May 2013 Medicaid Bulletin

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Attention: All Providers

NCTracks: The new multi-payer system for N.C. DHHS coming on July 1, 2013

Note to Providers: This article was originally published in March 2013.

NCTracks is a multi-payer system that will consolidate several claims processing platforms into a single solution for multiple divisions within the N.C. Department of Health and Human Services (DHHS), including the Division of Medical Assistance, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the Division of Public Health, and the Office of Rural Health and Community Care. The new NCTracks system will go live on July 1, 2013. There are a number of things that providers can do to prepare for the transition, including taking advantage of upcoming training opportunities.

For more information, go to the Website ncmmis.ncdhhs.gov/communication.asp and sign up to receive the NCTracks Connections newsletter. Also, see the *April 2013 Special Bulletin - Cutoff Dates for Transition from Legacy Claims Processing and Payment Systems to NCTracks* (www.ncdhhs.gov/dma/bulletin/pdfbulletin/0413_Special_Bulletin_NCTracks.pdf).

NCTracks Communications Team
N.C. Office of MMIS Services (OMMISS), 919-647-8300

Attention: All Providers

2013 NCTracks Provider Checkwrite Schedule Available

The first NCTracks checkwrite will be July 9, 2013, but will apply only to pharmacy point-of-sale (POS) providers. Other providers will receive their first claims payments the following week with a checkwrite on July 17 and EFT on July 18 (See chart on following page).

NCTracks will go live July 1, replacing the 35-year-old N.C. Medicaid claims-processing system known as Medicaid Management Information System (MMIS), as well as other state N.C. Department of Health and Human Services (DHHS) systems that process and pay claims for mental health, public health and rural health services.

The last checkwrite for N.C. Medicaid and N.C. Health Choice (NCHC) providers under the legacy MMIS is June 27, 2013 with funds transferred electronically the next day, June 28, 2013. The cutoff date for claims submission in that checkwrite cycle is June 20, 2013.

Although NCTracks will pay claims on a weekly cycle, DHHS and its fiscal agent, CSC, determined that a first checkwrite for all providers could not be accomplished during the first week of operations. Pharmacy POS claims presented a special case – the real-time nature of processing and the need to avoid blackouts. NCTracks will process the POS claims backlogged since June 20, 2013 plus new ones submitted by July 5, 2013 for a July 9, 2013 checkwrite and July 10, 2013 electronic payment.

The next checkwrite cycle (July 12 cutoff, July 16 checkwrite and July 17 effective electronic payment) will include all provider claims.

Providers should note that claims left pending during the last checkwrite cycle of legacy systems will be denied, and those claims must be resubmitted in NCTracks. For additional information, refer to the April 24, 2013 Special Bulletin outlining cutoff dates and other transition information.

The payment cycle of NCTracks will be weekly. Valid claims submitted by midnight on Friday (midnight Thursday for mental health, public health and rural health claims) will be processed for a checkwrite the following Tuesday, with funds transferred to bank accounts on Wednesday, except in cases of a holiday. This allows 50 checkwrites annually, with anticipated exceptions being the last week of June (end of the fiscal year) and the week of Christmas (Dec. 23-27). Providers should note that NCTracks has a scheduled checkwrite the week of Thanksgiving (Nov. 25-29).

The NCTracks checkwrite schedule for July-December, 2013 is below. A schedule for 2014 will be available in the fall.

For more information about NCTracks, including a checklist of actions providers must take prior to go-live on July 1, 2013, visit www.ncmmis.ncdhhs.gov.

NCTracks Checkwrite Schedule, July-December 2013

Cutoff Date	Checkwrite Date	EFT Effective Date
7/5/2013 [1]	7/9/2013	7/10/2013
7/12/2013	7/16/2013	7/17/2013
7/19/2013	7/23/2013	7/24/2013
7/26/2013	7/30/2013	7/31/2013
8/2/2013	8/6/2013	8/7/2013
8/9/2013	8/13/2013	8/14/2013
8/16/2013	8/20/2013	8/21/2013
8/23/2013	8/27/2013	8/28/2013
8/30/2013	9/4/2013	9/5/2013
9/6/2013	9/10/2013	9/11/2013
9/13/2013	9/17/2013	9/18/2013
9/20/2013	9/24/2013	9/25/2013
9/27/2013	10/2/2013	10/3/2013
10/4/2013	10/8/2013	10/9/2013
10/11/2013	10/15/2013	10/16/2013
10/18/2013	10/22/2013	10/23/2013
10/25/2013	10/29/2013	10/30/2013
11/1/2013	11/5/2013	11/6/2013
11/8/2013	11/13/2013	11/14/2013
11/15/2013	11/19/2013	11/20/2013
11/22/2013	11/26/2013	11/27/2013
11/29/2013	12/3/2013	12/4/2013
12/6/2013	12/10/2013	12/11/2013
12/13/2013	12/17/2013	12/18/2013
12/27/2013	12/31/2013	1/2/2014

1. The first checkwrite date applies to pharmacy point of sale providers only.

CSC 866-844-1113

Attention: All Providers

Enrollment and Application Fees – REVISED

Note to Providers: The original version of this article was published in December 2012. A revised version of the article was published in February 2013.

Affordable Care Act (ACA) Application Fee

October 1, 2012, the N.C. Division of Medical Assistance (DMA) began collecting the federal application fee required under Section 1866(j)(2)(C)(i)(l) of the Affordable Care Act (ACA) from certain Medicaid and N.C. Health Choice (NCHC) providers. The Centers for Medicare & Medicaid Services (CMS) set the application fee, which may be adjusted annually. The application fee for enrollment in calendar year 2013 is $532. The fee is used to cover the cost of screening and other program integrity efforts. The application fee will be collected **per site location** prior to executing a provider agreement from an initially enrolling or re-enrolling provider.

Initial enrollment is defined as an in-state or border-area provider who has never enrolled to participate in the N.C. Medicaid/Health Choice programs. The provider's tax identification number is used to determine if the provider is currently enrolled or was previously enrolled.

This requirement does not apply to the following providers:

(1) Individual physicians or non-physician practitioners
(2) (i) Providers who are enrolled in either of the following categories:
(A) Title XVIII of the Social Security Act ("Health Insurance for the Aged and Disabled"), or
(B) Another State's Medicaid or Children's Health Insurance Program plan
(ii) Providers who have paid the applicable application fee to:
(A) A Medicare contractor, or
(B) Another State

Providers who are required to pay this fee will be sent an invoice via mail. States must collect the applicable fee for any initial or re-enrolling provider.

Providers initially enrolling or re-enrolling in the N.C. Medicaid or NCHC program who do not pay the fee within 30 days of receipt of invoice will have their applications voided at the Eligibility, Verification and Credentialing (EVC) Operations Center of CSC. Providers in border states located within 40 miles of N.C. who have paid the fee to that state will be required to provide proof of payment.

North Carolina Enrollment Fee

Session Law 2011-145 Section 10.31(f)(3) mandated that DMA collect a $100 enrollment fee from providers upon initial enrollment with the Medicaid/Health Choice programs, upon program reenrollment and at three-year intervals when the provider is re-credentialed.

Applicants should not submit payment with their application. Upon receipt of the enrollment application, an invoice will be mailed to the applicant if either fee is owed. An invoice will be issued only if the tax identification number in the enrollment application does not identify the applicant as a currently enrolled Medicaid and N.C. Health Choice provider.

Providers initially enrolling or re-enrolling in the N.C. Medicaid or NCHC program who do not pay the fee within 30 days of receipt of invoice will have their applications voided by CSC. Providers who are submitting a re-credentialing application and do not pay the fee within 30 days of receipt of invoice may see an interruption in payment.

Provider Services
DMA, 919-855-4050

Attention: All Providers and N.C. Health Choice Providers

Subscribe and Receive Email Alerts on Important N.C. Medicaid and N.C. Health Choice Updates

Note to providers: This article was originally published in November 2011, but the Website address for subscriptions has changed.

The N.C. Division of Medical Assistance (DMA) allows providers the opportunity to sign up for N.C. Medicaid/N.C. Health Choice (NCHC) email alerts. Providers will receive email alerts on behalf of all Medicaid and NCHC programs. Email alerts are sent to providers when there is important information to share outside the general Medicaid Provider Bulletins. To receive email alerts, subscribe at www.seeuthere.com/hp/medicaidalert.

Providers and their staff members may subscribe to the email alerts. Contact information – including an email address, provider type, and specialty – is essential for the subscription process. You may unsubscribe at any time. **Email addresses are never shared, sold or used for any purpose other than Medicaid and NCHC email alerts.**

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

Attention: All Providers

HCPCS Procedure Code Changes for the Physician's Drug Program

Note: There has been a correction in the New HCPCS code for Firazyr. The correct new HCPSC code is J7144. It is reflected in the second table.

The following HCPCS procedure code changes have been made to comply with Centers for Medicare & Medicaid Services (CMS) HCPCS procedure code changes starting January 1, 2013 for the Medicaid and N.C. Health Choice (NCHC) programs.

Note: The process for adding new drugs and products – or new indications for drugs or products that are already covered through Physician's Drug Program (PDP) – is not automated. Therefore, there is always a delay between the effective date of coverage or change to the MMIS+ and the announcement of the change in the Medicaid Bulletin.

End-Dated Codes with Replacement Codes

The following HCPCS codes were end-dated effective with date of service December 31, 2012, and replaced with new codes effective with date of service January 1, 2013. Claims submitted for dates of service on or after January 1, 2013, using the end-dated codes will be denied.

End-Dated HCPCS Code	Description	Unit	New HCPCS Code	Description	Unit
J1051 and J1055	Injection, medroxyprogesterone acetate (Depo-Provera)	50 mg and 150 mg, respectively	J1050	Injection, medroxyprogesterone acetate (Depo-Provera) Note: **For Medicaid claims**, **bill the FP modifier** when Depo-Provera is used **for contraception**.	1 mg
Q2045	Injection, human fibrinogen concentrate (Riastap)	1 mg	J7178	Injection, human fibrinogen concentrate (Riastap)	1 mg
Q2046	Injection, aflibercept (Eylea)	10 mg	J0178	Injection, aflibercept (Eylea)	1 mg

End-Dated HCPCS Code	Description	Unit	New HCPCS Code	Description	Unit
Q2048	Injection, doxorubicin hydrochloride, liposomal (Doxil)	10 mg	J9002	Injection, doxorubicin hydrochloride, liposomal (Doxil)	10 mg

New Codes That Were Previously Billed with the Miscellaneous or Unclassified Drug Codes

Effective with date of service January 1, 2013, the N.C. Medicaid and NCHC programs cover the individual HCPCS codes for the drugs listed in the following table. Claims submitted for dates of service on or after January 1, 2013, using the unlisted drug codes J3590 or J9999 for these drugs will be denied. An invoice is not required.

Old HCPCS Code	Description	Old Unit	New HCPCS Code	Description	New Unit
J3590	Injection, belatacept (Nulojix)	12.5 mg	J0485	Injection, belatacept (Nulojix)	1 mg
J3590	Injection, centruroides immune f(ab)2 (Anascorp)	120 mg	J0716	Injection, centruroides immune f(ab)2 (Anascorp)	Up to 120 mg
J3590	Injection, icatibant (Firazyr)	10 mg	J7114	Injection, icatibant (Firazyr) **Note: Ages 018 through 115 years are covered.**	1 mg
J9999	Injection, asparaginase (Erwinaze)	1000 IU	J9019	Injection, asparaginase (Erwinaze)	1000 IU
J9999	Injection, brentuximab vedotin (Adcetris)	50 mg	J9042	Injection, brentuximab vedotin (Adcetris)	1 mg

Refer to the fee schedule for the PDP on the N.C. Division of Medical Assistance (DMA) Website at www.ncdhhs.gov/dma/fee/fee.htm for the latest available fees.

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

Attention: All Providers

Occupational and Physical Therapists and Orthotics and Prosthetics Providers

Outpatient Specialized Therapies, Clinical Coverage Policy 10A and Clinical Coverage Policy 10B and Orthotics and Prosthetics, Clinical Coverage Policy 5B address correct billing for orthotic and prosthetic devices.

N.C. Medicaid and N.C. Health Choice (NCHC) fee schedules do not include HCPCS Codes for initial fabrication or initial fitting of upper-extremity or lower-extremity orthotic or prosthetic devices authorized to be billed by a licensed Occupational Therapist (OT) or a licensed Physical Therapist (PT). The initial fabrication and the initial fitting of orthotic and prosthetic devices must be provided by a Certified Orthotist (CO), Certified Prosthetist/Orthotist (CPO), or a Certified Pedorthist (CPed).

However, a licensed OT or PT may provide the initial fabrication or fitting in accordance with their respective licensure or practice acts in cases where:

1. The knowledge **and** skill of a CO, CPO, or CPed is not required **and,**

2. The device will **not** be billed to N.C. Medicaid/NCHC using a CO, CPO, or CPed provider number.

This does not prohibit a licensed OT or PT within the scope of their licensure or practice from the subsequent fitting, management, and training of orthotic and prosthetic devices as outlined in CPT codes 97760, 97761, and 97762. Failure to comply with these guidelines may result in a post-payment review audit and/or recoupment of N.C. Medicaid or NCHC funds.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

NC Medicaid EHR Incentive Program – May 2013 Updates

IRS Guidance for the NC Medicaid EHR Incentive Program

The NC Medicaid Electronic Health Record (EHR) Incentive Program has posted one frequently asked question regarding IRS Guidance for providers. For more information, refer to the NC Medicaid EHR Incentive Program's FAQ Web page at www.ncdhhs.gov/dma/ehr/ehrfaq.htm.

We've Moved

The NC Medicaid EHR Incentive Program has a new telephone number. Direct all questions or comments to 919-814-0180.

Change in NC-MIPS Help Desk

The NC-MIPS Help Desk will soon be moving in-house to the N.C. Division of Medical Assistance (DMA).

Beginning June 1, 2013, providers should use the phone number, email, and mailing addresses listed below for all correspondence with the EHR Incentive Program, including program and attestation inquiries and sending signed attestations and supporting documentation.

Email:	NCMedicaid.HIT@dhhs.nc.gov
Phone Number:	919-814-0180
Mailing Address:	NC Medicaid EHR Incentive Program 2501 Mail Service Center Raleigh, NC 27699-2501

Until May 31, 2013, providers should continue to use the following contact information for all correspondence with the EHR Incentive Program:

Phone:	1-866-844-1113
Mail:	NC-MIPS CSC EVC Center P.O. Box 300020 Raleigh, NC 27622-8020
Fax:	866-844-1382
Scan & Email:	ncmips@csc.com

NC Medicaid Health Information Technology (HIT)
DMA, 919-855-4200

Attention: All Providers

Clinical Coverage Policies

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

- *1A-20, Sleep Studies and Polysomnography Services (4/1/13)*
- *1A-25, Spinal Cord Stimulation (4/1/13)*
- *1A-27, Electrodiagnostic Studies (4/1/13)*
- *2A-3, Out-of-State Services (4/1/13)*
- *NCHC Durable Medical Equipment and Supplies (Date of termination 4/1/2013)*
- *NCHC Implantable Bone Conduction Hearing Aids (BAHA) (Date of termination 3/31/2013)*
- *NCHC Out-of-State Services (Date of termination 3/31/2013)*

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

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Pneumococcal Conjugate Vaccine (Prevnar 13, PCV13, CPT Code 90670) Update: Revised Billing Guidelines for PDP

On October 12, 2012, the Advisory Committee on Immunization Practices (ACIP) published updated recommendations regarding 13-valent pneumococcal conjugate vaccine (PCV13; Prevnar 13). These recommendations included routine use of PCV13 for adults over the age of 18 with immunocompromising conditions, functional or anatomic asplenia, cerebrospinal fluid (CSF) leaks, or cochlear implants.

In order to align with the ACIP recommendations for dates of service on and after October 12, 2012, the N.C. Medicaid program updated the coverage of Prevnar 13, PCV13, to include adults over the age of 18, when Prevnar 13, PCV13, is billed with HCPCS code 90670 through the Physician's Drug Program (PDP).

This is in addition to the N.C. Medicaid and N.C. Health Choice (NCHC) coverage already in place that aligns with the ACIP recommendations for children and youth.

Note: Providers are requested NOT to bill with a National Drug Code (NDC) for this vaccine.

Refer to the following Website for detailed information regarding the updated ACIP recommendations: www.cdc.gov/mmwr/preview/mmwrhtml/mm6140a4.htm.

Note: The process for adding new drugs and products – or new indications for drugs or products that are already covered through PDP – is not automated. Therefore, there is always a delay between the effective date of coverage or change to the MMIS+ system and the announcement of the change in the Medicaid Bulletin.

Refer to the fee schedule for the Physician's Drug Program on N.C. Division of Medical Assistance (DMA) Website at www.ncdhhs.gov/dma/fee/fee.htm for the latest available fees.

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

Attention: All Providers

Payment Error Rate Measurement (PERM) in North Carolina

The second and third in a series of 2013 Payment Error Rate Measurement (PERM) Provider Education Webinar/conference calls will be on:

- **Wednesday, June 5, 2013,** 3:00 - 4:00 p.m. EST
- **Tuesday, June 18, 2013,** 3:00 - 4:00 p.m. EST

The Webinar, titled "Provider Education Calls," will allow participants to learn more about the PERM process and provider responsibility. It can be accessed at the following Website: www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Provider_Education_Calls.html.

PERM is an audit program that was developed and implemented by the Centers for Medicare & Medicaid Services (CMS) to comply with the Improper Payments Information Act (IPIA) of 2002. PERM examines eligibility determinations and claims payment made to Medicaid and Children's Health Insurance Programs (CHIP) for accuracy, and to ensure states only pay for appropriate claims. In North Carolina, CHIP is called N.C. Health Choice (NCHC). North Carolina's next PERM cycle is Federal Fiscal Year 2013 (October 1, 2012 – September 30, 2013).

A+ Government Solutions is the Review Contractor for the Federal FY 2013 PERM cycle. It will start requesting documentation from selected providers in June 2013. Throughout the cycle, A+ Government Solutions will be responsible for collecting Medicaid and NCHC policies; conducting data processing reviews; requesting medical records from providers; conducting medical reviews; and hosting the State Medicaid Error Rate Findings (SMERF) Website. States can use the Website to track medical records requests, view review findings, request different resolutions or appeals on identified errors, and more.

Providers can find more information at the following sites:

- CMS Website at www.cms.gov/PERM/.
- CMS PERM "Providers" Web page: www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Providers.html.
- Central PERM email for providers**:** PERMProviders@cms.hhs.gov

The dates for the series of 2013 PERM Provider Education Webinar/conference calls are:

- **Tuesday, May 21, 2013,** 3:00 - 4:00 p.m. EST
- **Wednesday, June 5, 2013,** 3:00 - 4:00 p.m. EST
- **Tuesday, June 18, 2013,** 3:00 - 4:00 p.m. EST
- **Tuesday, July 2, 2013,** 3:00 - 4:00 p.m. EST

Program Integrity
DMA, 919-814-0000

Attention: All Providers

Providers with Pended Claims for Inactive Electronic Funds Transfer (EFT) Status

In September 2009, the N.C. Division of Medical Assistance (DMA) discontinued issuance of paper checks for claims payments. All payments are made electronically by automatic deposit to the account specified in the provider's Electronic Funds Transfer (EFT) Authorization Agreement for Automatic Deposits. For providers who submitted claims to HP Enterprise Services without completing the EFT Agreement process, the MMIS system will suspend claims for 45 days to allow providers time to complete the EFT agreement process.

Any provider who has claims in pended status must complete the Electronic Funds Transfer (EFT) Authorization Agreement for Automatic Deposits process within 10 business days of this notice. Failure to complete the EFT process will result in claim denials.

Provider Services
DMA, 919-855-4050

Attention: Community Care of North Carolina/Carolina ACCESS (CCNC/CA) Primary Care Providers

Enrolling Beneficiaries with a CCNC/CA Medical Home at the Provider's Office

In order to maximize enrollment, providers may enroll patients by following these procedures:

- Inform patients of their right to choose any Community Care of North Carolina/Carolina ACCESS (CCNC/CA) primary care provider who is accepting new patients and their right to change primary care providers at any time pursuant to processing deadlines;

- Some beneficiaries, including pregnant women and Medicare beneficiaries, are optional for enrollment. For optional beneficiaries, providers must also inform the beneficiary of their right to declare their intention not to enroll at any time in the future. Beneficiaries may discuss their enrollment options by contacting the local Department of Social Services (DSS). For a listing of all the county DSS offices, refer to www.ncdhhs.gov/dss/local/;

- Complete the enrollment form and it send to the CCNC/CA contact at the DSS in the county in which the beneficiary resides. The form can be found on the N.C. Department of Medical Assistance (DMA) Website at www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm; and,

- Provide the Medicaid beneficiary with a CCNC/CA Member handbook. Handbooks may be obtained by contacting the DMA at 919-855-4780.

A copy of the handbook is also available on the DMA Website at www.ncdhhs.gov/dma/pub/consumerlibrary.htm#ca. Providers with questions regarding enrolling beneficiaries can contact their Regional Consultant. Contact information for your Regional Consultant is available at: www.ncdhhs.gov/dma/ca/MCC_0212.pdf.

CCNC/CA Managed Care Section
DMA, 919-855-4780

Attention: Community Care of North Carolina/Carolina ACCESS (CCNC/CA) Primary Care Providers

How Providers Can Assist with Medicaid Beneficiary Education

Providers should inform beneficiaries about the following:

- The availability of medical advice 24 hours a day, seven days a week, and the preferred method for contacting the Primary Care Provider (PCP);
- Their responsibility to bring their current Medicaid identification (MID) card to each appointment;
- The need to contact the PCP for a referral before going to any other doctor;
- The need to contact the PCP before going to the emergency department, unless the beneficiaries believe their life or health may be in immediate danger;
- The importance of regular preventive care visits, such as the Health Check Well Child screening assessments for children and Preventive Medicine Annual Health Assessments for adults; as well as routine visits to monitor chronic health conditions, such as asthma and diabetes;
- The availability of additional information for beneficiaries from their county Department of Social Services (DSS). For a listing of all the county DSS offices, refer to www.ncdhhs.gov/dss/local/; and,
- Co-payment requirements

Community Care of North Carolina/Carolina ACCESS (CCNC/CA) providers may also find it helpful to contact all new beneficiaries by telephone or in writing soon after enrollment to schedule an appointment and establish a medical record.

Those with questions regarding beneficiary education can contact their Regional Consultant. Contact information for your Regional Consultant is available at www.ncdhhs.gov/dma/ca/MCC_0212.pdf

CCNC/CA Managed Care Section
DMA, 919-855-4780

Attention: Institutional (UB-04) Billers

Submission Guidelines for Medicare HMO Claims

Providers are reminded of the following guidelines for submitting Medicare Health Maintenance Organization (HMO) claims for institutional services on the UB-04 claim form. These guidelines are also found in the October 2012 *Basic Medicaid and N.C. Health Choice Billing Guide*.

Note: Due to the transition of legacy claims processing and payment systems to NCTracks, the deadline for HP Enterprise Services to receive HMO claims is **May 31, 2013**. For more information, see the *April 2013 Special Bulletin - Cutoff Dates for Transition from Legacy Claims Processing and Payment Systems to NCTracks* (www.ncdhhs.gov/dma/bulletin/pdfbulletin/0413_Special_Bulletin_NCTracks.pdf).

General Guidelines

- **The claim should not be altered for processing purposes. The claim should be billed to Medicaid as it was billed to the Medicare HMO. Medicaid's liability is only the Medicare HMO cost share, which includes copayment, coinsurance, and/or deductible.**

- The claim must be submitted with a Medicare HMO Explanation of Benefits (EOB) attached to the claim. If the EOB is on multiple pages, submit all of those pages with the claim. The amount billed to Medicaid on the claim form must equal the cost share amount indicated on the EOB.

- All charges should be reflected on the UB-04 claim form. Do not combine charges or destroy the integrity of the claim by "rolling up" charges into one revenue code.

- If the recipient has a monthly liability or deductible, that information should be reflected on inpatient stays, if applicable.

UB-04 Line Item Explanations

- FL47 – Indicate the total charges

- FL50 – Enter the two-digit payer code
(see the *December 2008 Medicaid Bulletin* article titled "New Payer Codes," for the list of acceptable codes)

- FL54 – Indicate HMO payment

- FL55 – Indicate the cost share amount
  (**Note:** The amount listed in FL55 should reflect the Medicare HMO cost share amount only. This amount must match the amount indicated on the Medicare EOB.)

- FL56 – Enter your NPI

- FL57 **–** Enter your Medicaid Provider Number

- FL80 – Write "This is a Medicare HMO claim"

Click here to see an example of a completed UB-04 claim form for a Medicare HMO.

The Medicare HMO EOB must be attached to the claim. Mail to this address:

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

Clearly write "Attn: UB Medicare HMO" on the mailing envelope. The envelope must contain **only** UB Medicare HMO claims. Ensure that all information is complete and correct prior to submission, as failure to follow guidelines will affect processing. **Claims that have incorrect, invalid, or missing information will be denied.** Adjudicated Medicare HMO claims will appear in the "Adjusted Claims" section of the RA.

Refer to the N.C. Division of Medical Assistance (DMA) Website for updates to policies and procedures. Questions regarding claim submission should be directed to the HPES Provider Services Unit at 1-800-688-6696, menu option 3.

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

Attention: Personal Care Services (PCS) Providers

Personal Care Services (PCS) Program highlights

Note: This article does not apply to providers billing for Personal Care Services (PCS) under the Community Alternative Program (CAP).

House Bill 5 Session Law 2013-4 – Special Funding for Group Homes and Special Care Units

On March 6, 2013, the General Assembly of North Carolina approved House Bill 5 Session Law (SL) 2013-4, an act requiring the N.C. Department of Health and Human Services (DHHS) to provide temporary, short-term financial assistance to:

1) Group Homes serving residents determined to be **ineligible** for Medicaid covered PCS as a result of changes to eligibility criteria that became effective on January 1, 2013; and,
2) Special Care Units serving residents who **qualify** for Medicaid covered PCS on or after January 1, 2013

Payments will be authorized to group homes in an amount not to exceed $694 per month for each resident, for a period not to exceed three months. At the end of the three-month period, the monthly payment for each resident shall be reduced by 25 percent for a maximum payment of $520.50 per month per resident. Payments made to group homes will begin February 1, 2013 and end on June 30, 2013.

Group home providers will bill House Bill 5 funds using the Centers for Medicare & Medicaid Services (CMS) 1500 electronic claims form using HCPCS code S5126 and one of the following modifiers:

- SE modifier for dates of service up to the 90th day, but no later than June 30, 2013; the per diem rate $23.13;
- TS modifier for dates of service from 91st day to 180th day, but no later than of June 30, 2013; the per diem rate $17.35

Payment will be authorized to Special Care Units in an amount not to exceed $268 per month for each resident who qualifies for House Bill 5 funds. Payments made to Special Care Units will begin March 1, 2013 and end on June 30, 2013. Special Care Unit providers will bill House Bill 5 funds using the CMS 1500 electronic claims form using the HCPCS code S5126 and the following modifier:

- HC modifier for service dates March 1, 2013 through June 30, 2013; the per diem rate of $8.93

All Providers will bill one unit per date of service at the associated per diem rate. Payments are available through June 30, 2013 only to the extent sufficient funds are

available. For additional information, providers can read House Bill 5 in its entirety at www.ncga.state.nc.us/Sessions/2013/Bills/House/PDF/H5v5.pdf.

To view the March 14, 2013 Webinar presented by the N.C. Division of Medical Assistance (DMA) on House Bill 5, visit www.ncdhhs.gov/dma/pcs/Webinar_House_Bill_5.ppt.

Special Transition Funds for Adult Care Homes Licensed Under 131D

In SL 2012-142 Section 10.23A (f), the N.C. General Assembly appropriated $39.7 million to the Community Living Fund for the implementation of the State's plan to provide temporary, short-term assistance to Adult Care Home (ACH) providers. This assistance is available from January 1, 2013 until June 30, 2013 to providers who:

- Continue to provide PCS to residents living in ACH receiving ACH-PCS on or before December 31, 2012;
- Are denied State Plan PCS effective January 1. 2013, and,
- Are certified by the appropriate Lead Agency not to have a safe and timely placement available.

Beneficiaries must be residing in the ACH and receiving ACH-PCS on or before December 31, 2012, for the ACH provider to access these funds. The funds will be paid by dates of service through the biweekly checkwrite process.

To access the funds, an ACH provider will refer a resident to whom they have issued a discharge notice to the local Department of Social Services (DSS). The local DSS will determine whether the Lead Agency is the local Department of Social Services (DSS) or Local Management Entity (LME). The Lead Agency will conduct a mini-assessment and certify to the N.C. DHHS that the beneficiary does not have an appropriate placement. Once the beneficiary has been certified, prior approval will be issued to allow the ACH provider to submit claims and receive reimbursement. Funds available to ACH providers are not to exceed $694 for days 1 to 90; funds are not to exceed $520.50 for days 91 to 180.

Claims for dates of service no earlier than January 1, 2012 – June 30, 2013 will be submitted using the CMS 1500 electronic form using HCPCS code S 5126 and the following modifiers:

- SE modifier for dates of services up to the 90th day, but no later than June 30, 2013; the per diem rate is $23.13
- TS modifier for dates of Service from days 91 to 180, but no later than June 30, 2013; the per diem rate is $17.35

DMA asks for 10 business days from the beneficiary certification date before submitting claims to allow for verification and transmission of prior approval. To view the

December 31, 2012 Webinar presented by DMA on special payment to ACH, visit www.ncdhhs.gov/dma/pcs/Forms/ACH_transition20130104p-12-31-12.pdf.

Providers can also view the special payment for ACH flowchart at: www.ncdhhs.gov/dma/pcs/Forms/provider-flow-chart-20130103.pdf.

Revised Personal Care Services Web Page

The PCS Website has been revised to help users access information about the PCS program. The previous pages dedicated to ACH and In-Home Care have been archived on the PCS Web page. All updates regarding PCS – regardless of setting – can be viewed at: www.ncdhhs.gov/dma/pcs/pas.html.

Upcoming Training

Regional trainings for all PCS providers will be conducted in June. Training dates, locations, and registration information will be available on the DMA PCS Website at www.ncdhhs.gov/dma/pcs/pas.html and the Carolina's Center for Medical Excellence (CCME) Website at www.thecarolinascenter.org.

PCS Program Contacts

To contact the PCS program, call 919-855-4340 or send an email to PCS_Program_Questions@dhhs.nc.gov. For PCS updates and important links, visit the PCS Website at www.ncdhhs.gov/dma/pcs/pas.html.

Home and Community Care
DMA, 919-855-4340

Attention: Physicians

Hyaluronan or Derivative, Gel-One, for Intra-Articular Injection: Billing Guidelines for PDP

Effective with date of service January 9, 2013, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover Gel-One for intra-articular injection when billed with HCPCS code J7326 through the Physician's Drug Program (PDP).

Providers are requested not to bill with a National Drug Code (NDC) for this device.

Note: The process for adding new drugs and products – or new indications for drugs or products that are already covered through PDP – is not automated. Therefore, there is always a delay between the effective date of coverage or change to the MMIS+ and the announcement of the change in the Medicaid Bulletin.

Refer to the fee schedule for the PDP on N.C. Division of Medical Assistance (DMA) Website at www.ncdhhs.gov/dma/fee/fee.htm for the latest available fees.

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

Attention: Podiatrists

Podiatrists Billing for CPT Procedure Code 27614, 27792 and 27829

Podiatrists are receiving denials for the following CPT procedure codes:

- 27614 (Biopsy, soft tissue of leg or ankle area; deep [subfascial or intramuscular];
- 27792 (Open treatment of distal fibular fracture[lateral malleolus], includes internal fixation; when performed); and,
- 27829 (Open treatment of distal tibiofibular joint [syndesmosis] disruption, includes internal fixation, when performed.

System updates have been completed to correct this issue. Podiatrists who received denials with EOB 79 (this service is not payable to your provider type or specialty in accordance with Medicaid guidelines) may resubmit claims that meet timely filing criteria for processing. Do not resubmit the claim as an adjustment.

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

Employment Opportunities with the N.C. Division of Medical Assistance (DMA)

Employment opportunities with DMA are advertised on the Office of State Personnel's Website at http://www.osp.state.nc.us/jobs/. To view the vacancy postings for DMA, click on "Agency," then click on "Department of Health and Human Services." If you identify a position for which you are both interested and qualified, complete a state application form online and submit it. 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/general.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. To submit a comment related to a policy, refer to the instructions on the Proposed Clinical Coverage Policies Web page at http://www.ncdhhs.gov/dma/mpproposed/. 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.

2013 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
May	05/02/13	05/07/13	05/08/13
	05/09/13	05/14/13	05/15/13
	05/16/13	05/21/13	05/22/13
	05/23/13	05/30/13	05/31/13
June	06/06/13	06/11/13	06/12/13
	06/13/13	06/18/13	06/19/13
	06/20/13	06/27/13	06/28/13

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.

Carol H. Steckel, MPH
Director
Division of Medical Assistance
Department of Health and Human Services

Melissa Robinson
Executive Director
HP Enterprise Services