March 2011 Medicaid Bulletin

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Attention: All Providers

Updated EOB Code Crosswalk to HIPAA Standard Codes

The implementation of standards for electronic transactions mandated by the Health Insurance Portability and Accountability Act allows providers the option to receive an Electronic Remittance Advice (ERA) in addition to the Remittance and Status Report (RA) in PDF format.

The EOB codes that providers currently receive on their RAs are not used on the ERA. 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 RA. An updated version of the list is available on DMA's website at http://www.ncdhhs.gov/dma/hipaa/EOBcrosswalk.htm.

New changes to the format of the crosswalk were added in July 2010. The changes 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.

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

Attention: All Providers

Clinical Coverage Policies

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

- 1D-4, *Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics* (posted 2/15/11)
- 1E-6, *Pregnancy Medical Home (PMH)* (3/1/11)
- 1M-3, *Health and Behavior Intervention* (3/1/11)
- 1M-4, *Home Visit for Newborn Care and Assessment* (3/1/11)
- 1M-5, *Home Visit for Postnatal Assessment and Follow-up Care* (3/1/11)
- 1M-6, *Maternal Care Skilled Nurse Home Visit* (3/1/11)
- 2A-1, *Acute Inpatient Hospital Services* (3/1/11)
- 5A, *Durable Medical Equipment* (3/1/11)
- 5B, *Orthotics & Prosthetics* (3/1/11)
- 8A, *Enhanced Mental Health and Substance Abuse Services* (posted 2/15/11; eff. 1/1/11)

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

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Provider Billing of Patients Who Are Medicaid Recipients

Accepting a Medicaid Recipient

In accordance with 10A NCAC 22J.0106, a provider may choose whether to accept a patient as a Medicaid patient. However, Medicaid providers must be consistent with their policies and procedures when accepting or refusing Medicaid recipients. Providers may not discriminate against a Medicaid recipient based on the recipient's race, religion, national origin, color, or handicap.

Agreeing to provide services to a Medicaid recipient and submission of a claim to the N.C. Medicaid Program for payment constitutes agreement to accept the Medicaid payment (in addition to any authorized copayment or third-party payment) as payment in full.

A provider may refuse to accept a Medicaid recipient and bill the recipient as private pay only if the provider informs the recipient prior to rendering the service, either orally or in writing, that the service will not be billed to Medicaid and that the recipient will be responsible for payment.

Billing the Recipient

Providers may not bill a recipient for

- the difference between the provider's charges and the Medicaid payment in addition to co-payment and third-party payment.
- any service covered by the Medicaid program unless the provider has specifically informed the recipient that Medicaid will not be billed, and the recipient understands and agrees to accept liability for payment.
- any service covered by the Medicaid program for which the provider is denied payment because the provider failed to follow program regulations including, but not limited to, errors on claims, late submission, lack of prior approval, failure to bill third-party resources, etc.
- any service for which the provider is denied payment due to an National Correct Coding Initiative edit.

When a non-covered service is requested by a recipient, the provider must inform the recipient either orally or in writing that the requested service is not covered under the Medicaid program, will not be billed to Medicaid, and will, therefore, be the financial responsibility of the recipient. This must be done prior to rendering the service.

A provider may also bill a Medicaid recipient for the following:

- Payments for services that are made to the recipient and not the provider by either commercial insurance or Medicare.
- Services not covered by Medicare if the recipient has Medicare-AID (MQB-Q) coverage.
- Allowable Medicaid deductibles or copayments*.
- Unduplicated prescriptions in excess of 11 per month unless recipient is locked in to their pharmacy of record*.
- Visits in excess of the legislative annual visit limit for provider visits for the state fiscal year (July 1–June 30)*. (See http://www.ncdhhs.gov/dma/provider/AnnualVisitLimit.htm for information on the annual visit limit.)
- The recipient's loss of eligibility for Medicaid as defined in 10A NCAC 21B.
- Part D copay.

*****Under federal EPSDT law, some limits and restrictions do not apply to recipients under the age of 21. Refer to DMA's website at http://www.ncdhhs.gov/dma/epsdt/ for information.

Craig L. Umstead, Provider Services
DMA, 919-855-4050

Attention: All Providers

False Claims Act Legislation

False Claims Act (State FCA) legislation was enacted by the N.C. General Assembly on January 1, 2010, in Session Law 2009-554 to deter persons from knowingly causing or assisting in causing the State to pay claims that are false or fraudulent. This legislation applies to any service that is reimbursed with State funds, not just claims for Medicaid services. The legislation stipulates that any person who presents or causes to be presented a false or fraudulent claim is liable for three times the amount of damages sustained by the State; the cost of the civil action brought by the State; and penalties of between $5,500 and $11,000.

The Act allows for a civil action for false or fraudulent claims to be brought by a private individual. This is referred to as a *qui tam* (whistleblower) action. If a private individual brings the action he/she is required to file a copy of the complaint together with written disclosure of all material evidence and information the person possesses with the Attorney General. If the State proceeds with the action, it assumes primary responsibility for its prosecution. If the States elects not to proceed with the action, the individual has the right to prosecute the action; the State can continue to monitor the action and, on motion for good cause, may intervene at a later date.

The Act further establishes the rights and protection of an individual who is discharged, demoted, suspended, threatened or harassed as a result of initiating a civil action or participating in the investigation or prosecution of an action. Any action that results in prosecution entitles the individual to between 15 to 30 percent of the proceeds from the settlement.

The Act amends NCGS 108A-63 to include provisions for a healthcare fraud subpoena to produce documents, which can be used to compel a corporation or governmental entity to produce documents relevant to a criminal investigation of a violation of the Medical Assistance Provider Fraud statute. As stated in the legislation, it is unlawful for any provider with the intent to obstruct, delay or mislead an investigation of a false or fraudulent claims payment to knowingly and willfully make or cause to be made a false entry in, alter, destroy or conceal or make a false statement about a financial, medical or other record related to the provision of a benefit, item or service.

Craig L. Umstead, Provider Services
DMA, 919-855-4050

Attention: All Providers

Quality Assurance Questionnaire

This month DMA Provider Services will begin publishing a series of quality assurance (QA) questionnaires to assist DMA in its efforts to improve customer service to enrolled providers and Medicaid recipients. The QA questionnaires are intended only for DMA's enrolled Medicaid providers. All enrolled providers are encouraged to complete the March 2011 QA questionnaire. Results obtained from the questionnaire will be kept confidential. Completed questionnaires may be submitted by e-mail to ncdma.providerqasurvey@lists.ncmail.net or by fax to 919-715-8548.

Craig L. Umstead, Provider Services
DMA, 919-855-4050

March 2011 Medicaid Provider Quality Assurance Questionnaire			
	Question	**Response**	
		YES	**NO**
1	Have you found your current experience in providing services to Medicaid recipients of significant value to the community and society as a whole?	☐	☐
2	Do you regard your experience as a N.C. Medicaid provider overall to be a positive experience?	☐	☐
3	Do your colleagues enrolled in the Medicaid program view their impact on improving health to recipients as value added?	☐	☐
4	Do you find the administrative services and education information provided by DMA on its website, bulletins, and customer service to be adequate in supporting a high level of health care for Medicaid recipients?	☐	☐
5	Do you or your staff ask all Medicaid recipients to present their Medicaid card as well as identification prior to providing services?	☐	☐
6	Would you be willing to support more use of telehealth monitoring, which is the remote exchange of a patient's vital signs and other biometric data between the patient's home and the medical provider?	☐	☐
7	Are you knowledgeable of changes in Medicaid clinical policy that affect your patients?	☐	☐
8	Have you (personally) recommended changes to N.C. Medicaid clinical policy on improvements that may positively affect your patient's outcome?	☐	☐
9	Do you believe that North Carolina's clinical policies addressing Medicaid patients are fair and meet the needs of a majority of the patients?	☐	☐
10	Are Medicaid recipients more likely to keep their initial appointments than other covered patients?	☐	☐
11	Are patients always notified in writing of a non-covered Medicaid service?	☐	☐
12	When Medicaid recipients are added to your schedule, are they allotted ample time for you to meet their often complex medical needs?	☐	☐
13	Do you have a formal process to measure Medicaid patient customer satisfaction in your practice?	☐	☐
14	Has your business relationship (i.e., billing, payment, clinical policy, and enrollment) experience with N.C. Medicaid been at a high professional level?	☐	☐
15	Do you or your staff need more training and direction (i.e., billing, payment, clinical policy, and enrollment) from DMA?	☐	☐
16	Would you consider your experience with the N.C. Medicaid Program to be a collaborative partnership?	☐	☐
17	Would you prefer to handle all enrollment and recertification and other communication with the Medicaid program electronically?	☐	☐
18	Are you knowledgeable of the Electronic Health Record (EHR) initiative and the federal funding available to support its development among practitioners?	☐	☐
19	Do you agree that there is a need to verify the criminal history of those that provide health care to Medicaid recipients?	☐	☐
20	Are the current EOBs easily understood and useable?	☐	☐
Please submit your completed questionnaire to DMA Provider Services by e-mail at ncdma.providerqasurvey@lists.ncmail.net or by fax to 919-715-8548. All responses will be kept confidential.			

Attention: All Providers

Changes to the N.C. Medicaid Preferred Drug List

N.C. Medicaid will implement changes to the N.C. Medicaid Preferred Drug List (PDL) on **March 7, 2011.** These changes will complete the final phase of the September 15, 2010, implementation of the PDL. The following drug classes were reviewed, with changes made to the preferred and non-preferred statuses: multiple sclerosis, growth hormones, ulcerative colitis, electrolyte depleters, psoriasis, and self-administered rheumatoid arthritis agents. Agents for gout and opioid dependence were re-reviewed to allow for updates reflecting recent changes in the drug classes.

The changes are the result of the clinical reviews completed at the January 28, 2011 Preferred Drug List panel meeting and represent specialty drug classes that required a more lengthy review process. The revised PDL as well as PDL updates can be accessed from DMA's Outpatient Pharmacy Program web page at http://www.ncdhhs.gov/dma/pharmacy/.

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

Attention: All Providers

Basic Medicaid Seminars

Basic Medicaid seminars are scheduled for the month of April 2011. These seminars are intended to educate all types of providers on the basics of billing for N.C. Medicaid, recent updates and changes, and the latest budget initiatives. The focus of the morning session will be the first seven sections of the revised April 2011 Basic Medicaid Billing Guide, which is the primary document that will be referenced during the seminar. The afternoon sessions will be broken out by claim type: Professional, Institutional, and Dental ADA/Pharmacy. The remaining sections of the April 2011 Billing Guide will be reviewed during these breakout sessions focusing on claims submission, National Correct Coding Initiative, resolving denied claims and the uses of N.C. Electronic Claims Submission/Recipient Eligibility Verification Web Tool.

Providers are encouraged to print the Billing Guide and/or the slide presentation, which will be posted on the DMA seminar webpage prior to the first scheduled session. This material will assist providers in following along with the presenters. Please note that the seminar slide presentation addresses the topics to be discussed and does not represent all of the information being presented. If preferred, you may download the Billing Guide and/or the slide presentation to a laptop and bring the laptop to the seminar. Or, you may access the Billing Guide and presentation online using your laptop during the seminar. **However, HP Enterprise Services cannot guarantee a power source or Internet access for your laptop.** Copies of these documents will not be provided.

Pre-registration is required for both the morning session and the afternoon session of your choice. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend, if space is available. Please bring your seminar confirmation with you to the morning and afternoon sessions of the seminar.

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. Confirmations will be sent within two business days of receiving the registration form. Please remember to register for the afternoon session you wish to attend.

The morning session will begin at 9:00 a.m. and end at 12:00 noon. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided; however, there will be a lunch break. The afternoon sessions will begin at 1:00 p.m. and end at 4:00 p.m. Providers are encouraged to arrive at 12:45 p.m. to complete registration. **Because meeting room temperatures vary, dressing in layers is advised.**

Seminar Dates and Locations

Date	Location
April 6, 2011	**Asheville** Crown Plaza Tennis & Gold Resort One Resort Drive Asheville NC 28806
April 12, 2011	**Greensboro** Clarion Hotel Airport 415 Swing Road Greensboro NC 27409
April 14, 2011	**New Bern** New Bern Convention Center 203 South Front Street New Bern NC 28563
April 19, 2011	**Raleigh** Wake Tech Community College Student Service Building Conference Center Second Floor, Rooms 212-215 9191 Fayetteville Road Raleigh NC 27603
April 27, 2011	**Charlotte** Crowne Plaza 201 South McDowell Street Charlotte NC 28204 **Note: Parking fee of $6.00 per vehicle for parking at this location.**

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

Basic Medicaid Billing
April 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 **morning** session:
(circle one)

☐ General Session, 9:00 a.m. to 12:00 a.m.

1 or **2** person (s) will attend the **afternoon** session **(select only one session):**
(circle one)

☐ Professional Billing, 1:00 p.m. to 4:00 p.m.
☐ Institutional Billing, 1:00 p.m. to 4:00 p.m.
☐ Dental/Pharmacy Billing, 1:00 p.m. to 4:00 p.m.

Please indicate seminar location and date:

☐ Asheville, April 6, 2011
☐ Greensboro, April 12, 2011
☐ New Bern, April 14, 2011
☐ Raleigh, April 19, 2011
☐ Charlotte, April 27, 2011

Please fax completed form to: 919-851-4014

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

Or register online by utilizing the link available within the bulletin

Attention: Pharmacists and Prescribers

Drug Utilization Review Intervention Letters

The N.C. Medicaid Drug Use Review (DUR) Board reviews prescription claims billed through the Outpatient Pharmacy Program. These reviews enhance the quality and appropriateness of patient care by educating prescribers and pharmacists on common drug therapy problems with the aim of improving prescribing and dispensing practices. Periodically, the DUR Board recommends sending letters to prescribers or pharmacies regarding a drug therapy concern. These letters help providers identify patients who are potentially at risk for adverse outcomes. Each letter explains the concern and contains pertinent recipient information as well as an intervention feedback form. Feedback from providers in this process helps DMA and the Board evaluate the intervention and assess outcomes. Feedback also assists in developing future relevant clinical issues. If you receive a letter from the DUR Board, please review and fax the completed intervention feedback form back as instructed in the letter.

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

Attention: Orthotics and Prosthetics Providers

Coverage for Lower Extremity Prosthetic Components

Effective with date of service March 1, 2011, newly established coverage criteria will be implemented for the following HCPCS codes:

HCPCS Code	Description
L5781	Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system
L5782	Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system, heavy duty
L5930	Addition, endoskeletal system, high activity knee control frame
L5968	Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature
L5980	All lower extremity prostheses, flex foot system
L5987	All lower extremity prostheses, shank foot system with vertical loading pylon
L5988	Addition to lower limb prosthesis, vertical shock reducing pylon feature

Refer to Section 5.3.10 of Clinical Coverage Policy 5B, *Orthotics & Prosthetics*, on DMA's website at http://www.ncdhhs.gov/dma/mp/ for details of the new coverage criteria and prior approval requirements. Medical documentation is required to show that all criteria are met and a completed **Prior Approval Form for Lower Extremity Prosthetic Component,** which is signed by the prescribing physician, must be submitted. The **Prior Approval Form for Lower Extremity Prosthetic Component** is available online at http://www.ncdhhs.gov/dma/services/oandp.htm. Lifetime expectancies and quantity limitations, and required provider certification for these HCPCS codes have not changed.

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

Attention: Pharmacists and Prescribers

Upcoming Policy Implementation: Off Label Antipsychotic Monitoring in Children through Age 17

The use of antipsychotic medications by children is an issue confronting parents, other caregivers, healthcare professionals, and related organized healthcare agencies across the United States. The use of antipsychotic medications in children and adolescent populations is not as well studied as in adults. It is recognized that many antipsychotic medications do not have Food and Drug Administration (FDA) approved labeling for use in children. Of increasing concern, children and adolescents appear to be at similar or greater risk than adults for a variety of significant side effects related to the use of antipsychotic medications.

Due to well documented safety considerations and limited efficacy information on the use of antipsychotic agents in children, DMA developed a policy titled *Off Label Antipsychotic Monitoring in Children through Age 17*. The policy creates an opportunity to gather information about antipsychotic prescribing trends within the child and adolescent Medicaid population of North Carolina.

DMA in partnership with North Carolina Community Care networks and AccessCare will implement a registry for providers to document the use of antipsychotic therapy in Medicaid-eligible individuals 0 through 17 years of age. This registry is supported by an advisory panel consisting of child psychiatrist representatives from North Carolina's four medical universities. The registry named **A+KIDS** (Antipsychotics-Keeping It Documented for Safety) encourages the use of appropriate baseline and follow-up monitoring parameters to facilitate the safe and effective use of antipsychotics in this population.

Objectives of the **A+KIDS** registry include improving the use of evidence-based safety monitoring for patients for whom an antipsychotic agent is prescribed, reduction of antipsychotic polypharmacy, and reduction of cases in which the FDA maximum dose is exceeded.

Data elements collected within the registry reflect a generally accepted monitoring profile for the safety and efficacy follow-up of the prescribed antipsychotic pharmacotherapy. The requirement of safety monitoring documentation in the registry by the prescriber occurs when:

- The antipsychotic is prescribed for an indication that is not approved by the federal FDA.
- The antipsychotic is prescribed at a higher dosage than approved for a specific indication by the federal FDA.
- The prescribed antipsychotic will result in the concomitant use of two or more antipsychotic agents.

Implementation of the registry requirement will be done in phases according to the age of the recipient for whom the antipsychotic is prescribed. Phase one will apply to children who are Medicaid-eligible and 12 years of age or younger. The subsequent phase for the 13 through 17 age group will occur under the same guidelines. The launch for phase one is targeted for April 2011. Providers will receive notification of the official implementation date for each age group.

A widespread training effort about the registry is slated to start in March 2011. Community Care of North Carolina and AccessCare will provide the training and education. Providers are directed to the **A+KIDS** website (http://www.documentforsafety.org) registration web page to register as an **A+KIDS** provider to enable access to the online registry or to learn more about this initiative. Registration is scheduled to begin the first week of March.

Charlene Sampson, Pharmacy Program
DMA, 919-855-4300

Attention: Pharmacists and Prescribers

Transition Period for Oral Inhaled Corticosteroids, Leukotrienes, and Statins

The six-month transition period for oral inhaled corticosteroids and corticosteroid combination products, leukotrienes, and statins, which includes Zetia, will end on March 15, 2011. This transition period was provided to allow prescribers time to complete the necessary prior approval form or to transition to a preferred product if the patient does not meet the clinical criteria.

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

Attention: Pharmacists and Prescribers

Update: Active Pharmaceutical Ingredients and Excipients

CMS has provided clarification regarding the inclusion of active pharmaceutical ingredients (APIs) and excipients in the Medicaid Drug Rebate system. An API is a bulk drug substance, which is defined by the Food and Drug Administration as any substance that is represented for use in a drug and that, when used in the manufacturing, processing, or packaging of a drug, becomes an active ingredient of the drug product. APIs do not meet the definition of a covered outpatient drug as defined in section 1927(k)(2) of the Social Security Act (Act). In addition, excipient products used in compounds are non-drug products.

Certain APIs and excipients previously identified as ineligible for coverage under the N.C. Medicaid Outpatient Pharmacy Program as of January 1, 2011, are now covered. In addition to this change, additional products have been identified for coverage removal. The list of identified API and excipient National Drug Codes can be found on the Policy & Reimbursement's Spotlight web page on the CMS website at http://www.cms.gov/Reimbursement/02_Spotlight.asp#TopOfPage.

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

Attention: All Providers

National Correct Coding Initiative Education

DMA has scheduled training during the month of March 2011 to educate providers on the National Correct Coding Initiative. The training is intended for practitioners, ambulatory surgical centers, outpatient hospital services (only for drugs, high-tech images, ultrasounds, and labs as they are billed at a CPT/HCPCS code level), and durable medical equipment providers. The training will be presented in two different formats: seminar and webinar. (For more information on the implementation of the National Correct Coding Initiative, please visit http://www.ncdhhs.gov/dma/provider/ncci.htm).

Pre-registration will be required for both the seminars and the webinars. Providers are encouraged to participate in the 3-hour training seminar. However, for those providers unable to attend one of the seminars, an abbreviated training session will be available in webinar format. Registration for the webinars will be limited to 50 participants per session.

Webinar Dates

Two webinar sessions are offered on each of the following dates. The morning sessions begin at 9:00 a.m. and end at 10:30 a.m. The afternoon sessions begin at 1:30 p.m. and end at 3:00 p.m. Providers will be given instruction upon registration confirmation on webinar participation and access requirements.

- March 3, 2011
- March 10, 2011
- March 17, 2011
- March 24, 2011
- March 31, 2011

Seminar Dates and Locations

The seminars are scheduled for the dates and locations listed below. The seminars will begin at 1:00 p.m. and end at 4:00 p.m. Providers are encouraged to arrive by 12:45 p.m. to complete registration. Due to limited seating, registration for the seminars will be limited to two staff members per office. Unregistered providers are welcome to attend if space is available. **Because meeting room temperatures vary, dressing in layers is advised.**

Date	Location
March 2, 2011	**Wilmington** Hampton Inn – Medical Park 320 South 17th Street Wilmington NC 28401
March 8, 2011	**Greensboro** Clarion Hotel Airport 415 Swing Road Greensboro NC 27409
March 15, 2011	**Greenville** Hilton Greenville 207 SW Greenville Boulevard Greenville NC 27834
March 22, 2011	**Raleigh** The Royal Banquet and Convention Center 3801 Hillsborough Street Raleigh NC 27607
March 29, 2011	**Asheville** Mountain Area Health Education Center 501 Biltmore Avenue Asheville NC 28801
March 30, 2011	**Charlotte** Crowne Plaza 201 South McDowell Street Charlotte NC 28204 **Note: There is a parking fee of $6.00 per vehicle for parking at this location.**

Providers may register for the seminars/webinars using the online registration form (http://www.ncdhhs.gov/dma/provider/seminars.htm) or by fax using the form below (fax it to the number listed on the form). Please include a valid e-mail address or fax number for your return confirmation. Please indicate the session you plan to attend on the registration form. Providers will receive a registration confirmation, and a separate email with a link to the seminar presentation that providers can print and bring to the seminar. For those providers who register for a webinar, the registration confirmation will include information on how to access the webinar.

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

National Correct Coding Initiative Seminar/Webinar Registration Form
March 2011
(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)

OR

1 or **2** person(s) will attend the **morning** or **afternoon** webinar session on _____
(circle one) (circle one) (date)

Please fax completed form to: 919-851-4014

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

Or register online by utilizing the link available within the bulletin

Attention: Nursing Facilities

Activities of Daily Living Clarification for Minimum Data Set 3.0 Validation Review

In the North Carolina case mix classification system for Medicaid reimbursement, the late loss Activities of Daily Living (ADLs) (including bed mobility, transfer, toilet use and an eating component) are scored and applied along with other clinical factors to place residents in the appropriate classification group. Once the resident is classified into the Resource Utilization Group (RUG), a predetermined Case Mix Index (CMI) value is assigned. The nursing facility is reimbursed based on the case mix system.

With the implementation of the Minimum Data Set (MDS) 3.0, effective October 1, 2010, the ADL keys used by the nursing facilities when coding Section G of the MDS 3.0 must be equivalent to the intent and definitions of the MDS ADL key according to the Resident Assessment Instrument (RAI) Manual to support a designated RUG category. Correct ADL definitions are an essential component to a successful MDS Validation Review.

Section G of the MDS 3.0 ADL Assistance values are reviewed for all assessments selected for the MDS Validation Review. Therefore, supporting the ADL transmitted value is vital to validating the assessment. Below is the key from the MDS 3.0 assessment.

ADL Self-Performance Key Descriptions

Code 0 – independent – no help or staff oversight at any time

Code 1 – supervision – oversight, encouragement or cueing

Code 2 – limited assistance – resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight bearing assistance

Code 3 – extensive assistance – resident involved in activity, staff provide weight-bearing support

Code 4 – total dependence – full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

Code 7 – activity occurred only once or twice – activity did occur but only once or twice

Code 8 – activity did not occur – activity (or any part of the ADL) was not performed by resident or staff at all over the entire 7-day period

ADL Support Provided Key Descriptions

Code 0 – no setup or physical help from staff

Code 1 – setup help only

Code 2 – one person physical assist

Code 3 – two+ persons physical assist

Code 8 – ADL activity itself did not occur during entire period

If the nursing facility's definitions deviate from the MDS 3.0 ADL keys, there are key words necessary to maintain the intent of the definitions. The MDS Validation Reviewers cannot support the ADL documentation without these key words.

The key words listed below in **bold** that are required to maintain the intent of the MDS 3.0 ADL keys.

ADL Self-Performance Key Descriptions

Code 0 – independent – **no help or staff oversight at any time**

Code 1 – supervision – **oversight, encouragement or cueing**

Code 2 – limited assistance – **resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight bearing assistance**

Code 3 – extensive assistance – **resident involved in activity, staff provide weight-bearing support**

Code 4 – total dependence – **full staff performance every time** during entire 7-day period

Code 7 – activity occurred only once or twice – **activity did occur but only once or twice during the entire 7-day period**

Code 8 – activity did not occur – **activity (or any part of the ADL) was not performed by resident or staff at all** over the entire 7-day period

Other ADL MDS Validation Review Comments

- Providers with no ADL key associated with the ADL values will be considered unsupported.
- Providers with more than one ADL supporting documentation (tool) per assessment (one the CNA completes and one the LPN/RN completes) will be asked to designate the one to be used for the MDS Validation Review. The designated tool must be maintained in the medical record as a legal document.
- ADL key supporting documentation with words for self-performance such as limited, extensive assist, etc., without the full definition will be considered unsupported for the MDS Validation Review.
- All MDS ADL codes must be represented on the ADL supporting documentation tool (with the exception of code "7"). ADL supporting documentation tools that lack any one of the codes will be considered unsupported. For example, for self performance, the ADL supporting documentation tool must contain the codes for independent, supervision, limited assistance, extensive assistance, totally dependent and activity did not occur. ADL tools that lack codes for all the possible MDS coding options (with the exception of code "7") will not be accepted as supporting documentation.
- The ADL supporting documentation tool must contain the appropriate keys for both the self-performance and the support provided.
- ADL supporting documentation will be reviewed consistent with current review protocol and guidelines for MDS 3.0.
- Electronically documented ADLs must meet the same requirements as hand-written ADL documentation.

Contacts for questions related to the MDS Coding or MDS Validation Program are listed below:

North Carolina State RAI/MDS Help Desk – MDS Coding
Cindy DePorter or Mary Maas, State RAI/MDS Coordinator
919-855-4583

Division of Medical Assistance – MDS Validation Program
Deana Dolan, RN, RAC-CT Nursing Facility Consultant
DMA, Clinical Policy
919-855-4354

Myers and Stauffer – Case Mix Validation
Patty Padula or Cindy Smith, Case Mix Validation
317-846-9521

Attention: Nursing Facilities

N.C. Preadmission Screening and Resident Review Process for Out-of-State Admissions to N.C. Nursing Facilities

The N.C. Preadmission Screening and Resident Review (NC PASRR) system is a free online tool available to all N.C. Medicaid providers. **N.C. Medicaid providers are required to enter their N.C. Medicaid Provider Number and the resident's current state of residency when completing the screen online.** When providers from other states wish to place an out-of-state resident in a nursing facility located in North Carolina, the out-of-state provider must pay for and complete their state's PASRR process for Level 1 and, if required, Level 2. **It is the responsibility of the nursing facility in North Carolina to ensure that the Level 1 and, if required, Level 2 PASRR documentation from the out-of-state provider has been received and that the out-of-state recipient has met all N.C. nursing facility requirements PRIOR TO ADMISSION.**

Note: The NC PASRR contractor (HP Enterprise Services) will review all out of state PASRR documentation PRIOR TO ADMISSION to ensure nursing facility placement is appropriate.

LEVEL 1

When an out-of-state provider has located a nursing facility bed in North Carolina for an individual, that provider has to complete his/her state's PASRR process. For Level 1, the out-of-state provider must submit the completed Level 1 evaluation to the nursing facility in North Carolina. The out-of-state provider pays for this review prior to the individual leaving that state of residence. **The Level 1 evaluation and determination must be completed before the person leaves the state of residence. The NC PASRR contractor (HP Enterprise Services) will review the out-of-state PASRR Level 1 documentation. If approved, the nursing facility will be given a NC PASRR number. It is the responsibility of the nursing facility in North Carolina to ensure that the Level 1 PASRR documentation from the out-of-state provider has been received and that the out-of-state recipient has met all N.C. nursing facility requirements PRIOR TO ADMISSION.**

LEVEL 2

If the Level 1 review determines that a Level 2 review needs to be performed, the out-of-state provider requesting placement in a facility in North Carolina must complete and pay for the Level 2 PASRR process in his/her state. The Level 2 evaluation and determination from the out-of-state PASRR must be received by the nursing facility in North Carolina **PRIOR TO ADMISSION**. **The Level 2 evaluation and determination must be completed before the person leaves the state of residence. The NC PASRR contractor (HP Enterprise Services) will review the out-of-state PASRR Level 2 documentation. If approved, the nursing facility will be given a NC PASRR number. It is the responsibility of the nursing facility in North Carolina to ensure that the Level 2 PASRR documentation from the out-of-state provider has been received and that the out-of-state recipient has met all N.C. nursing facility requirements PRIOR TO ADMISSION.**

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

Attention: Anesthesiologist and Certified Registered Nurse Anesthetists

Clarification and Correction for CPT Codes 01967 and 01996

N.C. Medicaid implemented system changes effective with date of service January 1, 2008, to deny claims billed with CPT procedure code 01996 (daily hospital management of epidural or subarachnoid continuous drug administration) when billed on the same date of service as procedure code 01967 [neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)]. However, anesthesiologists are receiving denials for CPT procedure code 01967 when billed on the same date of service as CPT procedure code 01996.

System updates have been completed to correct this issue. Providers who received denials when billing for CPT procedure code 01967 with EOB 1888 (one anesthesia procedure allowed per same date of service) may resubmit claims that meet timely filing criteria for processing (not as an adjustment). Providers who received denials when billing for CPT procedure code 01967 appended with modifier AA and received denials with EOB 2989 (resubmit claim with appropriate directed anesthesia modifier) may resubmit claims that meet timely filing criteria for processing (not as an adjustment).

Previously paid claims for CPT procedure code 01996 or 01996 appended with modifier QX will be recouped if a claim is resubmitted for CPT procedure code 01967 on the same date of service.

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

Attention: Anesthesiologist and Certified Registered Nurse Anesthetists

Correction and Reimbursement Requirements for AD Modifier Billing

When an anesthesiologist is supervising more than four concurrent anesthesia procedures, the AD modifier is appended to the billing code. (Please refer to Clinical Coverage Policy 1L-1 for clarification of medical direction versus medical supervision of anesthesia services.) The certified registered nurse anesthetist (CRNA) bills with modifier QZ when providing the service with or without supervision by the anesthesiologist. There is no reduction in the reimbursement for the supervised CRNA.

Multi-specialty physician groups are receiving denials when the attending anesthesiologist is billing the AD modifier for supervision of CRNA services. System updates have been completed to correct this issue. Providers who received denials related to the AD modifier with EOB 7704 (Provider type and specialty combination is not allowed to bill the modifier submitted. Correct and resubmit denied detail if necessary) may resubmit claims that meet timely filing criteria for processing (not as an adjustment).

In a review of these claims, it was noted that providers are billing multiple units for supervision (AD modifier) services. The anesthesiologist will be reimbursed 45 base units for every procedure being supervised, and may bill a one-time, 15-minute block of time if the anesthesiologist has documented presence at anesthetic induction on the medical record. The anesthesiologist bills the same procedure code as the CRNA but appends modifier AD to the procedure code and indicates 0 (zero) units (the provider will be reimbursed for 45 base units). If the anesthesiologist is present during anesthetic induction, the anesthesiologist bills the same procedure code as the CRNA but appends modifier AD to the procedure code and indicates 15 units (reimbursement will be for 60 base units). Only one claim detail for each procedure, with either 0 or 15 units indicated, will be accepted. All other combinations of AD modifier and number of units will be denied.

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

Attention: N.C. Health Choice Optical Services Providers

Reminder: N.C. Health Choice Eyeglasses Fabrication by Nash Optical Plant

Effective March 1, 2007, optical providers were given the option of obtaining prescription eyeglasses for N.C. Health Choice recipients through Nash Optical Plant, a division of North Carolina Correction Enterprises. Nash Optical Plant continues to be available for N.C. Health Choice eyeglasses fabrication.

To obtain eyeglasses through Nash Optical Plant, follow the procedure outlined below:

1. Order a Medicaid Dispensary Fitting Kit. Instructions and order information may be obtained by calling Nash Optical Plant at 1-888-388-1353 or 252-459-6200.
2. Review the child's N.C. Health Choice membership card to determine if the child is a current member.
3. Complete the required N.C. Health Choice Request for Visual Aids/Verification of Eligibility Form.
4. Call the Claims Processing Contractor (CPC) for N.C. Health Choice at 1-800-422-1582 in order to complete Section 10. Documentation of the phone call must include confirmation of the following:
    - The child is currently enrolled in N.C. Health Choice.
    - The child has not received frames within the past two years or lenses within the past year.
    - Prior approval, if required.
5. Fax the completed form to 252-459-7400.
6. Nash Optical Plant will fabricate and mail the eyeglasses to the provider.
7. Nash Optical Plant will file the eyeglasses fabrication claim with the CPC.
8. The provider will file the eyeglasses dispensing fee claim with the CPC.

The phone call to the CPC for N.C. Health Choice (item 4 above) is critical to the success of this process. If the child is not eligible, the provider and Nash Optical Plant cannot bill for services.

When ordering N.C. Health Choice eyeglasses from Nash Optical Plant, the provider must bill only for the dispensing fees (item 8 above). N.C. Health Choice eyeglasses dispensing fees are paid at Medicaid rates. Medicaid eyeglasses dispensing fees can be obtained through DMA's website at http://www.ncdhhs.gov/dma/services/optical.htm.

The N.C. Health Choice frame warranty covers manufacturer defects for 12 months after the original N.C. Health Choice approval date. This warranty does not cover abuse, neglect, loss, or theft. Complete defective frames (front and temples) and a copy of the Nash Optical Plant invoice must be returned to Nash Optical Plant for inspection. If the frame is not defective, the provider must order a replacement frame from the frame manufacturer.

N.C. Health Choice information can be obtained from the DMA website at http://www.ncdhhs.gov/dma/healthchoice/.

Contact Information

Topic	Contact
Questions About Eligibility, Benefits, and Completion of Request Form	N.C. Health Choice Prior Approval Department 1-800-422-1582 or 1-800-422-4658
Fax Medical Records for Prior Approval	N.C. Health Choice Prior Approval Department Fax: 919-765-2047

Topic	Contact
Mailing Address for CPC	Claims Processing Contractor PO Box 30111 Durham NC 27702-3111
Questions about frames and lenses	Nash Optical Plant 1-888-388-1353 or 252-459-6200
Fax Request Form to Nash Optical Plant	Nash Optical Plant Fax: 252-459-7400
Mailing Address for Nash Optical Plant	Nash Optical Plant 2869 US Hwy 64-A Nashville NC 27856 Attn: Tony Hendricks
Additional Support	Ronda Owen, LDO Optical Services Program Manager 919-855-4310

Ronda Owen, Optical Manager
DMA, 919-855-4310

Attention: Community Care of North Carolina/Carolina ACCESS Providers

Policy Clarification Regarding 24-Hour Coverage

24-Hour Coverage

Community Care of North Carolina/Carolina ACCESS (CCNC/CA) requires primary care providers (PCPs) to provide access to medical advice and care to enrolled recipients 24 hours a day, 7 days a week. There must be prompt **(within one hour)** access to a qualified medical practitioner who is able to provide medical advice, consultation and authorization for service when appropriate. PCPs must have at least one telephone line that is answered by the office staff during regular office hours.

Providers may not bill their CCNC/CA enrollees for after-hours consultations or for any other service that is part of their contractual agreement with DMA (refer to the Agreement for Participation in North Carolina's Patient Access and Coordinated Care Program). **Providers may not contract with a third party on the basis that the third party will bill the CCNC/CA enrollee. Additionally, providers may not imply by way of their after-hours coverage message or arrangement, including any arrangement the provider makes with a third party, or by any other means that there may be a charge to their enrollees for access to medical advice or care. CCNC/CA providers are prohibited from posting statements on the practice premises or otherwise notifying enrollees or recording statements on telephone lines that might discourage CCNC/CA enrollees from contacting their PCP for medical advice and care when the office is closed.**

Refer to the Basic Medicaid Billing Guide on DMA's website (http://www.ncdhhs.gov/dma/basicmedicaid/) for additional information on 24-hour coverage.

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

Attention: Community Care of North Carolina/Carolina ACCESS Providers

Provider Satisfaction Survey

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

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

Attention: N.C. Health Choice Providers

Non-Covered N.C. Health Choice Policies

Effective February 20, 2011, the following policies are not covered by N.C. Health Choice:

1. Intra Articular Hyaluronan Injections for Osteoarthritis of the Knee
2. Lung Volume Reduction Surgery
3. Varicose Veins, Treatment of

For a complete list of policies that are not covered by N.C. Health Choice refer to the Non-Covered Health Choice Policies web page at http://www.ncdhhs.gov/dma/hcmp/noncovered.html.

Margaret Watts, N.C. Health Choice
DMA, 919-855-4104

Attention: Durable Medical Equipment Providers

Removal of Prior Approval Requirement From HCPCS Code W4016, Bath Seat, Pediatric

Effective with date of service March 1, 2011, HCPCS code W4016 (bath seat, pediatric), does not require prior approval.

A Certificate of Medical Necessity and Prior Approval form must be completed for all items, regardless of the requirement for prior approval. The coverage criteria for this item have not changed. Refer to Clinical Coverage Policy 5A, *Durable Medical Equipment*, on DMA's website (http://www.ncdhhs.gov/dma/mp/) for detailed coverage information. Please refer to the DME Fee Schedule on DMA's website (http://www.ncdhhs.gov/dma/fee/) for the maximum allowable rates for this code and for all of the codes covered by N.C. Medicaid for durable medical equipment.

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

Attention: HIV Case Management Providers

Reminders and Updates for HIV Case Management Services

The Carolinas Center for Medical Excellence (CCME) and DMA are pleased to announce that the process to become a certified HIV Case Management agency is now open to new providers. See the information listed below under training.

Training

Registration is now open for training on the **New Policy Requirements for HIV Case Managers** and Application Process (see schedule below). **This training is an opportunity for potential new providers to learn more about the program and certification requirements. Attendance at one of the one-day trainings is mandatory in order to obtain an application for certification. This training is also required for those currently certified agencies who did not attend one of the sessions in November 2010 but still wish to retain their certification as a Medicaid HIV Case Management provider.**

The second training listed is mandatory training for HIV Case Managers and Supervisors who have not previously attended training on the new clinical coverage policy requirements. This training is limited to those individuals who are currently employed by an agency that is currently certified as an HIV Case Management agency.

Date	Session Topic	Required Attendees
March 7, 2011	New Certification/Application Process	The official agency/program administrator (i.e., the agency owner or director)
March 8, 2011	New Certification/Application Process	The official agency/program administrator (i.e., the agency owner or director)
March 9 and 10, 2011	New Policy Requirements	HIV Case Managers and HIV Case Manager Program Supervisors

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

Frequently Asked Questions

Medicaid in collaboration with CCME has created a list of frequently asked questions (FAQs), which are now available on CCME's website at http://www.thecarolinascenter.org/hivcm.

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

Attention: Nurse Practitioners and Physicians

Eribulin Mesylate (Halaven, HCPCS Code J9999): Billing Guidelines

Effective with date of service November 16, 2010, the N.C. Medicaid Program covers eribulin mesylate (Halaven) for use in the Physician's Drug Program when billed with HCPCS code J9999 (not otherwise classified, antineoplastic drugs). Halaven is available as a 1 mg per 2 mls single-use vial.

Halaven is a microtubule inhibitor indicated for the treatment of patients with metastatic breast cancer who have previously received at least two chemotherapeutic regimens for the treatment of metastatic disease. Prior therapy should have included an anthracycline and a taxane in either the adjuvant or metastatic setting.

Halaven should be administered as a 1.4mg/m^2 dose via IV over 2 to 5 minutes on days 1 and 8 of a 21-day cycle. The safety and effectiveness of Halaven in pediatric patients below the age of 18 years have not been established.

For Medicaid Billing

- Halaven is not covered for recipients under the age of 18.
- Providers must bill Halaven with HCPCS code J9999 (not otherwise classified, antineoplastic drugs).
- One of the following ICD-9-CM diagnosis codes must be billed with Halaven:
  - 174.0 through 175.9 (malignant neoplasm of the breast)
- Providers must indicate the number of HCPCS units in field 24G of the CMS-1500 claim form, or in the appropriate unit field on the 837P, 837I or the NCECSWeb Tool. Claims must be filed electronically unless they meet the criteria on the exceptions list for electronic claims.
- One Medicaid unit of coverage is 1 mg. Providers may bill for an entire single-use vial. The maximum reimbursement rate per unit is $884.86.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Halaven should be reported as "ML." To bill for the entire 1-unit single-use vial (1 mg/2 mls) of Halaven, report the NDC units as "ML2." 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 new fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Nurse Practitioners and Physicians

Pegloticase (Krystexxa, HCPCS Code J3590): Billing Guidelines

Effective with date of service November 30, 2010, the N.C. Medicaid Program covers pegloticase (Krystexxa) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologics). Krystexxa is a PEGylated uric acid-specific enzyme indicated for the treatment of adult patients with gout who are refractory to conventional therapy. Krystexxa is not indicated for the treatment of asymptomatic hyperuricemia.

Krystexxa is available as 8 mg per 1 ml of pegloticase protein in a single-use vial. Krystexxa should be administered as 8 mg of pegloticase diluted in 250 ml of 0.9% sodium chloride injection or 0.45% sodium chloride injection and infused intravenously over no less than 120 minutes every two weeks. Providers are encouraged to read the detailed label information regarding warnings and precautions related to the administration of Krystexxa.

For Medicaid Billing

- Krystexxa is not covered for recipients under the age of 18.
- One of the following ICD-9-CM diagnosis codes must be billed with Krystexxa:
  - 274.00 through 274.03 (gouty arthropathy)
- Providers must bill Krystexxa with HCPCS code J3590 (unclassified biologics).
- Providers must indicate the number of HCPCS units in field 24G of the CMS-1500 claim form, or in the appropriate unit field on the 837P, 837I or NCECSWeb Tool. Claims must be filed electronically unless they meet the criteria on the exceptions list for electronic claims.
- One Medicaid unit of coverage is 8 mg. An entire single-use vial may be billed. The maximum reimbursement rate per unit (8-mg vial) is $2,394.33.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Krystexxa should be reported as "ML." To bill for the entire 8 mg per 1 ml single-dose vial of Krystexxa, report the NDC units as "ML1." 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 new fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Nurse Practitioners and Physicians

Denosumab (Xgeva, HCPCS Code J3590): Billing Guidelines

Effective with date of service November 20, 2010, the N.C. Medicaid Program covers denosumab (Xgeva) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologics). Xgeva is available as 120 mg per 1.7-ml single-use vials.

Xgeva is indicated for the prevention of skeletal-related events in patients with bone metastases from solid tumors. It is not indicated for the prevention of skeletal-related events in patients with multiple myeloma.

Xgeva should be administered as a 120-mg (1-vial) dose injected subcutaneously every four weeks into the upper arm, upper thigh or abdomen. Calcium and vitamin D are recommended to be given as necessary to treat or prevent hypocalcemia. The drug label indicates that the safety and effectiveness of Xgeva in pediatric patients have not been established and that treatment with Xgeva may impair bone growth in children with open growth plates and may inhibit eruption of dentition.

For Medicaid Billing

- Xgeva is not covered for recipients under the age of 18.
- ICD-9-CM diagnosis code 198.5 (secondary malignant neoplasm of other specified sites, bone and bone marrow) must be billed with Xgeva.
- Providers must bill Xgeva with HCPCS code J3590 (unclassified biologics).
- Providers must indicate the number of HCPCS units in field 24G of the CMS-1500 claim form, or in the appropriate unit field on the 837P, 837I or the NCECSWeb Tool. Claims must be filed electronically unless they meet the criteria on the exceptions list for electronic claims.
- One Medicaid unit of coverage is 1 mg. An entire single-dose vial may be billed. The maximum reimbursement rate per unit is $14.31. The maximum reimbursement for the full 1.7 ml vial (120 mg) is $1,717.20.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Xgeva should be reported as "ML." To bill for the entire 1.7-ml single-dose vial of Xgeva, report the NDC units as "ML1.7." 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 new fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Nurse Practitioners and Physicians

Ceftaroline Fosamil Acetate (Teflaro, HCPCS Code J3490): Billing Guidelines

Effective with date of service November 22, 2011, the N.C. Medicaid Program covers ceftaroline fosamil acetate (Teflaro) for use in the Physician's Drug Program when billed with HCPCS code J3490 (unclassified drugs). Teflaro is available in 400 mg and 600 mg single-dose vials.

Teflaro is indicated for the treatment of acute bacterial skin and skin structure infections and community-acquired bacterial pneumonia (CABP) caused by designated susceptible bacteria. Teflaro should be administered as a 600 mg dose; infused intravenously over 1 hour, every 12 hours for 5 to 14 days, depending on indication.

For Medicaid Billing

- Providers should select the most appropriate ICD-9-CM diagnosis codes with the highest level of specificity to describe the patient's condition. All codes must be supported with adequate documentation in the medical record.
- Providers must bill Teflaro with HCPCS code J3490 (unclassified drugs).
- 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 the criteria on the exceptions list for electronic claims.
- One Medicaid unit of coverage is 200 mg. The maximum reimbursement rate per unit is $21.34. The cost is the same for both the 400 mg vial and 600 mg vial. The maximum reimbursement for the entire 400 mg vial is $42.68 and for the entire 600 mg vial is $42.68.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Teflaro should be reported as "UN." To bill for the entire single-dose vial of Teflaro (400 mg or 600 mg), 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 new fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Outpatient Behavioral Health Providers

Clarification on Units of Service for Outpatient Behavioral Health Unmanaged Visits

This is an update to the January 2005 Medicaid Special Bulletin, *Expansion of Provider Types for Outpatient Behavioral Health Services,* that discussed limitations and prior approval for outpatient services. As a reminder, per legislation, beginning January 1, 2011, children have 16 unmanaged outpatient visits before prior authorization is required. Adults continue to have 8 unmanaged visits before prior authorization is required. All outpatient policy guidelines can be found in DMA Clinical Coverage Policy 8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers* (http://www.ncdhhs.gov/dma/mp/).

For adults and children, the number of unmanaged outpatient visits is a count that begins each calendar year starting January 1 through December 31. These visits are defined by dates of service and not by the individual units of service provided. The data system counts each date of service as one visit **with the exception of the following codes for group therapy:** 90849, 90853, 90857, H0005, and H004 HQ. These five codes are counted as ½ visits for the unmanaged unit counts for **both adults and children.** When the recipient (child or adult) reaches the maximum number of unmanaged units (dates of service), the following visits (dates of service) will be denied unless prior approval is obtained. For example:

- When I child has had 15½ visits (dates of service) and the next date of service is for procedure code 90806 (individual therapy, 45 minutes), the claim will deny unless prior approval has been obtained for that procedure code.
- When an adult has reached 8 dates of services, the next claim for H004 HQ (group therapy) will deny unless prior approval is on file.

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. **Once prior approval is on file for the recipient, the system considers the unmanaged count as "used" for that calendar year, regardless of the amount of previous services provided. Please remember, the system is counting visits (dates of service) per each recipient, not per each provider.**

Behavioral Health Unit
DMA, 919-855-4290

Attention: All Providers

Process for Returning Unused Mirena Units

DMA is working with Bayer HealthCare to develop a process for providers to return unused Mirena units that have been billed to North Carolina Medicaid. This new process will allow Medicaid to receive credit for Mirena units that have not been used by recipients. Updates regarding this process will be available on DMA's Outpatient Pharmacy Program web page at http://www.ncdhhs.gov/dma/pharmacy/.

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

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

Pregnancy Medical Home Seminars

The Pregnancy Medical Home (PMH) initiative seeks to improve birth outcomes in North Carolina by improving the quality of perinatal care given to Medicaid recipients. Any provider who offers prenatal care and currently bills using any of the standard obstetric codes (global delivery fee, ante partum package, etc.) is eligible to join a Community Care of North Carolina (CCNC) network as a PMH. CCNC networks will sign agreements locally with providers to become PMHs. CCNC networks will also sign agreements with local health departments for pregnancy care management. Each agreement will address the responsibilities for each type of service provider (pregnancy home provider or pregnancy case manager). Prenatal care providers who do not offer obstetric delivery services are eligible to serve as PMHs; they will be asked to describe the process by which they ensure coordination for care with the intrapartum care provider.

PMH providers will be offered incentives and enhanced rates for agreeing to meet the defined program goals. For more information on the program please visit DMA's website at http://www.ncdhhs.gov/dma/services/pmh.htm.

PMH seminars are scheduled for the month of March 2011. Seminars are intended to educate providers on the new PMH project. The presentation will cover policy information and billing 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 using the online registration form (http://www.ncdhhs.gov/dma/provider/seminars.htm) or by fax using the form below (fax it to the number listed on the form). Please include a valid e-mail address or fax number for your return confirmation. Indicate the session you plan to attend on the registration form. Providers will receive a registration confirmation, and a separate email with a link to the seminar presentation that providers can print and bring to the seminar.

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 advised.**

Seminar Dates and Locations

Date	Location
March 2, 2011	**Wilmington** Hampton Inn – Medical Park 320 South 17th Street Wilmington NC 28401
March 8, 2011	**Greensboro** Clarion Hotel Airport 415 Swing Road Greensboro NC 27409
March 15, 2011	**Greenville** Hilton Greenville 207 SW Greenville Boulevard Greenville NC 27834

Date	Location
March 22, 2011	**Raleigh** The Royal Banquet and Convention Center 3801 Hillsborough Street Raleigh NC 27607
March 29, 2011	**Asheville** Mountain Area Health Education Center 501 Biltmore Avenue Asheville NC 28801
March 30, 2011	**Charlotte** Crowne Plaza 201 South McDowell Street Charlotte NC 28204 **Note: There is a parking fee of $6.00 per vehicle for parking at this location.**

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

Pregnancy Medical Home
March 2011 Seminar Registration Form
(No Fee)

Provider Name and Discipline _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (____) _____ Fax Number _____

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

Please fax completed form to: 919-851-4014

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

Or register online by utilizing the link available within the bulletin

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Proposed Clinical Coverage Policies

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

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

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

2011 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
March	2/24/11	3/1/11	3/2/11
	3/3/11	3/8/11	3/9/11
	3/10/11	3/15/11	3/16/11
	3/17/11	3/24/11	3/25/11
April	3/31/11	4/5/11	4/6/11
	4/7/11	4/12/11	4/13/11
	4/14/11	4/21/11	4/22/11

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

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

Melissa Robinson
Executive Director
HP Enterprise Services