February 2013 Medicaid Bulletin

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

Attention: All Providers

Enrollment and Application Fees – REVISED

Note to Providers: This article is a revised version of one which was originally published in December 2012. The revised portions are in ***bold and italicized***.

Affordable Care Act (ACA) Application Fee

As of October 1, 2012 the N.C. Division of Medical Assistance (DMA) began collecting the federal application fee required under Section 1866 (j) (2) (C) (i) (l) of the Affordable Care Act (ACA) from certain Medicaid and N.C. Health Choice (NCHC) providers.

The Centers for Medicare & Medicaid Services (CMS) sets the application fee, which may be adjusted annually. ***The application fee for enrollment in 2013 is set at $532.*** The purpose of the fee is to cover the cost of screening and other program integrity efforts. The application fee will be collected **per site location** prior to executing a provider agreement from a prospective or re-enrolling provider.

This requirement does not apply to the following providers:

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

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

Providers newly enrolling or re-enrolling in the N.C. Medicaid or NCHC program that do not pay the fee within 30 days of receipt of invoice will have their applications voided by CSC. Providers located in Border States within 40-miles of N.C. who have paid the fee to that state will be required to provide proof of payment in that state.

North Carolina Enrollment Fee

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

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

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

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

Provider Services
DMA, 919-855-4050

Attention: All Providers

NC Medicaid Provider Direct Enrollment and Screening – UPDATE

Notice to Providers: This is an updated version of an article which originally ran in August 2012.

Beginning October 1, 2012, the N.C. Division of Medical Assistance (DMA) implemented Federal regulations 42 CFR 455.410 and 455.450 – requiring all participating providers to be screened according to their categorical risk level. These screenings will take place both upon initial enrollment and re-enrollment.

42 CFR 455.450 establishes the following three categorical risk levels for N.C. Medicaid and N.C. Health Choice (NCHC) providers to assess the risk of fraud, waste, and abuse:

- Low
- Moderate
- High

Provider types and specialties that fall into the moderate- and high-risk categories are subject to a pre-enrollment site visit, unless a screening and site visit has been successfully completed by Medicare or another state agency within the previous 12

months. Senate Bill 496 §108C-3 further defines provider types that fall into each category.

The Centers for Medicare & Medicaid Services (CMS) sets the application fee, which may be adjusted annually. **The application fee amount for enrollment in 2013 is set at $532.** The purpose of the fee is to cover the cost of screening and other program integrity efforts. The application fee will be collected per site location prior to executing a provider agreement from a prospective or re-enrolling provider.

This requirement does not apply to the following providers:

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

Providers who are required to pay this fee will be sent an invoice via mail. States must collect the applicable fee for any newly enrolling, reenrolling or reactivating institutional provider.

North Carolina Senate Bill 496 108C-9.c, also requires that – prior to initial enrollment in the N.C. Medicaid or NCHC programs – an applicant's representative shall attend trainings as designated by DMA, including, but not limited to, the following:

- The *N.C. Basic Medicaid and N.C. Health Choice Billing Guide*, common billing errors, and how to avoid them.
- Audit procedures, including explanation of the process by which the DMA extrapolates audit results.
- Identifying Medicaid recipient fraud.
- Reporting suspected fraud or abuse.
- Medicaid recipient due process and appeal rights.

This training is completely web-based and will be made available to online.

It is imperative for providers to submit their application with a valid e-mail address that is frequently checked. Providers will be notified via e-mail when it is time to complete the training and the steps necessary to complete the training.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Recredentialing is Required for All N.C. Medicaid and N.C. Health Choice Providers a Minimum of Every Three Years

The N.C. Division of Medical Assistance (DMA) is federally mandated to ensure that all provider information is accurate and current in the Enrollment, Verification and Credentialing (EVC) System. To that end, it is the State's policy to recredential providers and provider groups a minimum of every three years.

The EVC Operations Center electronically generates and distributes contract renewals for all enrolled providers 75 days prior to their three-year anniversary date or the date of their last renewal contract. Within 30 days of receiving the invitation letter, providers must verify their provider information and submit any additional information requested via the online recredentialing application.

Providers that do not take action within the specified time frame will experience an interruption in claims payment and risk eventual termination from the N.C. Medicaid and N.C. Health Choice programs. As a reminder, termination from the programs requires providers to re-enroll and pay any applicable fees. Additionally, no claims will be paid during the time that providers are not enrolled in the programs. Providers are encouraged to be on the lookout for recredentialing invitations. Additional information regarding the recredentialing process can be found at: https://www.nctracks.nc.gov/provider/providerEnrollment/assets/onlineHelp/recredentialing_101_help.pdf

Questions should be directed to the EVC Operations Center at 866.844.1113 or by e-mail at NCMedicaid@csc.com.

Provider Services
DMA, 919-855-4050

Attention: All Providers

NC DHHS Secretary Wos Calls for Immediate Freeze on Old Medicaid Computer System

The N.C. Department of Health and Human Services (DHHS) Secretary Aldona Wos, M.D., has ordered an immediate stop to any changes to the state's 35-year old Medicaid computer system that are not mission-critical. In a letter to Hewlett Packard Enterprise Services (HPES), the vendor operating the current Medicaid billing system, Wos instructed the company to "immediately stop the implementation of any changes" as the department focuses on transitioning to its replacement Medicaid Management Information system (MMIS).

"We have a responsibility to patients, providers and the taxpayers of North Carolina to put our limited resources where they are needed most," Wos said. "In the coming weeks and months, our department's priority is to ensure the transition from our current Medicaid computer system to the replacement MMIS is smooth, efficient and on time."

The legacy computer system currently processes 88 million Medicaid claims annually on behalf of more than 1.5 million Medicaid enrollees, and writes checks totaling more than $11 billion to 70,000 health service providers throughout the state. Like most computer systems, including home computers, the current Medicaid computer system requires software patches and other updates. New Medicaid policies and rates account for much of the changes, ensuring Medicaid regulations are followed and that providers are paid correctly.

As DHHS prepares to switch to the replacement MMIS, the old and new computer systems must be in sync as much as possible. Further emphasizing its commitment to a successful transition, DHHS has enlisted outside evaluators to determine whether the replacement MMIS faces any impediments to successful, punctual completion.

Secretary Wos said the only changes to the older system she will approve will be those "that are absolutely necessary to be sure people are getting the services they need and providers are being paid."

Public Affairs
DMA, 919-855-4840

Attention: All Providers

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

Note to providers: This article was originally published in November 2011, but the Web address for subscriptions was changed in December 2012.

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

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

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

Attention: All Providers

NC Medicaid Recovery Audit Contract II (RACII)

On September 16, 2011, the Centers for Medicare & Medicaid Services (CMS) published the *Final Rule for Medicaid Recovery Audit Contractors (RAC)*. Under the Medicaid RAC program, states must enter into contracts consistent with State law in accordance with 42 CFR subpart F with one or more eligible Medicaid RACs to perform post-payment audits in order to identify Medicaid payments that may have been underpaid or overpaid. RACs must follow Federal and State guidelines to recover overpayments or inform the N.C. Division of Medical Assistance (DMA) of underpayments.

As described in the October *2012 Medicaid Bulletin*, DMA partnered with HMS to become the second RAC vendor for the State of North Carolina. HMS will perform post-pay audits on inpatient and outpatient hospital, long-term care, laboratory, x-ray, and specialized outpatient therapy claims. As reported previously, HMS is establishing a review schedule for RAC II audits and will initiate this review process with inpatient hospital medical record reviews. HMS plans to send the first hospital records requests out by the end of January or the first part of February 2013. Providers will have the usual 10 business days to send in the requested records. It is anticipated that outpatient lab services will be the second provider type to undergo review.

Providers are reminded that DMA and its agents are authorized by Section 1902 (a) (27) of the Social Security Act and 42 CFR Section 431.107 to access patient records for purposes directly related to the administration of the Medicaid Program. Federal regulations and provider agreements with DMA require the provider to keep any records necessary to disclose the extent of services furnished – including but not limited to, all information contained in beneficiary financial and medical records and agency personnel records.

Additional questions should be directed to:

Linda Marsh, linda.marsh@dhhs.nc.gov DMA, 919-814-0000

HMS provider email: NCRACII@HMS.com; Toll free: 1-855-438-6415

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Updated EOB Code Crosswalk to HIPAA Standard Codes

The list of standard national codes used on the Electronic Remittance Advice (ERA) has been cross-walked to Medicaid Explanation of Benefits (EOB) codes as an aid to research adjudicated claims listed on the Remittance and Status Report (RA). An updated version of the list is available on the N.C. Division of Medical Assistance (DMA) Website at www.ncdhhs.gov/dma/hipaa/EOBcrosswalk.htm.

New changes to the format of the crosswalk were added in July 2010. The changes allow codes to be filtered and sorted in a more efficient manner when multiple codes map to the same Medicaid EOB. In addition, the crosswalk has been divided into separate crosswalks based on claim types – Institutional, Professional, Dental, and Pharmacy. This will eliminate some of the extraneous mappings.

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

Attention: All Providers

Clinical Coverage Policies

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

- *1E-1, Hysterectomy (1/1/13)*
- *1G-2, Bioengineered Skin (1/4/13)*
- *1S-1, Genotyping and Phenotyping for HIV Drug Resistance Testing (1/1/13)*
- *2B-2, Geropsychiatric Units in Nursing Facilities (1/1/13)*
- *3L, Personal Care Services (1/1/13)*
- *3E, In-Home Care for Adults (Date of Termination 12/31/12)*
- *3F, In-Home Care for Children (Date of Termination 12/31/12)*

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

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Medicaid Prior Approval Policies and Procedures, Recipient Due Process (Appeals), and Early Periodic Screening, Diagnosis and Treatment (EPSDT) Webinar

N.C. Medicaid will hold a Prior Approval, Recipient Due Process, and EPSDT Webinar for providers on March 27, 2013.

The Webinar will address Medicaid's prior approval policies and procedures and the Medicaid recipient **appeal process** when a Medicaid service is denied, reduced, terminated, or suspended. The Webinar will also provide an overview of **EPSDT-Medicaid for Children**.

The Webinar is not intended to address billing questions.

The session will begin at 9:00 a.m. and end at 4:00 p.m. Providers are encouraged to log on by 8:30 a.m. to ensure access to the site and presentation.

Providers may register for the Webinar using the online Webinar registration form or by fax. Please include a valid email address or fax number for return confirmation. For those providers who register, the registration confirmation will include information on how to access and navigate within the Webinar setting.

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

Attention All Providers

Password Management Changes for NCECS Web Tool and Secure FTP Users

N.C. Medicaid will implement new software to provide functionality for self-management of access passwords in 2013. This will affect all NCECS Web Tool and Secure FTP connectivity. Continue to monitor the N.C. Division of Medical Assistance (DMA) Website for additional information and timelines.

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

Attention: All Providers

CPT Code Update: Special Ophthalmological Services

Special ophthalmological services are a special evaluation of part of the visual system, which goes beyond the services included under general opthmalogical services, or in which special treatment is given. Interpretation and report by the physician is an integral part of special ophthalmological services, where indicated.

The CPT code for scanning laser glaucoma tests (CPT 92135) was deleted and end-dated on December 31, 2010. It was replaced by three new codes (CPT 92132, 92133 and 92134) on January 1, 2011 requiring an update of the Medical Clinical Coverage Policy 1A-18 "Scanning Laser Glaucoma Tests" policy. **On January 15, 2013, the Medicaid policy name and number was changed to 1T-2, Special Ophthalmological Services.** Please review the policy unit limitations for the three scanning computerized ophthalmic diagnostic imaging codes (SCODI) – CPT codes 92132, 921333, and 92134 – listed in the new 1T-2 policy.

This new policy also includes coverage for fundus photography (CPT code 92250) for early detection of diabetic retinopathy for diabetic recipients. CPT code 92250 is limited to one unit per 365 days for beneficiaries with a diagnosis of diabetes mellitus.

Please note: Providers used procedure code 92135 to bill for scanning laser glaucoma tests until the code was end dated on December 31, 2010. The 2011 CPT Update replaced the code with 92132, 92134 and 92135. Providers were notified in the January 2011 bulletin article *2011 CPT Update* that DMA was covering the new codes. The policy was then merged into the Special Ophthalmological policy which has very recently made it through the process due to the requirement for fiscal note approval. However, providers have been notified and have been using these codes since January 1, 2011.

Practitioner, Clinical and Facility Services
DMA, 919-855-4331

Attention: All Providers

CPT Procedure Code 36147

Providers billing procedure code 36147 – [Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula) initial access with complete radiological evaluation of dialysis access including fluoroscopy, image documentation and report (includes access of shunt, injection (s) of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)] – on or after January 1, 2012 have received denial EOB 7741 (service is included in global surgery package). System updates have been completed to correct this issue.

Providers who received these denials and have kept claims in a timely manner may resubmit as a **new claim** (not as an Adjustment Request) for processing.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

EHR Webinar Series for Providers

Notice to Providers: The initiation of this webinar series was announced in the *January 2013 Medicaid Bulletin*, as well as the N.C. Medicaid EHR webpage.

Starting January 30, 2013, the N.C. Medicaid Electronic Health Record (EHR) Incentive Program will hold a series of **30-minute webinars** for its provider community. Join them **every Wednesday at 12:30 p.m.** for important information from the N.C. Medicaid EHR Incentive Program.

Here is the schedule:

January 30 - Introduction to the N.C. Medicaid EHR Incentive Program
This webinar will walk providers through the basics of the N.C. Medicaid EHR Incentive Program. This high-level overview will be a must-attend webinar for those who are new to the program.

BONUS WEBINAR!
January 30th – Stage 1 Changes per the Stage 2 Final Rule: What You Need to Know For Program Year 2013
Do you know all the changes to Stage 1 MU coming down the pike? The Centers for Medicare & Medicaid Services (CMS) recently made some changes to Stage 1 meaningful use – effective as of program year 2013. The EHR Team is making these changes a little bit easier for our providers to understand through this webinar.
**Please note, this bonus webinar is scheduled to begin at 2 p.m.*

February 6 – Preparing for Attestation
This webinar is for providers who have been determined to be eligible for participation in the N.C. Medicaid EHR Incentive Program. This webinar will provide a step-by-step tour through the planning process, covering program registration with CMS, ensuring your EHR is certified with the ONC Certified Health IT Product List, creating an account with the N.C. Medicaid Incentive Payment System (NC-MIPS), as well as orientation to our program website and attestation guide resources.

February 13– Attesting for Your Incentive Payment in NC-MIPS
Tune in to this webinar to learn all the tips and tricks for attesting for a Medicaid incentive payment. Learn the easiest way to navigate through the NC-MIPS Portal when attesting for an adopt, implement or upgrade (AIU) or Meaningful Use (MU) payment. Find out how to easily get help through a website or telephone.

February 20 – Understanding Patient Volume
This webinar will cover everything there is to know about the Medicaid Patient Volume requirements. We'll guide you through the process of choosing your methodology (individual or group) and reporting accurate encounter data.

February 27 – Question & Answer Session
Do you have any questions? Join us for this Q&A session where DMA answers your questions.

March 6 – Audits: What to Expect
As with any other Medicaid program, audits are going to happen. This webinar will guide you through what to expect and how to prepare for an N.C. Medicaid EHR Incentive Program audit. We'll cover the different audit types, tips for documenting your participation and compliance, how Eligible Participants (EPs) and Eligible Hospitals (EHs) will be selected for audit, and what information the auditors will be looking for so that you will be ready if you are visited by one of our audit team members.

March 13 – Meaningful Use 101: What Is MU?
What is meaningful use? In this webinar we will tell you all about Stage 1 meaningful use and how providers can meet this goal. This will clear up any confusion for providers who have just finished AIU and are not quite sure what MU is or what they need to do next.

March 20 – Meaningful Use 102: Looking Ahead to Stage 2 and Beyond
Are you ready for Stage 2 MU? With the official release of the Stage 2 MU requirements, the preparation begins. In this webinar, we'll explain how to tell if your EHR is Stage 2 certified, what new MU measure requirements you'll have to meet, what to expect for public health reporting, the Stage 2 timeline, and more.

March 27 – Question & Answer Session
Do you have any questions? Join us for this Q&A session where DMA answers your questions.

April 3– Hospitals and the NC Medicaid EHR Incentive Program
Hospitals play a unique role in the N.C. Health Information Technology (HIT) landscape. In this webinar, we will be reviewing hospital-specific information such as how to accurately report HMO bed days and out-of-state days, calculate patient volume, Medicaid/Medicare attestation schedules, and much more. Designed specifically for hospital staff, this is your chance to have a hospital-specific guide through the N.C. Medicaid EHR Incentive Program!

Missed a webinar? DMA will be recording the entire series and will post the podcasts on our website for later viewing. Audio information and the current week's webinar registration link can be found on our website at www.ncdhhs.gov/dma/provider/ehr.htm.

N.C. Medicaid Health Information Technology (HIT)
DMA, 919-855-4200

Attention: All Providers

Benzoyl Peroxide Products

Benzoyl peroxide products that are preferred on the N.C. Medicaid and N.C. Health Choice (NCHC) Preferred Drug List (PDL) are now over-the-counter and the equivalent prescription products appear to be on backorder and may no longer be manufactured.

N.C. Medicaid does **not** cover over-the-counter benzoyl peroxide products. There continues to be preferred products in the topical acne drug class on the PDL. Prescribers may continue to prescribe Azelex, Benzaclin, clindamycin phosphate gel, clindamycin phosphate lotion, clindamycin phosphate solution, clindamycin phosphate swab, Differin, Retin-A Micro, or tretinoin (generic of Retin-A) for N.C. Medicaid and NCHC beneficiaries without having to obtain a prior authorization. A prior authorization would continue to be required for topical acne agents that are non-preferred on the PDL.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: All Providers

A+KIDS Facsimile Form Revision Effective March 1, 2013

Due to well-documented safety considerations and limited efficacy information on the use of antipsychotic agents in children, N.C. Medicaid developed a policy titled "Off Label Antipsychotic Monitoring in Children through Age 17." The policy was implemented in April, 2011.

N.C. Medicaid and Community Care of North Carolina (CCNC) partnered with child psychiatry experts from the four N.C. medical schools to develop and implement the registry (*Antipsychotics-Keeping It Documented for Safety* or *A+KIDS*) to document the use of antipsychotic therapy in the child and adolescent Medicaid population. This safety monitoring program is designed to make sure N.C. Medicaid and N.C. Health Choice (NCHC) beneficiaries age 0-17 who are prescribed an antipsychotic medication for an "off label" indication are monitored according to generally accepted guidelines. Through participation in the A+KIDS registry, best practice baselines and follow-up monitoring parameters are encouraged in order to facilitate the safe and effective use of antipsychotics in this population.

The facsimile form used to submit safety documentation for patients affected by this policy has been revised. Use of this revised form will allow enhanced safety documentation to be captured, and more closely emulates the information captured in the on-line version of the registry.

Until March 1, 2013, both the revised and previous versions of the form will be accepted. Effective March 1, 2013, only the revised safety documentation facsimile form will be accepted.

This newly revised form is currently located on both the North Carolina Division of Medical Assistance (DMA) and the Document for Safety websites at:

- www.documentforsafety.org/pub/resources?context=akids
- www.ncmedicaidpbm.com/

Prescribers are strongly encouraged to submit the safety documentation using the web-based A+KIDS registry which grants a 6-12 month approval. Using the facsimile form always results in a three month approval.

Questions regarding this change may be directed to DMA at
919-855-4300 or to the Document for Safety provider support desk at 855-272-6576.

Outpatient Pharmacy,
DMA, 919-855-4300

Attention: All Providers

Provider Responsibilities in a PERM and Program Integrity Review or Audit

Notice to Providers: This article was originally published in November 2011.

In compliance with the Improper Payments Information Act of 2002, the Centers for Medicare & Medicaid Services (CMS) implemented a national Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid Program and the State Children's Health Insurance Program (SCHIP). PERM and Program Integrity (PI) reviews or audits may be conducted in person or by mail (referred to as a desk review).

A+ Government Solutions, the PERM review contractor, will mail medical record requests and conduct desk reviews. Onsite visits to providers and their beneficiaries may be unannounced (this is a routine procedure) or announced. These reviews may be referred to as post payment reviews, quality assurance reviews or compliance audits. In order for these reviews to run as smoothly as possible, providers should adhere to the following steps when a review has been initiated. PI will request medical and/or financial records either by mail or in person. A+ Government Solutions will request medical record documentation by mail. The records must be provided upon request.

The intent of the record request is to substantiate that all services and billings to N.C. Medicaid or N.C. Health Choice (NCHC) adhere to the required medical record documentation standards, to substantiate provider qualifications, and to substantiate that delivery of services was in accordance to policy, requirements and rules, and that business and administrative practices are within acceptable practices.

Financial or business record requests may include such documents as personnel and timekeeping records, invoices, chart of accounts, general ledger, minutes of committee meetings, audited or internally prepared financial statements and bank loan documents. Failure to submit the requested records will result in recoupment of all payments for the services, suspension of payments, and may constitute further actions of investigation resulting in termination from the N.C. Medicaid/NCHC program and referral to the Medicaid Fraud Investigative Unit for review for criminal or civil prosecution.

For the purpose of N.C. Medicaid and NCHC billing, providers must maintain records for six years in accordance with the record keeping provisions of the Medicaid Provider Administrative Participation Agreement. Other record retention schedules may be required by other State or federal oversight agencies, funding streams or accrediting/certification bodies and Medicaid/NCHC requirements do not override those requirements of other oversight bodies.

If you receive a Tentative Notice of Overpayment letter from PI, review the information in the letter and chart. You have two options:

1. If you agree with the findings of an overpayment decision, use the form sent with the letter to indicate your preferred method for reimbursing DMA. The options include sending check or having the repayment withheld from future Medicaid payments. It is the preference of DMA to have the funds withheld in a future checkwrite. If you choose to submit a check, send your check, along with the form issued to you from DMA Program Integrity which includes your case number, to DMA Accounts Receivable at the address on the letter. **Do not send the check to HP Enterprise Services, as this could result in a duplication of your payment or failure to accurately record the submission of the payment.** Also, do NOT request that HP Enterprise Services adjust for the amount or items identified, as this could result in duplicate recoupment.

2. If you disagree with the findings of an overpayment decision by PI and want a reconsideration review, return the enclosed hearing request form enclosed in the letter and return to the DHHS Hearing Unit at the address on the letter. **Please pay close attention to the time frames and procedures for requesting a reconsideration review.**

Appeals:

Informal: Reconsideration Review – A provider who disagrees with the decision may request an informal reconsideration review and submit additional relevant documentation for review. Read the letter from DMA regarding the time frame for submitting a reconsideration review request. The reconsideration review is an informal procedure. The case will be reviewed by an independent Hearing Officer who will send the provider a written decision.

Formal: Contested Case Hearing – If the provider is not satisfied with the outcome of the informal review, or if the provider chooses not to have an informal review, the provider may file a request for a contested case hearing at the Office of Administrative Hearings (OAH). Pay close attention to the specific time frames and procedures for requesting a contested case hearing at OAH. Once the request is received, OAH will contact the provider regarding scheduling of the case.

Program Integrity
DMA, 919-814-0000

Attention: All Providers

Maintaining the Security and Accessibility of Records after a Provider Agency Closes

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

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

Documentation that is required to be maintained by all providers includes clinical service records, billing and reimbursement records, and records to support staff qualifications and credentials (personnel records).

Clinical service records include, but are not limited to:

- Diagnostic testing results (X-rays, lab tests, EKGs, psychological assessments, etc.)
- Records from other providers used in the development of care plans
- Nurses' notes or progress notes
- Service orders that authorize treatment
- Treatment service or treatment plans
- Billing and reimbursement records should include recipient demographic information.

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

The following sanctions, penalties, and fees may be imposed for HIPAA violations:

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

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

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

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

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Medicaid Beneficiary Fee-for-Service (Dental, Behavioral Health, Medical) Hearings

When a prior approval request for Medicaid services cannot be approved as submitted, beneficiaries or their authorized personal representatives (for example: legal guardians) will receive a written notice and appeal request form via trackable/certified mail. The provider requesting the service will receive a courtesy copy of the notice only.

The beneficiaries or authorized personal representatives must determine whether they agree or disagree with the Medicaid decision and if they wish to file a fair hearing request with the Office of Administrative Hearings (OAH).

The provider may not make the determination for the beneficiary or their personal representative to appeal Medicaid's decision, may not sign the fair hearing request on behalf of the beneficiary or their personal representative, and should never pressure or force a beneficiary or personal authorized representative to file an appeal against their wishes.

However, the provider **may** assist the beneficiary by:

- Explaining the contents of the notice and the hearing/mediation processes
- Filing the appeal request form by faxing or mailing the form to the OAH (with the beneficiary's or authorized personal representative's written consent)
- Participating in the hearing/mediation processes **if requested to do so** by the beneficiary or his authorized personal representative.

Pursuant to the Social Security Act, 42 C.F.R. 431.200 et. seq., a final agency decision is required following a fair hearing. The final agency decision is made by the N.C. Department of Health and Human Services (DHHS). At the request of the N.C. General Assembly – in an effort to reduce duplication and costs – DHHS asked the federal Centers for Medicare and Medicaid Services (CMS) to transfer the final agency decision authority to OAH. CMS approved this request on December 27, 2012, effective July 01, 2012. This means that any decision made by OAH is the decision that the provider and beneficiary can act upon and that a final agency decision by DHHS is no longer required. OAH will mail a copy of the decision via trackable mail to the parties identified on the appeal request form.

Important Reminders about Medicaid Beneficiary Appeals

- Adverse prior approval decision notices are mailed to the beneficiary or authorized representative by trackable/certified mail. Additionally, all initial OAH communications are mailed by trackable/certified mail. It is important

for the beneficiary/personal authorized representative to accept delivery of the trackable/certified mail by signing for it. If the beneficiary/authorized representative does not sign for the notice, he/she will be unaware of the right to appeal Medicaid's decision or the status of their case if appealed to OAH. **When the provider receives a copy of Medicaid's adverse notice or OAH communication (if named a party on the appeal request form), it would be helpful if providers notified the beneficiary/authorized representative that they received a copy of the notice or communication from OAH and remind beneficiaries to sign for their trackable/certified mail.** If the beneficiary is currently receiving services and wishes to appeal a decision made by Medicaid, submitting an appeal request after the dates contained in the trackable/certified notice will affect services during the appeal process. Specifically, if the appeal request form is received by OAH:

- Within 10 days of the date of the notice, services will continue without a break in service during the appeal process.

- More than 10 days after the date of the notice but before 30 days from the date of the notice, services will stop until OAH receives the appeal request.

- More than 30 days after the date on the notice, services will not be provided during the appeal.

- The changes specified below should be reported by beneficiaries or their personal authorized representatives to their county Department of Social Services or the Social Security Administration (for Supplemental Security Income, SSI, beneficiaries).

  - Changes in the beneficiary's or personal authorized representative's name or mailing address.

  - Addition of a personal authorized representative, health care power of attorney, or durable power of attorney with mailing address

  If beneficiaries or their personal authorized representative do not report these changes, they will not receive their Medicaid mail in a timely manner. Submitting an appeal request after the deadlines will affect services during an appeal as stated above.

  Providers are requested to remind beneficiaries of the importance of reporting these changes to their county Department of Social Services or the Social Security Administration (for SSI beneficiaries).

- Duplicate notices with appeal request forms will be issued at the request of beneficiaries or their personal authorized representative. Beneficiaries or their

representatives may request a duplicate notice and appeal form by calling the Medicaid Appeal Section at 919-855-4350, Monday-Friday, 8:00 a.m.-5:00 p.m.

It should be noted that most beneficiaries do not receive their notice and appeal request form because they do not sign for the trackable/certified notice or have not reported name and address changes to their county Department of Social Services or the Social Security Administration (for SSI beneficiaries). Duplicate notices will be mailed in accordance with the Division's prior approval and due process instructions located at www.ncdhhs.gov/dma/provider/URVendorInstruct.pdf.

Appeals
DMA, 919-855-4350

Attention: All Providers

Bone Conduction Hearing Aids Policy and Billing Instructions for Medicaid Providers

Clinical Coverage Policy No.: 1A-36, Implantable Bone Conduction Hearing Aids (BAHA) – procedure codes 69714, 69715, 69717 and 69718 – has been promulgated and can be found at: www.ncdhhs.gov/dma/mp.

Effective February 1, 2013, BAHA is covered for N.C. Medicaid and N.C. Health Choice (NCHC) beneficiaries when medically necessary for any of the indications listed in 3.2 of the Clinical Coverage Policy.

It is no longer necessary to submit a non-covered request form for a BAHA procedure; however, prior approval must be obtained from the fiscal agent using the Request for Prior Approval form located at: www.ncdhhs.gov/dma/forms/prior.pdf.

Due to the conversion of the claims payment from HP to the new fiscal intermediary, CSC, payment system changes have been delayed. Providers will receive a denial when an electronic claim is submitted. Submit the RA (remittance advice) indicating the denied claim along with the prior approval authorization number to:

Ms. Maria Welch
N.C. Department of Health and Human Services
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501.

Upon receipt of this information, the fiscal agent will be sent a memorandum instructing them to pay the claim. Allow a minimum of six to eight weeks for the fiscal agent to make the necessary system adjustments.

Clinical Policy
DMA, 919-855-4318

Attention: NC Health Choice Providers

Bone Conduction Hearing Aids Policy and Billing Instructions for N.C. Health Choice Providers

Effective March 1, 2013, a new combined clinical coverage policy for the Medicaid and N.C. Health Choice (NCHC) programs will be posted at www.ncdhhs.gov/dma/mp/. This policy will replace BAHA Policy No. NCHC 2009.23. The reimbursement requirements in Policy No. NCHC 2009.23 will apply for all BAHA services rendered on or before February 28, 2013. The reimbursement requirements in the new combined policy will apply for all BAHA services provided on or after March 1, 2013.

Billing Instructions:

1. This policy requires prior approval (PA) from HP Enterprise Services.
2. N.C. Department of Medical Assistance (DMA) is aware that even when a provider obtains PA, the HP system will deny claims for the service codes. However, at this time, HP cannot modify the system.
3. Upon receipt of a denied claim for BAHA services, mail or fax your RA to DMA, Attn: Health Choice at 2501 Mail Service Center, Raleigh, NC 27699-2501 [FAX: 919-733-6608].

DMA will re-submit the claim to HP for a manual override, and HP will remit payment to providers who acquired PA and billed according to the policy reimbursement requirements.

N.C. Health Choice
DMA, 919-855-4107

Attention: Pharmacists

Recipient Opt-In Program and Monthly Prescription Limits

The restricted pharmacy services program called the Recipient Opt-In program for beneficiaries receiving more than 11 prescriptions per month will end on **February 7, 2013**.

Medicaid beneficiaries participating in this program will no longer be restricted to one pharmacy in order to receive more than 11 prescriptions per month. In addition to this change, the eight monthly prescription limit and the three additional prescription overrides each month will end on February 7, 2013, in conjunction with removal of the Opt-In program. Beneficiaries with low adherence to chronic medications and polypharmacy will be referred to the Community Care of North Carolina Network for medication therapy management to ensure coordinated care.

Note: The Recipient Management Lock In program is still active for beneficiaries receiving opioid analgesics and certain benzodiazepines. Beneficiaries in this program will continue to be restricted to one pharmacy and one prescriber to receive prescriptions for opioid analgesics and certain benzodiazepines.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Pharmacists and Prescribers

Prescribers not Enrolled in Medicaid

Note to Providers: The article was previously published in December 2012.

The Affordable Care Act established a new rule that prohibits Medicaid programs from paying for prescriptions written by prescribers who are not enrolled in the Medicaid program. On January 1, 2013, pharmacy providers will begin to receive a message at point-of-sale for prescriptions written by prescribers not enrolled in the Medicaid program. The actual message will say "***Prescriber not enrolled in Medicaid - claims will deny starting on April 1, 2013.***" This will hold true for originals and refills, so if a prescriber has an un-enrolled status anytime during the life of the prescription, the claim will deny after April 1, 2013.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Physicians

Affordable Care Act Enhanced Payments to Primary Care Physicians – REVISED

Notice to Providers: An article on this topic was originally published in October 2012. However, *significant* revisions have been made to give more information about the process (paragraphs 3 -5) and how the policy relates to physician assistants and nurse practitioners (paragraph 8).

According to Section 1202 of the Affordable Care Act (ACA) – which amends section 1902(a)(13) of the Social Security Act – Medicaid is federally required to pay up to the Medicare rate for **certain primary care services** and to reimburse 100% of the Medicare Cost Share for services rendered and paid in calendar years 2013 and 2014.

Section 1902(a) (13) (C) now specifies that physicians with a primary specialty designation of family medicine, general internal medicine or pediatric medicine are primary care providers. Those who render evaluation and management (E&M) codes and services related to immunization administration for vaccines and toxoids for specified codes would be eligible for reimbursement.

The Final Rule for this section was released by Centers for Medicare & Medicaid Services (CMS) in November 2012. It can be found at: www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/Downloads/CMS%E2%80%9310422.pdf. N.C. Medicaid will begin paying the Section 1202 primary care payments when CMS approves the State Plan Amendment (SPA). The eligible primary care physician (PCP) will receive a supplemental payment to the Medicaid payment when the eligible CPT code is paid. Because the law only provides these additional payments of services rendered to Medicaid beneficiaries, those services rendered to Health Choice (Title XXI) beneficiaries will not receive the additional reimbursement.

The primary care physicians will be able to self attest through a web portal that they are Board Certified in one of the specialties OR that 60% of their paid CPT codes are the eligible codes. Providers can attest to having board certification in a specialty (family medicine, general internal medicine or pediatric medicine) or subspecialty designated in the statute and attest to billing at least 60% for Evaluation & Management (E&M) and vaccine/toxoid codes through a N.C. Division of Medical Assistance (DMA) website portal using their N.C. Medicaid provider numbers.

N.C. Medicaid will systematically reimburse eligible providers retroactively if they have already been paid for dates of service beginning January 1, 2013 or after.

The codes included in this provision include E&M services and immunization administration for vaccines and toxoids. The MMIS+ claims processing system will reference both the Medicaid fee schedule, as well as the Medicare fee schedule to determine the enhanced payment amount.

DMA will notify providers through upcoming Medicaid bulletins, e-mail blasts, remittance advices or banner messages as the ACA Enhanced Payments to Primary Care Physicians provider portal is available.

Physician Assistants and Nurse Practitioners will also be able to access the same web portal and self attest to the under the 60% criteria and list their eligible supervising physician. *Final rule: CMS-2370-F; RIN 0938-AQ63; Section b. Services Furnished by a Specified Physician*. CMS has stressed that these enhanced payments are for physicians, however, those Physician Assistants and Nurse Practitioners who are under the direct supervision of an eligible physician could also receive the enhanced payment. CMS has stated that direct supervision shall mean that the supervising physician shall accept full professional liability for the services rendered by the Physician Assistant or Nurse Practitioner.

Provider Services,
DMA, 919-855-4050

Attention: All providers

Psychiatric Services Available to Pregnant Medicaid Beneficiaries

Approximately two-thirds of pregnant Medicaid beneficiaries are in the Medicaid for Pregnant Women (MPW) eligibility category. Per Clinical Coverage Policy 1E-5, Obstetrics, beneficiaries in the MPW category have coverage for services treating any condition related to the pregnancy or the well-being of the mother or fetus, as stated in Section 2.1.2:

> **2.1.2 Medicaid for Pregnant Women**
> Female beneficiaries of all ages with MPW coverage are eligible for pregnancy-related antepartum, labor and delivery, and postpartum care as well as services for conditions that — in the judgment of their physician — may complicate pregnancy. Conditions that may complicate their pregnancy can be further defined as any condition that may be problematic or detrimental to the well-being or health of the mother or the unborn fetus such as undiagnosed syncope, excessive nausea and vomiting, anemia, and dental abscesses (This list is not all-inclusive.). The eligibility period for MPW coverage ends on the last day of the month in which the 60th postpartum day occurs [42 CFR 447.53(b)(2)].

As with other eligibility categories, behavioral health treatment (including treatment for substance abuse) is covered for MPW beneficiaries, as are other medical specialty services needed to maintain the health of the woman or fetus during pregnancy. As stated in Section 5.1 of Clinical Coverage Policy 1E-5, certain services require prior authorization for beneficiaries in the MPW category, including podiatry, chiropractic, optometric/optical services, home health, personal care services, hospice, private duty nursing, home infusion therapy, and durable medical equipment.

Regardless of eligibility category, all pregnant Medicaid beneficiaries are exempt from co-payments for pregnancy-related services, including behavioral health and prescription drugs. Beneficiaries in any eligibility category, including MPW, may be linked to a Carolina Access/Community Care of NC (Carolina Access/CCNP) primary care provider (PCP). Pregnant beneficiaries who are linked to a Carolina Access/CCNC PCP need a referral from their PCP to receive care from specialists, including obstetricians.

Linkage to a PCP is optional for MPW beneficiaries, so some MPW beneficiaries (those who are not linked to a PCP) will not require referrals from a PCP. However, for behavioral health services for patients under 21, a referral is required and may be obtained from the PCP, the Local Management Entity-Managed Care Organization (LME-MCO) or a Medicaid-enrolled psychiatrist. Referrals are not required but are strongly encouraged for adult patients 21 and over receiving behavioral health services.

Prior authorization through the LME-MCO or N.C. Department of Health and Human Services utilization review contractor applies to most behavioral health services (refer to Clinical Coverage Policies, including 8A and 8C)

Behavioral Health Section
DMA, 919-855-4290

Attention: Behavioral Health Providers

Referrals for Outpatient Behavioral Health Services

N.C. Medicaid Clinical Coverage Policy 8C specifies that referrals must be made and documented for Medicaid beneficiaries under the age of 21 and N.C. Health Choice (NCHC) beneficiaries by *either* a:

- Community Care of North Carolina/Carolina Access (CCNC/CA) primary care provider,
- Local Management Entity/Managed Care Organization, or,
- Medicaid-enrolled psychiatrist.

"Blanket" referrals that are not specific to the beneficiary will not be considered acceptable documentation of a referral. Referrals must be individualized for each beneficiary. "Blanket" referrals have never been allowed since the purpose of the referral is to promote coordination of care between behavioral health and medical providers.

Behavioral Health Section
DMA, 919-855-4290

Attention: All Providers, Behavioral Health Providers, and LME/MCOs

Updates to Recommended Referral Forms for Use between Primary Care and Behavioral Health Providers

Community Care of North Carolina (CCNC), in partnership with other stakeholders, developed a set of three referral forms for primary care and behavioral health providers to facilitate easier consultation and communication. Initially released in June 2012, the forms have been updated based on feedback received, to include the following changes:

1. Field for primary care practice name on Form No. 1.
2. Field for confirmation that the beneficiary belongs to the named primary care practice on Form No. 1.
3. Field for Carolina Access Referring NPI number, if applicable, on Form No. 2.
4. On all three forms, "Pain Contract" has been replaced with "Pain Agreement."
5. There are now two versions of each form: a fillable PDF, and a Word document. The Word document allows providers to insert their own logos in the header in addition to the standard CCNC logo.

To access the referral forms, please visit https://www.communitycarenc.org/population-management/behavioral-health-page/referral-forms/. Referral form No. 2 (*Referral to Behavioral Health Services*) may count as the required referral for Medicaid beneficiaries under the age of 21 and N.C. Health Choice(NCHC) beneficiaries as described in the N.C. Division of Medical Assistance (DMA) Clinical Coverage Policy (CCP) 8C as long as the information required by CCP 8C is filled out.

Behavioral Health Section
DMA, 919-855-4290

Attention: Nurse Practitioners

Addition of Medical Evaluation and Management (E/M) Codes for Use by Psychiatric Nurse Practitioners

Note to Providers: Originally published as a special bulletin in January 2013.

This bulletin is intended as an update to the previous January 2013 bulletin listing new CPT Codes. Effective January 2013, Psychiatric Nurse Practitioners and Nurse Practitioners enrolled as Psychiatric Nurse Practitioners per guidelines in Clinical Coverage Policy 8C, can bill Medical Evaluation and Management (E/M) codes and associated add-on codes as listed in the attached table. These updates will be added to DMA Clinical Coverage Policy (CCP) 8C.

Please remember:

- Psychiatric coding guidelines were revised to require the use of Medical Evaluation and Management (E/M) codes as *separate and distinct services* from psychotherapy services for **Medical/Medication Management**.
- These services will be managed by LME-MCOs as they become active under the 1915 b/c waiver. Please note that services for children ages 0-2 and services for NC Health Choice beneficiaries will continue to be covered by the DMA utilization management contractor (Value Options).
- Behavioral Health (BH) visit limits and Prior Authorization rules found in CCP 8C remain in effect. Note that the number of unmanaged visits allowed may be increased by local LME-MCOs with permission from DMA.

E/M Prolonged Service Codes

Prolonged Service Codes (99354-99357) may not be used on the same day, by the same provider, for E/M services with psychotherapy add-on (90833, 90836, or 90838).

Training and Education

All providers are encouraged to pursue training and education regarding the use and documentation requirements of the new codes. The requirements are found in the American Medical Association's 2013 CPT Manual. It is each billing provider's responsibility to read, understand, and ensure compliance with published 2013 CPT guidance and DMA policy for services billed to Medicaid and LME-MCOs. There is no substitute for reading the 2013 CPT manual. Providers may view the following webinar as additional training materials: www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page. Many of the state and national professional associations offer live and archived trainings on the new codes.

Fee Schedules

The updated Fee Schedules has been posted on DMA's website at www.ncdhhs.gov/dma/fee/mhfee/nurse_practitioner_011713.pdf.

Table 1. New Codes – UPDATED

Code	Description	Psychiatric NP	Prior Authorization (PA) / Unmanaged Visit Limits
90785+	Interactive Complexity Add-On	X	PA and visit limits do not apply; "add-on" to other codes (90791, 90792, 90832-90838, 90853) that do have PA and visit limits
90791	Psychiatric diagnostic evaluation	X	BH visit limits/PA requirements in CCP 8C
90792	Psychiatric diagnostic evaluation with medical services	X	BH visit limits/PA requirements in CCP 8C
90832	Psychotherapy, 16-37 minutes	X	BH visit limits/PA requirements in CCP 8C
90833+	Psychotherapy, 16-37 minutes with E/M service, listed separately	X	BH visit limits/PA requirements in CCP 8C; code must be used with E/M code
90834	Psychotherapy, 38-52 minutes	X	BH visit limits/PA requirements in CCP 8C
90836+	Psychotherapy, 38-52 minutes with E/M service, listed separately	X	BH visit limits/PA requirements in CCP 8C; code must be used with E/M code
90837	Psychotherapy, 53+ minutes	X	BH visit limits/PA requirements in CCP 8C
90838+	Psychotherapy, 53+ minutes with E/M service, listed separately	X	BH visit limits/PA requirements in CCP 8C; code must be used with E/M code
90839	Psychotherapy for Crisis, 30-74 minutes	X	Two per calendar year per attending provider, no PA required; see new policy 8C
90840+	Psychotherapy for Crisis, Each additional 30-minutes beyond initial 74min, up to two add-ons per 90839	X	Must be used with 90839; two add-ons per 90839 event; see new policy 8C
E/M Codes: 99201-99205; 99211-99215; 99217-99226; 99231-99237; 99239; 99241-99245; 99251-99255; 99307-99310; 99315-99318; 99324-99328; 99334-99337; 99341-99350; 99354-99357	Physicians select the appropriate E/M codes based on history, exam, and medical decisions, **not on time** if using psychotherapy add-on.	X	**E/M Visit limit is separate; DMA established adult limit is 22, does not count toward BH limits; Limit does not apply to diagnoses listed here: http://www.ncdhhs.gov/dma/provider/VisitLimitDiagnosesList.pdf**

Behavioral Health Policy Section, DMA, 919-855-4290

Attention: In-Home Care, Adult Care Home Providers, Family Care Home Providers, and Supervised Living Homes Billing PCS Services

Update on Consolidated Personal Care Services

This article does not apply to providers billing for Personal Care Services (PCS) under the CAP program.

Consolidated Personal Care Services Policy and State Plan Amendment

Effective January 1, 2013, Medicaid PCS for recipients in all settings – including private residences and licensed adult care homes, family care homes, 5600a and 5600c supervised living homes, and combination homes with adult care home (ACH) beds – are provided under a consolidated PCS benefit. On November 30, 2012, the Centers for Medicare & Medicaid Services (CMS) approved the N.C. Medicaid State Plan Amendment (SPA) 12-013. Clinical Coverage Policy 3L, Personal Care Services, is effective January 1, 2013 and is posted in final version on DMA's Medicaid Clinical Coverage Policy webpage.

Personal Care Services Rate Effective January 1, 2013

On November 30, 2012, the Centers for Medicare & Medicaid Services (CMS) approved the Personal Care Services (PCS) State Plan Amendment with an effective date of January 1, 2013. The new PCS rate will be $3.88 per 15-minute unit. The below referenced fee schedule is posted on the DMA website at www.ncdhhs.gov/dma/fee/.

Procedure Code	Modifier	Description	Program Description	Billing Unit	Maximum Allowable
99509	HA	Attendant Care Services	Personal Care Services, Private Residences, Beneficiaries Under 21 Years	15 min.	$3.88
99509	HB	Attendant Care Services	Personal Care Services, Private Residences, Beneficiaries 21 Years and Older	15 min.	$3.88
99509	HC	Attendant Care Services	Personal Care Services, Adult Care Homes	15 min.	$3.88

Procedure Code	Modifier	Description	Program Description	Billing Unit	Maximum Allowable
99509	HH	Attendant Care Services	Personal Care Services, Supervised Living Facilities, Adults with MI/SA	15 min.	$3.88
99509	HI	Attendant Care Services	Personal Care Services, Supervised Living Facilities, Adults with MR/DD	15 min.	$3.88
99509	HQ	Attendant Care Services	Personal Care Services, Family Care Home	15 min.	$3.88
99509	SC	Attendant Care Services	Personal Care Services, Adult Care Homes, Special Care Unit	15 min.	$3.88
99509	TT	Attendant Care Services	Personal Care Services, Adult Care Homes, Combination Home	15 min.	$3.88

Providers are reminded to bill their usual and customary charges.

New Admission Reporting and Independent Assessments for PCS Beneficiaries receiving services on or post January 1, 2013

PCS New Referrals Beginning January 1, 2013

Beneficiaries, who seek admission, are admitted, first receive services in licensed homes, or are seeking in-home services on January 1, 2013 or later may request new referral assessments through:

- Primary care of attending physicians
- Nurse practitioners
- Physician Assistants

The new referral form is available on the DMA Consolidated PCS webpage. PCS reimbursement will not be available for a beneficiary admitted to a licensed facility on or after January 1, 2013, unless and until the beneficiary has received an independent assessment and Clinical Coverage Policy 3L qualifying criteria are met.

Change of Status Request Process

Effective January 1, 2013, providers may report status changes for beneficiaries approved for PCS services. A Change of Status reassessment should be requested for a beneficiary who, since the previous assessment, has experienced a change in condition that affects the needs for hands-on assistance with Activities of Daily Living (ADLs) or other services covered under Clinical Coverage Policy 3L. Note that Change of Status requests cannot be processed for beneficiaries who have not been approved for PCS.

The Change of Status request form is available on the DMA Consolidated PCS webpage. The form may be completed by the licensed home provider and should be submitted by fax to: The Carolinas Center for Medical Excellence (CCME) at 877-272-1942. After receipt, CCME will contact your facility to schedule a return visit to assess beneficiaries whose Change of Status requests support the need for reassessment. The form must be complete and include a description of the status change causing the change in need for PCS assistance.

Beneficiary Annual Reassessments

Annual reassessments of approved PCS beneficiaries will begin the week of January 21, 2013. Annual reassessment dates for current beneficiaries approved to transition effective January 1, 2013 are determined by the beneficiary FL-2 date documented on the medical attestations form and beneficiary independent assessment. Providers are not required to contact CCME to initiate reassessments for beneficiaries.

Preadmission Screening and Resident Review (PASRR) Process for Adult Care Homes licensed under G.S. 131 D-2

Preadmission Screening Resident Review

Beginning January 1, 2013 any individual being considered for admission to an adult care home, regardless of the source of payment, must be screened by an independent screener to determine whether the individual has Serious Mental Illness/Serious and Persistent Mental Illness (SMI/SPMI). The State shall connect any individual with SMI/SPMI to the appropriate Local Management Entity/Managed Care Organization (LME/MCO) for a prompt determination of eligibility for mental health services. To learn more, read the following article titled *Adult Care Homes licensed under G.S. § 131D, Article 1 and defined in G.S. § 131D-2.1* by following this URL: www.ncdhhs.gov/dma/bulletin/0113bulletin.htm#ach

Billing for Personal Care Services

Effective January 1, 2013, providers billing for Personal Care Services (PCS) must submit claims on the CMS-1500 claim form. All claims must be submitted electronically and can be submitted by utilizing the web tool at https://webclaims.ncmedicaid.com/ncecs or by hiring a vendor. To utilize the web tool users must have a password and login provided by HP Enterprise Services. Those who do not have a login can contact HP at 1-800-688-6696, menu option 1.

For Billing Questions regarding **denials**, **missing or incorrect Carolina Access Number**, **Incorrect CPT code**, **Assistance with the Web tool**, or **requests for onsite visits**, contact HP at 1-800-688-6696.

Additional billing resources and trainings are available on the DMA Consolidated PCS webpage and below at the following links.

- Technical Assistance Billing Webinar: CMS 1500 required fields included www.ncdhhs.gov/dma/pcs/ACH_011513_transition.ppt
- Special Bulletin December 2011: www.ncdhhs.gov/dma/bulletin/NCECSWebGuide.pdf
- N.C. Electronic Claims Submission/Recipient Eligibility Verification Web tool: https://webclaims.ncmedicaid.com/ncecs
- Crosswalk of paper CMS 1500 fields to electronic from equivalent fields: www.nucc.org
- Place of Service Codes- General Bulletin December 2005**:** www.ncdhhs.gov/dma/bulletin/pdfbulletin/1205bulletin.pdf
- CMS 1CD-9 lookup tool: www.cms.gov/medicare-coverage-database/staticpages/icd-9-code-lookup.aspx

Appeals/Maintenance of Service

Beneficiaries who have received adverse decisions notices of service and have filed a timely appeal will be granted Maintenance of Service (MOS). Due to the current volume of appeals being processed, providers may experience a delay in the processing of MOS. Providers are unable to bill claims for beneficiaries until they have received MOS. MOS will be retroactive from the date the appeal was received by the Office of Administrative Hearing. Providers will be notified of Maintenance of Service through the Provider Interface QiReport. Providers who are not registered with QiReport will receive a facsimile from the Carolina's Center for Medical Excellence (CCME). For additional questions regarding Appeals and Maintenance of Service contact the Office of Administrative Hearing at 919-431-3000 or CCME at 1-800-228-3365.

Attention Licensed Residential Facility's (Special Care Unit)

On December 28, 2012, the Center for Medicaid and Medicare Services agreed to allow DMA to provide Maintenance of Service (MOS) using the current hours for Special Care

Unit beneficiaries. The approval of 161 hours for SCU beneficiaries applies only to Maintenance of Service (MOS) hours issued while the beneficiary goes through the appeal process. The appeal must have been filed by January 30, 2013 for the beneficiary to be entitled to MOS. Once the appeal decision has been made, the highest level of service a beneficiary receiving Personal Care Services (PCS) can receive is 80 hours – regardless of setting.

Provider Interface

Licensed facility provider registration for the PCS Provider Interface began on November 29, 2012. To register to use the Provider Interface, complete the Provider Registration For Licensed Facility PCS Provider Use of QiRePort form and send it to:

The Carolinas Center for Medical Excellence (CCME)

Fax: 877-272-1942

Mail:
CCME
ATTN: PCS Independent Assessment
100 Regency Forest Drive, Suite 200
Cary, NC 27518-8598.

Registered users will receive an email notification from support@QiRePort.net which includes the QiRePort website link and a login (i.e., temporary password). Providers are strongly encouraged to use the Provider Interface QiReport. The Registration form for QiReport is available at www.ncdhhs.gov/dma/pcs/QiRePort_Registration_112712.pdf

Upcoming Provider Trainings

Regional trainings for all PCS providers will begin in February 2013. Registration information and training topics will be available on the DMA Consolidated PCS Webpage. For additional information about the new PCS program, refer to the DMA Consolidated PCS webpage and to previous and future Medicaid Bulletins.

PCS Regional Trainings

Date	City	Location
Monday, February 18, 2013	Raleigh	McKimmon Center NC State University
Tuesday, February 19, 2013	Greenville	Hilton Hotel
Wednesday, February 20, 2013	Fayetteville	Embassy Suites
Monday, February 25, 2013	Asheville	Crown Plaza Resort
Tuesday, February 26, 2013	Charlotte	Hilton, Charlotte Center City

PCS Available Resources

- PCS Clinical Coverage Policy 3L: Effective Date January 1, 2013: www.ncdhhs.gov/dma/mp/3L.pdf
- State Plan Amendment: www.ncdhhs.gov/dma/pcs/NC12013_Approval_Letter_179.pdf
- House Bill 950 S. L 2012-142
- Appeals and QiReport Webinar: www.ncdhhs.gov/dma/pcs/011013_PCSWebinar.pdf
- Technical Assistance Billing Webinar: www.ncdhhs.gov/dma/pcs/ACH_011513_transition.ppt

Home and Community Care
DMA, 919-855-4340

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

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

Proposed Clinical Coverage Policies

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

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

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

2013 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
February	02/07/13	02/12/13	02/13/13
	02/14/13	02/20/13	02/21/13
	02/21/13	02/28/13	03/01/13
March	02/28/13	03/05/13	03/06/13
	03/07/13	03/12/13	03/13/13
	03/14/13	03/19/13	03/20/13
	03/21/13	03/28/13	03/29/13

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

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

Melissa Robinson
Executive Director
HP Enterprise Services