February 2011 Medicaid Bulletin

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

Attention: All Providers

Provider Quality Assurance Questionnaire

In March 2011, DMA's Provider Services Section will begin publishing monthly provider quality assurance (QA) questionnaires. A link to the questionnaire will be published each month in the Medicaid Bulletin. The QA questionnaire is intended only for DMA's enrolled Medicaid providers. All enrolled providers are encouraged to complete the questionnaire. Results obtained from the questionnaire will assist DMA in its efforts to improve customer service to enrolled providers and Medicaid recipients. All of the information provided in the surveys will be kept confidential, and should be returned electronically to DMA. A secured e-mail address will be provided with next month's initial release of the survey.

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

Attention: All Providers

Child Service Coordination Program and Maternity Care Coordination Program

Effective with date of service March 1, 2011, the Child Service Coordination (CSC) and Maternity Care Coordination (MCC) programs will no longer be offered as fee-for-service programs through DMA. CSC and MCC providers must submit all claims to the N.C. Medicaid Program for services provided prior to March 1, 2011.

Clinical Coverage Policy 1M-1, *Child Service Coordination,* and 1M-8, *Maternity Care Coordination*, will be end-dated to reflect these changes. HCPCS procedure codes T1016 and T1017 will be end-dated for MCC and CSC services provided after February 28, 2011.

Effective March 1, 2011, the new Care Coordination for Children (CC4C) and the Pregnancy Care Management programs will be offered through the Community Care of North Carolina (CCNC). These programs will be a population-based model and paid on a per-member, per-month basis and not fee-for-service. Please refer to other articles in this bulletin for additional information on these new programs.

Clinical Policy and Programs
DMA, 919-855-4320

Attention: All Providers

Clinical Coverage Policies

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

- 8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers* (posted 2/1/11; eff. 1/1/11)

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

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Preparation for National Correct Coding Initiative Implementation

In October 2010, DMA began alerting providers of DMA's plan to implement the National Correct Coding Initiative (NCCI) in March 2011. N.C. Medicaid, as well as other state Medicaid agencies, is required to implement NCCI editing within the claims processing system by April 1, 2011. Federal law mandates that the following types of edits must be implemented: procedure-to-procedure editing (CCI) and units of service, also called medically unlikely edits (MUE).

The potential exists that these edits may impact claims payments for practitioners, ambulatory surgical centers, outpatient hospital services (only for drugs, high-tech images, ultrasounds, and labs as they are billed at a CPT/HCPCS code level), and durable medical equipment. New CCI and MUE EOBs will be reported on the provider's Remittance and Status (RA) Report. Upon implementation of CCI and MUEs, an explanation and justification for all NCCI edits will be available on a claim and line-level basis using the ConVergence Point Web Portlet, which will be accessed through the N.C. Electronic Claims Submission Web Tool (NCECSWeb Tool). For example, incompatible code pairs will be cited and code lines exceeding MUE limits will be identified.

Providers who currently have an NCECSWeb Tool logon ID and password and can view their RA in PDF format will be automatically enrolled for access. If you do not currently have an NCECSWeb Tool logon ID and password, you must complete a Remittance and Status Reports in PDF Format/NCCI Information Request Form. The form and instructions may be obtained from the DMA website at http://www.ncdhhs.gov/dma/provider/forms.htm.

Providers are encouraged to frequently visit DMA's NCCI web page (http://www.ncdhhs.gov/dma/provider/ncci.htm) and to review published bulletin articles for information and updates on the status of the project and for information on provider training opportunities.

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

Attention: All Providers

Basic Medicaid Seminars

Basic Medicaid seminars are scheduled for the month of April 2011. Seminars are intended to educate providers on the basics of Medicaid billing as well as to provide an overview of Medicaid updates and resources. The seminar sites and dates will be announced in the March 2011 Medicaid Bulletin. The April 2011 *Basic Medicaid Billing Guide* will be used as the training document for the seminars and will be available prior to the seminars on DMA's Basic Medicaid Billing Guide web page (http://www.ncdhhs.gov/dma/basicmed/).

Pre-registration will be required. Due to limited seating, registration will be limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

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

Attention: HIV Case Management Providers

Reminders and Updates for HIV Case Management Services

Status of Current Certifications

As stated in the September 2010 Medicaid Bulletin, until all changes have been implemented, providers should continue to operate under their current certification previously issued by the AIDS Care Unit.

Physician Referral Form

In response to the numerous questions posed on this topic and requests for guidance, DMA and The Carolinas Center for Medical Excellence (CCME) are providing a sample Physician Referral Form. It is recognized that your agency may already have a form for this purpose; therefore, this serves as a recommendation. The sample form and instructions are available online at http://www.thecarolinascenter.org/hivcm. Refer to page 8 for additional information about the physician referral form.

Training

We are pleased to announce registration is now open for the training on the **New Policy Requirements for HIV Supervisors and Case Managers** scheduled for **February 17, 2011 and February 18, 2011** (see schedule below). **This training is limited to those HIV supervisors and case managers who are employed by providers who are currently enrolled with Medicaid to provide HIV Case Management.**

Date	Session Topic	Required Attendees
February 17 and 18, 2011	New Policy Requirements	HIV Case Supervisors and Case Managers

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

Frequently Asked Questions

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

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

Attention: All Providers

Individual Behavior Change Intervention Services Provided in Federally Qualified Health Centers and Rural Health Clinics

Individual behavior change intervention services indicated by the CPT codes listed in the table below are considered to be a core service. These CPT codes are not reimbursable when provided by a federally qualified health center or rural health clinic on the same day that a core service is provided.

CPT Code	Description
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit ; intensive, greater than 10 minutes
99408	Alcohol and/or substance, other than tobacco, abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409	Alcohol and/or substance, other than tobacco, abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes

These individual behavior change intervention services are covered Medicaid services but are not separately billable as a core service or an ancillary service. The services must be rendered as a component of a primary core service visit.

Refer to Clinical Coverage Policy 1D-4, *Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics*, on DMA's website at http://www.ncdhhs.gov/dma/mp for additional information.

HP Enterprise Services
1-800-688-6696 or 919-855-8888

Attention: N.C. Health Choice Providers

N.C. Health Choice Non-Covered Policies

Effective December 8, 2010, the following policies are not covered by N.C. Health Choice:

1. Ultrasound Screening for Abdominal Aneurysm
2. Periurethral Bulking Agents for the Treatment of Urinary Incontinence
3. Mohs Micrographic Surgery
4. Magnetoencephalography / Magnetic Source Imaging
5. Isolated Limb Perfusion
6. Intravascular Ultrasound Imaging
7. Bone Morphogenic Protein

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

Attention: All Providers

Checking the Status of an Application

When an applicant uses the online application process on NC Tracks (http://www.nctracks.nc.gov/) to submit an enrollment application for participation with N.C. Medicaid he/she should receive an acknowledgement of the receipt of the application. The acknowledgement is sent by e-mail to the attention of the contact person indicated on the application. (The contact person is the individual that is authorized to make business decisions on behalf of the applying provider.)

If you do not receive acknowledgement within two weeks of submitting your application through the online process, you may contact the CSC EVC Call Center at 1-866-844-1113 to confirm that the application has been received. The CSC EVC Call Center is available Monday through Friday, 8:00 a.m. through 5:00 p.m.

CSC, 1-866-844-1113

Attention: Child Service Coordination Providers and Physicians

Care Coordination for Children

DMA, in partnership with Community Care of North Carolina (CCNC) and other community stakeholders including providers, local health departments, and the Division of Public Health (DPH), has created a new program called Care Coordination for Children (CC4C). The current Child Service Coordination (CSC) program will transition into the CC4C model. In addition to the community based interventions for children to maximize health outcomes, the program will target the highest risk and highest cost children for care management.

Services

CC4C services will be provided based on patient need and according to risk stratification guidelines. The amount of contacts will be determined by the patient's individual needs and plan of care, in order to effectively meet desired outcomes. Contacts may occur in various settings including the health care provider office, community, or patient's home, as well as by phone. A transition plan is being developed for existing recipients of Child Service Coordination (CSC) services. In partnership with DPH, additional information will be forthcoming.

CC4C Outcome Measures

The overall program model seeks to improve health outcomes for enrolled children, which will be measured by: the length of time from neonatal intensive care unit discharge to first medical home visit; hospital admissions, readmissions, and emergency department use; and the number of children with special health care needs and/or children in foster care who have a medical home. Specific measures will determine to what extent the CC4C services are achieving project goals, including: the rate of comprehensive assessments completed for children/families with a priority risk factor; the percent of enrolled children who receive a Life Skills Progression assessment on entry into the system, every six months thereafter, and upon discharge from CC4C services; the number of infants ages 1 year or under referred to Early Intervention; and, as evidenced by the child making progress towards the defined goals in their treatment plan, self-sufficiency and self management of the condition.

Managed Care Section
DMA, 919-855-4780

Attention: Maternity Care Coordination Providers and Physicians

Pregnancy Care Management Services

DMA, in partnership with Community Care of North Carolina (CCNC) and other community stakeholders including providers, local health departments, and the Division of Public Health, has created a program that provides pregnant Medicaid recipients with a pregnancy medical home (PMH). This program includes Pregnancy Care Management Services. The goal of the PMH model is to improve the quality of maternity care, improve birth outcomes, and provide continuity of care. This model will involve engaging medical practices as PMH providers and local health departments as providers of Pregnancy Care Management.

Pregnancy Medical Home

Licensed qualified private physicians and public or private clinics organized for the delivery of obstetrical care can become a PMH by signing a contract with the local Community Care network and agreeing to meet the requirements of the program. A PMH practice is expected to meet specific performance standards, including eliminating elective delivery before 39 weeks' gestation, offering and providing 17P to eligible patients, reducing the primary cesarean section rate, and screening all new obstetric patients for pregnancy risk factors using a standardized risk screening tool. PMH practices will receive incentives for completed risk screenings and completed postpartum visits, as well as an enhanced rate of reimbursement for vaginal deliveries and exemption from prior authorization for obstetric ultrasounds. Clinical prenatal services will continue to be reimbursed on a per service and/or package basis. PMH practices that do not offer obstetric delivery will be asked to describe the processes by which they coordinate care with the intrapartum provider.

Pregnancy Care Management

Target Population and Eligibility: Care management services are provided for pregnant Medicaid recipients who are determined to be at risk for poor birth outcome. All patients identified as having priority risk factors will be assessed by a Pregnancy Care Manager. Priority risk factors include: A history of preterm birth; a history of low birth weight; multiple gestation; fetal complications; chronic conditions that may complicate pregnancy; unsafe living environment (homelessness, inadequate housing, violence or abuse); substance use; tobacco use; missing two or more prenatal appointments without rescheduling; and inappropriate hospital utilization. All PMH providers are required to complete a pregnancy risk screening to identify these and other risk factors. Non-PMH providers will also be able to refer their patients for Pregnancy Care Management services.

PMH Partnership: Each PMH will have a specific Pregnancy Care Manager(s) assigned to work with their patients. This stable relationship with consistent staff will support the effective exchange of information between the PMH and the Pregnancy Care Manager. Further, each PMH will commit to dedicating staff time for necessary communication with the Pregnancy Care Manager(s) supporting their patients.

Services: Pregnancy Care Management services will be provided based on patient need and according to risk stratification guidelines. Contacts will be determined by the patient's individual needs and plan of care, in order to effectively meet desired outcomes. Contacts may occur in multiple settings including the health care provider office, community, or patient's home, as well as by phone. All documentation for Pregnancy Care Management services will be completed online in the CCNC Case Management Information System (CMIS).

Managed Care Section
DMA, 919-855-4780

Attention: Ambulatory Surgical Centers

Addition of 2010 CPT Procedure Codes to Be Paid Separately to Ambulatory Surgical Centers

DMA has received guidelines from CMS indicating which of the codes included in the 2010 CPT Update could be paid separately under the Ambulatory Surgical Center (ASC) payment system. System changes have now been completed to allow for reimbursement for ASC providers for dates of service January 1, 2010, and after, for the procedure codes listed in the table below:

14301	14302	21011	21012	21013	21014	21016	21552	21554	21558
21931	21932	21933	21936	22901	22902	22903	22904	22905	23071
23073	23078	24071	24073	24079	25071	25073	25078	26111	26113
26118	27043	27045	27059	27337	27339	27364	27616	27632	27634
28039	28041	28047	29581	32552	36147	37761	45171	45172	46707
51727	51728	51729	53855	57426	63661	63662	63663	63664	77338
78451	78452	78453	78454						

One of the following modifiers, as applicable, must be appended to the procedures code: SG, 73, or 74. Claims submitted without applicable modifiers will be denied. ASC providers who have received claim denials for these procedure codes with EOB 24 (This procedure code not allowed for your provider type) may resubmit new claims for processing.

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

Attention: Physicians

Physician Referral Form for HIV Case Management Services

Effective October 1, 2010, a physician's written order was required for the initiation of HIV Case Management services. A second order is required if it is deemed that the recipient continues to need HIV Case Management beyond two months (a maximum of 32 units). To ensure that HIV Case Management continues to be appropriate to meet a recipient's needs, the provider shall obtain a physician's written order annually.

The intent of Clinical Coverage Policy 12B, sub-section 5.2 is for the physician to make a "referral" for HIV Case Management services rather than "order" the service. In doing so the physician is attesting to the medical necessity for HIV Case Management.

The request for the referral may come from the Medicaid recipient or the HIV Case Management provider agency. In addition, physicians have the option of making referrals if deemed appropriate.

Attached is a sample physician referral form. Note that a statement attesting to the validity of the client's HIV positive status is included within the form. The form is available on CCME's website at http://www.thecarolinascenter.org/hivcm.

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

Client ID # (If applicable) _____ Date _____

(INSERT AGENCY NAME)

HIV CASE MANAGEMENT

PHYSICIAN REFERRAL FORM

SUBMIT FORM TO THE HIV CASE MANAGEMENT PROVIDER/AGENCY

COMPLETE THIS FORM AND SEND TO: _____

PHYSICIAN OPTIONS FOR SUBMISSION TO THE HIV CASE MANAGEMENT PROVIDER/AGENCY:
SUBMIT VIA FAX AT: (___) _____
OR SUBMIT VIA MAIL TO: _____
_____
_____

***PHYSICIAN MAY ALSO SUBMIT THE COMPLETED FORM VIA THE CLIENT TO DELIVER TO THE HIV CASE MANAGEMENT PROVIDER IN PERSON.**

CLIENT INFORMATION			
CLIENT NAME:	**DOB:**	**GENDER: MALE ☐ FEMALE ☐ TRANSGENDER ☐**	
RESIDENCE/PERMANENT ADDRESS:	**CITY:**	**COUNTY:**	**ZIP:**
CLIENT PHONE:	**PRIMARY LANGUAGE:**		
EMERGENCY CONTACT NAME:	**RELATIONSHIP:**		
ADDRESS:	**PHONE:**		
IF UNDER 18, NAME OF LEGAL GUARDIAN:	**RELATIONSHIP:**		
ADDRESS:	**PHONE:**		
PROVIDER/AGENCY NAME:	**PROVIDER/AGENCY CONTACT NUMBER:**		
PHYSICIAN/PRACTITIONER NAME:	**FACILITY/PRACTICE NAME:**		
PHYSICIAN/PRACTICTIONER PHONE:	**PHYSICIAN/PRACTICTIONER FAX:**	**PHYSICIAN/PRACTICTIONER E-MAIL:**	

I,_____, RECOMMEND THAT _____ RECEIVE MEDICAID HIV CASE MANAGEMENT SERVICES BASED ON A REVIEW OF THE CLIENT'S MEDICAL RECORDS.

I ATTEST TO THE VALIDITY OF THE POTENTIAL CLIENT'S HIV + STATUS.

_____ _____
PHYSICIAN/PRACTITIONER SIGNATURE **DATE**

Attention: Personal Care Services Providers

Independent Assessment Updates and Reminders

Provider Interface registration forms are still being accepted. The Provider Interface allows Personal Care Services (PCS) agencies to receive and respond to recipient referrals, view independent assessments and decision notices, update service area information, and perform other reporting functions using a secure internet-based system. If you would like to register to use the Provider Interface, please complete and submit the QiRePort Provider Registration Form available on the **Independent Assessment website** (http://www.qireport.net).

Please report recipient discharges from your agency as they occur. Recipient discharges may be reported via the Provider Interface. Providers not yet registered to use the interface may report recipient discharges using Part 2 of the Weekly Summary Form available on the **Independent Assessment website** (http://www.qireport.net).

Continue to visit the **Independent Assessment website** (http://www.qireport.net) regularly for PCS forms, reference documents, educational content, announcements, and frequently asked questions.

Questions may be directed to the CCME Independent Assessment Help Line at 1-800-228-3365 and by e-mail to PCSAssessment@thecarolinascenter.org. Please direct questions regarding recipient status or referrals to the Help Line for faster response and to avoid the transmission of protected health information over e-mail.

CCME, 1-800-228-3365

Attention: Community Care of North Carolina/Carolina ACCESS Providers

Enrolling Medicaid/Medicare Recipients (Dually Eligible Recipients) with Your Practice

Community Care of N.C./Carolina ACCESS (CCNC/CA) providers are allowed to enroll their patients into CCNC/CA by having the patient sign the Carolina ACCESS Enrollment Form for Providers. The form is sent to the local department of social services for entry into the recipient eligibility file. Providers who enroll their patients are also responsible for providing appropriate education using the Community Care of North Carolina/Carolina ACCESS Member Handbook.

There is some additional information that must be provided to dually eligible recipients. It is important to note that enrollment in CCNC/CA is optional for dually eligible recipients and they can choose not to enroll. CMS has created a fact sheet for dually eligible recipients titled *Facts About Medicare*. This fact sheet must be inserted into the Community Care of North Carolina/Carolina ACCESS Member Handbook, which is also provided at the time the enrollment form is signed. The enrollment form used by providers has been revised to allow dually eligible recipients to attest that they have read the fact sheet. The second page of the enrollment form is a fact sheet that can be used to help educate dually eligible recipients about their rights and the benefits of being a member of CCNC/CA.

The revised enrollment form and fact sheet can be found on the DMA website at http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm.

Managed Care Section
DMA, 919-855-4700

Attention: Durable Medical Equipment Providers

2011 HCPCS Code Changes for Durable Medical Equipment

Effective with date of service December 31, 2010, the following HCPCS codes for durable medical equipment (DME) were end-dated and removed from the DME Fee Schedule:

- K0734 (skin protection wheelchair seat cushion, adjustable, width less than 22 in., any depth)
- K0735 (skin protection wheelchair seat cushion, adjustable, width 22 in. or greater, any depth)
- K0736 (skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 in., any depth)
- K0737 (skin protection and positioning wheelchair seat cushion, adjustable, width 22 in. or greater, any depth)

Effective with date of service January 1, 2011, the following code descriptions were changed:

Code	Description
B4034	Enteral feeding supply kit; syringe fed, per day includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape
B4035	Enteral feeding supply kit; pump fed, per day includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape
B4036	Enteral feeding supply kit; gravity fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape
A7013	Filter, disposable, used with aerosol compressor or ultrasonic generator
A4399	Ostomy irrigation supply; cone/catheter, with or without brush

Effective with date of service January 1, 2011, the following codes were added to the DME Fee Schedule:

New Code	Description	Modifier	Lifetime Expectancy/Quantity Limitations
A7020	Interface for cough stimulating device, includes all components, replacement, only	NU (New)	2 per year/ages 000 through 115
E2622	Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth	NU (New) UE (Used) RR (Rental)	Every 3 years/ages 000 through 115
E2623	Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	NU (New) UE (Used) RR (Rental)	Every 3 years/ages 000 through 115
E2624	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth	NU (New) UE (Used) RR (Rental)	Every 3 years/ages 000 through 115
E2625	Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	NU (New) UE (Used) RR (Rental)	Every 3 years/ages 000 through 115

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. Refer to Clinical Coverage Policy 5A, *Durable Medical Equipment*, on DMA's website (http://www.ncdhhs.gov/dma/mp/) for detailed coverage information. Please refer to the DME Fee Schedule on DMA's website (http://www.ncdhhs.gov/dma/fee/) for the maximum allowable rates for these new codes and for all of the codes covered by N.C. Medicaid for DME.

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

Attention: Orthotics and Prosthetics Providers

2011 HCPCS Code Changes for Orthotics and Prosthetics

Effective with date of service December 31, 2010, the following codes were end-dated and removed from the Orthotics and Prosthetics (O&P) Fee Schedule.

- L3672 [shoulder orthotic (SO), abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment]
- L3673 [shoulder orthotic (SO), abduction positioning (airplane design), thoracic component and support bar, includes nontorsion joint/turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment]

Effective with date of service January 1, 2011, the following code descriptions were changed:

Code	New Description
L3671	Shoulder orthosis, shoulder joint design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3677	Shoulder orthosis, shoulder joint design, without joints, may include soft interface, straps, prefabricated, includes fitting and adjustment

Effective with date of service January 1, 2011, the following codes were added to the O&P Fee Schedule:

New Code	Description	Modifier	Lifetime Expectancy/Quantity Limitations	Required Provider Certification
L3674	Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, with or without nontorsion joint/turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment	NU (New) LT (Left) RT (Right)	6 months: all ages	CO, CPO
L4631	Ankle foot orthosis, walking boot type, varus/valgus correction, rocker bottom, anterior tibial shell, soft interface, custom arch support, plastic or other material, includes straps and closures, custom fabricated	NU (New) LT (Left) RT (Right)	1 year: all ages	CO, CPO
L5961	Addition, endoskeletal system, polycentric hip joint, pneumatic or hydraulic control, rotation control, with or without flexion and/or extension control	NU (New) LT (Left) RT (Right)	1 year: ages 00 through 20 3 years: ages 21 and older	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. Refer to Clinical Coverage Policy 5B, *Orthotics and Prosthetics*, on DMA's website (http://www.ncdhhs.gov/dma/mp/) for detailed coverage information. Please refer to the O&P Fee Schedule on DMA's website (http://www.ncdhhs.gov/dma/fee/) for the maximum allowable rates for these new codes and for all of the codes covered by N.C. Medicaid for O&P.

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

Attention: Critical Access Behavioral Health Agencies

Electronic Commerce Requirements for Billing

This article serves as a reminder to Critical Access Behavioral Health Agencies (CABHAs) that once you have completed the Medicaid provider enrollment process and received your CABHA Medicaid Provider Number (MPN) you must complete and submit an **Electronic Funds Transfer (EFT) Authorization Agreement for Automatic Deposits** to initiate the process for electronic payment of claims billed with the National Provider Identifier (NPI) associated with your CABHA MPN.

A separate **EFT Authorization Agreement** must be submitted for each MPN issued to a provider. A copy of the EFT Authorization Agreement can be obtained on DMA's website at http://www.ncdhhs.gov/dma/provider/forms.htm. A voided check must be attached to the EFT Authorization Agreement to confirm the CABHA's account number and bank transit number. Completed forms can be returned by fax to the HP Enterprise Services Financial Unit at 919-816-3186 or by e-mail to NCXIXEFT@hp.com.

Remittance and Status Reports (RAs) are available only through the N.C. Electronic Claims Submission/Recipient Eligibility Verification Web Tool (NCECSWeb Tool). Therefore, CABHAs must also complete and submit a **Remittance and Status Reports in PDF Format and NCCI Information Request Form** to obtain a logon ID and password to their RAs for claims billed with the NPI associated with their CABHA MPN.

The **Request Form** and instructions can be found on DMA's Provider Forms web page at http://www.ncdhhs.gov/dma/provider/forms.htm. Providers who are new to billing or providers without an RA cover page must state on the form that an RA has not been received. Completed forms can be returned by fax to the HP Enterprise Services Electronic Commerce Unit at 919-859-9703 or by e-mail to ECSPDF@hp.com.

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

Attention: Local Education Agencies

2009/2010 Local Education Agencies Cost Report

The School Based Services (LEA Cost Report) for state fiscal year (SFY) 2009/2010 is due on or before March 1, 2011, for the following Medicaid services:

a. Audiology
b. Occupational Therapy
c. Physical Therapy
d. Psychological/Counseling Services
e. Speech
f. Nursing Services

Providers who fail to fully and accurately complete the SFY 2009/2010 School Based Services (LEA) Cost Report within the time period specified by DMA or that fail to furnish required documentation and disclosures required within the time period specified by DMA, may be subject to penalties for non-compliance. A 20% withhold of Medicaid payments may be imposed upon the delinquent provider 30 days after the SFY 2009/2010 School Based Services (LEA) Cost Report filing deadline unless the provider has made a written request for an extension of the SFY 2009/2010 School Based Services (LEA) cost report filing due date to DMA and has received a written approval from DMA.

The School Based Services (LEA) Cost Report, instructions and contact information are available on DMA's website at http://www.ncdhhs.gov/dma/cost/leareports.htm.

Tameca Bowe, Rate Setting and Reimbursement Section
DMA, 919-647-8170

Attention: Critical Access Behavioral Health Agencies

Changes of Ownership, Mergers, and Acquisitions

Critical Access Behavioral Health Agencies (CABHAs) must notify N.C. Medicaid when acquiring a Community Intervention Agency's services. The acquisition of a non-CABHA Community Intervention Service Agency is a two-step process. The first step is for the CABHA to complete a new enrollment application and indicate that it is being submitted due to a change of ownership. The second step is to complete a CABHA Addendum to Add Services to affiliate the Community Intervention Services with your CABHA.

Step One – Enrollment Application

Refer to the following instructions to ensure that the application is completed correctly.

- **Organization Information:** Enter the organization name, National Provider Identifier, Employer Identification Number, Month of Fiscal Year End and Doing Business As information, as applicable, associated with your CABHA Medicaid Provider Number.
- **Effective Date and Provider Number:** Enter the effective date for the acquisition. Select "Yes" to indicate that the CABHA is enrolled as a provider with DMA. Enter the Medicaid Provider Number associated with your CABHA.
- **Change of Ownership/Merger/Acquisition:** Select "Yes" to indicate that the application is being submitted as a change in ownership/merger/acquisition. Enter the date of the ownership change. Enter the Community Intervention core service Medicaid Provider Number assigned to the previous owner.
- **Provider Type:** Select Community Intervention Services.
- **CIS Services:** Select each Community Intervention Service that your CABHA is acquiring and has been endorsed to provide.
- **Certification, Licensure, Accreditation, and Endorsement:** Complete, as applicable, for the Community Intervention Services that your CABHA is acquiring and has been endorsed to provide.

Complete the remainder of the application, as applicable, with information for the Medicaid Provider Number associated with your CABHA.

You will be notified once the change of ownership (enrollment) process is completed. The notification will include a new Community Intervention core service Medicaid Provider Number and a new Medicaid Provider Number for each of the Community Intervention Services that you are acquiring and have been endorsed to provide.

Step Two – CABHA Addendum to Add Services

Once the change of ownership (enrollment) process is complete, the CABHA must submit a CABHA Addendum to Add Services to affiliate the newly acquired Community Intervention Services with the CABHA. Refer to the following instructions to ensure that the addendum is completed correctly.

- **Current Medicaid Provider Information and Contact Person:** Enter the information associated with your CABHA Medicaid Provider Number.
- **CABHA Service:** Indicate the CABHA services to be affiliated with your organization.
- **Attending Provider Information:** Using the information from the notification you received upon completion of the change of ownership (enrollment) process, enter the attending provider name, the Medicaid Provider Number, National Provider Identifier, and indicate the CABHA service. Repeat this step as needed to accommodate each service to be affiliated with your CABHA.

Complete the remainder of the addendum, as applicable, with information for the Medicaid Provider Number associated with your CABHA.

CSC, 1-866-844-1113

Attention: Critical Access Behavioral Health Agencies

Billing Core Services "Incident To" the Medical Director or Other Critical Access Behavioral Health Agency Physician

Physician assistants, direct-enrolled licensed behavioral health professionals (per DMA Clinical Coverage Policy 8C) and provisionally licensed professionals providing any of the Critical Access Behavioral Health Agency (CABHA) core services (comprehensive clinical assessments, outpatient therapy, medication management) within their scope of practice may render the service "incident to" a physician. This physician may be the CABHA medical director or another CABHA physician as long as the guidelines for billing "incident to," outlined in the March 2009 Medicaid Bulletin and the May 2005 Special Medicaid Bulletin are followed. As a reminder, the behavioral health professionals listed in DMA Clinical Coverage Policy 8C must be direct-enrolled with Medicaid. All Medicaid direct-enrolled providers may bill with their own "attending number."

When making a request for prior authorization for services that will be provided "incident to," the Medicaid Provider Number (MPN) of the physician should be listed as the "Attending Provider" on the ORF2. This individual physician MPN is the individual physician that the physician assistant, licensed behavioral health professional or provisionally licensed professional practices "incident to."

If individuals will be providing services "incident to" the CABHA medical director or another CABHA physician, the medical director's or physician's name and MPN need to have been included on the enrollment application (in the Attending Provider Information section). If this was not done at the time of the original CABHA enrollment, providers may complete item #4 on the Provider Change Form and an Electronic Claim Submission (ECS) Agreement from the NC Tracks website at http://www.nctracks.nc.gov/provider/cis.html.

Psychiatric CPT codes listed in DMA Clinical Coverage Policy 8C or in the March 2009 Medicaid Bulletin do not count towards the 22 annual visit limit for adults. Any E/M codes that are billed "incident to" (i.e., 99213 through 99215) a physician by a physician assistant or advanced practice nurse do count towards the 22 annual visit limit for adults. As a reminder, CABHAs must have a referral from a Community Care of N.C./Carolina ACCESS physician to provide and bill any E/M codes.

When submitting a claim for a core service that was rendered "incident to," the CABHA NPI is the billing number and the individual physician's NPI (associated with the MPN that was used to obtain the prior authorization) is the attending number. **It is imperative that documentation in the chart clearly indicate who provided the service and that it was provided "incident to," particularly in situations where the medical director is doing only administrative functions for the CABHA and is not directly billing for services. This information will be reviewed in monitoring visits and should clearly indicate who performed the service.**

Behavioral Health Unit
DMA, 919-855-4290

CSC, 1-866-844-1113, Option "2"

Provider Services
DMA, 919-855-4050

Attention: All Behavioral Health Providers

Post-Payment Reviews by Public Consulting Group

Since January 28, 2010, Public Consulting Group (PCG) has been assisting DMA's Program Integrity, Behavioral Health Review Section, in eliminating a backlog of cases and maintaining a steady rate of case reviews, preventing a future backlog of cases from accumulating. PCG will continue to provide full scale operations, beginning with the receipt of a case file, conducting the administrative/clinical review, establishing a statistically valid claim review sample for review, and extrapolating these findings to calculate the overpayment. PCG is using the RAT-STATS Software 2007 Version 2.0 (Windows-based software approved by the U.S. Office of the Inspector General) to determine the sample size and extrapolated overpayment amount.

PCG will continue to initiate contact with the provider by sending the provider a certified cover letter from DMA and a PCG introduction letter with the request for records. PCG will inform the provider of the post-payment review process requirements and work closely with the provider and DMA. Providers are asked to submit documentation electronically via PCG secure web-based application. PCG will provide detailed instructions on how to submit records for the review, and will address provider questions regarding the post-payment review process. PCG has implemented a new call center (1-888-805-1083) to handle the increased volume of provider calls and has developed a WebEx training (https://web.pcgus.com/ncdma) to assist providers with navigating the PCG secure web-based application to upload provider documentation.

PCG will notify the provider regarding missing documentation and give the provider a designated timeframe to submit requested documentation. Once PCG has conducted its review of the documentation, if it finds the provider to be out of compliance, a Tentative Notice of Overpayment letter is sent to the provider. The provider will have reconsideration and appeals rights should he or she not agree with the findings of the review. Appeal instructions will be sent out with the Tentative Notice of Overpayment letter.

Program Integrity, Behavioral Health Review Section
DMA, 919-647-8000

Attention: Critical Access Behavioral Health Agencies, Outpatient Behavioral Health Providers, Local Management Entities, and Physicians

Clinical Coverage Policy Updates

DMA Clinical Coverage Policy 8C has been updated to reflect the new allowance of 16 unmanaged visits for children. The effective date of the policy is January 1, 2011.

DMA Clinical Coverage Policy 8A will be updated to include the new policy for Peer Support Services and policy updates for Community Support Team, Intensive In-Home, Child and Adolescent Day Treatment, and Outpatient Opioid Treatment. A complete list of the changes will be documented in **Section 8.0, Policy Implementation/Revision Information.** The effective date of the policy is January 1, 2011. The revised policy will be available by February 15, 2010.

Both policies can be accessed at http://www.ncdhhs.gov/dma/mp/.

Behavioral Health Unit
DMA, 919-855-4290

Attention: Enhanced Behavioral Health (Community Intervention) Services Providers and Local Management Entities

Clarification to Critical Access Behavioral Health Agency Certification and Endorsement for Community Support Team, Intensive In-Home, and Child and Adolescent Day Treatment Services after January 1, 2011

This article is reprinted from the January 2010 Medicaid Bulletin with clarifications on the process for certification and endorsement (and endorsement renewal) of Community Support Team (CST), Intensive In-Home (IIH), or Child and Adolescent Day Treatment (DT) services.

Providers who want to become a Critical Access Behavioral Health Agency (CABHA) after January 1, 2011, will follow the steps detailed in 10A NCAC 22P.0101 through .0603 [found on the Office of Administrative Hearings (OAH) website at http://www.oah.state.nc.us/rules]. These steps include submitting a letter of attestation (see IU #75 for information on this process), which must include evidence of the three core services (Comprehensive Clinical Assessment, Medication Management, and Outpatient Behavioral Health Therapy), two endorsed enhanced services to create an age and disability specific continuum, key leadership positions (medical director, clinical director, quality management/training director), 3-year national accreditation, etc. If, during a desk review, the attestation packet is found to be complete, the next step is the clinical interview followed by an on-site verification.

Providers may continue to apply for CABHA certification using the CABHA-only services of CST, IIH, or DT as one of the two endorsed services that create their age and disability specific continuum or both of the two endorsed services that create their age and disability specific continuum (if using a child mental health continuum of IIH and DT).

If the provider is not already endorsed for the service, the CABHA attestation letter and packet should be submitted to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) prior to applying for endorsement. DMH/DD/SAS will conduct a desk review and, if the provider meets the requirements of the CABHA desk review (except for endorsement), the provider will be contacted and may then apply to the local management entity (LME) for endorsement (CST, IIH, DT).

If the provider is already endorsed for CST, IIH, or DT and that endorsement is set to expire, the CABHA attestation letter and packet should be submitted to DMH/DD/SAS prior to applying for endorsement renewal. DMH/DD/SAS will conduct a desk review and, if the provider meets the requirements of the CABHA desk review (except for endorsement), the provider will be contacted and may then apply to the LME for endorsement (CST, IIH, DT) renewal. If the renewal timeframe runs out while the CABHA desk review is being conducted, the provider will not be required to go through the full endorsement application and review process but will still be able to go through the endorsement renewal process.

If the provider applies for endorsement for one or all of the services (CST, IIH, DT) before submitting the CABHA attestation letter and packet to DMH/DD/SAS, the LME will return the application and instruct the provider to reapply for endorsement once the desk review has been completed.

The CABHA desk review includes all of the required elements except the missing endorsement(s) for CST, IIH or DT. The LME will process the endorsement application for CST, IIH or DT once the provider has met all the other required elements of the CABHA full desk review. Upon endorsement, the provider must notify DMH/DD/SAS by e-mailing/faxing/or mailing a copy of the Notification of Endorsement Action (NEA) to be included in the attestation letter packet and to finalize the desk review process.

Providers that are currently endorsed for CST, IIH, and/or DT will be able to remain endorsed (as long as the NEA doesn't expire). However, they will not be eligible to receive authorizations or bill for services until they are CABHA-certified and enrolled. If an LME has recently involuntarily withdrawn a provider's endorsement for CST, IIH, and/or DT because the provider was not going to achieve certification as a CABHA, and the expiration date on the NEA has not occurred yet, the LME should reinstate the endorsement. Per the endorsement policy, effective January 1, 2011, providers will need to be serving consumers within 60 calendar days of the date of the DMA enrollment letter and if not serving consumers within 60 calendar days of the date of the DMA enrollment letter, endorsement will be withdrawn.

Behavioral Health Unit
DMA, 919-855-4290

Attention: All Providers

Medicaid Recipient Appeal Process/Early and Periodic Screening, Diagnosis, and Treatment Seminars

Medicaid **Recipient** Appeal Process/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) seminars are scheduled for the month of February 2011. Seminars are intended to address the Medicaid **recipient** appeal process when a Medicaid service is denied, reduced or terminated. The seminar will also focus on an overview of EPDST – Medicaid for Children. Providers should print a copy of the *Medicaid Recipient Due Process Rights and Prior Approval Policies and Procedures* and a copy of the slide presentation and bring them to the seminar. The document and the presentation are available on DMA's website at http://www.ncdhhs.gov/dma/provider/priorapproval.htm under the heading "Additional Information."

Pre-registration is required. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the seminars by completing and submitting the online registration form (http://www.ncdhhs.gov/dma/provider/seminars.htm). Please include a valid e-mail address for your return confirmation. Providers may also register by fax using the form below (fax it to the number listed on the form). Please include a fax number or a valid e-mail address for your return confirmation. Please indicate on the registration form the session you plan to attend. Providers will receive a registration confirmation outlining the training materials that each provider should bring to the seminar.

Sessions will begin at 9:00 a.m. and end at 4:00 p.m. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided at the seminars. However, there will be a scheduled lunch break. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Seminar Dates and Locations

Date	Location
February 1, 2011	**Greensboro** Clarion Hotel Airport 415 Swing Road Greensboro NC 27409
February 3, 2011	**Charlotte** Crowne Plaza 201 South McDowell Street Charlotte NC 28204 **Note: There is a parking fee of $6.00 per vehicle for parking at this location.**

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

Medicaid Recipient Appeal Process/Early and Periodic Screening, Diagnosis and Treatment
January/February 2011 Seminar Registration Form
(No Fee)

Provider Name and Discipline _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (____) _____ Fax Number _____

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

Please fax completed form to: 919-851-4014

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

Or register online by utilizing the link available within the bulletin

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

Pregnancy Medical Home Seminars

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

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

PMH seminars are scheduled for the month of March 2011. Seminars are intended to educate providers on the new PMH project. The presentation will cover policy information and billing guidelines.

Pre-registration is required. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

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

Sessions will begin at 9:00 a.m. and end at 12:00 p.m. Providers are encouraged to arrive by 8:45 a.m. to complete registration. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Seminar Dates and Locations

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

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

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

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

Provider Name and Discipline _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (____) _____ Fax Number _____

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

Please fax completed form to: 919-851-4014

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

Or register online by utilizing the link available within the bulletin

Attention: CAP/C Case Managers and CAP/C Service Providers

Video Conference Seminar for CAP/C Case Managers and CAP/C Service Providers

The video conference seminar for CAP/C case managers and CAP/C service providers is scheduled for February 24, 2011. Information presented at this video conference seminar will include a review of CAP/C service authorizations and related processes for CAP/C. This will be an interactive video conference seminar providing virtual training with live video and audio communication.

The video conference seminar is scheduled at the locations listed below. The session will begin at 9:00 a.m. and will end at 12:00 noon. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided at the seminar. **Because meeting room temperatures vary, dressing in layers is strongly advised.** Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the CAP/C Seminar by completing and submitting the online registration form (http://www.ncdhhs.gov/dma/provider/seminars.htm) or providers may register by fax using the CAP/C Registration Form (fax it to the number listed on the form). **Pre-registration is required.** Providers will receive a registration confirmation outlining the training material(s) each attendee should bring to the seminar. All locations will have live audio and visual feed from the central Raleigh location.

Seminar Schedule – 9:00 a.m. to 12:00 noon, February 24, 2011

City	Address
Asheville	UNC-Asheville Robinson Hall, Room 129 University Heights Asheville NC 28804
Charlotte	Central Piedmont Community College Harris Conference Center, Harris 2 Building Video Conference Room 3216 CPCC Harris Campus Drive Charlotte NC 28208
Greenville	Pitt County Community College Fulford Building, Room 153 1986 Pitt Tech Road Winterville NC 28590

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

Video Conference Seminars for CAP/C Case Managers and CAP/C Service Providers
February 24, 2011
Seminar Registration Form
(No Fee)

Provider Name and Discipline _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (_____) _____ Fax Number _____

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

Please fax completed form to: 919-851-4014

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

Or register online by utilizing the link available within the bulletin

Attention: Ambulatory Surgical Centers, Durable Medical Equipment Providers, Hospital Outpatient Services, and Practitioners

National Correct Coding Initiative Education

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

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

Webinar Dates

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

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

Seminar Dates and Locations

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

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

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

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

National Correct Coding Initiative Seminar/Webinar Registration Form
March 2011
(No Fee)

Provider Name and Discipline _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (____) _____ Fax Number _____

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

OR

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

Please fax completed form to: 919-851-4014

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

Or register online by utilizing the link available within the bulletin

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Proposed Clinical Coverage Policies

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

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

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

2011 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
February	1/27/11	2/1/11	2/2/11
	2/3/11	2/8/11	2/9/11
	2/10/11	2/15/11	2/16/11
	2/17/11	2/24/11	2/25/11
March	2/24/11	3/1/11	3/2/11
	3/3/11	3/8/11	3/9/11
	3/10/11	3/15/11	3/16/11
	3/17/11	3/24/11	3/25/11

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

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

Melissa Robinson
Executive Director
HP Enterprise Services