May 2010 Medicaid Bulletin

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

Attention: All Providers

MedSolutions' Commitment to Assuring a Collaborative, Successful Ultrasound Management Program in North Carolina

DMA and MedSolutions are working with physicians in North Carolina to ensure the success of the State's ultrasound management program. We are continuing to proactively reach out to physicians in North Carolina to share details of the program and to request their feedback. This effort is part of MedSolutions' commitment to ensuring the highest quality of care for Medicaid recipients in North Carolina and the best value for the State's taxpayers.

1. We have discovered a great deal of common ground during our discussions with physicians, including our most recent conversations with the NC OB/GYN Society. At the direction of DMA, MedSolutions will convene a group of North Carolina physician stakeholders and provider representatives from counties across the State. Together, DMA, MedSolutions, and these stakeholders will discuss details of the program to provide education and any needed clarification regarding DMA's obstetrical ultrasound program rules and guidelines for ensuring the appropriate use of ultrasound services.

2. MedSolutions will review any additional suggestions made by stakeholders, with due consideration to current American College of Obstetricians and Gynecologists (ACOG) and American Institute of Ultrasound in Medicine (AIUM) criteria, as well as CPT coding conventions.

3. MedSolutions will submit any new recommendations regarding the program to DMA for review and approval. As applicable, the N.C. Physician's Advisory Group (PAG) will also review and advise in accordance to their legislative authority. DMA will communicate any program revisions to the obstetrical providers in North Carolina.

4. In addition, for the next 90 days, MedSolutions will initiate a notification-only program for requested obstetrical ultrasound studies from eligible providers as requested for eligible Medicaid recipients. Providers must continue to contact MedSolutions for registration of the obstetrical ultrasounds in order to receive reimbursement from Medicaid.

5. During the 90-day period, MedSolutions will provide retrospective review of requests as a basis for reaching out to providers and supporting them with education.

6. MedSolutions will continue to authorize high-tech imaging and all ultrasound studies to practices based on the practice's ability to meet accuracy and quality assessment standards.

7. During the 90-day time frame, MedSolutions will also work with DMA to understand and prepare for the implications of the proposed "Pregnancy Home" program that may be implemented later this summer or early fall, which will encompass 25 to 30 obstetrical groups throughout North Carolina.

DMA and MedSolutions continue to believe that working in a positive, collegial manner with North Carolina's physicians will assure a superior quality ultrasound management program for the benefit of the State's physicians and, more importantly, their patients, as well as all of North Carolina's constituents who depend on an efficient and viable Medicaid program.

Practitioner and Clinic Services
DMA, 910-355-1883

Attention: All Providers

Reimbursement for the Duplication of Medical Records

The Medicaid Participation Agreement documents the requirements in Section 1902(a)(27) of the Social Security Act and 42 CFR 431.107 for providers to keep all records necessary to disclose the extent of services provided to individuals and, upon request, furnish these records to the Medicaid agency. Medicaid does not reimburse providers for maintaining these records or for the costs associated with copying and/or mailing these records upon request to DMA or its agents. These functions are a cost of doing business and are considered when rates for covered Medicaid services are established.

Martha O. Stilwell, Program Integrity
DMA, 919-647-8000

Attention: All Providers

Payment Error Rate Measurement in North Carolina

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

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

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

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

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Medicaid Integrity Contractors Audit

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

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

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

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

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

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

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

MIC Audit Process

1. **Identification of potential audits through data analysis.** The MIG and the Review MICs examine all paid Medicaid claims using the Medicaid Statistical Information System. Using advanced data mining techniques, MIG identifies potential areas that are at risk for overpayments that require additional review by the Review MICs. The Review MICs, in turn, identify specific potential provider audits for the Audit MICs on which to focus their efforts. This data-driven approach to identifying potential overpayments helps ensure that efforts are focused on providers with truly aberrant billing practices.

2. **Vetting potential audits with the state and law enforcement.** Prior to providing an Audit MIC with an audit assignment, CMS vets the providers identified for audit with state Medicaid agencies, state and federal law enforcement agencies, and Medicare contractors. Vetting is the process whereby CMS provides a list of potential audits generated by the data analysis mentioned above. If any of these agencies are conducting audits or investigations of the same provider for similar billing issues, CMS may elect to cancel or postpone the MIC audit to avoid duplicating efforts.

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

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

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

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

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

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

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

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

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

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

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Critical Access Behavioral Health Agencies

The Department of Health and Human Services (DHHS) has approved a definition and description of a new category of provider agency, a Critical Access Behavioral Health Agency (CABHA) for mental health and substance abuse services.

The goals in developing the CABHA designation are to

1. Ensure that critical services are delivered by a clinically competent organization with appropriate medical oversight and the ability to deliver a robust array of services.
2. Move the public system over time to a more coherent service delivery model that reduces clinical fragmentation at the local level and begins to prepare the provider community for the changes that will be required in a waiver environment.
3. Ensure that consumer care is based upon a comprehensive clinical assessment and an appropriate array of services for the population to be served. For example, a provider who will serve only children with mental health issues might offer outpatient therapy, case management, intensive in-home, and day treatment. The array will vary depending upon the age and needs of the consumers to be served by the agency.

CABHA status will be certified once for the entire State through a review by a certification team comprised of endorsement staff from Local Management Entities (LMEs) in the region where the CABHA provider is located and State staff. The certification process includes a demonstration by the agency of its ability to meet the terms of a standardized performance contract developed by DHHS. The contract will include requirements related to geographic areas to be served and requirements prohibiting rejection or premature discharge of consumers served (no eject or reject provisions). The provider will still be required to enter into standardized Memoranda of Agreements (MOAs) with LMEs in the catchment areas in which they deliver services and a standardized contract with those same LMEs for State-funded services. Continued certification as a CABHA will be based upon the agency's meeting or exceeding the required performance standards established by DHHS.

Additional information about CABHA can be found at http://www.ncdhhs.gov/mhddsas/cabha/.

Behavioral Health Section
DMA, 919-855-4290

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

Update on Community Based Rehabilitative Services

A workgroup with members from DMA and the Division of Public Health (DPH) finalized a new draft definition of Community Based Rehabilitative Services (CBRS) and submitted the revised definition to the N.C. Physician's Advisory Group (PAG) in late March. The revised definition will be posted for public comment on DMA's website as soon as the PAG finishes the review. DMA will submit a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) after the public comment period. It remains our goal to ensure that the newly revised service definition and SPA will be approved for Medicaid reimbursement under the N.C. Medicaid State Plan. **Providers should continue to provide and bill for this service through July 1, 2010.**

Behavioral Health Section
DMA, 919-855-4290

Attention: All Providers

Pneumococcal Conjugate Vaccine, 13 Valent, (PCV13) for Intramuscular Use (Prevnar 13, CPT Code 90670): Coverage Guidelines

The Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) recently added the new 13-valent pneumococcal conjugate vaccine (PCV13) to its list of recommended vaccines. PCV13 (Prevnar 13) is replacing the PCV7 (Prevnar) vaccine (CPT code 90669).

Effective with date of service March 22, 2010, the N.C. Medicaid Program recognized PCV13 vaccine as a covered vaccine in the North Carolina Immunization Program (NCIP). This program provides recipients who are eligible for the Vaccines for Children (VFC) program with all of the vaccines recommended by the ACIP. For the complete NCIP coverage criteria document, go to http://www.immunizenc.com/coveragecriteria.htm.

PCV13 will be available from the NCIP for children who are **both** VFC-eligible **and** are either

- aged 2 months through 59 months; or
- high-risk children aged 60 months through 71 months (that is, having underlying medical conditions that increase their risk of pneumococcal disease or complications); or
- aged 6 years through 18 years and are at risk for invasive pneumococcal disease because of certain conditions.

The recommendations from the ACIP for the use of PCV13 (Prevnar 13) are available online at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5909a2.htm. These recommendations contain all of the information on administering PCV13 including after a child began the series with PCV7 and for those children needing a supplemental dose of PCV13 after completing their PCV7 series. This link also provides information regarding underlying medical conditions that indicate the need for PCV13.

Medicaid does not reimburse for the actual vaccine because State-supplied vaccines are available to all providers enrolled in NCIP for VFC-eligible recipients. Medicaid covers a vaccine administration fee, if applicable.

For Medicaid Billing

- Report PCV13 vaccine with CPT code 90670.
- The ICD-9-CM diagnosis code V03.82 should be indicated on the claim when appropriate.
- Refer to the April 2010 Special Bulletin, *Health Check Billing Guide 2010* (http://www.ncdhhs.gov/dma/healthcheck/), for detailed billing guidelines.
- National Drug Codes are not required when billing or reporting vaccines.
- Providers should not report PCV7 (Prevnar) vaccine, CPT code 90669, after date of service June 30, 2010.

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

Attention: All Providers

Remittance and Status Reports in PDF Format

Effective with the June 8, 2010, checkwrite, the N. C. Medicaid Program will implement an expansion of the NC Electronic Claims Submission/Recipient Eligibility Verification (NCECS) Web Tool to allow providers to download a PDF version of their paper Remittance and Status Report (RA). There will be a transition period during the month of June when the paper RA will continue to be printed and mailed to providers. Beginning with the July 7, 2010, checkwrite, RAs will only be available through the NCECS Web Tool. The NCECS Web Tool will retain ten checkwrite versions of the PDF version of the RA. If a provider needs an RA that is older than ten checkwrites, they will follow the current procedure of requesting a copy through HP Enterprise Services Provider Services and will continue to be assessed a fee.

All providers who wish to be able to download a PDF version of their RA are required to register for this service regardless if they already have an NCECSWeb logon ID. The provider request form and instructions can be found on DMA's website at http://www.ncdhhs.gov/dma/provider/forms.htm. Providers are encouraged to complete the form immediately and return it to the HP Enterprise Services Electronic Commerce Services Unit to ensure adequate time for set up.

As a part of this expansion, there will be some minor changes to the layout of the RA. Some fields that are either duplicated or not used will be removed to allow room to report the HIPAA Claim Adjustment Reason Codes and Remark Codes along with the adjustment amounts. A complete list of changes will be published prior to implementation in a future bulletin article or special bulletin.

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

Attention: Independent Practitioners Respiratory Therapy Services

Posting of Respiratory Therapy Services Policy

Coverage information on respiratory therapy services will be removed from Clinical Coverage Policy 10B, *Independent Practitioners*. A separate clinical coverage policy, 10D, *Independent Practitioners Respiratory Therapy Services*, will be posted on June 1, 2010. This policy limits schools as a place of service to two visits per school year as well as limiting services in the home when a nurse is present. Care plans must be reviewed and signed off by the recipient's primary care physician or attending physician. All treatment services remain subject to prior approval. Because providers are approved for the care plan and not for the place of service, no changes will be needed to current authorizations. To ensure compliance with all criteria and requirements, refer to Clinical Coverage Policy 10D on DMA's website at http://www.ncdhhs.gov/dma/mp/.

Nora Poisella, Clinical Policy and Programs
DMA, 919-855-4310

Attention: Nurse Practitioners and Physicians

Tocilizumab Injectable (Actemra, HCPCS Code J3590): Billing Guidelines

Effective with date of service January 18, 2010, the N.C. Medicaid Program covers tocilizumab (Actemra) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologics). Actemra is available in 80-mg/4-ml, 200-mg/10-ml, and 400-mg/20-ml single-use vials.

Actemra is a recombinant humanized antihuman IL-6 receptor monoclonal antibody. It is indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response to one or more tumor necrosis factor (TNF) antagonist therapies. Safety and efficacy in children have not been established.

The recommended starting dose, when used in combination with DMARDs or as monotherapy, is 4 mg/kg, followed by an increase to 8 mg/kg based on clinical response. For adults, Actemra should be administered once every 4 weeks as a 60-minute single intravenous drip infusion.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Actemra is 714.0 through 714.2 (rheumatoid arthritis).
- Providers must bill Actemra with HCPCS code J3590 (unclassified biologics).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage is 10 mg (0.5 ml). Providers may bill for an entire single-use vial. The maximum reimbursement rate, per 10 mg (0.5 ml), is $34.56.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Actemra should be reported in "MLs." To bill for the entire 80-mg/4-ml single-use vial, report the NDC units as "ML4. To bill for the entire 200-mg/10-ml single-dose vial, report the NDC units as "ML10." To bill for the entire 400-mg/20-ml single-dose vial, report the NDC units as "ML20." If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Providers must bill their usual and customary charge.

The fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Nurse Practitioners and Physicians

Sildenafil Injectable (Revatio, HCPCS Code J3490): Billing Guidelines

Effective with date of service March 8, 2010, the N.C. Medicaid Program covers sildenafil (Revatio) for use in the Physician's Drug Program when billed with HCPCS code J3490 (unclassified drugs). Revatio is available in 10-mg/12.5-ml vials.

Revatio is indicated for the treatment of pulmonary arterial hypertension (WHO Group I) to improve exercise ability and delay clinical worsening. The safety and efficacy of Revatio in pediatric pulmonary hypertension patients have not been established. Revatio is contraindicated in patients who are using organic nitrates, either regularly or intermittently, in any form.

The recommended dose is one 10-mg intravenous (IV) bolus injection administered three times a day.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Revatio is 416.0 through 416.9 (primary pulmonary hypertension).
- Providers must bill Revatio with HCPCS code J3490 (unclassified drugs).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage is one 10-mg/12.5-ml single-dose vial. Providers may bill for an entire vial. The maximum reimbursement rate, per vial, is $97.16.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Revatio should be reported in "MLs." If billing for the entire 10-mg vial of Revatio, report the NDC units as "ML12.5." 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, Local Management Entities, and Physicians

Olanzapine Injectable (Zyprexa Relprevv, HCPCS Code J3490 and Zyprexa, S0166): Billing Guidelines

Effective with date of service February 8, 2010, the N.C. Medicaid Program covers olanzapine (Zyprexa Relprevv) extended release injection for use in the Physician's Drug Program when billed with HCPCS code J3490 (unclassified drugs). Zyprexa Relprevv is available in 210-mg, 300-mg, and 405-mg vials. Zyprexa Relprevv is indicated for the treatment of schizophrenia in adults. The safety and efficacy in children have not been established. The recommended usual dose of Zyprexa Relprevv is 150 mg to 300 mg administered intramuscularly (IM) every two weeks or 405 mg administered every four weeks. Doses greater than 405 mg every four weeks or 300 mg every two weeks have not been evaluated in clinical trials.

Effective with date of service February 8, 2010, Medicaid also covers olanzapine (Zyprexa) immediate-release formulation when billed with HCPCS code S0166. Zyprexa immediate-release formulation is available in 10-mg/ml vials, and is indicated in adults for agitation associated with schizophrenia and bipolar 1 mania. The safety and efficacy in children have not been established. For agitation associated with schizophrenia and bipolar 1 mania, the recommended usual dose is 10 mg given intramuscularly (IM). If agitation warranting additional IM doses persists following the initial dose, subsequent doses of up to 10 mg IM may be given. The safety of total daily doses higher than 30-mg or 10-mg injections given more frequently than two hours after the initial dose and four hours after the second dose have not been evaluated in clinical trials.

Medicaid Billing

For Zyprexa Relprevv

- The ICD-9-CM diagnosis code required for billing Zyprexa Relprevv is 295.0 through 295.9 (schizophrenic disorders).
- Providers must bill Zyprexa Relprevv with HCPCS code J3490 (unclassified drugs).
- One Medicaid unit of coverage is 1 mg. The maximum reimbursement rate, per mg, is $2.86. An entire 210-mg, 300-mg, or 405-mg single-dose vial may be billed.

For Zyprexa

- Providers must bill the ICD-9-CM diagnosis code to the highest level of specificity that supports medical necessity since there may be more than one diagnosis for a recipient.
- Providers must bill Zyprexa immediate-release injection with HCPCS code S0166.
- One Medicaid unit of coverage is 10 mg. The maximum reimbursement rate, per 10 mg, is $30.96. An entire 10-mg single-dose vial may be billed.

For Both Zyprexa and Zyprexa Relprevv

- Providers must indicate the number of HCPCS units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Zyprexa or Zyprexa Relprevv should be reported in "units." Report the NDC units according to the number of single-dose vials used. To bill for an entire single-dose vial, 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: Physicians

Collagenase Clostridium Histolyticum Injectable (Xiaflex, HCPCS Code J3590): Billing Guidelines

Effective with date of service March 3, 2010, the N.C. Medicaid Program covers collagenase clostridium histolyticum (Xiaflex) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologics). Xiaflex is available in 0.9-mg vials.

Xiaflex is a biologic product containing collagenase clostridium histolyticum, an enzyme that disrupts collagen. It is indicated for the treatment of adult patients with Dupuytren's contracture with a palpable cord. The safety and effectiveness of collagenase clostridium histolyticum in pediatric patients less than 18 years old have not been established.

Xiaflex should be injected intralesionally. The recommended dose is 0.58 mg per cord affecting a metacarpophalangeal (MP) joint or a proximal interphalangeal (PIP) joint. If contracture persists, finger extension procedure should be performed 24 hours after the injection to facilitate cord disruption. If MP or PIP contracture remains, re-inject cord four weeks following initial injection; injections and finger extension procedures may be administered up to three times per cord separated by approximately 4-week intervals.

Note: Only one cord should be injected at a time; if other palpable cords exist, injection should be performed in a sequential order.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Xiaflex is 728.6 (contracture of palmar fascia).
- Providers must bill Xiaflex with HCPCS code J3590 (unclassified biologics).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage is one 0.9-mg vial. Providers may bill for an entire single-use vial. The maximum reimbursement rate, per 0.9-mg vial, is $3,510.00.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Xiaflex should be reported in "units." If billing for the entire 0.9-mg vial of Xiaflex, 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 919-851-8888

Attention: Nurse Practitioners and Physicians

Coagulation Factor VIII Complex /von Willebrand Factor (Human) (Wilate, HCPCS Code J3590): Billing Guidelines

Effective with date of service January 1, 2010, the N.C. Medicaid Program covers coagulation factor VIII complex/von Willebrand factor (human) (Wilate), for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologics). Wilate is available in 450-IU/5-ml and 900-IU/10-ml single-dose vials.

Wilate is a concentrated blood-clotting factor extracted from human blood and pasteurized. Wilate is indicated for the treatment of spontaneous or trauma-induced bleeding episodes in patients with severe von Willebrand disease (VWD) as well as for patients with mild or moderate VWD in whom the use of desmopressin is known or suspected to be ineffective or contraindicated.

The recommended loading dosage of Wilate for minor hemorrhages is 20 to 40 units/kg of body weight, and for major hemorrhages is 40 to 60 units/kg of body weight. A maintenance dosage of 20 to 40 units/kg every 12 to 24 hours may need to be continued for up to three days for minor hemorrhages, and for up to 5 to 7 days for major hemorrhages.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Wilate is 286.4 (von Willebrand's disease).
- Providers must bill Wilate with HCPCS code J3590 (unclassified biologics).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage is 1 IU. The maximum reimbursement rate, per IU, is $1.20.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Wilate should be reported in "units." If billing for the entire 450-IU/5-ml single-dose vial, report the NDC units as "UN450." If billing for the entire 900-IU/10-ml single-dose vial, report the NDC units as "UN900." If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Providers must bill their usual and customary charge.

The fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Nurse Practitioners and Physicians

Ecallantide Injectable (Kalbitor, HCPCS Code J3490): Billing Guidelines

Effective with date of service January 28, 2010, the N.C. Medicaid Program covers ecallantide (Kalbitor) for use in the Physician's Drug Program when billed with HCPCS code J3490 (unclassified drugs). Kalbitor is available as 10-mg/ml single-use vials, packaged as three 10-mg/ml vials per carton.

Kalbitor is indicated for treatment of acute attacks of hereditary angioedema (HAE) in patients 16 years of age and older. By directly inhibiting plasma kallikrein, Kalbitor reduces the conversion of high molecular weight kininogen to bradykinin, and thereby treats symptoms of the disease during acute episodic attacks of HAE.

The recommended dosage of Kalbitor is 30 mg (3 ml) given subcutaneously in three 10-mg (1 ml) injections. If the attack persists, an additional dose of 30 mg maybe administered within a 24-hour period.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Kalbitor is 277.6 (other deficiencies of circulating enzymes, hereditary angioedema).
- Providers must bill Kalbitor with HCPCS code J3490 (unclassified drugs).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage is one 10-mg/ml single-use vial. The maximum reimbursement rate, per 10 mg, is $2,758.68.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Kalbitor should be reported in "MLs." To bill for the entire 10-mg/1-ml single-use vial, 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

Bevacizumab (Avastin, HCPCS Code J9035): Update to Billing Guidelines

Effective with date of service July 31, 2009, the N.C. Medicaid Program added the FDA-approved diagnosis of renal cell carcinoma to the required list of diagnoses for bevacizumab (Avastin) when billed through the Physician's Drug Program.

Certain ICD-9-CM diagnosis codes are required when billing for Avastin.

1. One of the following diagnosis codes must be billed with **V58.11** (encounter for chemotherapy):
    a. **153.0** through **154.8** (malignant neoplasm of the colon, rectum, recto-sigmoid junction, and anus); or
    b. **162.2** through **162.9** (unresectable, locally advanced, recurrent or metastatic non-squamous, non-small-cell lung carcinoma); or
    c. **174.0** through **175.9; 198.2; 198.81;** or **238.3** (breast cancer); or
    d. **191.0** through **191.9** (malignant neoplasm of brain)**;** or
    e. **189.0** through **189.1** (malignant neoplasm of kidney).
2. Diagnosis code **362.52** (exudative senile macular degeneration, wet) may be billed for Avastin, but does **not** require V58.11.

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

Attention: Durable Medical Equipment Providers

Rates for Codes B4100, B4103, B4104, and S8265

Rates have been established for these manually priced oral nutrition codes.

Effective with date of service **May 1, 2010,** providers should bill for these codes at the following rates. Providers no longer need to submit an invoice for pricing with the claim.

Code	Description	Rate
B4100	Food thickener, administered orally, per oz **Note:** (1 ounce = 1 unit)	$ 0.56 unit
B4103	Enteral formula. for pediatrics, used to replace fluids and electrolytes (e.g. clear liquids), 500ml = 1 unit	$ 3.36 per unit
B4104	Additive for enteral formula, (e.g. fiber) **Note:** (1 ounce = 1 unit)	$ 1.33 unit
S8265	Haberman feeder for cleft lip/palate **Note:** (1 bottle/1nipple = 1 unit)	$28.68 per unit

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

Attention: Durable Medical Equipment Providers

Rate Adjustment for Selected HCPCS Codes

Effective with date of service April 1, 2010, rates for the following durable medical equipment (DME) codes were adjusted, based on the January 1, 2010, version of the Medicare fee schedule. Medicare rates were adjusted downward by 0.57% to DME base codes, effective October 1, 2009.

HCPCS Code	Modifier	Descriptions
E0148	**NU**	Walker, heavy duty without wheels, rigid or folding, any type, each
E0148	**UE**	Walker, heavy duty without wheels, rigid or folding, any type, each
E0149	**NU**	Walker, heavy duty, wheeled, rigid or folding, any type
E0149	**UE**	Walker, heavy duty, wheeled, rigid or folding, any type
E0168	**RR**	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type
E0168	**NU**	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type
E0168	**UE**	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type
E0303	**RR**	Hospital bed, heavy duty, extra wide w/weight capacity greater than 350 lbs but less than or equal to 600 lbs, with any type side rails, with mattress
E0303	**NU**	Hospital bed, heavy duty, extra wide w/weight capacity greater than 350 lbs but less than or equal to 600 lbs, with any type side rails, with mattress
E0303	**UE**	Hospital bed, heavy duty, extra wide w/weight capacity greater than 350 lbs but less than or equal to 600 lbs, with any type side rails, with mattress
E0304	**RR**	Hospital bed, extra heavy duty w/weight capacity greater than 600 lbs with any type side rails, with mattress
E0304	**NU**	Hospital bed, extra heavy duty w/weight capacity greater than 600 lbs with any type side rails, with mattress
E0304	**UE**	Hospital bed, extra heavy duty w/weight capacity greater than 600 lbs with any type side rails, with mattress
E1037	**RR**	Transport chair pediatric size
E1037	**NU**	Transport chair pediatric size
E1037	**UE**	Transport chair pediatric size

Refer to the DME fee schedule (http://www.ncdhhs.gov/dma/fee/) for the maximum allowable rates for these codes and for all of the codes covered by N.C. Medicaid for DME. As stated in the N.C. Medicaid State Plan, there shall be no retroactive payment changes for fee changes.

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

Attention: Durable Medical Equipment Providers and Pharmacists

Additional Information on Prodigy Diabetic Supplies

The following additional information is provided regarding the Prodigy Diabetic Supply program:

Transition Period

The transition period for Prodigy ended on April 16, 2010. No additional overrides will be allowed for non-Prodigy brands of diabetic supplies available under the Prodigy program

Certificate of Medical Necessity/Prior Approval Form for Diabetic Supplies

The date span on the Certificate of Medical Necessity/Prior Approval Form (CMN/PA) for diabetic supplies can be valid for up to one calendar year with a corresponding valid physician prescription.

Insulin Pump Users

There is an **override** process available for recipients who, for clinical reasons, cannot use Prodigy products. In these instances, the provider must be a durable medical equipment (DME) provider or a pharmacy/DME provider. The following protocol, documented in Section 5.5 of Clinical Coverage Policy 5A, *Durable Medical Equipment* (http://www.ncdhhs.gov/dma/mp/), should be followed: fax the denial from the remittance advice to DMA at the designated diabetic supply override fax number, 919-715-3166, along with the required medical necessity forms. Consideration will be given to the request and a written decision will be returned to the provider.

Durable Medical Equipment Limitations

Medicaid may place appropriate limits, based on medical necessity criteria, on DME items and supplies. When the prescribing physician, physician's assistant or nurse practitioner orders equipment or supplies beyond these limits, the provider must seek authorization for payment for these items from DMA. The DME provider must send a written request to DMA, along with a letter of medical necessity from the prescribing physician, physician's assistant or nurse practitioner. Consideration will be given to the request and a written decision will be returned to the provider. Recipients will be notified in writing if the request is denied.

Step-by-Step Instructions

1. Send a copy of the completed CMN/PA and/or Letter of Medical Necessity indicating the type of pump being used and the brand-specific test strips that are needed and the quantity that is needed per month.
2. The CMN/PA and/or Letter of Medical Necessity must also indicate that the pump and the current glucometer communicate directly with each other. If there is any additional or other medical justification, it should also be presented.
3. All medical justification must be signed off on by the physician.
4. There must also be legible contact information for the provider and the physician.

Information can be faxed, preferably by the provider, to 919-715-3166. If there are any questions, please call 919-855-4310.

CMN/PA forms can be obtained by calling the HP Enterprise Services Provider Services Unit at 1-800-688-6696 or 919-851-8888.

DME Provider Billing for Diabetic Supplies

- There is no change in billing HCPCS units presently compared to the past.
- Calculate NDC units by multiplying the HCPCS units by the number of pieces in the package. For example, test strips HCPCS units = 1 (for 1 box) x 50 strips per box = 50 NDC units.

Durable Medical Equipment Program
DMA, 919-855-4310

Outpatient Pharmacy Program
DMA, 919-855-4300

Attention: Community Alternatives Program Case Managers and Durable Medical Equipment Providers

New Enrollment for Durable Medical Equipment Suppliers for Community Alternatives Program Waiver Supplies

Effective July 1, 2010, durable medical equipment (DME) providers may enroll with DMA as Community Alternatives Program (CAP) providers and bill for CAP waiver supplies. The CAP/DA and CAP/C case manager and ValueOptions will provide a service authorization to the CAP DME provider, which authorizes the amount and codes that are approved on the CAP Cost Summary. Case managers are responsible for ensuring that DME providers comply with the authorized quantity. Case managers, DMA and applicable UR vendors will conduct random audits of DME CAP waiver charges. Any reimbursement for unauthorized supplies will be subject to recoupment by Program Integrity. The case manager is responsible for securing the signed and dated physician order and retaining it on file. The order must detail the specific quantity and frequency of the supplies. The DME vendor must send a copy of the itemized monthly invoice to the CAP case manager.

Use of the BO modifiers for enteral supplies procedure codes being provided and billed as a CAP waiver supply apply only to recipients 21 years of age and older. These products are currently available for Medicaid recipients 20 years of age and younger as a State Plan service from an enrolled DME provider and are not covered as a waiver supply for children. Refer to the section on oral nutrition in Clinical Coverage Policy 5A, *Durable Medical Equipment*, for specific information for non-CAP recipients.

The enrollment period will begin on June 1, 2010. Specific criteria for enrollment as a DME CAP Waiver Supplier will be available on the CSC EVC NC Tracks website at http://www.nctracks.nc.gov/provider/providerEnrollment/index.jsp.

The following table lists HCPCS codes for CAP waiver supplies. Refer to the DMA Fee Schedules at http://www.ncdhhs.gov/dma/fee/ for maximum reimbursement rates. Provider must bill their usual and customary charges.

CAP Program	Procedure Code	Description	Limitations	Billing Unit	Maximum Allowable
CAP/C CAP/DA CAP/Choice	T4535	Disposable liner/shield/guard/pad/undergarment	*		$ 0.34
CAP/C CAP/DA CAP/Choice	T4539	Incontinent product, diaper/brief, reusable, any size	*		$ 21.22
CAP/DA CAP/Choice	T2028	Specialized supply, not otherwise specified, waiver (medication dispensing boxes)	*		$ 11.11
CAP/MR-DD	T1999	Specialized Equipment and Supplies	$3,000 per waiver year		
CAP/DA CAP/MR-DD	B4150 BO	Enteral formula nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, orally administered nutrition, not by feeding tube, 100 calories = 1 unit	*	100 CAL	$ 0.70

CAP Program	Procedure Code	Description	Limitations	Billing Unit	Maximum Allowable
CAP/DA CAP/MR-DD	B4152 BO	Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5kcal/ml with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may includes fiber orally administered nutrition, not by feeding tube 100 calories = 1 unit	*	100 CAL	$ 0.59
CAP/DA CAP/MR-DD	B4153 BO	Enteral formula nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, orally administered nutrition, not by feeding tube, 100 calories = 1 unit	*	100 CAL	$ 2.01
CAP/DA CAP/MR-DD	B4154 BO	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism includes altered composition proteins fats, carbohydrates, vitamins and/or minerals, may include fiber, orally administered nutrition, not by feeding tube, 100 calories = 1 unit	*	100 CAL	$ 1.29
CAP/DA CAP/MR-DD	B4155 BO	Enteral formula nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (E.G medium chain triglycerides) or combination, orally administered nutrition, not by feeding tube, 100 calories = 1 unit	*	100 CAL	$ 1.00
CAP/DA CAP/MR-DD	B4157 BO	Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism includes proteins, fats, carbohydrates, vitamins & minerals, may include fiber, orally administered nutrition, not by feeding tube, 100 calories = 1 unit	*	100 CAL	$ 1.20
CAP/DA CAP/MR-DD	B4158 BO	Enteral formula , for pediatric, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins & minerals, may include fiber, orally administered nutrition, not by feeding tube, 100 calories = 1 unit	*	100 CAL	$ 0.65
CAP/DA CAP/MR-DD	B4159 BO	Enteral formula, for pediatric, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins & minerals may include fiber and/or iron, orally administered nutrition, not by feeding tube, 100 calories = 1 unit	*	100 CAL	$ 0.65

CAP Program	Procedure Code	Description	Limitations	Billing Unit	Maximum Allowable
CAP/DA CAP/MR-DD	B4160 BO	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 KCAL/ML) with intact nutrients, includes proteins, fats carbohydrates, vitamins & minerals may includes fiber, orally administered nutrition, not by feeding tube, 100 calories - 1 unit	*	100 CAL	$ 0.56
CAP/DA CAP/MR-DD	B4161 BO	Enteral formula, for pediatric, hydrolyzed/amino acids & peptide chain proteins, includes fats, carbohydrates, vitamins & minerals, may include fiber, orally administered nutrition, not by feeding tube 100 calories = 1 unit	*	100 CAL	$ 1.90
CAP/DA CAP/MR-DD	B4162 BO	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, orally administered nutrition, not by feeding tube, 100 calories = 1 unit	*	100 CAL	$ 1.20

***** – As specified by service authorization

Clinical Policy and Program
DMA, 919-855-4360

Attention: Institutional Claim (UB-04/837I) Billers

Medicare Health Maintenance Organization: Institutional Services

In order for Medicaid to consider payment for Medicare HMO, providers are requested to bill all institutional charges on the UB-04 claim form. (Medicare HMO claims meet the criteria for an exception to electronic claims submission. See http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm.) The claims should not be altered for processing purposes. **The claim should be billed to Medicaid as it was billed to Medicare HMO. Medicaid liability is only for the Medicare HMO cost share, which includes copayment, coinsurance, and/or deductible.** The following information is required for claim processing:

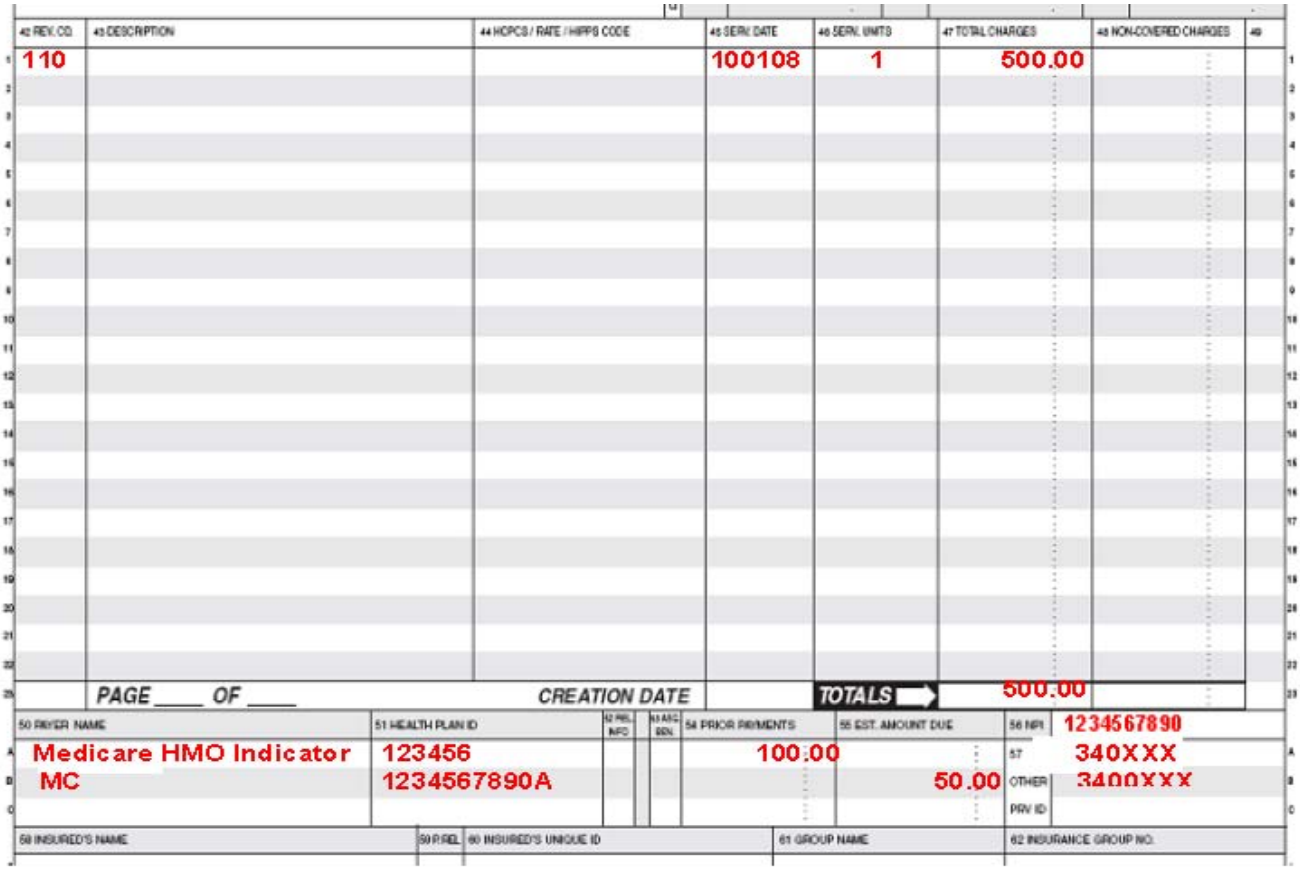
- The claims must be submitted with a Medicare EOB attached to the claim. If the EOB is on multiple pages, please submit all of the pages of the EOB with the claim.
- All charges must be reflected on the UB-04 claim form. Do not combine or destroy the integrity of the claim by "rolling up" the charges into one revenue code.

- If the recipient has patient monthly liability or deductible, the information must be reflected on inpatient stays, if applicable.
- **Form locator 47 (Total Charges) and form locator 56 (Estimated Amount Due) should reflect the Medicare HMO cost share amount only.**
- Indicate in form locator 80 that "This is a Medicare HMO claim."
- The Medicaid Provider Number (MPN) is required when submitting a UB-04 Medicare HMO claim along with the NPI of the Billing Provider. Enter the MPN in form locator 57 on the UB-04 claim form.

Mail the UB-04 claim form and Medicare HMO EOB to

DMA/Third Party Recovery
2508 Mail Service Center
Raleigh, NC 27699-2508

Example of a UB-04 HMO Claim Form



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

Attention: Professional Claim (CMS-1500/837P) Billers

Medicare Health Maintenance Organization – Professional Services

In order for Medicaid to consider payment for Medicare HMO, providers are requested to bill only the **cost share**, which includes the copayment, coinsurance, and/or deductible amount shown on the Medicare EOB. **Medicaid liability is only for the Medicare HMO cost share.** If there is no qualifying cost share amount, then Medicaid is not liable for payment. HMO claims must be filed on paper (see http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm).

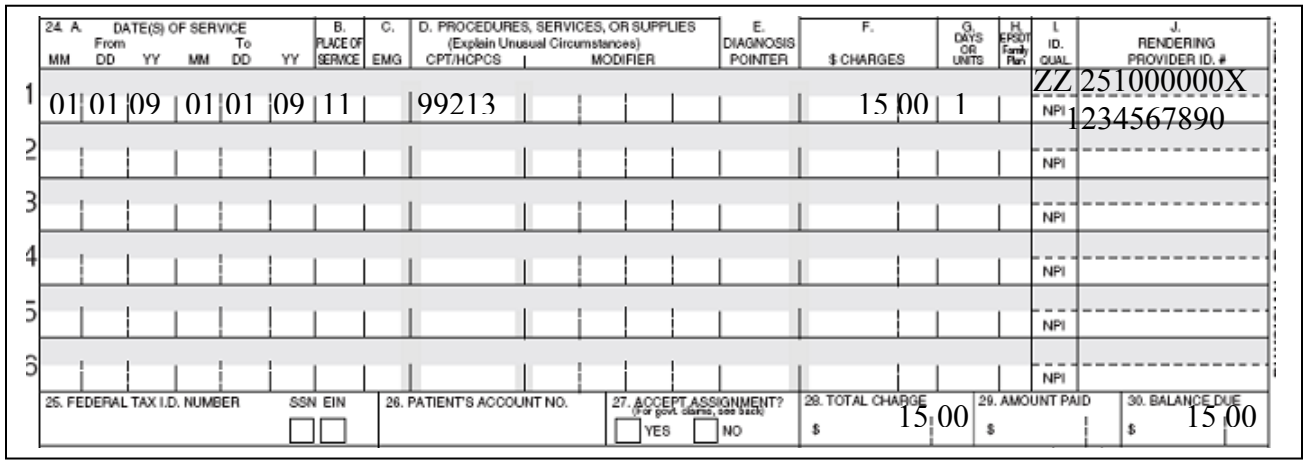
Providers filing on the CMS-1500 claim form must complete specific blocks following these instructions:

- Blocks 24F, 28, and 30 should reflect the Medicare HMO cost share amount only. If blocks 24F, 28, and 30 do not reflect the Medicare HMO cost share amount, the claim will be returned to the provider for correction.
- Block 29 should reflect third-party insurance payments only. Providers are not to indicate the Medicare HMO payment in this block. If the recipient does not have a third-party insurance payment, the block should be left blank. If the Medicare HMO payment is indicated in block 29, the claim will be returned to the provider for correction.

All CMS-1500 Medicare HMO claims should be submitted with the Medicaid Resolution Inquiry Form (http://www.ncdhhs.gov/dma/provider/forms.htm) indicating that the claim attached is a Medicare HMO. The Medicaid Resolution Inquiry Form, as well as the CMS-1500 claim form and Medicare HMO EOB, should be mailed to

HP Enterprise Services
Attn: Medicare HMO Claims
P.O. Box 30968
Raleigh NC 27622

Example of CMS-1500 HMO Claim Form



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	01	01	09	01	01	09	11		99213			15 00	1		ZZ 251000000X
2														NPI	1234567890
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
				YES NO	$ 15 00	$	$ 15 00

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

Attention: Personal Care Services Providers

Implementation of Independent Assessment, Prior Authorization, and New Personal Care Services and PCS-Plus Clinical Coverage Policy

Independent assessment of personal care services (PCS) recipients was implemented April 1, 2010, in response to Session Law 2009-451 (Senate Bill 202), Section 10.68A.(a)(3) (http://www.ncga.state.nc.us/Sessions/2009/Bills/Senate/PDF/S202v8.pdf). The Carolinas Center for Medical Excellence (CCME) is now conducting all Medicaid PCS independent assessments.

The new clinical coverage policy for PCS and PCS-Plus (http://www.ncdhhs.gov/dma/mp/) was implemented April 1, 2010. Effective April 16, 2010, service hours for qualifying recipients are determined by the method described in Attachment B2 of the posted policy.

Each of the following program requirements and procedures is now in effect:

1. **New Referrals and Admissions**
   CCME is conducting all new referral assessments. All individuals applying for admission to PCS or PCS-Plus must obtain a referral from their primary care or attending physician. Referrals will not be accepted from PCS provider agencies and must be submitted to CCME by the physician's office. New referral forms and instructions may be accessed on the DMA website (http://www.ncdhhs.gov/dma/services/pcs.htm) and the **Independent Assessment website** (http://www.qireport.net/).

2. **Change of Status Reviews**
   CCME is conducting all change of status reassessments. Referral forms and instructions for requesting change of status reviews may be accessed on the DMA website (http://www.ncdhhs.gov/dma/services/pcs.htm) and the **Independent Assessment website** (http://www.qireport.net/).

3. **Continuing Service (Annual) Reassessments**
   CCME is conducting all PCS and PCS-Plus continuing service reassessments. CCME will contact recipients to schedule these reassessments and may request assistance from providers when unable to contact recipients. CCME will continue to notify providers by fax or regular mail of reassessments scheduled through May 31, 2010. Beginning June 1, 2010, CCME will notify providers of reassessments only when scheduled to occur more than a month before recipients' annual reassessment dates. Providers who wish to contact CCME with information pertinent to a recipient's reassessment should do so a month or more before the recipient's annual reassessment date. Recipients and providers will be notified of assessment results.

4. **Recipient Choice of Provider**
   Individuals approved for PCS may choose any qualified home care agency licensed to provide PCS in the recipient's county and enrolled with DMA as an eligible PCS provider. It is the provider agency's responsibility to ensure that its DMA provider enrollment information is current.

5. **Prior Authorization**
   All assessments and reassessments conducted by CCME will determine recipient eligibility and authorized service levels. Prior approval of these recipients' claims is required.

6. **Claims Processing Requirements**
To ensure prompt claims processing and payment, providers who have not previously submitted PACT forms for all current recipients should submit recipient information immediately. Use one of the following two methods:

a. Submit PACT forms for all current recipients using and following instructions on the PACT Face Sheet (see the **Independent Assessment website**).

b. In lieu of submitting recipient PACT forms, providers may prepare and submit to CCME a summary that includes the following:

1) Agency name;

2) Medicaid provider number;

3) Agency physical address;

4) Agency contact person, telephone number, and e-mail address; and

5) A list, alphabetized by recipient last name, of each PCS recipient's Medicaid identification number, date of birth, date of current PACT form, and first and last name.

Please allow two weeks after sending recipient information before submitting claims, as payments will be delayed until CCME receives and transmits this information to the claims vendor.

7. **Weekly Summaries**
Submit by no later than May 15, 2010 to CCME updates of new recipients you assessed and admitted through April 16, 2010, and updates of continuing recipients you reassessed through April 30, 2010. Either use and follow instructions in Part 1 of the Weekly Summary Form (see the **Independent Assessment website**), or use the method described in paragraph 6.b., above, to submit information for newly admitted and reassessed recipients.

Until further notice, continue to submit weekly discharge updates to CCME, using and following instructions in Part 2 of the Weekly Summary Form (see the **Independent Assessment website**).

Do not submit new admission or reassessment updates for recipients assessed by CCME.

8. **Compliance with New PCS Clinical Coverage Policy**
The new PCS and PCS-Plus Clinical Coverage Policy 3C (http://www.ncdhhs.gov/dma/mp/) is in effect. The policy includes changes required by Session Law 2009-451 (Senate Bill 202), Section 10.68A.(a)(3), including changes in Non-Covered Tasks. Provider agencies are required to have completed and implementd POC revisions necessary to comply with the new policy by April 30, 2010. Refer to the **Independent Assessment website** for additional information on required POC revisions.

Refer to the **Independent Assessment website** and future bulletin articles for additional information and updates. Questions also may be directed to the CCME Independent Assessment Help Line at 1-800-228-3365 and by e-mail to PCSAssessment@thecarolinascenter.org.

CCME, 1-800-228-3365

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

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

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

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

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

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

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

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

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

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

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

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

Proposed Clinical Coverage Policies

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

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

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

2010 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
May	4/29/10	5/4/10
	5/6/10	5/11/10
	5/13/10	5/18/10
June	5/20/10	5/27/10
	6/3/10	6/8/10
	6/10/10	6/15/10
	6/17/10	6/24/10

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

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

Melissa Robinson
Executive Director
HP Enterprise Services