



## May 2012 Medicaid Bulletin

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**Attention: All Providers**

**P**rovider Self-Audit Protocol

The Program Integrity Unit of the N.C. Division of Medical Assistance (DMA) relies upon the health care industry to assist in the identification and resolution of matters that adversely affect the N.C. Medicaid and N.C. Health Choice (NCHC) programs. A cooperative effort serves a common interest of protecting the financial integrity of the Medicaid and NCHC programs while ensuring proper payments to providers. DMA recommends that providers conduct periodic, **voluntary self-audits** to identify instances where services reimbursed by Medicaid or Health Choice programs are not in compliance with the programs' requirements. This protocol does not affect the requirements of the Single Audit Act or other independent audit requirements.

The **self-audit** protocol facilitates the resolution of matters that, in the provider's reasonable assessment, potentially violate State or federal administrative law, regulation or policy governing the Medicaid and NCHC programs, or matters exclusively involving overpayments or errors that do not suggest violations of law. Upon review of information submitted by the provider or upon further investigation, DMA may determine that the matter violates state criminal or federal law. In such instances, DMA will refer the matter to the appropriate state or federal agency for further investigation.

**Voluntary Self-Audit Package information is located at:**

<http://www.ncdhhs.gov/dma/program%20integrity/SelfAuditPackagePISA0001.pdf>

**Program Integrity**  
DMA, (919) 647-8000

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**Attention: All Providers**

**N.C. Medicaid Tamper Resistant Prescription Pad Guidance Update**

N.C. Medicaid added the following to the list of acceptable features to meet characteristic No. 2 for tamper resistant prescription pads:

*g. Dispense and refill number bordered by asterisks and optionally spelled out to prevent modification*

The N.C. Medicaid Tamper Resistant Prescription Pads Guidance document was updated on March 2, 2012 to reflect this change.

**Clinical Policy**  
DMA, 919-855-4260

**Attention: All Providers****Basic N.C. Medicaid and N.C. Health Choice Seminars**

Basic N.C. Medicaid and N.C. Health Choice (NCHC) seminars are scheduled for May 2012. Seminars will educate providers on the basics of N.C. Medicaid and NCHC billing, as well as provide an overview of policy updates, contact information, and fraud, waste and abuse. The focus of the morning session will be the first seven sections of the revised [April 2012 Basic Medicaid and N.C. Health Choice 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 /Pharmacy. The remaining sections of the April 2012 Billing Guide will be reviewed during these breakout sessions focusing on claims submission, 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, which will be posted on the N.C. Division of Medical Assistance (DMA) seminar Webpage prior to the first scheduled session. This material will assist providers in following along with the presenters. If preferred, you may download the Billing Guide to a laptop and bring the laptop to the seminar. Or, you may access the Billing Guide 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 and afternoon sessions.** 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 both the morning and afternoon sessions.

Providers may register for the seminars by completing and submitting the [online registration form](#). Providers may attend just the morning session, the afternoon session, or both.

The morning session will begin at 9:00 a.m. and end at 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 are listed on the next page.

**Seminar Dates and Locations**

<b>Date</b>	<b>Location</b>
<b>May 1, 2012</b>	<b>Asheville</b> Crowne Plaza Tennis & Golf Resort One Resort Drive Asheville, N.C. 28806  <a href="#">get directions</a>
<b>May 8, 2012</b>	<b>Greensboro</b> Clarion Hotel Airport 415 Swing Road Greensboro, N.C. 27409  <a href="#">get directions</a>
<b>May 10, 2012</b>	<b>Raleigh</b> McKimmon Conference & Training Center 1101 Gorman Street Raleigh, N.C. 27606  <b>Note: Visitors are asked to park in designated visitor parking spaces in order to avoid ticketing.</b>  <a href="#">get directions</a>

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

**Attention: All Providers**

***E*rollment of Physician Assistants**

All Physician Assistants (PAs) providing services to N.C. Medicaid recipients must be enrolled under their own NPI number by June 30, 2012. **Effective July 1, 2012, the services of PAs must be billed under their own NPI number and not “incident to”.**

The Individual and Organization online provider enrollment applications are updated to include both PA provider types. Please visit the NCTracks [Provider Enrollment](#) Webpage to begin the online enrollment process. PAs and PA Groups who do not wish to apply online can continue to use the downloadable applications, which were also updated. Please review the [Provider Qualifications and Requirements Checklist](#) to ensure that the outlined criteria are met and all required documentation is furnished.

For questions regarding this notice, please contact the CSC EVC Operations Center. Customer Service Agents are available Monday through Friday, 8 a.m. through 5 p.m. Eastern Time, at 1-866-844-1113.

For billing or claims questions, please contact the HP Enterprise Services Help Desk. Representatives are available Monday through Friday, 8 a.m. through 4:30 p.m., at 919-851-8888 or 1-800-688-6696.

**EVC Operations Center**  
**CSC, 866-844-1113 or [NCMedicaid@csc.com](mailto:NCMedicaid@csc.com)**

**Attention: All Providers**

***E*rollment of Nurse Practitioners**

All Nurse Practitioners (NPs) providing services to N.C. Medicaid recipients must be enrolled under their own NPI number by June 30, 2012. **Effective July 1, 2012, the services of NPs must be billed under their own NPI number and not “incident to”.**

Please visit the NCTracks [Provider Enrollment](#) page to begin the online enrollment process. Nurse Practitioner and Nurse Practitioner Groups who do not wish to apply online can continue to use the downloadable applications, which were also updated. Please review the [Provider Qualifications and Requirements Checklist](#) to ensure that the outlined criteria are met and all required documentation is furnished.

For questions regarding this notice, please contact the CSC EVC Operations Center. Customer Service Agents are available Monday through Friday, 8 a.m. through 5 p.m. Eastern Time, at 1-866-844-113.

For billing or claims questions, please contact the HP Enterprise Services Help Desk. Representatives are available Monday through Friday, 8 a.m. through 4:30 p.m., at 919-851-8888 or 1-800-688-6696.

**EVC Operations Center**  
CSC, 866-844-1113 or [NCMedicaid@csc.com](mailto:NCMedicaid@csc.com)

**Attention: All Providers****Injection, Gadobutrol (Gadavist, HCPCS Code A9585): Billing Guidelines**

Effective with date of service January 1, 2012, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover gadobutrol injection (Gadavist) when billed with HCPCS code A9585 (Injection, gadobutrol – Per 0.1 ml). Gadavist is available in 7.5 ml, 10 ml, and 15 ml single-dose vials and single-dose pre-filled disposable syringes.

Gadavist is indicated for intravenous use in diagnostic magnetic resonance imaging in adults and children (2 years of age and older) to detect and visualize areas with disrupted blood brain barrier (BBB) and/or abnormal vascularity of the central nervous system. The recommended dose of gadobutrol is 0.1 ml/kg body weight administered as an intravenous bolus injection at a flow rate of approximately 2 ml/second.

**For N.C. Medicaid Billing**

- Providers must bill Gadavist with HCPCS code A9585 (Injection, gadobutrol – Per 0.1 ml).
- One of the following CPT codes are required when billing for Gadavist:
  - 70551-70553 Magnetic Resonance Imaging: Brain and Brain Stem
  - 72141-72158 Magnetic Resonance Imaging: Spine
- Providers must indicate the number of HCPCS units.
- The Medicaid unit of coverage is 0.1 ml.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. Report the number of milliliters for the NDC units.
- Refer to the [January 2012, National Drug Code Implementation, Update](#), on the N.C. Division of Medical Assistance (DMA) Website for additional instructions.
- Providers must bill their usual and customary charge.

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

**Attention: All Providers****Injection, Ioflupane I 123, 185 MBq (DaTscan, HCPCS Code A9584): Billing Guidelines**

Effective with date of service January 1, 2012, the N.C. Medicaid and N.C. Health Choice programs cover ioflupane <sup>123</sup>I injection (DaTscan) when billed with HCPCS code A9584 (Iodine I-123 ioflupane, diagnostic). DaTscan is available in single-use vials containing 185 MBq (5mCi) in 2.5 ml sterile solution for intravenous injection.

DaTscan is indicated for striatal dopamine transporter visualization using single photon emission computed tomography (SPECT) brain imaging to assist in the evaluation of adult patients with suspected Parkinsonian syndromes (PS). The recommended dose of ioflupane <sup>123</sup>I is 111 to 185 MBq (3 to 5 mCi) in an adult administered intravenously 3–6 hours prior to SPECT scan.

**For N.C. Medicaid Billing**

- Providers must bill DaTscan with HCPCS code A9584 (Iodine I-123 ioflupane, diagnostic).
- The following CPT code is required when billing for DaTscan:
  - 78607 Brain imaging, tomographic (SPECT)
- Providers must indicate the number of HCPCS units.
- The Medicaid unit of coverage is per study dose up to 5 MCI (millicuries)
- Providers are not required to append an NDC with A9584 on the claim at this time.
- Providers must bill their usual and customary charge.

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



**Attention: All Providers****Bevacizumab (Avastin, HCPCS Code J9035)—Update to Billing Guidelines**

This article provides new billing guidance regarding N.C. Medicaid's coverage of the drug Avastin. Effective with date of service on and after April 1, 2012, the N.C. Medicaid program discontinued coverage of Avastin under the Physician's Drug Program for recipients who are newly diagnosed and/or beginning treatment for breast carcinoma. Medicaid continues to reimburse for Avastin for those recipients who were already receiving Avastin treatment for breast carcinoma prior to date of service April 1, 2012. Unless a recipient was started on Avastin treatment prior to April 1, 2012, the last date of service providers may bill for Avastin for recipients with breast carcinoma is March 31, 2012. Claims paid for Avastin on and after April 1, 2012, for breast carcinoma recipients not already on Avastin treatment prior to April 1, 2012, may be recouped.

For dates of service April 1, 2012, and after, providers must bill for recipients **who have already been receiving Avastin for breast carcinoma** and are continuing treatment for breast carcinoma by **appending the EJ modifier ("Subsequent claims for a defined course of therapy") to HCPCS code J9035**. For all other recipients who do not have breast carcinoma diagnoses, providers should continue to bill as usual.

Effective with date of service April 1, 2012, and after, **one** of the following ICD-9-CM diagnoses must be billed with J9035 (**with EJ modifier**) for those recipients with **breast carcinoma who are continuing on Avastin treatment**:

- 174.0 – 175.9 malignant neoplasm of breast
  - secondary malignant neoplasm of skin of breast
- 198.81 secondary malignant neoplasm of breast
- 238.3 neoplasm of uncertain behavior of breast

**Note:** ICD-9-CM diagnosis code V58.11 **must** be billed with one of the diagnoses above. Effective with date of service April 1, 2012, and after, **for recipients other than those with breast carcinoma**, one of the following ICD-9-CM diagnoses must be billed with J9035:

- 153.0 – 154.8 malignant neoplasm of colon, rectum, rectosigmoid junction and anus;
- 162.2 – 162.9 malignant neoplasm of lung;
- 189.0 – 189.1 malignant neoplasm of kidney;
- 191.0 – 191.9 malignant neoplasm of brain; or
- 362.52 wet age-related macular degeneration.

**Note:** ICD-9-CM diagnosis code V58.11 **must** be billed with one of the diagnoses above **except for 362.52**.

**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 the N.C. Division of Medical Assistance (DMA) Website at <http://www.ncdhhs.gov/dma/mp/>:

- *1A-8, Hyperbaric Oxygenation Therapy (3/1/12)*
- *1G-1, Burn Treatment (1/1/12)*
- *1S-3, Laboratory Services (4/1/12)*
- *5A, Durable Medical Equipment (10/1/11)*

The following new or amended combined N.C. Medicaid and N.C. Health Choice (NCHC) clinical coverage policies are now on the DMA Website at <http://www.ncdhhs.gov/dma/mp/>:

- *1A-2, Preventive Medicine Annual Health Assessment (3/12/12)*
- *1A-7, Neonatal and Pediatric Critical and Intensive Care Services (3/12/12)*
- *1A-21, Endovascular Repair of Aortic Aneurysm (3/12/12)*
- *1A-31, Wireless Capsule Endoscopy (3/12/12)*
- *1C-1, Podiatry Services (3/12/12)*
- *1C-2, Medically Necessary Routine Foot Care (3/12/12)*
- *1E-3, Sterilization Procedures (3/12/12)*
- *1E-6, Pregnancy Medical Home (3/12/12)*
- *1K-6, Radiation Oncology (3/1/12)*
- *1S-2, HIV Tropism Assay (3/12/12)*
- *1S-4, Cytogenetic Studies (3/12/12)*
- *3K-1, Community Alternatives Program for Children (CAP/C) (3/1/12)*
- *12A, Case Management Services for Adults and Children at Risk for Abuse, Neglect, or Exploitation (3/12/12)*

The following new or amended NCHC policies are now available on the DMA Website at <http://www.ncdhhs.gov/dma/hcmp/>:

- *Burn Treatment (1/1/12)*
- *Deep Brain Stimulation (DBS) (3/1/12)*
- *Hyperbaric Oxygen Therapy (3/1/12)*
- *Laboratory Services (3/12/12)*
- *Durable Medical Equipment and Supplies (10/1/11)*
- *Moderate (Conscious) Sedation (3/1/12)*
- *Out-of-State Services (3/12/12)*

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**  
**DMA, 919-855-4260**

**Attention: All Providers and Vendors**

**HIPAA ASC X12 4010 A1 and 5010 837 - Extension of Enforcement Discretion Period through June 30, 2012**

On March 15, 2012, the US Centers for Medicare & Medicaid Services' (CMS) Office of E-Health Standards and Services (OESS) announced that it will not initiate enforcement action to comply with the updated transaction standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA): ASC X12 Version 5010 and National Council for Prescription Drug Programs (NCPDP) Versions D.0 and 3.0, for an additional three months through June 30, 2012.

Given this OESS notice, the N.C. Division of Medical Assistance (DMA) has decided to continue the dual processing of 4010A1 and 5010 837 transactions **only** through June 30, 2012. **The remaining HIPAA-covered ASC X12 4010A1 transactions and NCPDP 5.1 transactions are no longer being accepted. Adjudication of claims submitted in the ASC X12 4010A1 format will also be suspended for a two-week period.**

Providers can contact the ECS unit of HP Enterprise Services, at 1-800-688-6696 or 919-851-8888; press option 1 for questions or assistance regarding this information about the ASC X12 5010 implementation.

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

**Attention: All Providers**

**Correct Coding Edits: Adjusting the Number of Units for Submitted Claims**

If a provider determines that the number of units billed for a service was incorrect, the original claim should be voided and a replacement claim submitted with the corrected number of units. Providers should not submit another claim with additional units, as this may result in the denial of the claim under a NCCI or other correct coding edit.

National Correct Coding Initiative (NCCI) methodologies require that if units of service exceed the Medically Unlikely Edit (MUE) limits, then the entire claim line must be denied.

With the implementation of standard claims transactions to comply with the Health Insurance Portability and Accountability Act (HIPAA), adjustments may be filed electronically. Electronic adjustments are the preferred method to report an overpayment or underpayment to N.C. Medicaid or N.C. Health Choice.

**There are two options that may be utilized:**

1. **Void** – In order to file a claim to be voided, the provider must mark the claim as a voided claim using the Claim Submission Reason Field (Dental ADA 2006/837D and CMS-1500/837P) and Type of Bill (UB-04/837I) on the 837 electronic claim transaction. The ICN for the original claim to be voided must also be provided. When processed, the claim associated with the original ICN will be recouped from the patient’s record and the payment will be recouped from the provider’s Remittance and Status Report (RA).
2. **Replacement** – A replacement claim may be filed by completing a corrected electronic claim and marking the claim as a replacement using the Claim Submission Reason Field (Dental ADA 2006/837D and CMS-1500/837P) and Type of Bill (UB-04/837I) on the 837 electronic claim transaction. The ICN for the original claim to be replaced must also be provided. The original claim will be recouped from the patient’s record and shown as a recoupment on the RA when the replacement claim is processed without error. If the replacement claim is denied, the entire replacement process will be denied, including the recoupment.

Step by step instructions about using the NCECSWeb Tool can be found in the December 2011 Medicaid Special Bulletin “NCECSWeb Tool Instruction Guide,” page 51 at <http://www.ncdhhs.gov/dma/bulletin/NCECSWebGuide.pdf>. For further assistance, providers may contact HP Enterprise Services Provider Services Department at 1-800-688-6696, menu option 3, Monday through Friday from 8:00 a.m. to 4:30 p.m.

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

**Attention: All Providers****Maintaining the Security and Accessibility of Records after a Provider Agency Closes**

All N.C. Medicaid and N.C. Health Choice (NCHC) providers are responsible for maintaining custody of the records and documentation to support service provision and reimbursement of services by the N.C. Division of Medical Assistance (DMA) for at least six years. See 10A NCAC 22F.0107 and Section 7 of the N.C. Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement. The Agreement is part of the enrollment application and may be accessed from the [NCTracks Provider Enrollment Webpage](#).

Mental Health, Developmental Disabilities, and Substance Abuse (MH/DD/SA) services records are subject to additional retention and management requirements, including those mandated by S.L. 2009-451 (Section 10.68A(a)(5)(j) and (k) for Community Support and Other MH/DD/SA Services and Section 10.68A(a)(7)(h) and (i) for MH Residential Services). MH/DD/SA providers should refer to guidance from Implementation Updates No. 79, No. 72, No. 62, No. 60, and No. 58 for more information.

Documentation that is required to be maintained by all providers includes clinical service records, billing and reimbursement records, and records to support staff qualifications and credentials (personnel records). Clinical service records include, but are not limited to:

- Diagnostic testing results (X-rays, lab tests, EKGs, psychological assessments, etc.)
- Records from other providers used in the development of care plans
- Nurses' notes or progress notes
- Service orders that authorize treatment and treatment
- Service or treatment plans

Billing and reimbursement records should include recipient demographic information.

Providers are **required** to arrange for continued safeguarding of the above-described records in accordance with the record retention guidelines. Failure to protect consumer or staff privacy by safeguarding records and ensuring the confidentiality of protected health information is a violation of the Health Insurance Portability and Accountability Act (HIPAA) and NCGS § 108A-80 and may be a violation of the North Carolina Identity Theft Protection Act. Violations will be reported to the Consumer Protection Section of the N.C. Attorney General's Office, the Medicaid Investigations Unit of the N.C. Attorney General's Office and/or the U.S. DHHS Office of Civil Rights, as applicable. The following sanctions, penalties, and fees may be imposed for HIPAA violations:

- Mandatory investigation and penalties for noncompliance due to willful neglect
- Willful neglect: \$50,000 up to \$1.5 million (\$10,000 up to \$250,000 if corrected within 30 days)
- Enforcement by the State Attorney General along with provisions to obtain further damages on behalf of the residents of the State in monetary penalties plus attorney fees and costs as provided for by the Health Information Technology for Economic and Clinical Health (HITECH) Act.

A provider's obligation to maintain the above-described records is independent from ongoing participation in the N.C. Medicaid or NCHC programs and extends beyond the expiration or termination of the Agreement or contract. See 10A NCAC 22F.0107 and Section 8 of the DHHS Provider Administrative Participation Agreement. Provider records may be subject to post-payment audits or investigations after an agency closes. Failure to retain adequate and accessible documentation of services provided may result in recoupment of payments made for those services, termination or suspension of the provider from participation with the N.C. Medicaid or NCHC programs and/or referral to the US DHHS Office of Inspector General for exclusion or suspension from federal and state health care programs.

If another provider takes over the functions of a closing entity, maintenance of the closing entity's records for the applicable recipients may be transferred to the new provider, if the new provider agrees to accept custody of such records in writing and a copy of this agreement is provided to the N.C. Division of Medical Assistance (DMA) upon request. When custody of records is not transferred, the closing providers should send copies of transitional documentation to the providers who will be serving the recipient for continuity of care. Consumer authorization should be obtained as necessary. Copies of records may be provided to the recipient directly for coordination of care.

DMA must be notified of changes in provider enrollment status, including changes in ownership and voluntary withdrawal from participation in the N.C. Medicaid and NCHC programs, as indicated on the [NCTracks Reporting a Provider Change Webpage](#). Providers who anticipate closure are required to develop and implement a records retention and disposition plan. The plan must indicate how the records will be stored, the name of the designated records custodian, where the records will be located, and the process to fulfill requests for records. Information must be included on how recipients will be informed of the contact information and the process to request their records. The plan should also designate retention periods and a records destruction process to take place when the retention period has been fulfilled and there is no outstanding litigation, claim, audit or other official action. The plan should be on file with the records custodian.

**Program Integrity**  
**DMA, 919-647-8000**

**Attention: All Providers**

**Session Law 2011-399 Senate Bill 496, § 108C-7. Prepayment Claims Review**

In order to ensure that claims submitted by a provider for payment by the N.C. Division of Medical Assistance (DMA) meet the requirements of federal and state law criteria, a provider may be required to undergo prepayment claims review by the Division or its vendors.

The DMA will process all “clean” claims submitted for prepayment review within 20 calendar days of receipt of documentation submitted by the provider. If the provider fails to initially provide any of the specifically requested supporting documentation necessary to determine if a claim is “clean,” the DMA will subsequently send the provider written notification of the lacking or deficient documentation within 15 calendar days of receipt of such claim.

**The provider shall remain subject to the prepayment claims review process until the provider achieves three consecutive months with a minimum seventy percent (70%) clean claims rate. Providers are advised that it is inappropriate to shift clients to other service locations in order to avoid prepayment review of claims.**

If the provider does not meet this standard within six months of being placed on prepayment claims review, the DMA may implement sanctions, including termination of the applicable Medicaid Administrative Participation Agreement, or continuation of prepayment review for an additional six-month period.

**Recipient Drift Reporting**

After a provider is placed on prepayment review, a Recipient Drift Report may be run. A Recipient Drift Report tracks recipients who received services from a provider who was placed on prepayment review before a certain date. It also displays all the providers who supplied services to the same recipients after that date. This report can be used to track recipients leaving a provider who is on prepayment review, or to measure the number of recipients still receiving a service once the provider on prepayment review stops billing.

**Program Integrity  
DMA, 919-647-8000**

**Attention: All Providers**

**Updated EOB Code Crosswalk to HIPAA Standard Codes**

The list of standard national codes used on the Electronic Remittance Advice (ERA) has been cross-walked to Medicaid Explanation of Benefits (EOB) codes as an informational aid to research adjudicated claims listed on the Remittance and Status Report (RA). An updated version of the list is available on the N.C. Division of Medical Assistance (DMA) 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: Durable Medical Equipment and Orthotics & Prosthetics Providers**

### **Webinar Training**

The N.C. Division of Medical Assistance (DMA) has scheduled training during the month of May 2012 to educate providers on Durable Medical Equipment (DME) and Orthotics & Prosthetics (O&P) billing, clinical policy updates and resources. The training will be presented in Webinar format. For updated clinical policies, please visit DMA's Webpage at:

- <http://www.ncdhhs.gov/dma/mp/dmepdf.pdf> for Durable Medical Equipment
- <http://www.ncdhhs.gov/dma/mp/5B.pdf> for Orthotics & Prosthetics.

Pre-registration is required for the Webinars. DME and O&P providers are encouraged to participate in the training. Registration for the Webinars will be limited to 75 participants per session.

#### **Webinar Dates/Times**

<b>Webinar Dates</b>	<b>Morning Webinar</b>	<b>Afternoon Webinar</b>
Tuesday, May 22, 2012	10:00 a.m. to noon	2:00 p.m. to 4:00 p.m.
Thursday, May 24, 2012	10:00 a.m. to noon	2:00 p.m. to 4:00 p.m.

Providers may register for Webinars using the [online Webinar registration form](#) or may [register by fax](#) (fax it to the number listed on the form). Please include an e-mail address or fax number for your return confirmation. In addition, please indicate the session you plan to attend. The registration confirmation will include information on how to access and navigate within the Webinar setting.

#### **HP Enterprise Services**

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

## **Attention: Independent Diagnostic Testing Facility (IDTF) Providers**

### **IDTF Billing Information and List of Procedure Codes**

Effective March 15, 2012, an **Independent Diagnostic Testing Facility (IDTF)** provider can bill globally or with the technical component (TC) for the procedure. If the IDTF bills globally, an appropriate professional must still provide a written interpretation and report with the results of the procedure. As a reminder, attached is a list of procedure codes that an IDTF can provide and bill to N.C. Medicaid. For a list of procedure codes that require prior approval, refer to Prior Approval for Imaging Policy 1L-7 at <http://www.ncdhhs.gov/dma/mp/1K-7.pdf>.

<b>CPT CODE</b>	<b>DESCRIPTION</b>
76536	Ultrasound, soft tissues of head and neck (e.g., thyroid, parathyroid, parotid), real time with image documentation
76604	Ultrasound, chest (includes mediastinum), real time with image documentation
76645	Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation
76700	Ultrasound, abdominal, real time with image documentation; complete
76705	Ultrasound, abdominal, real time with image documentation; limited (e.g., single organ, quadrant, follow-up)
76770	Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), real time with image documentation; complete
76775	Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), real time with image documentation; limited
76776	Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation
76800	Ultrasound, spinal canal and contents
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation
76802	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation
76810	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)

<b>CPT CODE</b>	<b>DESCRIPTION</b>
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation
76812	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)
76813	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation
76814	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation (List separately in addition to code for primary procedure)
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (e.g., fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses
76816	Ultrasound, pregnant uterus, real time with image documentation, follow-up (e.g., re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal
76818	Fetal biophysical profile; with non-stress testing
76819	Fetal biophysical profile; without non-stress testing
76820	Doppler velocimetry, fetal; umbilical artery
76821	Doppler velocimetry, fetal; middle cerebral artery
76825	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;
76826	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; follow-up or repeat study
76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete
76828	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; follow-up or repeat study
76830	Ultrasound, transvaginal
76831	Saline infusion sonohysterography (SIS), including color flow Doppler, when performed
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete
76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (e.g., for follicles)
76870	Ultrasound, scrotum and contents
76872	Ultrasound, transrectal;

<b>CPT CODE</b>	<b>DESCRIPTION</b>
76881	Ultrasound, extremity, nonvascular, real-time with image documentation; complete
76882	Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific
76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method
77055	Mammography; unilateral
77056	Mammography; bilateral
77057	Screening mammography, bilateral (2-view film study of each breast)
93303	Transthoracic echocardiography for congenital cardiac anomalies; complete
93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study
93306	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography
93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete
93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study
93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)
93875	Noninvasive physiologic studies of extracranial arteries, complete bilateral study (e.g., periorbital flow direction with arterial compression, ocular pneumoplethysmography, Doppler ultrasound spectral analysis)
93880	Duplex scan of extracranial arteries; complete bilateral study
93882	Duplex scan of extracranial arteries; unilateral or limited study
93922	Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries (e.g., for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with transcutaneous oxygen tension measurements at 1-2 levels)

CPT CODE	DESCRIPTION
93923	Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (e.g., for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional, Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more level(s), or single level study with provocative functional maneuvers (e.g., measurements with postural provocative tests, or measurements with reactive hyperemia)
93924	Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing (i.e., bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study
93925	Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study
93926	Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study
93930	Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study
93931	Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study
93965	Noninvasive physiologic studies of extremity veins, complete bilateral study (e.g., Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study
93975	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study
93976	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study

<b>CPT CODE</b>	<b>DESCRIPTION</b>
93979	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study
93990	Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)

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

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***Attention: HIV Case Management Providers***

***HIV Case Management Basic Training***

The Carolinas Center for Medical Excellence (CCME) and N.C. Division of Medical Assistance (DMA) are pleased to announce that in **May 2012** we are offering HIV Basic Training for case managers and supervisors employed by an agency that is currently certified by CCME. This four-day training runs **May 14 through May 17**.

The training is **mandatory** for:

- Individuals hired after May 1, 2011 who have not attended Basic Training, and,
- Individuals hired prior to May 1, 2011 who did not attend one of the two-day trainings on Clinical Coverage Policy 12B.

The training will be held at the Comfort Inn Suites on Page Road in Durham. Providers should monitor CCME's Website (<http://www.thecarolinascenter.org/HIVCM>) for details and updates on this issue.

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

**Attention: North Carolina Health Choice Providers**

**N.C. Health Choice Well Visits and Immunizations - Update**

Providers were previously notified by bulletin and e-mail alert that the N.C. Division of Medical Assistance (DMA) was working with its fiscal agent, HP Enterprise Services, to correct a processing issue that caused N.C. Health Choice wellness exams to be denied when billed in conjunction with vaccines for the same date of service. The resulting denial was EOB 2066 (Immunization Administration and Therapeutic Injections not allowed same day as E/M).

The system update has now been completed. N.C. Health Choice providers who have received EOB 2066 may now re-file those claims. Providers who elected to hold all claims for preventive services for N.C. Health Choice until the system was corrected may now file those claims.

In addition, questions have been raised about the reimbursement for the N.C. Health Choice wellness exam. DMA is in the process of defining a wellness package of services that will be reimbursed as Medicaid reimburses for the Health Check exam. Additional information will be provided when that program is developed. Until that time, for dates of service on or after Oct. 1, 2011, in addition to the preventive medicine codes, providers may bill separately and receive reimbursement for the following services for NCHC recipients – if appropriate.

- Developmental Screening CPT Code 96110
- Hearing CPT Code 92551 or 92552;  
For children 6-10 and then as appropriate based on risk.
- Autism Screening CPT Code 99420
- Health Risk Assessments, CPT Code 99420 (GAPS/HEADSSS) and Behavioral/Mental Health Screening (PSC/SDQ/PSQ-A/Beck's);
- CPT 99406-99407  
For Smoking/Tobacco Use Cessation; and
- CPT 99408-99409  
For Alcohol/Substance Abuse Structured Screening and Brief Intervention (CRAFFT)

For further assistance, providers can contact HP Enterprise Services Provider Services Department at 1-800-688-6696, menu option 3, Monday through Friday from 8:00 a.m. to 4:30 p.m.

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

## **Attention: Professional Billers**

### ***M*edicare Override Function via the NCECSWeb Tool**

The NCECSWeb Tool has the capability to override Medicare electronically. Providers who receive a denial for a Medicare non-covered service can utilize the NCECSWeb Tool instead of submitting a paper Medicare override on the N.C. Medicaid Resolution Inquiry Form.

The claims can be overridden electronically on the NCECSWeb Tool as long as documentation is kept on file that substantiates that the service is a non-covered Medicare service.

Within the *Miscellaneous Claims Information* Section, providers must select “Yes,” as indicated below, confirming that they have paperwork on file to override Medicare.

**Paperwork on file at Provider Site for Medicare Override?:**  **Yes**  **No**

Dental providers no longer have the Medicare Override Field on the NCECSWeb Tool dental claim format. This was removed with the 5010 HIPAA changes.

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

**HP Enterprise Services**

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



## Attention: All Providers

### Upcoming Policy Implementation: BRANDS Monitoring

On June 5, 2012, the N.C. Division of Medical Assistance (DMA), partnering with Community Care of North Carolina (CCNC), will implement a policy that creates a prior authorization process called BRANDS. Similar to the A+KIDS program, BRANDS (Brand Request-Adverse event Needs Documentation) is a Web-based application available on the Document for Safety Website, [www.documentforsafety.org](http://www.documentforsafety.org).

The BRANDS program supports the NC Medicaid policy *Prior Approval for Brand-Name Drugs (DAW-1)*. To request a brand name medication for a patient when multiple generic equivalents are available in the marketplace, this policy requires documentation of an adverse event experienced by the patient that was associated with use of a generic equivalent. The BRANDS application allows the provider to request a brand name medication for a patient and document the adverse effect related to the generic equivalent at the same time. All requests must use the BRANDS application; fax requests will not be accepted. In addition to the BRANDS authorization, the words "Medically Necessary" must still be written on the face of the prescription in the prescriber's own handwriting in order for the pharmacy to be able to process the prescription for the brand name drug.

- Authorization of a brand name medication generally includes authorization of any brand product, in any available strength and dosage form, that contains the same generic ingredient(s).
- Medications used for the treatment of seizures and those designated as Narrow Therapeutic Index drugs by the N.C. Board of Pharmacy (e.g., Coumadin, Synthroid) are exempt from the requirements of this policy.
- Adverse event reports created in the Web application may be submitted to the FDA MedWatch program.

Providers who have registered on the Document for Safety Website to use the A+KIDS application, or on the SmartDUR Website to use the Synagis application, do not need to register again; the same User ID and Password will give access to the BRANDS application. Providers without a User ID and Password can go to the Document for Safety Website at any time to register.

Registered providers may start requesting brand medications through the BRANDS application at any time starting on May 10, 2012; however, point-of-sale messaging will not start until June 5.

**Clinical Policy**  
**DMA, 919-855-4305**

**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://agency.governmentjobs.com/northcarolina/default.cfm>. To view the vacancy postings for DMA, click on “Agency,” then click on “Department of Health and Human Services”. If you identify a position for which you are both interested and qualified, complete a **state application form online** and submit it to the contact person listed for the vacancy. If you need additional information regarding a posted vacancy, call the contact person at the telephone number given in the vacancy posting. General information about employment with North Carolina State Government is also available online at <http://www.osp.state.nc.us/jobs/gnrinfo.htm>.

**Proposed Clinical Coverage Policies**

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

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

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

**2012 Checkwrite Schedule**

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
<b>May</b>	5/3/12	5/8/12	5/9/12
	5/10/12	5/15/12	5/16/12
	5/17/12	5/22/12	5/23/12
	5/24/12	5/31/12	6/1/12
<b>June</b>	6/7/12	6/12/12	6/13/12
	6/14/12	6/19/12	6/20/12
	6/21/12	6/28/12	6/29/12

***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.***

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

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**Melissa Robinson**  
**Executive Director**  
**HP Enterprise Services**