



June 2011 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

Add-on Code Denials

It has come to the attention of N.C. Medicaid that claims billed for add-on CPT procedure codes 76802, 76810, 76812 or 76814 were being denied inappropriately with EOB 3011 (Add-on code must be billed with a paid primary procedure code for reimbursement). Effective immediately, providers who have received prior approval for these services can resubmit these charges as a new day claim (not as an adjustment) for processing.

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

Attention: All Providers

Enrollment of Recipients in SSA (Special Services for the Aged) Eligibility Group into CCNC/CA (Community Care of North Carolina/Carolina Access)

This is to notify Medicaid providers that CMS has approved recipients in this program aid category to be enrolled in CCNC/CA effective March 1, 2011. Until this date, SAA recipients were not eligible to be enrolled. SAA recipients are optional for enrollment; therefore, they can choose not to enroll. At this time, the eligibility information system has not been programmed to accept enrollment. Providers will be notified when enrollment will begin.

Managed Care
DMA, 919- 855-4784

Attention: All Providers**Affordable Care Act Implementation Updates**

N.C. Medicaid will begin providing monthly updates on North Carolina's efforts to implement the Patient Protection and Affordable Care Act (ACA), also known as "health care reform".

The North Carolina Institute of Medicine (NCIOM) health care reform taskforces work to provide implementation recommendations to the Department of Health and Human Services (DHHS) and the N.C. General Assembly. Taskforces include workgroups on Quality, the Safety Net, Medicaid, Fraud and Abuse, Health Benefits Exchange and Insurance Oversight, Prevention, Health Professional Workforce, and New Models of Care. DMA is working closely with stakeholders and providers in the development of appropriate systems and policies required by the act, as well as exploring opportunities to improve the delivery and quality of care. DMA participates in all workgroups and chairs the workgroups on Medicaid, Fraud and Abuse, and New Models of Care.

For more information about the NCIOM taskforces, please see: <http://www.nciom.org/task-forces-and-projects/current-task-forces-projects/>

For the NCIOM interim report on the "Implementation of the Patient Protection and Affordable Care Act in North Carolina", please see:

<http://www.nciom.org/wp-content/uploads/2011/03/HR-Interim-Report.pdf>

In addition to working to meet the requirements of ACA, DMA is pursuing several initiatives that will be discussed in more detail in future bulletins, including

- Health homes for Medicaid recipients with chronic health problems;
- Family planning services through a State Plan Amendment (SPA), instead of the current waiver, to men or women of childbearing age who meet the income guidelines that would apply for pregnant women (185% FPL);
- Medicaid Incentives for Prevention of Chronic Diseases grant to provide incentives to at risk and chronically ill patients with hypertension and diabetes to better self-manage their care; and
- Dual Eligible's Planning grant to better coordinate care for individuals receiving health care services through both Medicare and Medicaid.

Director's Office
DMA, 919-855-4109

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

In January and February 2011, N.C. Medicaid held Recipient Due Process, and EPSDT training for providers. Additional training seminars are scheduled for June 2011. Seminars are intended to address changes in Medicaid's prior approval policies and procedures and the Medicaid **recipient** appeal process when a Medicaid service is denied, reduced, terminated, or suspended. The seminar will also focus on an overview of EPSDT-Medicaid for Children.

The seminars are scheduled at the locations listed below. Sessions will begin at 9:00 a.m. and will end at 4:00 p.m. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided at the seminars. **Because meeting room temperatures vary, dressing in layers is strongly advised.** Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the Changes in Medicaid Prior Approval Policies and Procedures, Recipient Due Process, and EPSDT seminars online at <http://www.ncdhhs.gov/dma/provider/seminars>. **Pre-registration is required.** Providers will receive a registration confirmation specifying the training material(s) each provider should bring to the seminar.

Date	Location
June 7, 2011	Morganton Western Piedmont Community College 1001 Burkemont Avenue Morganton, NC 28655
June 14, 2011	Wilmington Hampton Inn-Medical Park 2320 South 17 th Street Wilmington, NC 28401
June 22, 2011	Raleigh The Royal Banquet and Convention Center 3801 Hillsborough Street Raleigh, NC 27607

**Medicaid Recipient Appeal Process/EPSDT Workshops
June 2011 Seminar Registration Form**
(No Fee)

Provider Name and Discipline _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number () _____ Fax Number _____

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

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

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

Attention: All Providers**Changes in Reimbursement for Immunization Administration**

In order to comply with the Centers for Medicare and Medicaid Services (CMS) and the federal rules regarding the reimbursement for the administration of vaccines, the N.C. Medicaid Program will reimburse for immunization administration billed with CPT codes 90471 through 90474 at the federal regional (state) administration cap rate, **effective with date of service July 1, 2011**. The federal regional (state) administration cap rate is defined as the maximum amount that a state Medicaid agency may pay per vaccine, and North Carolina's current rate is \$13.71. CPT codes 90460 and 90461 ("per component") will be end dated on June 30, 2011. "Claim details billed with CPT codes 90460 and 90461 with dates of service on and after July 1, 2011, will be denied."

The descriptors for CPT codes 90471 through 90474 are listed in the table below:

Procedure Code	Description	Billing Guidance
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)	No special requirements.
90472+ (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)	Use 90472 in conjunction with 90471 or 90473.
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)	Do not report 90473 in conjunction with 90471.
90474+* (add-on code)	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid)	List separately in addition to code for primary procedure. Use 90474 in conjunction with 90471 or 90473.*

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

For Medicaid Billing:

The following principles should guide the billing of these codes.

1. A "first" administration is defined as the first vaccine administered to a recipient during a single patient encounter.
2. CPT code 90471 should be considered the primary code to 90472 and 90474 for the purpose of Medicaid billing.
3. Append modifier EP to all immunization administration codes billed for Medicaid recipients in the Health Check age range, 0 through 20 years of age.
4. Do NOT append modifier EP to an immunization administration code billed for Medicaid recipients who are 21 years of age or older.
5. Do NOT append the EP modifier to CPT vaccine codes.

6. All of the units billed for CPT codes 90471EP, 90472EP, 90473EP, and 90474EP must be billed on **ONE** detail to avoid duplicate audit denials. Currently, 90474EP cannot be billed with 90473EP because there are no two oral/intranasal vaccines that would be given to a recipient. Only one unit of either 90473EP or 90474EP is allowed.
7. Refer to individual bulletin articles on specific vaccines at <http://www.ncdhhs.gov/dma/bulletin/> for additional billing guidelines (e.g., use of the SC modifier for purchased vaccine).
8. For recipients 21 years of age and older, an evaluation and management (E/M) code *cannot* be reimbursed to any provider on the same day that an immunization administration code is reimbursed, unless the provider bills an E/M code with modifier 24 or 25 appended to the E/M code.
9. CPT vaccine codes for the vaccines administered **must** be reported or billed, as appropriate, even if administration codes are not being billed.

Billing of Immunization Administration Codes by Private Sector Providers and Local Health Departments for Health Check Age Recipients:

An immunization administration fee code(s) may be billed if it is the only service provided that day, or if any immunizations are provided in addition to a Health Check assessment or an office visit.

Billing of Immunization Administration Codes by Federally Qualified Health Centers or Rural Health Centers for Health Check Age Recipients and Recipients 21 Years of Age and Older:

An immunization administration fee code(s) may be billed if it is the only service provided that day, or if any immunizations are provided in addition to a Health Check assessment. An immunization administration fee code(s) cannot be billed in addition to a core visit code. Report the CPT vaccine code(s) without billing the administration fee. For recipients 21 years of age and older, the cost of the administration may be included on the cost report for those recipients.

Claim Examples:

1. Billing for a 2-month old infant based on the current immunization schedule when an oral vaccine is included:

Vaccines Provided	CPT Administration Codes	CPT Vaccine Codes
DTaP (diphtheria, tetanus, pertussis)	90471	90700
Hepatitis B and Haemophilus influenza type b	90472	90748
Inactivated poliovirus	90472	90713
Pneumococcal conjugate vaccine, 13 valent	90472	90670
Rotavirus (oral)	90474	90681

Coding on the claim:

90471 EP modifier	1 unit	There would be a billed amount.
90472 EP modifier	3 units	There would be a billed amount.
90474 EP modifier	1 unit	There would be a billed amount.
90700	1 unit	There would be a \$0.00 billed amount.

90748	1 unit	There would be a \$0.00 billed amount.
90713	1 unit	There would be a \$0.00 billed amount.
90670	1 unit	There would be a \$0.00 billed amount.
90681	1 unit	There would be a \$0.00 billed amount.

2. Billing for a 4-year old child when all vaccines are injectable:

Vaccines Provided	CPT Administration Codes	CPT Vaccine Codes
DTaP	90471	90700
PCV13	90472	90670
Influenza, split virus, preservative free, 3 years and older	90472	90656

Coding on the claim:

90471 EP modifier	1 unit	There would be a billed amount.
90472 EP modifier	2 units	There would be a billed amount.
90700	1 unit	There would be a \$0.00 billed amount.
90670	1 unit	There would be a \$0.00 billed amount.
90656	1 unit	There would be a \$0.00 billed amount.

3. Billing for a male recipient who is 19 years of age who receives a *purchased* injectable vaccine:

Vaccines Provided	CPT Administration Codes	CPT Vaccine Codes
HPV (Gardasil)	90471	90649

Coding on the claim:

90471 EP modifier	1 unit	There would be a billed amount.
90649	1 unit	There would be a billed amount

4. Billing for a 21 year old recipient who received a *purchased* injectable vaccine

Vaccines Provided	CPT Administration Codes	CPT Vaccine Codes
Influenza	90471	90656

Coding on the claim:

90471	1 unit	There would be a billed amount.
90656	1 unit	There would be a billed amount.

Please refer to the general Medicaid Bulletins at <http://www.ncdhhs.gov/dma/bulletin/> for updates on immunizations and administration codes. Refer to the appropriate fee schedule at <http://www.ncdhhs.gov/dma/fee/> under *Physician Services CPT/HCPCS* for rate changes for immunizations and administration codes.

HP Enterprise Services

1-800-688-6696 or 919-851-8888

Attention: All Providers***E*nactment of the Affordable Care Act**

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively known as the Affordable Care Act) makes a number of changes to the Medicare and Medicaid programs and to the Children's Health Insurance Program.

These changes will enhance the provider enrollment process to improve the integrity of the services through the reduction of fraud, waste, and abuse. A full copy of the final rule is available in the [Federal Register, Vol 76, No. 22, page 5862](#).

NC Medicaid and NC Health Choice Provider Screening:

The department must screen all initial applications for enrollment in NC Medicaid or Health Choice. This includes all applications for a new practice or site location, and any revalidation applications. The providers will be categorized based on a risk level. The risk levels will be limited, moderate, and high. If a provider could fit within more than one risk level, the highest level of screening will be applied.

Provider Enrollment Criteria:

Providers must submit an attestation and complete certain required training sessions prior to being granted billing privileges. The attestation shall contain a statement that the individual or entity seeking to enroll or seeking revalidation has necessary to comply with all federal and state requirements governing the Medicaid and Children's Health Insurance programs, that the individual or entity does not owe any outstanding taxes or fines to the U.S. or N.C. Departments of Revenue or Labor or the Employment Security Commission, and that the individual or entity does not owe any overpayment, assessment, or fine to any other State Medicaid or Children's Health Insurance Program.

The Department shall establish rules designating the types of training requirements based upon the level of risk. Failure to complete the required training sessions or to submit an attestation accurately may be grounds to termination.

Background screening; prohibited offenses:

All employees required by law to be screened pursuant to this section must undergo security background investigations as a condition of employment and continued employment which includes, but need not be limited to, employment history checks, electronic fingerprinting for statewide criminal history records checks, national criminal history records checks through the Federal Bureau of Investigation, and a check of the National Sex Offender Public Website, and may include local criminal records checks through local law enforcement agencies.

Background screening pursuant to this chapter must be conducted on each of the following persons:

- (a) All owners and operators;
- (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider;
- (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider;
- (d) Any and all other managing employees; and
- (e) Any person seeking employment or contracting with a health care provider who is expected to, or whose responsibilities may require him or her to, provide care or services directly to clients or

have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the provider.

Provider Criteria Performance Bonds:

The purchase and maintenance of a performance bond or executed letter of credit shall be a condition of eligibility for non-licensed providers or non-Medicare certified providers as those terms are defined in Rule .0401 of this Subchapter.

Evidence of the performance bond or executed letter of credit issued by a financial institution shall be submitted to the Division of Medical Assistance annually for five years.

- i. In the first year, the provider shall obtain a performance bond or executed letter of credit in the amount of twenty thousand dollars (\$20,000)
- ii. In subsequent years, the amount of the performance bond or executed letter of credit shall equal the actual paid claims total for the most recent calendar year of participation, not to exceed one hundred thousand dollars (\$100,000).
- iii. Each performance bond or executed letter of credit shall exist for a term of one year.

Federal Enrollment Fee:

With the exception of physicians, non-physician practitioners, physician group practices and non-physician group practices, providers and suppliers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information, must submit with their application in the amount of \$505 through December 31, 2011. The amount will be adjusted by the percentage change for the consumer price index for the 12-month period ending June 30 of the prior year.

**Provider Services
DMA, 919-855-4050**

Attention: All Providers**Enrollment Fee Final Notice**

As the Enrollment, Verification, and Credentialing (EVC) vendor for the North Carolina Medicaid Program, CSC processes all enrollment applications, enrollment additions, and Medicaid Provider Change Forms. On September 1, 2009, DMA implemented a \$100 fee for providers enrolling for participation with the N.C. Medicaid Program. This requirement was implemented in response to legislation mandated by [Session Law 2009-451](#).

CSC will send an invoice to the provider with instructions for payment. If the enrollment fee payment is not provided within 30 days from the date of the invoice, CSC sends a system-generated e-mail to the provider (see below) informing the provider that the application will be voided. Any applicant who feels that he/she has received this notice in error should contact the CSC EVC Call Center immediately. CSC will promptly investigate and address your concerns.

The following paragraph is the message that CSC sends to the provider when an application is voided due to CSC has not received the enrollment fee payment within 30 days.

The N.C. Medicaid Provider Enrollment Packet for the applicant referenced above has been voided due to the absence of payment of the State-required \$100 provider enrollment fee. This fee has been invoiced in writing to the address shown above, with at least one reminder notice issued via U.S. mail and/or e-mail. Our accounting system shows no receipt of any payment on the above referenced application.

If you have questions regarding the notice, please contact the CSC EVC Center and reference the Enrollment Tracking Number (ETN) featured in the final notice. Customer Service Agents are available Monday through Friday, 8:00 a.m. through 5:00 p.m. Eastern Time, at 1-866-844-113.

CSC, 1-866-844-1113

Attention: All Providers**Family Planning Waiver**

The “Be Smart” Family Planning Waiver (FPW) program is experiencing an increasing number of calls from recipients who are referred by their physician’s office to a hospital for ancillary services, such as mammograms and other radiology services. In addition, the FPW program is receiving calls from recipients who are seeking care at hospital emergency departments. In both of these instances, prior to receiving services, the recipients state they asked, and were told by the hospital billing staff that these services were covered under the Medicaid “Be Smart” Family Planning Waiver Program. The recipient subsequently receives a bill from the hospital and/or radiology service when the claim is denied. The FPW program then receives a call from the recipient to resolve their hospital bills due to the denied claims received by the hospital or provider of specialty or ancillary services, which has been passed on to the recipient.

The “Be Smart” Family Planning Waiver programs covers family planning services and supplies, screening and one course of treatment for sexually transmitted infections in conjunction with an annual exam and screening for HIV in conjunction with an annual exam. With the exception of sterilization procedures for men and women, the program does not cover hospital services, including radiology, anesthesiology, surgery or other specialty and ancillary services received at the hospital or hospital outpatient facility. Further, the “Be Smart” program does not cover emergency room or emergency department care at the hospital.

There are no co-pays for recipients for basic family planning services and supplies received as a result of care in a provider’s office and that are not specialty or ancillary hospital-based services. Under FPW, non-hospital based providers are not allowed to bill a recipient for family planning services received as a result of such care in their offices, unless the recipient requests a non-covered service and that provider, prior to rendering the service, informs the recipient, either orally or in writing, that the services will or cannot be billed to Medicaid. Further, that provider must inform the recipient that he or she will be responsible for payment of the non-covered service. Similarly, referring non-hospital based providers should inform recipients that non-family planning, specialty or ancillary services such as mammograms provided at a hospital, are not covered under the Family Planning Waiver program, and therefore, are the financial responsibility of the recipient. Providers are also encouraged to educate recipients on the appropriate use of an emergency room visit.

When recipients are enrolled in FPW, they are informed that the program generally only covers family planning services and supplies. In addition, once the recipient receives a bill for non-covered, non-family planning services received at a hospital, the FPW program is unable to relieve the recipient of financial responsibility for bills incurred as a result of these services and care. It is important for physicians and their office staff to be familiar with services covered under the family planning program. In addition, referring physicians need to educate and remind recipients that when they receive services at a hospital (or outpatient facility of the hospital), such as a mammogram, those services are not covered under the program. A copy of the “North Carolina Medicaid Special Bulletin Revised May 2006 Family Planning Waiver Be Smart” can be found on the DMA website at <http://www.ncdhhs.gov/dma/medicaid/familyplanning.htm>.

If a recipient must be referred to the hospital for services, prior to receiving the service, the recipient should be encouraged to inquire about available resources for assistance with paying bills, including meeting with hospital patient financial services and billing staff. Though they may vary by hospital, payment arrangements and plans can often be set up to ease the immediate financial burden on the recipient who must receive further specialty care at a hospital or specialty care outpatient facility of a hospital. Questions regarding claims and billing can also be obtained by contacting HP Enterprises at 1-800-6886696, or (919) 851-6888.

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

Attention: All Providers**H**Health Check Seminars

Health Check seminars are scheduled for the month of June 2011. Seminars are intended to educate providers on Health Check guidelines. **Pre-registration is required.** Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the seminars by completing and submitting the online registration form. Please include a valid e-mail address for your return confirmation. Providers may also register by fax (fax it to the number listed on the form). Please include a fax number or a valid e-mail address for your return confirmation. Please indicate the session you plan to attend on the registration form. Providers will receive a registration confirmation. Please bring a copy of the latest version of the Health Check Billing Guide with you to the seminar. Copies will not be provided.

Sessions will begin at 9:00 a.m. and end at 12:00 p.m. Providers are encouraged to arrive by 8:45 a.m. to complete registration. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Seminar Dates and Locations

Date	Location
June 9, 2011	Greensboro Clarion Hotel Airport 415 Swing Road Greensboro NC 27409
June 16, 2011	Morganton Western Piedmont Community College-Moore Building 1001 Burkemont Avenue Morganton NC 28655
June 21, 2011	Raleigh The Royal Banquet and Convention Center 3801 Hillsborough Street Raleigh NC 27607
June 23, 2011	Greenville Greenville Hilton 207 SW Greenville Boulevard Greenville NC 27834

**Health Check Seminar
June 2011 Registration Form**
(No Fee)

Provider Name and Discipline _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (____) _____ Fax Number _____

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

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

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

Attention: All Providers**Implementation of Additional Correct Coding Edits: Age/Gender and Add-on Codes**

As previously announced in the May bulletin, DMA will begin implementing additional correct coding guidelines. These new correct coding guidelines and edits will be nationally sourced by organizations such as the Centers for Medicare and Medicaid Services (CMS) and The American Medical Association (AMA). These edits will identify any inconsistencies with CPT, HCPCS, AMA, CMS and/or DMA policies and will deny the claim line.

Additional correct coding edits for Age/Gender and Add-on codes will be implemented on June 1, 2011 for dates of service June 1, 2011 and greater.

Age/Gender edits will ensure that the appropriate CPT and HCPCS codes are utilized based on the age and gender of the patient. The following edits are examples of Age/Gender edits:

- CPT code 99396 (Preventative medicine, established patient age 40-64 years) should not be utilized if the patient is 21. This edit would deny the claim line based on an age edit.
- CPT code 58150 (total abdominal hysterectomy with or without removal of the tubes, with or without removal of ovaries) should not be utilized if the patient is male. This edit would deny the claim line based on a gender edit.

These additional edits include:

Add-on codes are designated in the CPT Manual with a “+” symbol and frequently contain descriptions such as “each additional” or “list separately in addition to primary procedure.” DMA will not allow an Add-On code in the absence of a primary procedure code. The Add-On edits will ensure that if a procedure code is submitted that requires a primary procedure code, DMA will verify that the primary procedure code has also been submitted for processing. If the primary procedure code is not identified within the claim processing system, then the claim line will deny. The following edits are examples of

Add-On edits:

- CPT 64484 (Epidural injection lumbar or sacral, each additional level) has a primary procedure of 64483 (Epidural injection, lumbar or sacral, single level). If the primary procedure is not present in the claim processing system, the Add-On procedure code of 64484 will be denied.
- CPT 19001 (Aspiration of each additional breast cyst) has a primary procedure code of 19100 (Puncture Aspiration of cyst of breast). If the primary procedure is not present in the claim processing system, the Add-On procedure code of 19001 will be denied.

DMA will notify providers through the [Medicaid Bulletin](#) as new additional correct coding edits are being implemented.

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

Attention: All Providers**Implementation of Additional Correct Coding Edits: Place of Service and Inpatient Only Services**

As previously announced in the May bulletin, DMA will begin implementing additional correct coding guidelines. These new correct coding guidelines and edits will be nationally sourced by organizations such as the Centers for Medicare and Medicaid Services (CMS) and The American Medical Association (AMA). These edits will identify any inconsistencies with CPT, HCPCS, AMA, CMS and/or DMA policies and will deny the claim line.

Additional correct coding edits for Place of Service and Inpatient only services will be implemented on July 1, 2011 for dates of service July 1, 2011 and greater.

Place of Service edits are based on AMA published criteria indicating where specific types of services may be performed. Procedure codes are billed in the appropriate place of service as defined by AMA and/or CMS. The following are examples of Place of Service edits:

- CPT 99204 (Office Visit for the evaluation and management of a new patient) in the Emergency Room (Place of Service 23) is not acceptable. Therefore, this claim line would be denied by a place of service edit.
- CPT 99238 (Hospital discharge day) in the outpatient setting (place of service 22) is not acceptable. Therefore, this claim line would be denied by a place of service edit.

Inpatient Only edits are based on a CMS policy where specific services may only be performed in an inpatient setting. The following are examples of Inpatient Only edits:

- CPT 21196 (Reconstruction of lower jaw) in an office setting (place of service 11) is not acceptable. Therefore, this claim line would be denied by an inpatient only edit.
- CPT 27130 (Total Hip Arthroplasty) in an outpatient setting (place of service 22) is not acceptable. Therefore, this claim line would be denied by an inpatient only edit.

DMA will notify providers through the [Medicaid Bulletin](#) as new additional correct coding edits are being implemented.

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

Attention: All Providers**Requests for Non-Covered Services: Alcohol and Drug Abuse Treatment Centers (ADATC)**

As of May 1, 2011, all requests for Alcohol and Drug Abuse Treatment Centers (ADATC) for consumers, age 18-21, will be reviewed as “non covered services requests” by Eastpointe LME, a Medicaid UR vendor. All new requests should follow guidelines for requesting approval found at: <http://www.ncdhhs.gov/dma/epsdt/> Providers should fill out the form on the website: <http://www.ncdhhs.gov/dma/Forms/NonCoveredServicesRequest.pdf>. Providers’ should not submit ITRs or PCPs.

All requests should be sent to:

Eastpointe LME
Eastpointe
ATTN: Anna North
PO Box 369
Beulaville, NC 28518
Fax: 910-298-7189

Note: A recipient under the age of 21 may receive a medically necessary service not included in the North Carolina Medicaid State Plan **only** when the service meets all EPSDT criteria, including coverable under federal Medicaid law and when it will “correct or ameliorate” a diagnosed condition in accordance with Federal Medicaid law at 42 U.S.C. § 1396d(a) and (r) of the Social Security Act

**Behavioral Health Section
DMA, 919-855-4290**

Attention: All Providers

W-9

As part of the enrollment process to become a Medicaid provider in North Carolina, applicants are required to submit a Form W-9 from the IRS. CSC’s Credentialing staff has determined that 60 percent of the enrollment applications contain errors related to Form W-9, which increases the amount of time it takes to process an application.

The State of North Carolina has agreed to eliminate the Form W-9 submission requirement provided that CSC add the following section to enrollment applications:

My Taxpayer Identification Number and Name (exactly as shown on my income tax return) associated with my Medicaid provider number is:

Taxpayer name _____

Taxpayer Identification Number _____

My Taxpayer Identification Number above is (check only one) :

____ *Social Security Number*

____ *Employer Identification Number (EIN)*

Under penalties of perjury, I certify that:

- 1. The payee’s TIN is correct.*
- 2. The payee is not subject to backup withholding due failure to report interest.*
- 3. The payee is a U.S. person.*

Signature _____ *Date:* _____

MMIS Financial Operations’ review of IRS publications support use of substitute language for applicant (the payee) to certify as to the accuracy of the tax information and name registered with the IRS. Such language will mitigate the potential of "B" notices in the future.

If you have questions regarding the notice, please contact the CSC EVC Operations Center. Customer Service Agents are available Monday through Friday, 8:00 a.m. through 5:00 p.m. Eastern Time, at 1.866.844.1113.

CSC, 1-866-866-1113

Attention: Cap/DA Lead Agencies***P*olicy Changes for Completing an Assessment, Completing A Reauthorization or Continued Needs Review, or For a Crisis/Emergency Situation**

In March 2010, the Division of Medical Assistance implemented a case management limitation policy. This policy outlined that no more than six additional hours (24 units) would be available if needed for completing an assessment, completing a reauthorization or continued needs review, or for a crisis/emergency situation. This policy imposed a six hour (24 units) limitation within a 365 days authorization period. According to current CAP/DA policy, the case manager is required to complete a Continued Needs Review (CNR) every 12 months during the CAP recipient's anniversary month to determine if the recipient remains appropriate for CAP/DA. Because the current 365th day rule does not permit the case manager to complete a continued needs review assessment of the client until the 366th day, it falls outside of the 12 month review period, thereby jeopardizing the recipient's eligibility for CAP/DA. **Effective immediately**, the 365 days authorization period will be reduced to a 330 days authorization period. By reducing the authorization period to 330 days, it would allow the case manager sufficient time to complete the CNR during the review month. Use HCPCS codes, T1016SC for CAP/DA and T2041SC for CAP/Choice for billing case management assessment/crisis activities.

Please direct questions about the case management limitation policy changes to the CAP/DA Unit in the Home and Community Care Section by calling 919-855-4360 or faxing 919-715-2372.

**Community Alternative Program for Disabled Adults
Home and Community Care Section
DMA, 919-855-4360**

Attention: All Community Care of North Carolina and Carolina Access Providers**C**hange in Carolina Access Participation Requirement

This is to notify all CCNC/CA Medicaid providers and potential CCNC/CA providers that all recipients enrolled in CCNC/CA are free to exercise his or her rights, and that the exercise of those rights must not adversely affect the way in which they are treated. Recipients enrolled or potentially enrolled in CCNC/CA have the right to:

- Receive information in a manner and format that may be easily understood
- Have assistance in understanding the program
- Interpretive services in the prevalent language of the recipient without cost to them
- Be treated in a respectful manner
- Be free from restraint or seclusion used as a means of coercion, discipline, convenience or retaliation as specified in federal regulations

Managed Care
DMA, 919- 855-4784

Attention: All Community Care of North Carolina and Carolina Access Providers**M**arketing Restrictions

This is to notify all CCNC/CA Medicaid providers and their employees are prohibited from marketing directly to potential recipient enrollees for the purpose of coercing or unfairly influencing potential recipients to enroll with that practice. The following are definitions of prohibited marketing activities:

- **Cold Call Marketing:** Unsolicited personal contact with potential recipients
- **Marketing:** Communication of any sort to a Medicaid recipient who is not enrolled with a provider but who may be influenced to enroll with a particular provider.
- **Marketing Materials:** Materials that are produced in any medium for the purpose of influencing recipient to enroll with a particular provider.

Managed Care
DMA, 919- 855-4784

Attention: Critical Access Behavioral Health Agencies (CABHA's)**Frequently Asked CABHA Billing Questions**

The following questions are those CABHA billing questions frequently received at HP Enterprise Services and at the Division of Medical Assistance (DMA). These answers can be found in the Department of Health and Human Services (DHHS) Implementation Update (IU) #73, the September 2010 Medicaid Bulletin, the DMA CABHA webpage found at <http://www.ncdhhs.gov/dma/services/cabha.htm> and the training packet from the Fall 2010 CABHA Enrollment, Authorization, and Billing Seminars found at <http://www.ncdhhs.gov/dma/cabha/CABHAPresentation092010.pdf>. They have been provided here again in an effort to consolidate the information.

Q1: How do providers bill for Dates of Service prior to becoming a CABHA?

A1: The effective date of the CABHA is extremely important. If billing for Dates of Service prior to the effective date of the CABHA, claims should be billed with the Enhanced Mental Health Services NPI. In other words, they should be billed as they were billed prior to becoming a CABHA. If billing for Dates of Service *on* the effective date of the CABHA and Dates of Service moving forward, claims should be billed with the CABHA NPI as the billing number. If claims are billed under the CABHA NPI for Dates of Service prior to the effective date of the CABHA, the claim will deny for "Provider not effective or eligible on Date of Service". If at enrollment a provider chose NOT to subpart and get a separate NPI for their CABHA, the CABHA NPI and the Enhanced Mental Health Services NPI may be the same. In that instance, providers would bill with the Enhanced NPI and the mapping solution would choose the Enhanced NPI based off of the effective date.

Q2: How do providers bill for Mental Health/Substance Abuse Targeted Case Management (MH/SA TCM) under the CABHA?

A2: This can differ based on how the provider chose to link these services at enrollment. If at enrollment they chose to subpart (meaning they obtained a separate NPI for their CABHA MPN), the MH/SA TCM MPN will be linked to the CABHA NPI. If this is the case, they would simply report the NPI that is associated with the CABHA twice, meaning at both the Billing and Attending levels. If at enrollment the provider chose NOT to subpart and CABHA, Enhanced/Core Services, and MH/SA TCM are all linked to the same NPI, they would once again list that NPI at both the Billing and Attending levels and the mapping solution would select the correct MPN based on the service billed. In the event a provider obtained a separate NPI for MH/SA TCM, then the CABHA NPI will be placed at the Billing level and the NPI associated with MH/SA TCM will be placed at the Attending level. The MH/SA TCM NPI will NEVER be placed at the Billing level, if placed at the Billing level, the claim will deny. Please see Clinical Coverage Policy on limitations of billing for MH/SA TCM services. *See Medicaid Bulletin September 2010

Q3: Where should provider list their CABHA NPI on the claim, at the Billing level or the Attending level?

A3: The CABHA NPI will ALWAYS be at the Billing level. If the CABHA NPI is placed at the Attending Level, the claim will deny.

Q4: What claim form should providers use to bill for their CABHA? What should they put on the claim?

A4: Claims for all core and enhanced mental health CABHA services will be billed using the professional claim (CMS-1500/837P) format. The CABHA NPI should be listed as the "Billing Provider". The NPI associated with the individual provider (for comprehensive clinical assessments, outpatient therapy, and medication management) or the enhanced service (i.e. Intensive In Home, MH/SA TCM etc.) for which Prior Authorization was obtained, should be listed as the "Attending Provider Number."

Claims for Residential Levels II-Program Type, III, and IV (provided by CABHA's) should continue to be billed using the Institutional Claim (UB-04/837I) format. In these instances, providers must continue to submit claims with the current billing NPI associated with the Level II-Program Type, III, or IV. In other words, providers should continue to submit claims for Levels II-Program Type, III, and IV services in the same way as they did prior to CABHA. **IF PROVIDERS SUBMIT RCC CLAIMS UNDER THE CABHA NPI, THE CLAIM WILL BE DENIED.**

Claims for Therapeutic Foster Care Level II-Family Type (provided by CABHA's) must continue to be submitted through the LME for processing. **IF PROVIDERS SUBMIT THESE CLAIMS UNDER THE CABHA NPI, THE CLAIM WILL BE DENIED.**

Q5: If a provider has multiple locations, how can they easily distinguish which location performed the service when all claims and reimbursement are returned on the Remittance and Status Report (RA) under the CABHA NPI?

A5: To determine the site where the service was performed, providers can include site identifying information within the Patient Account Number submitted on the claim. If billing on the 837P, the Patient Account Number is located within Loop 2300 Segment CLM01. If billing on the NCECSWeb Tool, this information is entered in the field titled Patient Account Number. The Patient Account Number cannot exceed 20 characters. This number will be returned on the RA allowing providers to distinguish which site performed the service for a particular claim.

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

Attention: Critical Access Behavioral Health Agencies (CABHA's)**New CABHA Provider Affiliation Denial Code**

The Division of Medical Assistance (DMA) in collaboration with the CSC EVC Call Center conducted provider outreach to all Critical Access Behavioral Health Agency (CABHA) providers to verify that the provider enrollment information on file with N.C. Medicaid is accurately linked to your CABHA billing provider number. **To ensure that claims adjudicate correctly, it is important to verify that attending provider(s) and service affiliation information has been correctly linked to your CABHA billing provider number.** Providers that have not responded to the email notification should immediately contact the CSC EVC Call Center at 1-866-844-1113.

Any attending provider (individual or service) not linked to the CABHA billing provider number that is billed through the CABHA billing provider will result in claim denials. A new EOB 1791 "The attending provider is not associated with the CABHA billing provider for the dates of service billed" was created. Providers that receive this EOB on their Remittance Advice (RA) should contact the CSC EVC Call Center to correct their attending provider(s) and service affiliation information prior to resubmitting their claim.

CSC, 1-866-844-1113

Attention: HIV Case Management Providers**HIV Case Management Services Training**

The Carolinas Center for Medical Excellence (CCME) and The Division of Medical Assistance are pleased to announce that on June 14th and 15th 2011 we are offering training on the Audit Process. See the information listed below under training.

Training:

Registration is now open for the following training: HIV Case Management Audit Process. (see schedule below). **All HIV Case Management providers who were previously certified by the AIDS Care Unit who have not withdrawn or been decertified will receive an audit as part of the current certification process. This training will take you through the Audit Process step by step. This is your opportunity to learn what to expect from the audit process. This one day training is being offered on two separate dates. The following individuals are encouraged to attend: Agency owners, HIV Case Supervisors and Case Managers. This training is limited to those individuals who currently own or are employed by an agency that is currently certified as an HIV Case Management agency.**

Date	Session Topic	Recommended Attendees
June 14, 2011	HIV Case Management Audit Process Training. A step by step presentation on what to expect during an audit of your program.	Agency owners, HIV Case Management Supervisors and Case Managers.
June 15, 2011	HIV Case Management Audit Process Training. A step by step presentation on what to expect during an audit of your program.	Agency owners, HIV Case Management Supervisors and Case Managers.

All of the trainings will be located at the McKimmon Center in Raleigh, North Carolina ([get directions](#)). Information for the June 2011 training is available on [CCMEs' HIV Case Management web page](#).

Updates:

Providers are reminded of the requirement to obtain 20 contact hours annually per Sub-section 6.4.2 in Clinical Coverage Policy 12 B. Continuing education opportunities outside of those provided by The Carolinas' Center for Medical Excellence require prior approval by Victoria Landes, DMA's HIV Case Management Consultant. Information regarding prior approval can now be [obtained at the following web site: http://www.ncdhhs.gov/dma/services/hivcm.htm](#).

We will announce future sessions of the Potential Provider Inquiry training in future bulletin articles. Information regarding training can also be obtained via CCMEs' web page. An FAQ document is now available at CCMEs' web page (<http://www.thecarolinascener.org/HIVCM>).

**HIV Case Management Program
DMA, 919-855-4389**

Attention: Local Health Departments, Nurse Midwives, Nurse Practitioners and Physicians**Compounded Hydroxyprogesterone Caproate (known as 17P) continues to be Available in the Physician's Drug Program**

With the addition of Makena, the branded version of hydroxyprogesterone caproate (known as 17P), to the marketplace, there has been some confusion on whether or not the compounded version of the drug continues to be covered by N.C. Medicaid. N.C. Medicaid continues to cover the compounded version and the Division of Medical Assistance **supports and encourages** the use of compounded hydroxyprogesterone caproate (known as 17P) for use in pregnant women with a singleton pregnancy and a prior spontaneous preterm birth (before 37 weeks of gestation) due to spontaneous preterm labor or premature rupture of the membranes.

For Medicaid Billing:

- The ICD-9-CM diagnosis code required for billing 17P is V23.41 (*supervision of pregnancy with history of pre-term labor*).
- Providers must verify that the recipient's history includes a singleton preterm birth (prior to 37 weeks gestation). The recipient must be pregnant with a single fetus. Treatment should begin between 16 weeks, 0 days and 20 weeks, 6 days of gestation. Treatment should continue until week 37 (through 36 weeks, 6 days) and must end at that time. It may be appropriate to start a recipient at a later gestational age if she presents late for prenatal care.
- Providers must bill 17P with HCPCS procedure code J3490 (*unclassified drugs*).
- One unit of coverage is 250 mg (weekly dose). Providers must bill their usual and customary charge. The maximum reimbursement rate for one unit is \$20.00.
- Providers must indicate the number of HCPCS units in field 24G on the CMS-1500 claim form, or in the appropriate field on the 837P, 837I or the NCECSWeb Tool. Claims must be filed electronically unless they meet one of the ECS-mandated exceptions (<http://www.ncdhhs.gov/dma/provider/ECSEExceptions.htm>).
- Providers must use rebatable 11-digit National Drug Codes (NDCs) and appropriate NDC units when billing for 17P.
- If the drug was purchased under the 340B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website (<http://www.ncdhhs.gov/dma/bulletin/>) for additional instructions.
- Refer to articles in the April 2007 and February 2009 general Medicaid bulletins.

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

Attention: Local Management Entities, Outpatient Behavioral Health Providers, and Provisionally Licensed Providers**Extension of Coverage for Provisionally Licensed Providers Billing Outpatient Behavioral Health Services through the Local Management Entity
National Correct Coding Initiative Update: Provisionally Licensed Professionals Billing Through the Local Management Entity (LME)**

The coverage of provisionally licensed providers delivering outpatient behavioral health services as a reimbursable service under Medicaid funds and billed through the Local Management Entity (LME) has been extended to June 30, 2012. The HCPCS procedure codes that may be utilized to bill for services delivered by the provisionally licensed individuals billing through the LME are H0001, H0004, H0005, and H0031. Provisionally licensed professionals billing HCPCS Codes should use generally accepted guidelines for timeframes for individual outpatient sessions (generally 45-60 minutes) and group outpatient sessions (generally 90 minutes). Overuse of HCPCS Code billing is being monitored by the Division of Medical Assistance (DMA) Program Integrity (PI) as part of federal Medicaid fraud initiatives. Providers should also review the March 2011 Medicaid Bulletin for guidance on counting unmanaged visits and requesting prior authorization.

DMA effectively implemented the federally-mandated National Correct Coding Initiative (NCCI) edits on March 31, 2011. Procedure-to-procedure editing (CCI) identifies procedures and services performed by the same provider on the same date of service for the same patient. Provisionally licensed professionals billing through the LME, use the LME's NPI number. If multiple provisionally licensed professionals provide individual, family, or group therapy to the same recipient on the same date of service the second code billed will deny because the same attending NPI is billed for both services. As always, documentation in the record should clearly indicate who provided the service.

Providers are strongly encouraged to review the DMA NCCI webpage at <http://www.ncdhhs.gov/dma/provider/ncci.htm> and the CMS NCCI webpage at <http://www.cms.gov/MedicaidNCCICoding/> for further information and to confirm which procedure code pair combinations are allowable.

**Behavioral Health Section
DMA, 919-855-4290**

Attention Outpatient Behavioral Health Providers**Clarification of Unmanaged Outpatient Behavioral Health Visits for Children Turning 21**

As clarified in the March 2011 Bulletin, beginning January 1, 2011, children under the age of 21 have 16 unmanaged outpatient visits before prior authorization is required. Adults (21 years and older) have 8 unmanaged outpatient visits before prior authorization is required. This visit count begins each calendar year and runs from January-December. For recipients reaching their 21st birthday in a calendar year: these recipients still count as 'children' for unmanaged visit counts until the end of that calendar year; therefore the 16 unmanaged visit limit applies to that calendar year. Beginning January 1 of the next calendar year, the 8 adult unmanaged visit limit will apply. Providers are responsible for recognizing when prior approval is required. While prior approval may not be required until later in each calendar year, it is prudent to seek prior approval as early as possible to assure payment. Please refer to the March 2011 Bulletin which explains the calculation of unmanaged visits.

Behavioral Health Section**DMA, 919-855-4290**

Attention: Outpatient Behavioral Health Providers**National Correct Coding Initiative Update: Provisionally Licensed Professionals Billing ‘Incident To’ the Physician**

This article is intended to further clarify the April 2011 Bulletin article regarding the National Correct Coding Initiative (NCCI) for Outpatient Behavioral Health Providers. The Division of Medical Assistance (DMA) effectively implemented the federally-mandated NCCI edits on March 31, 2011. Procedure-to-procedure editing (CCI) identifies procedures and services performed by the same provider on the same date of service for the same patient. Provisionally licensed professionals billing ‘incident to’ the physician, use the physician’s NPI number. If the physician were to provide medication management (i.e. 90862) and the provisionally licensed professional were to provide individual, family, or group, therapy on the same date of service, the second code would deny because the same attending NPI is billed for both services.

There are certain services/codes that provisionally licensed professionals will be able to provide on the same date of service that a physician provides medication management. When billing the service/code rendered by the provisionally licensed professional, the NCCI modifier 59 should be appended to CPT codes 90801, 90802, 90846, 99408, or 99409. The SC modifier should also be used (as it is used currently) to indicate that the service was rendered by a provisionally licensed professional billing ‘incident to’. The use of these modifiers will allow the system to recognize that the service was provided by a different attending provider. The other CPT codes (90804, 90806, 90847, and 90853) that provisionally licensed professionals bill ‘incident to,’ cannot be overridden by appending modifiers, per federal guidelines. These codes can continue to be billed ‘incident to’ but will need to be provided on a separate date of service to be considered for reimbursement. Alternatively, for individual therapy codes 90804 and 90806, if medication management is provided on the same date of service, one code (90805 or 90807) can be billed to indicate that medication management and individual therapy were rendered. The SC modifier should be used when billing the combined codes. As always, documentation in the record should clearly indicate who provided the service.

Providers are strongly encouraged to review the DMA NCCI webpage at <http://www.ncdhhs.gov/dma/provider/ncci.htm> and the CMS NCCI webpage at <http://www.cms.gov/MedicaidNCCICoding/> for further information and to confirm that code pair combinations are allowable.

**Behavioral Health Section
DMA, 919-855-4290**

Attention: Nursing Facility Providers**Minimum Data Set 3.0 Validation Seminar**

“THE DAWN OF A NEW DAY” *The MDS 3.0 Is Here To Stay* is an educational seminar offered by Myers and Stauffer under contract with the Division of Medical Assistance. This new seminar will detail the Minimum Data Set (MDS) 3.0 application to the RUG-III calculation based on the coded information submitted on the MDS 3.0 RUG items. New exercises have been developed including new examples of activities of daily living (ADL). The revised (version “B”) Supportive Documentation Guidelines with an emphasis on the new MDS 3.0 RUG items will be reviewed. Finally, the Case Mix Reports will be reviewed. A basic understanding of the MDS 3.0 is helpful.

This workshop includes an instructional binder containing the following:

- The RUG-III 34-Group Classification System including the CMS coding slides for informational purposes.
- New MDS 3.0 exercises.
- New ADL exercises.
- Updated MDS 3.0 Supportive Documentation Guidelines.
- Understanding the Case Mix Report.

The seminar begins promptly at 8:30 AM and will conclude at 4:30 PM. Registration begins at 8:00 AM. Morning continental and afternoon beverages will be provided. Lunch will not be provided. Because meeting room temperatures vary, please dress accordingly.

How To Register: Go to <http://nc.mslc.com> and click on "Seminars". ***There is no charge to attend; however, you must be registered in advance.*** Registrations will be accepted on a first-come, first-served basis. Due to limited seating, we encourage you to register early.

Date	Location
July 28 and 29, 2011 2 Separate Sessions Register for only one	Charlotte Hilton Charlotte Executive Park 5624 Westpark Dr. Charlotte, NC 28217
August 1, 2011	Greenville Hilton Greenville 207 SW Greenville Blvd. Greenville, NC 27834
August 2 and 3, 2011 2 Separate Sessions Register for only one	Raleigh Hilton North Raleigh 3415 Wake Forest Road Raleigh, NC 27609
August 4 and 5, 2011 2 Separate Sessions Register for only one	Asheville Crowne Plaza Asheville One Resort Drive Asheville, NC 28806

**MDS Validation Coordinator,
DMA Clinical Policy, 919-855-4354**

Attention: Nurse Practitioners and Physicians**Belimumab Injection (Benlysta®, HCPCS code J3590): Billing Guidelines**

Effective with date of service March 29, 2011, the NC Medicaid Program covers belimumab (Benlysta) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologicals). Benlysta is available in 120 mg and 400 mg vials.

Benlysta is a B-lymphocyte stimulator (BLyS)-specific inhibitor indicated for the treatment of **adult patients** with active, autoantibody-positive, systemic lupus erythematosus who are receiving standard therapy. Benlysta should be administered as a one-hour intravenous infusion of 10 mg/kg at two-week intervals for the first three doses and at four-week intervals thereafter..

For Medicaid Billing:

- Providers must bill Benlysta with HCPCS code J3590 (unclassified biologicals).
- ICD-9-CM diagnosis code 710.0 (lupus erythematosus) must be billed with Benlysta.
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage is 1 mg. The maximum reimbursement rate per unit is \$3.84. Providers may bill for an entire single-dose 120 mg or 400 mg vial.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Benlysta should be reported as "UN." To bill for the entire 120 mg vial of Benlysta, report the NDC units as "UN1." To bill for the entire 400 mg vial of Benlysta, report the NDC units as "UN1." If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website (<http://www.ncdhhs.gov/dma/bulletin/>) for additional instructions.
- Providers must bill their usual and customary charge. The fee schedule for the Physician's Drug Program is available on DMA's website at: <http://www.ncdhhs.gov/dma/fee/>.

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

Attention: Nurse Practitioners and Physicians***I*pilimumab Injection (Yervoy™, HCPCS code J999): Billing Guidelines**

Effective with date of service March 29, 2011, the NC Medicaid Program covers ipilimumab (Yervoy) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologicals). Yervoy is available in 50 mg/10 ml and 200 mg/40 ml single-use vials.

Yervoy is a human cytotoxic T-lymphocyte antigen 4 (CTLA-4)-blocking antibody indicated for the treatment of unresectable or metastatic melanoma. Yervoy should be administered intravenously as a 3 mg/kg dose over 90 minutes every three weeks for a total of 4 doses.

For Medicaid Billing:

- Providers must bill Yervoy with HCPCS code J9999 (Not otherwise classified antineoplastics).
- An ICD-9-CM diagnosis code in the range of 172.0 through 172.9 (malignant melanoma of skin) must be billed with Yervoy.
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage is 1 mg. The maximum reimbursement rate per unit is \$124.92. Providers may bill for the entire 50 mg/10 ml or 200/40 ml single-use vial. To bill for the entire 50 mg/10 ml vial, bill 50 HCPCS units. To bill for the entire 200 mg/40 ml vial, bill 200 HCPCS units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Yervoy should be reported as "ML." To bill for the entire 50 mg/10 ml vial of Yervoy, report the NDC units as "ML10." To bill for the entire 200 mg/40 ml vial of Yervoy, report the NDC units as "ML40." If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website (<http://www.ncdhhs.gov/dma/bulletin/>) for additional instructions
- Providers must bill their usual and customary charge. The fee schedule for the Physician's Drug Program is available on DMA's website at: <http://www.ncdhhs.gov/dma/fee/>.

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

Attention: Skilled Nursing Providers and ICF-MR Providers**WIRM Portal**

As of July 1, 2011, which will be for the June assessments, all Skilled Nursing and ICF-MR providers will need to key the monthly assessment fee statements in the Division of Medical Assistance's (DMA's) WIRM Portal. No manually calculated assessment forms will be accepted.

If you are a first time user to the WIRM Portal and to gain access to the WIRM Portal, please go to the DMA website: <http://www.ncdhhs.gov/dma/provider/financial.htm>. Once on the website, click on New Administrator User for the WIRM Portal, fill out the form and either fax to 919-715-4220 or email to Stacey.crute@dhhs.nc.gov. Please be sure to fill this form out completely. This form will aid in gaining you access to the database. Once DMA has received your information, you will be notified when your access has been granted.

The information you will be receiving will give you the website address for the WIRM Portal, instructions on how to use the WIRM Portal, and how to submit your assessment and payment to DMA. The due date and the address of where you send your assessment and payment have not changed.

Rate Setting**DMA, 919-855-4210**

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

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

Proposed Clinical Coverage Policies

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

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

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

2011 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
June	6/2/11	6/7/11	6/8/11
	6/9/11	6/14/11	6/15/11
	6/16/11	6/23/11	6/24/11
July	6/30/11	7/6/11	7/7/11
	7/7/11	7/12/11	7/13/11
	7/14/11	7/21/11	7/22/11
	7/28/11	8/2/11	8/3/11

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

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

Melissa Robinson
Executive Director
HP Enterprise Services