentive Payments for EHR Meaningful Use may be available as early as January, 2011, if the State receives approval of the SMHP, secures funding through approved I-APDs, and is able to develop and test systems that comply with the CMS National Level Repository (NLR) interface requirements. OMMISS is currently in the planning and analysis phase to determine when North Carolina will be prepared to begin making incentive payments. Eligible providers will be able to apply for the incentive payments under Medicaid in any 5-year consecutive period during this 10-year program, which ends in 2021.

For additional information on the EHR incentive, refer to DMA's web page at http://www.ncdhhs.gov/dma/provider/ehr.htm.

Director's Office
DMA, 919-855-4100

Attention: All Providers

Incomplete Provider Enrollment Applications

Effective August 1, 2010, DMA has instructed CSC, the enrollment, verification, and credentialing vendor for the N.C Medicaid Program, to issue a Final Notice letter to any applicant with an incomplete provider enrollment application that has been inactive for 30 days or more.

Applicants are notified by CSC when an application is deemed to be incomplete due to documents or information that is missing at the time that the application is processed. If no response is received within 30 days, the application is considered to be inactive.

For those applicants with an inactive, incomplete application, CSC will send a final notice stating that the application will be voided. Any applicant who feels that he/she has received this notice in error (e.g., the requested documents or information have actually been submitted) should contact CSC immediately. CSC will promptly investigate and address your concerns.

We appreciate your assistance with this matter and thank you for your participation with the N.C. Medicaid Program.

CSC, 1-866-844-1113

Attention: All Providers

Provider Information Regarding Changes in N.C. Health Choice Copayments

Effective with date of service July 1, 2010, copayment changes were made to the benefits for N.C. Health Choice (NCHC). Based on a child's current NCHC ID card, the following copayment changes apply.

- If **all** copayment amounts on the NCHC ID card are $0, they are still $0; there are no changes.
- If the emergency room (ER) copayment on the NCHC ID card is $0 but there are other copayment amounts, the following changes apply:
  - ER copayment is changing from $0 to $10
  - Generic drug copayment is changing from $1 to $2
  - Brand drug copayment with no generic available is changing from $1 to $2
  - Brand Drug copayment with a generic available is changing from $3 to $5
- If the ER copayment on the NCHC ID card is $20, the following changes apply:
  - ER copayment is changing from $20 to $25
  - Generic drug copayment is changing from $1 to $2
  - Brand drug copayment with no generic available is changing from $1 to $2
  - Brand drug copayment with a generic available will stay the same at $10

These changes in copayments are effective for all non-emergency ER visits and for prescriptions filled starting on July 1, 2010.

Cinnamon Narron
N.C. Health Choice, 919-855-4149

Attention: All Providers

Changes to the EOB Code Crosswalk to HIPAA Standard Codes

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

Effective July 1, 2010, please review the changes to the format of the crosswalk, which allow for codes to be filtered and sorted in a more efficient manner when multiple codes map to the same Medicaid EOB. In addition, the crosswalk has been divided into separate crosswalks based on claims types – Institutional, Professional, Dental, and Pharmacy. This will eliminate some of the one-to-many mappings. For additional information, refer to the June 2010 Medicaid Bulletin (http://www.ncdhhs.gov/dma/bulletin/.

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

Attention: All Providers

Provider Information Regarding Changes in N.C. Health Choice Administration

Effective July 1, 2010, the administration of the N.C. Health Choice (NCHC) program moved from the State Employees Health Plan to DMA. This change does not directly impact providers or recipients of NCHC. Blue Cross Blue Shield of North Carolina will continue to process claims for NCHC.

Effective July 1, 2010, the NCHC medical policies currently located on the State Employees Health Plan website have been moved to DMA's website at http://www.ncdhhs.gov/dma/hcmp.

Medco will continue as the pharmacy benefit manager for NCHC. However, Medco has a new customer service number for NCHC. That number is 1-800-466-4115. There is also a new Rx group number that pharmacists should begin using on July 1. That number is NCDHHS1. It is listed on the new NCHC ID cards issued on and after July 1, 2010.

Provider Information Regarding Changes in NC Health Choice Benefits

Effective July 1, 2010, NCHC covers certain over-the-counter (OTC) medications if prescribed by a doctor. The covered OTC medications follow Medicaid's policy for OTC medications (see http://www.ncdhhs.gov/dma/mp/).

NCHC families received notices in early June 2010 informing them of these changes. New NCHC ID cards may not arrive to families until after July 1, so these notices also serve to remind families of their new copayments, the new Medco customer service number, and the Rx group number as well as the addition of the OTC medications benefit.

Cinnamon Narron
N.C. Health Choice, 919-855-4149

Attention: All Providers

UD Modifier and 340B Purchased Drugs

The 340B Drug Pricing Program resulted from the enactment of the Veterans Health Care Act of 1992, which is Section 340B of the Public Health Service Act. Providers are able to acquire drugs through that program at significantly discounted rates. Due to the discounted acquisition cost, these drugs are not eligible for the Medicaid Drug Rebate Program. State Medicaid programs are obligated to ensure that rebates are not claimed on 340B drugs. The DRA 2005 does not exclude 340B drugs; therefore, all providers must also meet these requirements.

N.C. Medicaid must be able to identify details that have 340B drugs and exclude them from the rebate collection process. Effective with date of processing on or after November 21, 2008, for dates of service on or after December 28, 2007, N.C. Medicaid **requires** the UD modifier to be billed on the CMS-1500/837P and the UB04/837I claims forms, with applicable HCPCS code and National Drug Code (NDCs) to properly identify 340B drugs. All non-340B drugs are billed using the associated HCPCS and NDC pair without the UD modifier.

This information was first published in the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* which is available on DMA's website (http://www.ncdhhs.gov/dma/bulletin/).

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

Attention: All Providers

Top EOB Codes for Claim Denials

The following table contains the top EOB codes, excluding NPI, which are listed in the second table.

EOB	EOB Description	Resolution
9271	Payment included in DRG reimbursement on first accommodation detail	Refer to first accommodation detail. If payment is indicated, no action necessary. If denial code is indicated, correct and resubmit claim based on EOB description given.
473	Nursing Home Days Denied Or Recouped to Pay Inpatient Hospital Days	Verify the patient was not in the nursing home facility while admitted to an inpatient hospital stay.
8925	Allowable reduced for deductible/patient liability	Prior payment amount exceeds the N.C. Medicaid allowable, or reduces the N.C. Medicaid allowable by the prior payment amount. No action necessary.
21	Exact duplicate	A claim with the same dates and services has paid, previously in history. If previous payment is incorrect, submit a replacement claim to address overpayment or underpayment. If payment is correct, no action necessary.
169	Bill Medicare Part A Carrier	Recipient is eligible for Medicare, Part A. Claim should be filed to Medicare.
11	Recipient not eligible on service date	Verify recipient eligibility via a 270/271 transaction or via the AVRS (1-800-723-4337, option 6). Refer to the *Basic Medicaid Billing Guide*, Appendix F for more details. If recipient's eligibility has updated since the original claim has processed, resubmit the claim.

Please contact HP Provider Services at 1-800-688-6696, Option 3, for assistance with the EOBs listed above.

The following table contains the top EOB codes for NPI claims.

EOB	EOB Description	Resolution
270	Billing provider is not the recipient's Carolina Access PCP. Authorization is missing or unresolved. Contact PCP for authorization or EDS Prov. Svcs. if authorization is correct	Submitted claim requires a referring NPI. The referring NPI is either not found on the claim or is unresolved (cannot map to single MPN). Correct and resubmit the claim.
286	Incorrect authorization number on claim form. Verify number and refile claim	Referring NPI on processed claim does not match the CCNC/CA PCP listed on the recipient's eligibility file for submitted date of service. Contact referring PCP, obtain the correct referral information and resubmit claim.

EOB	EOB Description	Resolution
8326	Attending provider ID is missing or unresolved. Attending prov is required. Verify attending provider ID and resubmit as a new claim or contact EDS prov svcs if ID is correct	Submitted claim requires an attending NPI. The attending NPI is either not found on the claim or is unresolved (cannot map to single MPN). Correct and resubmit the claim.

Please contact HP Provider Services at 1-800-688-6696, Option 3, then Option 1, for assistance with the EOBs listed above.

Although the suggested resolution is for common denial cases, each claim may propose a unique processing scenario. For further questions or claim research, contact HP Provider Services for claim-specific diagnostics.

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

Attention: All Providers

Important Safety Information on Valproate

The N.C. Medicaid Drug Utilization Review (DUR) Board has requested that the following information be shared with N.C. Medicaid providers regarding the use of the drug valproate during pregnancy.

Reviews conducted under the N.C. Medicaid DUR Program indicate that the drug valproate (divalproex sodium, valproic acid, sodium valproate) is being prescribed to N.C. Medicaid recipients who may be pregnant. A Pregnancy Category D drug indicates that there is known harm to the fetus associated with the use of a drug but the benefits may outweigh the risk for pregnant women who have a serious condition that cannot be treated effectively with a safer drug. Recent data, published by the Food and Drug Administration (FDA) in December 2009, states that the risks of major congenital malformations (MCMs) may be higher with valproate when compared to other anti-epileptic medications. Additionally, the risks of MCMs seem to be higher when the doses exceed 1,000 mg per day.

Using Medicaid data from September 2009 through January 2010, the N.C. Medicaid DUR Board identified 141 patients who had a diagnosis of pregnancy and also had a prescription for valproate or a similar derivative. Additionally, the Board identified 405 female patients of child-bearing age (13 to 50 years of age) who are currently prescribed a valproate derivative. Since approximately half of all pregnancies are not planned, it is important that prescribers perform a risk-versus-benefit analysis and discuss contraceptive options with the patient or legal guardian for women of child-bearing age for which valproate is a recommended treatment option.

More information regarding the risk of birth defects following a prenatal exposure to valproate can be found at http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm192645.htm.

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

Attention: Community Care of North Carolina/Carolina ACCESS Providers

Recipient Enrollment by Primary Care Providers

Primary care providers are encouraged to start the enrollment process for their Medicaid patients who are eligible to be enrolled in Community Care of North Carolina/Carolina ACCESS (CCNC/CA). (Refer to the *Basic Medicaid Billing Guide* on DMA's website at http://www.ncdhhs.gov/dma/basicmed/ for information on recipients who are exempt from CCNC/CA.)

- Use the Carolina ACCESS Member Handbook to explain the benefits of being a member of CCNC/CA.
- Give the recipient a copy of the *Carolina ACCESS Member Handbook*. The handbook, which is available in both English and Spanish, can be obtained
  - by e-mail to Adrienne.Frederick@dhhs.nc.gov
  - online at http://www.ncdhhs.gov/dma/ca/
  - by faxing a request to 919-715-0844 or 919-715-5235
- Inform recipients that they have the freedom to choose their primary care provider and that they can choose to change primary care providers at any time. If a recipient requests to change from your practice, refer them to a caseworker at his/her local county department of social services (DSS), which maintains a directory of providers serving that county.
- Provide information about any extended office hours, after-hours policy, and any other pertinent information regarding office protocols and services.

The enrollment **should be sent to the local DSS** in the county where the patient resides. The CCNC/CA Enrollment Form for providers and instructions for completing the form can be found on the DMA website at http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm.

Managed Care
DMA, 919-855-4780

Attention: Personal Care Services Providers

Independent Assessment Reminders

Independent assessment of personal care services (PCS) recipients was implemented April 1, 2010. The Carolinas Center for Medical Excellence (CCME) is conducting all Medicaid PCS independent assessments. Refer to the DMA website (http://www.ncdhhs.gov/dma/services/pcs.htm) and the **Independent Assessment website** (http://www.qireport.net) for PCS referral forms and instructions.

Not all PCS and PCS-Plus recipients will receive independent assessments before the annual reassessment dates indicated on client PACT assessments. Continue to provide and bill for services in keeping with recipient Plans of Care until you are notified of independent assessment results by CCME.

In order for PCS claims to process correctly, CCME must have a record of the provider agency's correct Medicaid provider number for each recipient. If you have not submitted to CCME updates of new recipients you assessed and admitted through April 16, 2010, and updates of continuing recipients you reassessed through April 30, 2010, do so immediately. Refer to the April and May Medicaid bulletins (http://www.ncdhhs.gov/dma/bulletin/) for instructions. Do not submit new admission or reassessment updates for recipients assessed by CCME. Do continue to submit weekly discharge updates to CCME using Part 2 of the Weekly Summary Form (see the **Independent Assessment website**).

Questions may be directed to the CCME Independent Assessment Help Line at 1-800-228-3365 and by e-mail to PCSAssessment@thecarolinascenter.org.

CCME, 1-800-228-3365

Attention: Enhanced Behavioral Health (Community Intervention) Services Providers

Community Support Team Service Revised Effective Date and Rate

The effective date for the following rate decrease is July 1, 2010.

Service Code	Service Description	Service Unit	Current Rate	New Rate
H2015 HT	Community Support Team	per 15 min unit	$ 15.60	$ 14.50

Fee schedules are available on DMA's website at http://www.ncdhhs.gov/dma/fee/. Providers must always bill their usual and customary charges.

Rate Setting
DMA, 919-647-8170

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

Update on Community Based Rehabilitative Services

The proposed revisions to the Community Based Rehabilitative Services (CBRS) policy are currently under review by the N.C. Physician's Advisory Group (NC PAG). The proposed policy will be available for public comment on DMA's website upon approval from the NC PAG. **Providers should continue to provide and bill for this service through and beyond July 1, 2010, until further notice. Providers should not stop providing this service on June 30, 2010.**

Behavioral Health Section
DMA, 919-855-4290

Attention: Intermediate Care Facilities for Individuals with Mental Retardation

ICF/MR Provider Assessment Fee Decrease

Effective November 1, 2009, DMA decreased the ICF/MR provider bed assessment tax by $0.86. This change is a result of the enactment of American Recovery and Reinvestment Act FMAP. The assessment was changed from $12.32 to $11.46. All facilities will be reimbursed the change in the assessment fee based on their completed assessments from November 2009 through May 2010.

This change in the assessment fee will have no effect on the current reimbursement rates to the individual facilities.

Rate Setting
DMA, 919-855-4200

Attention: Durable Medical Equipment Providers and Pharmacists

Changes to HCPCS Codes A4253, A4259, and S8490

Effective July 1, 2010, the diagnosis limitation requirement has been removed from HCPCS codes A4253 and A4259 (blood glucose strips and lancets). Also, for HCPCS codes A4253, A4259, and S8490, the quantity limitation for ages birth through 20 has been removed. The quantity limitation for ages 21 through 115 for these codes remain unchanged.

Please refer to Clinical Coverage Policy 5A, *Durable Medical Equipment*, on DMA's website http://www.ncdhhs.gov/dma/mp/ for specific coverage details.

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

Attention: CAP Case Managers, Durable Medical Equipment Providers, and Orthotics and Prosthetics Providers

Video Conference Seminars for Providers of Durable Medical Equipment and Orthotics and Prosthetics

The video conference seminar for providers of durable medical equipment (DME) and orthotics and prosthetics (O&P) is scheduled for August 12, 2010. Information presented at this video conference seminar will include a review of policy and billing for DME and O&P. New enrollment and policy requirements for CAP Waiver Supplies will also be discussed. 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 DME and O&P seminar online at http://www.ncdhhs.gov/dma/provider/seminars.htm. **Pre-registration is required.** Providers will receive a registration confirmation outlining the training material(s) each attendee should bring to the seminar. All locations will have live audio and visual feed from the central Raleigh location.

Seminar Schedule – 9:00 a.m. to 12:00 noon, August 12, 2010

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 West Campus Drive Charlotte NC 28208
Greensboro	UNC-G TeleLearning Center Stone Building, Room 186 110 McIver Street Greensboro NC 27412
Raleigh	Department of Public Instruction 301 N. Wilmington Street Raleigh NC 27601

City	Address
Williamston	Martin Community College Building 1, Room 10A 1161 Kehukee Park Road Williamston NC 27892
Wilmington	South East Area Health Education Center (SEAHEC) SEAHEC Building, Pelican Room 2511 Delaney Avenue Wilmington NC 28403

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

Durable Medical Equipment and Orthotics and Prosthetics
August 12, 2010 Video Conference 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 _____
(circle one) (location)

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

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

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

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

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

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

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

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

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

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

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

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

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

Proposed Clinical Coverage Policies

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

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.

2010 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
July	7/1/10	7/7/10
	7/8/10	7/13/10
	7/15/10	7/22/10
	7/29/10	8/3/10
August	8/5/10	8/10/10
	8/12/10	8/17/10
	8/19/10	8/26/10

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

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

Melissa Robinson
Executive Director
HP Enterprise Services