



January 2012 Medicaid Bulletin

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Attention: All Providers**Fraud and Abuse Laws**

The five most important Federal fraud and abuse laws that apply to providers are the False Claims Act (FCA), the Anti-Kickback Statute (AKS), the Physician Self-Referral Law (Stark law), the Exclusion Authorities, and the Civil Monetary Penalties Law (CMPL). Government agencies, including the Department of Justice, the Department of Health & Human Services Office of Inspector General (OIG), and the Centers for Medicare & Medicaid Services (CMS), are charged with enforcing these laws. It is crucial to understand these laws not only because following them is the right thing to do, but also because violating them could result in criminal penalties, civil fines, exclusion from the Federal health care programs, or loss of your medical license from your State medical board.

I. False Claims Act [31 U.S.C. §§ 3729–3733]

The civil FCA protects the Government from being overcharged or sold shoddy goods or services. **It is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent.** Filing false claims may result in fines of up to three times the programs' loss plus \$11,000 per claim filed. Under the civil FCA, each instance of an item or a service billed to Medicare or Medicaid counts as a claim, so fines can add up quickly. The fact that a claim results from a kickback or is made in violation of the Stark law also may render it false or fraudulent, creating liability under the civil FCA as well as the AKS or Stark law. Under the civil FCA, no specific intent to defraud is required. The civil FCA defines "knowing" to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Further, the civil FCA contains a whistleblower provision that allows a private individual to file a lawsuit on behalf of the United States and entitles that whistleblower to a percentage of any recoveries, for example, whistleblowers could include current or ex-business partners, hospital or office staff, patients, or competitors. There also is a criminal FCA (18 U.S.C. § 287). Criminal penalties for submitting false claims include imprisonment and criminal fines. Physicians have gone to prison for submitting false health care claims. The OIG also may impose administrative civil monetary penalties for false or fraudulent claims, as discussed below.

II. Anti-Kickback Statute [42 U.S.C. § 1320a-7b(b)]

The AKS is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (*e.g.*, drugs, supplies, or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies. **In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime.** The statute covers the payers of kickbacks—those who offer or pay remuneration—as well as the recipients of kickbacks—those who solicit or receive remuneration. Each party's intent is a key element of their liability under the AKS. Criminal penalties and administrative sanctions for violating the AKS include fines, jail terms, and exclusion from participation in the Federal health care programs. Under the CMPL, providers who pay or accept kickbacks also face penalties of up to \$50,000 per kickback plus three times the amount of the remuneration.

Safe harbors protect certain payment and business practices from criminal and civil prosecution that could otherwise implicate the AKS. To be protected by a safe harbor, an arrangement must fit squarely in the safe harbor and satisfy all of its requirements. Some safe harbors address personal services and rental agreements, investments in ambulatory surgical centers, and payments to *bona fide* employees. **Providers are attractive targets for kickback schemes** because you can be a source of referrals for peers or other health care providers and suppliers. You decide what drugs your patients use, which specialists they see, and what health care services and supplies they receive.

III. Physician Self-Referral Law [42 U.S.C. § 1395nn]

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits providers from referring patients to receive “designated health services” payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship. Financial relationships include both ownership/investment interests and compensation arrangements. “Designated health services” include:

- clinical laboratory services;
- physical therapy, occupational therapy, and outpatient speech-language pathology services;
- radiology and certain other imaging services;
- radiation therapy services and supplies;
- DME and supplies;
- parenteral and enteral nutrients, equipment, and supplies;
- prosthetics, orthotics, and prosthetic devices and supplies;
- home health services;
- outpatient prescription drugs; and
- inpatient and outpatient hospital services.

The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required. The Stark law prohibits the submission of or causing the submission of claims in violation of the law’s restrictions on referrals. Penalties for providers who violate the Stark law include fines as well as exclusion from participation in the Federal health care programs.

IV. Exclusion Statute [42 U.S.C. § 1320a-7]

The OIG is legally required to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses: (1) Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid; (2) patient abuse or neglect; (3) felony convictions for other health-care-related fraud, theft, or other financial misconduct; and (4) felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances. The OIG has discretion to exclude individuals and entities on several other grounds, including misdemeanor convictions related to health care fraud other than Medicare or Medicaid fraud or misdemeanor convictions in connection with the unlawful manufacture, distribution, prescription, or dispensing of controlled substances; suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity; provision of unnecessary or substandard services; submission of false or fraudulent claims to a Federal health care program; engaging in unlawful kickback arrangements; and defaulting on health education loan or scholarship obligations. If a provider is excluded by the OIG from participation in the Federal health care programs, then Medicare, Medicaid, and other Federal health care programs, such as TRICARE and the Veterans Health Administration will not pay for items or services that you furnish, order, or prescribe.

Excluded providers may not bill directly for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a group practice. In addition, if you furnish services to a patient on a private-pay basis, no order or prescription that you give to that patient will be reimbursable by any Federal health care program. You are responsible for ensuring that you do not employ or contract with excluded individuals or entities, whether in a provider practice, a clinic, or in any capacity or setting in which Federal health care programs may reimburse for the items or services furnished by those employees or contractors. This responsibility requires screening all current and prospective employees and contractors against the OIG's List of Excluded Individuals and Entities. This online database can be accessed from the OIG's Exclusion Web site. If you employ or contract with an excluded individual or entity and Federal health care program payment is made for items or services that person or entity furnishes, whether directly or indirectly, you may be subject to a civil monetary penalty and/or an obligation to repay any amounts attributable to the services of the excluded individual or entity.

V. Civil Monetary Penalties Law [42 U.S.C. § 1320a-7a]

The OIG may seek civil monetary penalties and sometimes exclusion for a wide variety of conduct and is authorized to seek different amounts of penalties and assessments based on the type of violation at issue. Penalties range from \$10,000 to \$50,000 per violation. Some examples of CMPL violations include:

- presenting a claim that the provider knows or should know is for an item or service that was not provided as claimed or is false or fraudulent;
- presenting a claim that the provider knows or should know is for an item or service for which payment may not be made;
- violating the AKS;
- violating Medicaid assignment provisions;
- violating the Medicaid physician agreement;
- providing false or misleading information expected to influence a decision to discharge;
- failing to provide an adequate medical screening examination for patients who present to a hospital emergency department with an emergency medical condition or in labor; and
- making false statements or misrepresentations on applications or contracts to participate in the Federal health care programs.

You are encouraged to report matters involving violation of the above laws or any Medicaid fraud, waste or abuse. If you suspect that any of the above provider fraud or abuse is taking place in North Carolina, please:

- Contact the Division of Medical Assistance by calling the **DHHS Customer Service Center** at 1-800-662-7030 (English, Spanish) or
- Call the **Medicaid fraud, waste and program abuse tip-line** at 1-877-DMA-TIP1 (1-877-362-8471) or
- Call the Health Care Financing Administration Office of Inspector General's Fraud Line at 1-800-HHS-TIPS or
- Call the State Auditor's Waste Line: 1-800-730-TIPS or
- Complete and submit a Medicaid fraud and abuse confidential online complaint form.
<http://www.ncdhhs.gov/dma/fraud/reportfraudform.htm>.

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

Attention: All Providers

***P*rovider Enrollment Fee**

The \$100 fee required from individual providers and organizations that submit an initial enrollment application, a re-credentialing application, or a re-enrollment application, for participation in the N.C. Medicaid or Health Choice programs will be directly associated with an applicants site/location. The effective date will be communicated to providers in future bulletin articles.

If a provider has the same tax identification number for multiple sites/locations a separate enrollment fee is required for each site/location. An individual provider who is linked to multiple provider groups is not responsible for paying an enrollment fee for each group affiliation. An individual provider who is linked to multiple provider groups is only responsible for one (1) \$100 enrollment fee.

The \$100 enrollment fee will apply concurrently with the \$505 application fee as set forth in Section 6401(a) of the Affordable Care Act (ACA) as amended by section 10603 of the ACA, amended section o1866 (j). The non-refundable \$100 enrollment fee will be due immediately upon receipt of invoice. Failure to remit payment within thirty (30) days will deem the provider enrollment application incomplete resulting in denial of participation with N.C. Medicaid.

Provider Services
DMA, 919-855-4050

Attention: All Providers**Letter of Attestation**

As previously announced in the September 2011 Medicaid bulletin, the Division of Medical Assistance (DMA) will no longer notify providers who received a minimum of \$5 million in Medicaid payments during the federal fiscal year (October 1, 2009 through September 30, 2010). As a condition of participation in the Medicaid and N.C. Health Choice programs, all providers are required to complete and sign the Letter of Attestation, irrespective of the amount received in Medicaid payments during the fiscal year. The letter of Attestation will be required initially from newly enrolling and re-enrolling providers; once enrolled all providers will be required to submit the letter of attestation *every three years at re-credentialing*.

In accordance with Session Law 2011-399, § 108C-9, the revised provider attestation shall contain a statement that the provider:

- has met the minimum business requirements necessary to comply with all federal and State requirements governing the Medicaid and Children's Health Insurance programs,
- does not owe any outstanding taxes or fines to the U.S. or North Carolina Departments of Revenue or Labor or the Employment Security Commission,
- does not owe any final overpayment, assessment, or fine to the North Carolina Medicaid or North Carolina Health Choice programs or any other State Medicaid or Children's Health Insurance program, and
- has implemented a corporate compliance program as required under federal law.

DMA is currently modifying the Letter of Attestation to include statements regarding educating employees, contractors, and agents about federal and state fraud and false claims laws and the whistleblower protections available under those laws, and to include additional statements as required in the Affordable Care Act and Session Law 2011-399. To avoid any delay in reimbursement, providers should review their corporate compliance programs and be prepared to submit the signed revised Medicaid Letter of Attestation. All providers will receive further guidance on completing and submitting attestations for Medicaid. Information will be available in upcoming Medicaid bulletins and on the “What’s New” page of the DMA’s website at <http://www.ncdhhs.gov/dma/provider/index.htm>.

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

Attention: All Providers***L*oan Fund to Improve Access to Electronic Health Records**

Small, rural and urban primary care practices in North Carolina may be eligible for a collaborative loan program that can provide funds to assist in the implementation of electronic health records (EHR) technologies to help improve the quality of the care.

The funds from the loan may be used to purchase certified EHR technology or upgrade existing equipment to meet certain criteria to train staff in the use of the technology, or improve the secure exchange of health information through the NC Health Information Exchange.

The loan program, formerly funded by the NC Health and Wellness Trust Fund, is now administered within the NC Department of Health and Human Services Office of Health Information Technology (HIT), in partnership with the NC Medical Society Foundation and the Center for Community Self-Help.

Prequalification information, applications and additional details are available at www.ncehrloanfund.org. Practices serving disproportionate numbers of Medicaid/Medicare and indigent patients will be given priority. Loan size will be based on the practice's need for equipment and training. The average loan ranges from \$40,000 to \$60,000.

In addition to any potential loan, providers may also be eligible for the NC Medicaid EHR Incentive Program and receive up to \$63,750 in incentive payments over six years. For more information, visit the EHR Incentive Program website at <http://www.ncdhhs.gov/dma/provider/ehr.htm>.

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

Attention: All Providers***N*C Medicaid Electronic Health Record Incentive Program Memo on Patient Volume**

In an effort to alleviate confusion and help eligible professionals (EPs) apply for and receive Electronic Health Record (EHR) incentive payments, the Division of Medical Assistance (DMA) has issued a memo to explain the patient volume requirements for the NC Medicaid EHR Incentive Program. The formula is simple; paid Medicaid encounters divided by total encounters in a continuous 90-day period from the previous year. This formula was established by the Centers for Medicare and Medicaid Services (CMS) Final Rule governing the Medicaid EHR Incentive Program.

The full memo including clarifications is located at:
<http://www.ncdhhs.gov/dma/ehr/PatientVolumeMemoDec2011.pdf>

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

Attention: All Providers**Implementation of Additional Correct Coding Edits: Professional Duplicates**

As announced in previous Medicaid bulletins, the Division of Medical Assistance (DMA) began implementing additional correct coding guidelines. These new correct coding guidelines and edits will be nationally sourced by organizations such as the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA). These edits will identify any duplicate submissions of CPT, HCPCS, AMA, CMS and/or DMA policies and will deny at the claim detail level. Additional correct coding edits for Professional Duplicates will not be implemented on January 1, 2012 as previously published. DMA will implement these edits on February 1, 2012 for dates of service on or after February 1, 2012.

Duplicates – Professional Claims

North Carolina Medicaid and Health Choice will be implementing edits that detect where duplicate submissions of a service were submitted on separate claims. The analytics examine codes that, by definition, cannot be billed more than once on the same date of service, within a defined date range, or over the lifetime of the patient for CPT and HCPCS codes. The following are examples of Professional Duplicate edits:

- Same Day Duplicate edits occur when the same provider submits a procedure on separate claims for the same date of service, and the procedure code description does not support multiple submissions.

Procedure	Claim	Description	Analysis
11200	XX159	Removal of skin tags, up to 15	Allow
11200	XX256	Removal of skin tags, up to 15	Deny

- Date Range Duplicate edits occur when the same provider submits the same procedure more than once on separate claims within a defined time period.

Procedure	Claim	Description	Analysis
94774	XX622	Pediatric home apnea monitoring per 30 days	Allow
94774	XX489	Pediatric home apnea monitoring, performed within 30 days of previous monitoring	Deny

- Lifetime Duplicate edits occur when a procedure is billed more than once in a patient's lifetime on separate claims (e.g. appendectomy, autopsy).

Procedure	Claim	Description	Analysis
58200	XX115	Total abdominal hysterectomy	Allow
58200	XX419	Total abdominal hysterectomy (billed two years later)	Deny

When clinically appropriate, a modifier may be appended to the claim detail to override the edit.

HP Enterprise Services

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

Attention: All Providers**Implementation of Additional Correct Coding Edits: Facility Duplicates**

As announced in previous Medicaid bulletins, the Division of Medical Assistance (DMA) began implementing additional correct coding guidelines. These new correct coding guidelines and edits will be nationally sourced by organizations such as the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA). These edits will identify any duplicate submissions of CPT, HCPCS, AMA, CMS and/or DMA policies and will deny at the claim detail level.

Additional correct coding edits for Facility Duplicates will be implemented in the first or second quarter of 2012. DMA will notify providers of the implementation date in a future Medicaid bulletin article.

Duplicates – Outpatient Facility Claims

For Hospital Outpatient services, DMA will only edit claim details related to drug, radiology, and laboratory services. Edits will reject only the claim line when all criteria match at the line and header level. If all other criteria match, but the two lines have different CPT/HCPCS codes, or one line has a CPT/HCPCS code and the other line has no CPT/HCPCS code, the two lines do not meet the criteria for line level Duplicate Outpatient Facility editing. If both lines have NO CPT/HCPCS codes, the line will not be considered for duplicate matching. The criteria for line level outpatient facility duplicate matching are as follows:

- Recipient/Patient
- Billing provider identification number
- Bill type
- Service date (line level)
- Charge amount (line level)
- HCPCS or CPT code

DMA has chosen to deny at the detail level rather than disallow the complete claim.

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

Attention: All Providers

National Correct Coding Initiative Update — 1-S4 Cytogenetic Studies Policy

CPT codes 88264 and 88273 which is listed in the 1S-4 Cytogenetic Studies Policy, changed unit limitations due to the National Correct Coding Initiative (NCCI). April 1, 2011 CPT code 88264 changed from four units per day to two units per day and CPT code 88273 changed from twenty-five units per day to three units per day.

ICD-9 diagnosis codes 655.22, 655.24, 631 and 743.60 are invalid and have been removed from 1S-4 Cytogenetic Studies Policy September 30, 2011. ICD-9 code 631.0 (Inappropriate change in quantitative human chorionic gonadotropin [HCG] in early pregnancy) was effective October 1, 2011.

HP Enterprise Services

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

Attention: All Providers

HCPCS Code G0328

The Division of Medical Assistance (DMA) approved coverage for HCPCS code G0328 (Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3) with a date of service July 1, 2011. System changes have been completed and providers may now bill for dates of service on or after July 1, 2011.

Practitioner and Clinical Services

DMA, 919-855-4329

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

The N.C. Medicaid program will discontinue coverage of Avastin for breast carcinoma under the Physician's Drug Program for recipients who are newly diagnosed and/or beginning treatment for breast carcinoma on and after date of service April 1, 2012, instead of January 1, 2012, as previously communicated in the December 2011 general Medicaid bulletin. Medicaid will also continue to reimburse for Avastin for those recipients who were already receiving Avastin for breast carcinoma prior to date of service April 1, 2012, so their treatment may be completed. 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.

Until date of service April 1, 2012, providers may continue to bill for recipients who receive Avastin for breast carcinoma and the other covered diagnoses. Refer to the May 2010 general Medicaid bulletin article for current billing guidelines. Providers should watch for a future bulletin articles with detailed billing guidelines regarding billing for breast carcinoma diagnoses on and after April 1, 2012.

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

Attention: All Providers**CPT Code Update 2012**

Effective with date of service January 1, 2012, the American Medical Association (AMA) has added new CPT codes, deleted others, and changed the descriptions of some existing codes. (For complete information regarding all CPT codes and descriptions, refer to the 2012 edition of **Current Procedural Terminology**, published by the American Medical Association.) New CPT codes that are covered by the N.C. Medicaid Program are effective with date of service January 1, 2012. Claims submitted with deleted codes will be denied for dates of service on or after January 1, 2012. Previous policy restrictions continue in effect unless otherwise noted.

New Covered CPT Codes (effective January 1, 2012)									
15271	15272	15273	15274	15275	15276	15277	15278	15777	20527
22633	22634	26341	29582	29583	29584	32096	32097	32098	32505
32506	32507	32607	32608	32609	32666	32667	32668	32669	32670
32671	32672	32673	32674	33221	33227	33228	33229	33230	33231
33262	33263	33264	36251	36252	36253	36254	37191	37192	37193
37619	38232	49082	49083	49084	62369	62370	64633	64634	64635
64636	74174	77424	77425	77469	78226	78227	78579	78582	78597
78598	87389	92071	92072	93998	94726	94727	94728	94729	95885
95886	95887	95938							
End-Dated CPT Codes (effective December 31, 2011)									
11975	11977	15170	15171	15175	15176	15300	15301	15320	15321
15330	15331	15335	15336	15340	15341	15360	15361	15365	15366
15400	15401	15420	15421	15430	15431	32095	32402	32500	32602
32603	32605	32657	32660	35548	35549	35551	35651	37620	49080
49081	64560	64577	64622	64623	64626	64627	69802	71090	73542
75722	78724	75940	77079	77083	78220	78223	78584	78585	78586
78587	78588	78591	78593	78594	78596	88107	88318	90470	90663
92070	92120	92130	93720	93721	93722	93875	94240	94260	94350
94360	94370	94720	94725						

New CPT Codes Not Covered							
86386	90654	90869	92558	92618	94780	94781	95939
New Molecular Pathology Procedures 81200 through 81408							
Category II and III Codes							

Billing Information

CPT Code	Information
38232	Requires prior approval – refer to http://www.ncdhhs.gov/DMA/

Additional information will be published in future [Medicaid bulletins](#) as necessary.

Clinical Policy and Programs
DMA, 910-355-1883

Attention: All Providers**Submitting Provider Refunds**

There are separate actions that may be filed when submitting Refunds with a Remittance and Status Report. When submitting a refund request use the following instructions:

- Highlight the appropriate recipient name and MID number, claim information (ICN) and dollar amount of the refund to apply to that recipient.
- Ensure that the check amount and notations on the RA agree to the same total being refunded.
- Attach a copy of the RA to the check and submit.
- Refund checks must be payable to HP Enterprise Services – Refund. Mail the refund with the requested information to:

HP Enterprise Services
ATTN: Finance - REFUND
P.O. Box 30968
Raleigh NC 27622-3011

If a copy of the RA is not available, providers are able to submit a refund request using the **Medicaid Provider Refund Form**. This form is available on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm> (under Claims and Claim Adjustment forms). When completing the **Medicaid Provider Refund Form**, follow these instructions:

- Enter the data electronically before printing the form to reduce questions from HP Enterprise Services when the check and form are received.
- Enter information for each claim by detail line. As entries are made into the form, the total refund amount will be automatically calculated.
- The sum of the entries **must** equal the amount of the refund check submitted with this form.
- Once the form entries are completed, compare the total amount on the refund check to the calculated total refund amount in cell L13 on the form. This will cross check the entries on the form with the intended refund amount.
- Print a copy of the completed **Medicaid Provider Refund Form** and submit.
- Refund checks must be payable to HP Enterprise Services– Refund. Mail the refund with the requested information to:

HP Enterprise Services
ATTN: Finance - REFUND
P.O. Box 30968
Raleigh NC 27622-3011

Tips for Submitting Refunds:

- If refunding from a central office for multiple provider numbers, submit separate refunds for **each provider**, as questions regarding one of the providers may impact the processing of all of the refunds when submitted on one check.
- Refund checks must be payable to HP Enterprise Services– REFUND. The bank may reject check made out otherwise, and your refund will not be processed.

- If the refund is in response to a written request from DMA, make the refund check payable to DMA and mail it to the address indicated in the refund request letter.
- If DMA, the DHHS Controller, the Attorney General, or a third-party collections agency has requested a payment, either refund or amount due, make the check payable as the correspondence indicates and mail it to the address indicated. Checks received by HP Enterprise Services are processed as refunds. Payments misdirected to HP Enterprise Services could result in additional actions by DMA, other government agencies, or their agents.
- If a refund is sent due to a claim billing error, it is important to ensure that the credit has processed on the RA, as noted above, prior to resubmitting the claim. This will eliminate any possibility of the resubmitted claim being denied due to a duplicate claim.
- If completing the **Medicaid Provider Refund Form**, save a copy of the form to the computer local drive so that providers have easy access to the form.

Note: Although the refund process is available to send monies back to Medicaid, the preferred method is through the void or replacement electronic adjustment process.

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

Attention: All Providers

***M*edicaid Transportation Training**

The Division of Medical Assistance (DMA) conducted statewide trainings in December 2011 for N.C. counties. DMA will continue the statewide trainings in January 2012. The training is provided by DMA Medicaid Eligibility Unit. The trainings focus on determining who is eligible for Medicaid transportation. It is an excellent opportunity for the county DSS staff and the local transportation providers who work with Medicaid transportation to learn about the revised policy. Effective January 1, 2012 the transportation policy will be revised. The transportation revisions will be located at DMA's website <http://www.ncdhhs.gov/dma/services/transportation.htm>.

Provider and Recipient Services
DMA, 919-855-4000

Attention: All Providers**O**utpatient Specialized Therapies

The Division of Medical Assistance's Outpatient Specialized Therapies Policy has been amended effective January 1, 2012. Please read the posted policy located at <http://www.ncdhhs.gov/dma/mp/8f.pdf> for changes.

As a budget initiative under the Appropriations Act of 2011 (House Bill 200) Outpatient Therapy Services will limit **adult** therapy services. A recipient 21 years of age or older may have:

- up to 3 treatment visits and
- 1 evaluation visit of all Physical Therapy (PT), Occupational Therapy (OT), Speech Language/Audiology (SLP/Aud) therapy services combined per calendar year from all therapy providers in any outpatient setting including Home Health.

Treatment by multiple disciplines in the same visit will each count separately toward the total visit limit.

A recipient 21 years of age or older who has had a joint replacement and is within 3 months post surgery or discharge from inpatient services may have;

- 1 PT evaluation and/or
- 1 OT evaluation visit and up to 10 therapy treatment visits combined (PT, OT, SLP/Aud) per calendar year from all outpatient therapy providers in all outpatient settings including office, home, hospital.

Treatment by multiple disciplines in the same visit will each count separately toward the total visit limit. A different joint replacement would trigger a new 10 visit limit segment along with 2 evaluations.

A recipient 21 years of age or older who has had a stroke, traumatic brain injury or spinal cord injury and is within 6 months post discharge from inpatient services may have;

- 1 physical therapy evaluation and/or
- 1 Occupational therapy evaluation and/or 1 Speech therapy evaluation and up to 30 therapy treatment combined visits (PT, OT, SLP) per calendar year, from all therapy providers, in any outpatient setting including Home Health.

Treatment by multiple disciplines in the same visit will each count separately toward the total visit limit. If a recipient receiving these services experiences a documented occurrence of a new stroke, a new cycle of 30 visits may start. A new stroke, TBI or spinal cord injury would trigger a new 30 visit segment along with 3 evaluations.

All limits are hard limits. Prior approval is required for all treatment visits. As is currently done, adult prior approvals will not span two calendar years. A new prior approval will be required for each calendar year.

Pharmacy and Ancillary Services
DMA, 919-855-4310

Attention: All Providers and NC Health Choice Providers**NC Health Choice Well Visits and Immunizations - Medicaid Alert**

The Division of Medical Assistance (DMA) is currently working with its fiscal agent for claims adjudication, HP Enterprise Services, to correct a processing issue for N.C. Health Choice well-child exams denying when billed in conjunction with immunizations for the same date of service. Claims affected are for dates of service on or after October 1, 2011. Providers will be notified by email alert and Medicaid Bulletin article when the system update is completed.

Providers who have received EOB 2066, *Immunization administration and Therapeutic injections not allowed same day as Evaluation Management* have several options until the system is updated:

- 1) Claims that had the E/M code denied can be voided and a replacement claim can be filed for the E/M code only. Once providers receive notification of the system correction, the vaccines and vaccine administration can be billed on a separate claim.
- 2) Providers may bill the individual services that are part of the well-child visit services for Medicaid recipients.
- 3) In the alternative, providers may elect to hold all HP claims processing for preventative services for Health Choice recipients until the HP Claims processing system is corrected.

For further assistance, providers can contact the 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.

**NC Health Choice
DMA, 919-855-4100**

Attention: North Carolina Health Choice Providers**NC Health Choice Claims Processing Transition**

Effective with dates of service on and after October 1, 2011, NC Health Choice (NCHC) medical **and** pharmacy claims will be processed by DMA's fiscal agent, HP Enterprise Services instead of BCBS. There will be a five-month run-out period for providers to file claims for dates of service through September 30, 2011 to BCBS. The run-out period will begin on October 1, 2011 and end on February 29, 2012. **You must file all claims for dates of service through September 30, 2011 with BCBS by February 29, 2012.**

As stated in previous bulletins, providers who want to begin or continue serving NCHC recipients after the transition date must enroll in NC Medicaid and file claims according to NC Medicaid guidelines. Legislation requires Medicaid enrolled providers to submit claims electronically (SL2011-145 § 10.31(b)(6)). However, certain exceptions require claims to be submitted on paper. The exceptions are listed on DMA's website at <http://ncdhhs.gov/dma/provider/ECSEExceptions.htm>.

Only those claims which comply with the exceptions will be accepted on paper. NCHC providers should mail paper claims and any NCHC claims related written correspondence to:

**HP Enterprise Services
P.O. Box 300001
Raleigh, NC 27622-0001**

The HPES mailing address for NCHC Prior Approval is:

**HP Enterprise Services
Prior Approval
P.O. Box 322490
Raleigh, NC 27622**

Questions regarding NCHC claims submission for dates of service 10/1/2011 and after should be directed to the HPES Provider Services Department at 1-800-688-6696, menu option 3.

**NC Health Choice
DMA, 919-855-4100**

Attention: Pharmacy Providers and NC Health Choice Providers**Point-of-Sale Override for Leukotrienes, Statins, Orally Inhaled Steroids, and Second Generation Anticonvulsants**

This is a reminder that pharmacists can override a point-of-sale (POS) message that prior authorization (PA) is required for leukotrienes, statins, orally inhaled steroids, and second generation anticonvulsants (for seizure disorders only) for both N.C. Medicaid and N.C. Health Choice drug claims. If the prescriber has indicated that the PA criteria have been met, by writing “Meets PA Criteria” on the face of the prescription in prescriber’s own handwriting, the pharmacist will be able to override the PA edit for these drugs. This information may also be entered in the comment block on e-prescriptions. If the prescribed drug in one of these drug classes has a generic version available, “medically necessary” must also be written on the face of the prescription in the prescriber’s own handwriting in order to dispense the brand name drug. A “1” in the PA field (461-EU) or a “2” in the submission clarification field (420-DK) will override the PA edit. These overrides will be monitored by Program Integrity.

Providers may also contact ACS at 1-866-246-8505 (telephone) or 1-866-246-8507 (fax) to request PA for these medications. The PA criteria and request form for these drug classes are available on the N.C. Medicaid Enhanced Pharmacy Program website at <http://www.ncmedicaidpbm.com>. If the PA is approved by ACS, the POS override codes will not be needed.

**Pharmacy and Ancillary Services Section
DMA, 919-855-4305**

Attention: Pharmacy Providers**Automatic Refills and Automatic Shipments No Longer Allowed**

Effective January 1, 2012, automatic refills and automatic shipments are not allowed under the N.C. Medicaid Outpatient Pharmacy Program. N.C. Medicaid does not pay for any prescription without an explicit request from a recipient or the recipient’s responsible party, such as a caregiver, for each refilling event. The pharmacy provider shall not contact the recipient in an effort to initiate a refill unless it is part of a good faith clinical effort to assess the recipient’s medication regimen. The possession by a provider of a prescription with remaining refills authorized does not in itself constitute a request to refill a prescription. Recipients or providers cannot waive the explicit refill request and enroll in an electronic automatic refill program.

Any prescriptions filled without a request from a recipient or responsible party will be subject to recovery. Any pharmacy provider with a policy that includes filling prescriptions on a regular date or any type of cyclical procedure will be subject to audit, claim recovery or possible suspension or termination of their Medicaid provider agreement.

**Pharmacy and Ancillary Services Section
DMA, 919-855-4305**

Attention: Pharmacists and Prescribers**Upcoming Policy Implementation: Off Label Antipsychotic Safety Monitoring in Recipients 18 and older**

The Division of Medical Assistance partnering with Community Care of North Carolina (CCNC) will implement a policy that creates a registration and/or prior authorization process for the off label prescribing of an antipsychotic for a Medicaid recipient 18 and older. The registry/prior authorization process will collect information about adherence to recommended standards established by the American Psychiatric Association as well as currently accepted standards of care for efficacious and safe use of antipsychotics. The information collected in the registry/prior authorization process encourages the use of appropriate baseline and follow-up monitoring parameters.

Data elements requested for documentation reflect generally accepted monitoring parameters for the prescribed antipsychotic pharmacotherapy. Prescribers may be prompted to provide safety monitoring documentation when:

- The antipsychotic is prescribed for an indication that is not approved by the federal Food and Drug Administration.
- The antipsychotic is prescribed at a different dosage than approved for an indication by the federal Food and Drug Administration.
- The prescribed antipsychotic will result in the concomitant use of two or more antipsychotic agents.

Exemptions are included in the policy to ensure an antipsychotic medication can be obtained readily when prescribed on label and/or for recipients having a schizophrenia or psychosis diagnosis. When any of these conditions are met, the recipient is exempt from the requirements of the policy and the prescriber may write "Meets PA Criteria" in his/her own handwriting on the face of the prescription. "Meets PA Criteria" may be entered in the comment block on e-prescriptions. By doing so, the pharmacist may override the prior authorization requirements when submitting a claim for an antipsychotic medication for this population.

Prescribers will be prompted to provide safety documentation for each antipsychotic medication prescribed for a recipient. After the initial documentation is submitted, prompts will occur for each new antipsychotic prescribed for the recipient. Generally, a dose change or change in strength will not trigger a prompt. Documentation may be requested at twelve month intervals.

Implementation of the registry/prior authorization process will occur in early 2012. Notification of the official implementation date will occur in future Medicaid Bulletins. The initial implementation will be atypical antipsychotics only.

A widespread training effort about the antipsychotic safety monitoring documentation initiative, led by CCNC has been underway since early 2011.

Objectives of the registry/prior authorization include improving the use of evidence based safety monitoring for patients for whom an antipsychotic agent is prescribed, reduction of antipsychotic polypharmacy, and reduction of occurrences where the antipsychotic is prescribed in an amount differing from the FDA approved dosage for an indication.

Attention: Pharmacists and Prescribers**Upcoming Policy Implementation: Off Label Antipsychotic Safety Monitoring in NC Health Choice Recipients**

Well documented safety considerations, and limited efficacy information on the use of antipsychotic medications in children led the North Carolina Division of Medical Assistance (DMA) to develop a policy entitled **Off Label Antipsychotic Safety Monitoring in Health Choice Recipients**. The use of antipsychotic medications by children is an issue confronting parents, other caregivers, healthcare professionals and related organized healthcare agencies across the United States. Children and adolescents appear to be at similar or greater risk than adults for a variety of significant side effects related to the use of antipsychotic medications. The policy creates an opportunity to gather information about antipsychotic prescribing trends for Health Choice recipients, promote monitoring of recommended parameters, and to positively influence antipsychotic prescribing practices.

DMA partnering with Community Care of North Carolina will implement a registration and/or prior authorization process for the off label prescribing of an antipsychotic for a Health Choice recipient. The information collected encourages the use of appropriate baseline and follow-up monitoring parameters to facilitate the safe and effective use of antipsychotics in this population. The registry process, known as A+KIDS (Antipsychotics-Keeping It Documented for Safety), is in use already for Medicaid recipients aged 0-17. Information about the registry can be found at www.documentforsafety.com

Data elements requested for documentation reflect a generally accepted monitoring profile for the prescribed antipsychotic pharmacotherapy. Prescribers are prompted to provide safety monitoring documentation when:

- The antipsychotic is prescribed for an indication that is not approved by the federal Food and Drug Administration.
- The antipsychotic is prescribed at a different dosage than approved for an indication by the federal Food and Drug Administration.
- The prescribed antipsychotic will result in the concomitant use of two or more antipsychotic agents.

Implementation of the registry/prior authorization process for Health Choice recipients will occur in early 2012. Providers will receive notification of the official implementation in future Medicaid Bulletins article. A widespread training effort about the safety monitoring documentation initiative has been underway since early 2011. CCNC is reaching out to providers in order to provide training and education.

Objectives of the registry/prior authorization include improving the use of evidence based safety monitoring for patients for whom an antipsychotic agent is prescribed, reduction of antipsychotic polypharmacy, and reduction of cases where the FDA maximum dose is utilized.

Pharmacy Program
DMA, 919-855-4306

Attention: Durable Medical Equipment and Pharmacy Providers**Roche ACCU-CHEK Diabetic Supplies Under the DME and Pharmacy Programs**

Effective November 15, 2011, Roche Diagnostics Corporation Diabetes Care is N.C. Medicaid's designated preferred manufacturer for blood glucose monitors, diabetic test strips, control solutions, lancets, and lancing devices. These products are covered under the Durable Medical Equipment and Outpatient Pharmacy Programs and will be reimbursed under the pharmacy point-of-sale system with a prescription.

The transition period has been extended from November 15, 2011 through March 14, 2012. During this period, both Roche and Prodigy diabetic supplies will be covered. Beginning on March 15, 2012, the second phase of the transition will take effect where both Roche and Prodigy diabetic supplies will be covered; however, a one-time override will be required for continued use of Prodigy products through April 14, 2012. As of April 15, 2012, only Roche diabetic supplies will be covered.

Prior authorization will be allowed for insulin-pump dependent recipients who cannot use Roche products. Pharmacy and DME providers need to ensure that invoices are easily retrievable in case documentation is needed to support the billing of these products. This could be requested to support the quantities being invoiced to Roche for the rebates due back to N.C. Medicaid and N.C. Health Choice.

Insulin Pump Users

Prior authorization will be allowed for insulin-pump dependent recipients who cannot use Roche products due to a dedicated glucometer communicating with their insulin pump. In these instances the provider must be a durable medical equipment (DME) provider or a pharmacy/DME provider. Prior authorization requests should be submitted to HP at P.O.Box 31188, Raleigh, NC 27622. Effective November 15, 2011, there are no designated preferred manufacturers of insulin syringes. The following are the list of NDC's that will be covered:

Covered Products	Package Size	Unit Type	NDC - 11
ACCU-CHEK Aviva Care Kit	1 Meter Kit	1 Meter	65702-0101-10
ACCU-CHEK Compact Plus Care Kit	1 Meter Kit	1 Meter	50924-0019-01
ACCU-CHEK Aviva Test Strips	50 count	1 bottle	65702-0103-10
ACCU-CHEK Compact Test Strips	51 count	1 bottle	50924-0988-50
ACCU-CHEK Aviva Plus Test Strips	50 count	1 bottle	65702-0407-10
ACCU-CHEK Aviva Control Solution (2 levels)	1 bottle	1 bottle	65702-0107-10
ACCU-CHEK Compact Control Solution (2 levels)	1 bottle	1 bottle	65702-0369-10
ACCU-CHEK Multiclix Lancets	102 count	1 box	50924-0450-01
ACCU-CHEK Softclix Lancets	100 count	1 box	50924-0971-10
ACCU-CHEK Softclix Lancing Device (Blue)	1 count	1	50924-0957-01
ACCU-CHEK Softclix Lancing Device (Black)	1 count	1	65702-0400-10
ACCU-CHEK Multiclix Lancing Device Kit	1 count	1	50924-0446-01

Billing Instructions for Submitting Diabetic Supplies under DME

Claims for diabetic test strips, control solution, lancets and lancing devices submitted under the DME program must be billed using the NDC in addition to the HCPCS code. The NDC will be entered in the shaded area of block 24A of the CMS-1500 claim form. During the time period March 15, 2012 through April 14, 2012 when the one-time override is available for Prodigy products, DME providers will need to place the SC modifier in block 24D of the CMS-1500 claim form to bypass the requirement to bill for Roche NDCs listed in the chart above. As of April 15, 2012, this modifier will no longer be accepted. These requirements will not apply to private duty nursing and home health providers until April 15, 2012.

HCPCS codes and supply limits for diabetic supplies are the same as outlined in Clinical Coverage Policy 5A, Durable Medical Equipment, as indicated below:

HCPCS Code	Product Description	Quantity Limit
A4253	Blood glucose test or reagent strips (1 unit = 50 strips)	4/month – age ≥21
A4253	Blood glucose test or reagent strips (1 unit = 50 strips)	6/month – age < 21
A4259	Lancets (1 unit = 100 lancets)	2/month
A4258	Lancing device	2/year
A4256	Normal, high, low calibrator solution	4/year

Prior Authorization Instructions for Insulin Pump Users

With an effective date based on date of service of January 15, 2012 prior authorization will be required for insulin-pump dependent recipients who cannot use Roche products due to a dedicated glucometer communicating with their insulin pump. In these instances the provider must be a durable medical equipment (DME) provider or a pharmacy/DME provider. Claims with a prior authorization on file will need to be submitted with a NU and U9 modifier. Claims for test strips not supplied by Roche that do not have a Prior authorization on file for A4253 NU, U9 will be denied for lack of authorization. The U9 modifier will indicate that test strips **not** supplied by Roche have been authorized for payment. Prior authorization requests should be submitted to HP at the following addresses:

NC Medicaid
P.O.Box 31188
Raleigh, NC 27622

NC Health Choice
P.O.Box 322490
Raleigh, NC 27622

Billing Instructions for Submitting Diabetic Supplies under Pharmacy Point-of-Sale System

Claims for diabetic test strips, control solution, lancets and lancing devices submitted at point-of-sale must be billed using the NDC. Test strips must be billed in multiples of 50 and lancets must be billed in multiples of 100 except for the ACCU-CHEK Compact Test Strips, 51 count package size and the ACCU-CHEK Multiclix Lancets, 102 count package size. In order to accommodate the unbreakable package sizes under the pharmacy point-of-sale system, the ACCU-CHEK Compact Test Strips (NDC 50924-0988-50) can be billed up to 204 test strips per month for recipients 21 years of age and older and up to 306 test strips per month for recipients under 21 years of age will be allowed. At this time, test strip quantities over 204 per

month must be requested through the DME program; however, point-of-sale system changes are underway to accommodate the higher quantity limits for pediatric recipients. Additional information will be provided when this system change has been completed. The same rules apply for the ACCU-CHEK Multiclix Lancets (NDC 50924-0450-01). For Medicaid billing, 1 lancing device = 1 unit. Rates apply to these diabetic supplies; therefore, no copayments and no dispensing fees apply.

During the time period March 15, 2012 through April 14, 2012 when the one-time override is available for Prodigy products, pharmacy providers can place a "1" in the prior authorization type code field (461-EU) or a "2" in the submission clarification field (420-DK) to override the requirement to bill for Roche NDCs. As of April 15, 2012, this override will no longer be available and only the Roche NDCs referenced above will be covered. Diabetic supply limits will be the same as under the DME program. Prior authorization requests for additional quantities or for non-Roche diabetic supplies must go through the DME program.

Blood Glucose Monitors

ACCU-CHEK Aviva and Compact Plus blood glucose monitors are free to N.C. Medicaid and N.C. Health Choice recipients through the DME and Outpatient Pharmacy Programs. DME providers will have access to free blood glucose monitors to supply to recipients. Pharmacy providers can dispense free blood glucose monitors to recipients by submitting the following information to Roche Diagnostics:

Rx GRP (Carrier Group): MAX26266

ID#: 1ACCUCHEK

Suffix (Dependent) Code: 01

Rx BIN#: 610415

PCN: PCS

COB: Primary

Other Coverage Code: Blank

For additional information, providers may call ACCU-CHEK Customer Care, 1-877-906-8969 or DMA Clinical Policies and Programs at 919-855-4310 (DME) or 919-855-4300 (Pharmacy).

Clinical Policies and Programs

DMA, 919-855-4310

Attention: Durable Medical Equipment and Orthotic & Prosthetics Providers**2012 HCPCS Code Changes**

Effective with date of service December 31, 2011, the following HCPCS codes were end-dated and removed from the MES and O&P fee schedules:

HCPCS Code	Description
W4633	Eggcrate Mattress Pad
W4651	Blood Glucose Test Strips (visual strips- not for use with blood glucose monitor), per bottle
W4672	Gray Adapter for use with External Insulin Pump, each
W4673	Piston Rod for use with External Insulin Pump, each
W4696	Manual wheelchair for weights 451# to 600#
W4697	Manual wheelchair for weights 6001# and greater
W4726	Total Electric Hospital Bed for weights 351# to 451# with mattress and any type side rails
W4731	Total Electric Hospital Bed for weights 451# to 1000# with width to 48" with mattress and any type side rails
W4732	Total Electric Hospital Bed for weights 451# to 1000# with width to 54" with mattress and any type side rails
W4734	Replacement Oversized Innerspring Mattress for Hospital Bed with to 48"
W4735	Replacement Oversized Innerspring Mattress for Hospital Bed with to 54"
W4736	Replacement Oversized Innerspring Mattress for Hospital Bed with to 60"
L1500	THKAO, mobility frame (Newington, Parapodium type)
L1510	THKAO, standing frame
L1520	THKAO, swivel walker
L3964	Shoulder elbow orthosis, mobile arm support attached to wheelchair, balanced, adjustable, prefabricated, includes fitting and adjustment
L3965	Shoulder elbow orthosis, mobile arm support attached to wheelchair, balanced, adjustable Rancho type, prefabricated, includes fitting and adjustment
L3966	Shoulder elbow orthosis, mobile arm support attached to wheelchair, balanced, reclining, prefabricated, includes fitting and adjustment
L3968	Shoulder elbow orthosis, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints), prefabricated, includes fitting and adjustment
L3969	Shoulder elbow orthosis, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support, prefabricated, includes fitting and adjustment
L3970	SEO, addition to mobile arm support, elevating proximal arm
L3972	SEO, addition to mobile arm support, offset or lateral rocker arm with elastic balance control
L3974	SEO, addition to mobile arm support, supinator
L4380	Pneumatic knee splint, prefabricated, includes fitting and adjustment
L5311	Knee disarticulation (or through knee), molded socket, external knee joints, shin, sach foot, endoskeletal system
L7500	Repair of prosthetic device, hourly rate (excludes V5335 repair of oral or laryngeal prosthesis or artificial larynx)

Effective with date of service January 1, 2012, the following code descriptions were changed:

Code	New Description
E0638	Standing frame/table system, one position (e.g. upright, supine or prone stander), any size including pediatric, with or without wheels
E0641	Standing frame/table system, multi-position (e.g. three-way stander), any size including pediatric, with or without wheels
E0642	Standing frame/table system, mobile (dynamic stander), any size including pediatric
E0691	Ultraviolet light therapy system, includes bulbs/lamps, timer, and eye protection; treatment area 2 square feet or less
L2005	Knee ankle foot orthosis, any material, single or double upright, stance control, automatic lock and swing phase release, any type activation, includes ankle joint, any type, custom fabricated
L6000	Partial hand, thumb remaining
L6010	Partial hand, little and/or ring finger remaining
L6020	Partial hand, no finger remaining

Effective with date of service January 1, 2012, the following codes were added to the MES fee schedule:

New Code	Modifier	Description	Lifetime Expectancy/ Quantity Limitations
A5056	NU	Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece), each	20 per month
A5057	NU	Ostomy pouch, drainable, with extended wear barrier attached with built in convexity, with filter, (1 piece), each	20 per month
E2358	NU UE RR	Power wheelchair accessory, group 34 non-sealed lead acid battery, each	2/yr
E2359	NU UE RR	Power wheelchair accessory, group 34 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)	2/yr
E2626	NU	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced adjustable	1 every 6 mo ages 000-020 1 every 3 yrs ages 021-115
E2627	NU	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable rancho type	1 every 6 mo ages 000-020 1 every 3 yrs ages 021-115

New Code	Modifier	Description	Lifetime Expectancy/ Quantity Limitations
E2628	NU	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced reclining	1 every 6 mo ages 000-020 1 every 3 yrs ages 021-115
E2629	NU	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints)	1 every 6 mo ages 000-020 1 every 3 yrs ages 021-115
E2630	NU	Wheelchair accessory, shoulder elbow, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support yoke type suspension support	1 every 6 mo ages 000-020 1 every 3 yrs ages 021-115
E2330	NU	Wheelchair accessory, addition to mobile arm support elevating proximal arm	1 every 6 mo ages 000-020 1 every 3 yrs ages 021-115
E2632	NU	Wheelchair accessory, addition to mobile arm support, offset or lateral rocker arm with elastic balance control	1 every 6 mo ages 000-020 1 every 3 yrs ages 021-115
E2633	NU	Wheelchair accessory, addition to mobile arm support, supinator	1 every 6 mo ages 000-020 1 every 3 yrs ages 021-115

Effective with date of service January 1, 2012, the following codes were added to the O&P fee schedule:

New Code	Modifiers	Description	Lifetime Expectancy/ Quantity Limitations	Required Provider Certification
L5312	NU	Knee disarticulation (or through knee), molded socket, single axis knee, pylon, each foot, endoskeletal system	1 per yr ages 000-020 1 per 3 yrs ages 021-115	CP, CPO

Note: A Certificate of Medical Necessity and Prior Approval must be completed for all items, regardless of the requirement for prior approval. The coverage criteria for these items have not changed.

Medical Equipment providers refer to Clinical Coverage Policy 5A, [Medical Equipment and Supplies](#), on DMA's [Clinical Coverage Policies and Provider Manuals web page](#) for detailed coverage information. Please refer to the MES Fee Schedule on DMA's [Fee Schedule web page](#) for the maximum allowable rates for these new codes and for all of the codes covered by N.C. Medicaid for MES.

O&P providers refer to Clinical Coverage Policy 5B, [Orthotics and Prosthetics](#), on DMA's [Clinical Coverage Policies and Provider Manuals web page](#) for detailed coverage information. Please refer to the O&P Fee Schedule on DMA's [Fee Schedule web page](#) for the maximum allowable rates for these new codes and for all of the codes covered by N.C. Medicaid for O&P.

Clinical Policy
DMA, 919-855-4316

Attention: HIV Case Management Providers

T ***Training Announcements***

Upcoming training

The Carolinas Center for Medical Excellence (CCME) will conduct a four day HIV Case Management Basic Training from January 23rd to 26th 2012. Attendance is restricted to staff who are employed by certified HIV Case Management agencies. Please contact CCME (919-461-5560) for details on location of the training and register at <http://www.thecarolinascenter.org/HIVCM>.

Reminder

January 1, 2012 begins a new calendar year for obtaining the required continuing education contact hours. As a reminder, the only courses that are pre-approved are those offered by CCME. While these trainings help in meeting the 20 hour requirement, they are not intended to provide all of the training needs for individuals. All other trainings must be pre-approved by the Division of Medical Assistance. Please utilize the form provided for this purpose. It can be accessed at the following web site: <http://www.ncdhhs.gov/dma/services/hivcm.htm>

HIV Case Management Program
DMA, 919-855-4389

Attention: Outpatient Behavioral Health Providers and CABHAs**Questions and Answers from the November 2011 Outpatient Seminars**

Questions and answers from the November 2011 Outpatient Behavioral Health Seminars will be posted on the Division of Medical Assistance's (DMA) website early January. The information will be located at the following websites: <http://www.ncdhhs.gov/dma/provider/index.htm>
<http://www.ncdhhs.gov/dma/services/outpatientbh.htm>.

The questions and answers are in the following categories:

- Enrollment
- Authorization
- Billing
- Managed Care (MCOs)
- Program Integrity
- General Policy (Referrals, 'Incident To', Documentation, H-Codes)
- Comprehensive Clinical Assessments
- Health Choice
- Other

As spelled out in Clinical Coverage Policy 8C, NC Medicaid currently allows LPAs, LPCs, LMFTs, nurse practitioners (with psychiatric certification or under the sunset clause), clinical nurse specialists, CCSs under the sunset clause, and LCASs to direct enroll and provide outpatient services to Medicaid recipients. Although H codes will be going away starting January 1, 2012, fully licensed direct enrolled behavioral health providers will be able to continue to provide outpatient services to Medicaid recipients, billing the appropriate CPT code. Each H code that is being eliminated has a comparable CPT code. When an individual has insurance such as Medicare, Medicaid is always the payer of last resort, meaning that Medicare must be billed first. As Medicare does not accept H codes and only recognizes certain clinicians (LCSWs and licensed psychologists) as providers eligible to bill for outpatient behavioral health services, the attending provider treating dually enrolled (Medicare/Medicaid) recipients, must be credentialed and enrolled with both Medicare and Medicaid. To circumvent filing the claim with Medicare, by billing H codes, would not be appropriate and could be considered fraud. The requirement to bill Medicare first and the requirement to meet Medicare qualifications in order to serve dual eligible's are not new requirements.

Behavioral Health Section
DMA, 919-855-4290

Attention: CAP-MR/DD Providers, I/DD TCM Case Managers, and LMEs**Extension of Current CAP-MR/DD Waiver and Process for Submitting Authorization Requests**

The Division of Medical Assistance (DMA) has asked the Centers for Medicare and Medicaid (CMS) for an extension for the current 2008 CAP MR/DD waiver. The extension was requested because DMA and DMHDDSAS are working with CMS to review NC's progress on our 2008 CAP MR/DD waiver transition plan for recipients residing in facilities with more than 16 beds and the Divisions are addressing final questions about transition to the new waiver requirements.

When the waiver is approved by CMS, DMA will publish the final services with the effective start date of the waiver. The proposed implementation date for the renewal CAP I/DD waivers will be April 1, 2012.

We appreciate the amount of time that recipients, families, case managers, and providers have spent working on developing transition plans. To that end, we have drafted the following guidelines in an attempt to minimize further disruption for recipients and their families. Please review the following bullets to determine if the case manager and recipient/family need to submit an updated revision (authorization request), including the PCP revision form with appropriate signatures, CTCM form, and updated cost summary.

- If services were authorized to fit the new waiver requirements and the recipient/legally responsible person accepted the plan/services, then a revision (authorization request) does not need to be submitted. Specifically, if a request to change Home Supports services to Home and Community Supports and Personal Care has been approved, those services can be provided.
- If services currently authorized under the 2008 CAP MR/DD waiver are not in compliance with the new proposed waiver requirements, then a revision (authorization request) does not need to be submitted at this time. A revision for authorization of new services must be submitted by April 1, 2012 to have services meet the requirements under the new waiver.
- If an authorization request was approved to change services to meet the new waiver requirements, and the recipient/legally responsible person would rather continue with their current services under the 2008 CAP waiver, then the case manager needs to document this information into a case management note and update the PCP and cost summary for the recipient record. This updated PCP will serve as the authorization in the interim until April 1, 2012. The case manager does not submit this information to the UR Vendor. The plan that was to go into effect on January 1, 2012 will now go into effect on April 1, 2012.
- If a revision request was sent to the UR vendor to change services to meet the new waiver requirements, the UR vendors will process the request with an effective date of April 1, 2012. The case manager will need to contact the UR Vendor if they would like the request that was submitted to be effective January 1, 2012 instead of April 1, 2012.
- If a Continued Needs Review (yearly CNR renewal) with an effective date of January 1, 2012 has been approved or is currently being reviewed by a UR Vendor, and the recipient/legally responsible person would rather continue with their current services, then the case manager needs to update the PCP and cost summary to show 3 months of services under the current waiver and 9 months of services in compliance with the requirements of the new waiver. This updated CNR must be submitted to the UR Vendor by April 1, 2012.

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

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

Proposed Clinical Coverage Policies

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

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

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

2012 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
January	1/5/12	1/10/12	1/11/12
	1/12/12	1/18/12	1/19/12
	1/19/12	1/26/12	1/27/12
February	2/2/12	2/7/12	2/8/12
	2/9/12	2/14/12	2/15/12
	2/16/12	2/22/12	2/23/12
	2/23/12	2/29/12	3/1/12

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.

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

Melissa Robinson
Executive Director
HP Enterprise Services