March 2010 Medicaid Bulletin

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Attention: All Providers

2010 Census

The Department of Health and Human Services (DHHS) is partnering with the U.S. Census Bureau and the N.C. Complete Count Committee to support the 2010 Census. Please help us spread the word about the 2010 Census to achieve a complete and accurate count of North Carolina's population.

Accurate census data guides decision-makers on where to build roads, hospitals, housing, schools, and senior centers and will ensure that North Carolina gets its fair share of federal funding. Every year, the federal government distributes more than $400 billion for improvements to public health, education, transportation, and more. These funds are distributed to state, local, and tribal governments based on census data. For each person who is not counted, North Carolina will loose approximately $10,000 over the next 10 years.

Every person counts in the Census. DMA encourages our providers and partners to promote Census awareness and participation by reminding consumers that

- You don't count unless you're counted.
- It's quick, easy, and safe.
- It's a patriotic duty.

For more information on the 2010 Census and to find out how you can get involved, visit the North Carolina Census website at http://2010census.nc.gov.

Director's Office
DMA, 919-855-4000

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/:

- 1A-26, *Deep Brain Stimulation (DBS)*

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

North Carolina Medicaid Preferred Drug List

DMA will establish a N.C. Medicaid Preferred Drug List (PDL) on March 15, 2010. The N.C. General Assembly [Session Law 2009-451, Sections 10.66(a)-(d)] authorized DMA to establish the PDL in order to obtain better prices for covered outpatient drugs through supplemental rebates. All therapeutic drug classes for which the drug manufacturer provides a supplemental rebate are considered for inclusion on the list with the exception of medications used for the treatment of human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS).

Initially, when the PDL goes into effect, there will **not** be any changes in the drugs that are currently covered. **In the future,** selected therapeutic drug classes will be reviewed by DMA and the Pharmacy and Therapeutics Committee of the N.C. Physicians Advisory Group. Specific drug products within the selected therapeutic drug classes will be "preferred" based on therapeutic effectiveness, safety and clinical outcomes. Generally these drugs will not require prior authorization (PA) unless there are other clinical PA requirements such as step therapy or quantity limits.

"Non-preferred" drugs (drug products not included in the therapeutic drug classes listed on the PDL) will be available if prior authorization criteria are met. The prior authorization process will be the same process as it is today. If a prescriber deems that the patient's clinical status necessitates therapy with a "non-preferred" drug, the prescriber will be responsible for initiating a prior authorization request.

For therapeutic drug classes that do not appear on the PDL, nothing has changed. Prescribers can prescribe drugs in these classes as in the past, unless existing prior authorization criteria exists.

The PDL is posted on DMA's Outpatient Pharmacy Program's website (http://www.ncdhhs.gov/dma/pharmacy/).

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

Attention: Children's Developmental Services Agencies and Early Intervention Services Providers

Update on Community Based Rehabilitative Services

A workgroup with members from DMA and the Division of Public Health (DPH) have been refining the definition of Community Based Rehabilitative Services (CBRS) and will be submitting the revised definition to the N.C. Physician's Advisory Group (PAG) in late March. The revised definition will also be posted for public comment on DMA's website. DMA continues to work closely with CMS to ensure that this newly revised service definition will be approved for Medicaid reimbursement under the N.C. Medicaid State Plan. DMA and DPH believe that CBRS is a valuable service and are making every effort to maintain the service without interruption.

Behavioral Health Section
DMA, 919-855-4290

Attention: All Providers

Clarification on the Provider Enrollment Fee

On September 1, 2009, DMA implemented a $100 fee for providers enrolling for participation with the N.C. Medicaid Program. This requirement was implemented in response to legislation mandated by Session Law 2009-451 (http://www.ncga.state.nc.us/Sessions/2009/Bills/Senate/PDF/S202v8.pdf).

The enrollment fee applies to the initial enrollment of a provider (in other words, an in-state or border-area provider who has never before enrolled to participate in the N.C. Medicaid Program). The provider's tax identification number is used to determine if the provider is currently enrolled or was previously enrolled. The enrollment fee also applies to currently enrolled providers at 3-year intervals when the provider is re-credentialed.

Providers should not submit payment with their enrollment applications or with their verification packets. Once a provider is approved for enrollment or has been re-credentialed, the CSC EVC Call Center will send an invoice to the provider with instructions for payment.

The enrollment fee does not apply to requests for changes to a provider's status even if a new enrollment application is required in order for the CSC EVC Call Center to complete the change. For example, a new provider application is required for group name changes. But, the enrollment fee does not apply because the provider is currently enrolled.

CSC, 1-866-844-1113

Attention: All Providers

Medicaid Credit Balance Reporting

All providers participating in the Medicaid Program are required to submit a quarterly **Credit Balance Report** to the DMA Third-Party Recovery Section identifying balances due to Medicaid. Providers must report any **outstanding** credits owed to Medicaid that have not been reported previously on a Medicaid Credit Balance Report. However, hospital and nursing facility providers are required to submit a report every calendar quarter even if there are no credit balances. The report must be submitted no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30, and December 31).

The Medicaid Credit Balance Report is used to monitor and recover "credit balances" owed to the Medicaid Program. A credit balance results from an improper or excess payment made to a provider. For example, refunds must be made to Medicaid if a provider is paid twice for the same service (e.g., by Medicaid and a medical insurance policy, by Medicare and Medicaid, by Medicaid and a liability insurance policy) or if the patient liability was not reported in the billing process or if computer or billing errors occur.

For the purpose of completing the report, a Medicaid Credit Balance is the amount determined to be refundable to the Medicaid Program. When a provider receives an improper or excess payment for a claim, it is reflected in the provider's accounting records (patient accounts receivable) as a "credit." However, credit balances include money due to Medicaid regardless of its classification in a provider's accounting records. If a provider maintains a credit balance account for a stipulated period (e.g., 90 days) and then transfers the account or writes it off to a holding account, this does not relieve the provider of liability to the Medicaid Program. The provider is responsible for identifying and repaying all monies owed the Medicaid Program.

The Medicaid Credit Balance Report requires specific information for each credit balance on a claim-by-claim basis. The reporting form provides space for 15 claims but may be reproduced as many times as necessary to accommodate all the credit balances being reported. Specific instructions for completing the report are on the reverse side of the reporting form.

Submitting the Medicaid Credit Balance Report does not result in the credit balances automatically being reimbursed to the Medicaid Program. **Electronic adjustments are the preferred method of satisfying the credit balances and can be performed through the North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool. Refer to the February 2010 Medicaid Bulletin article, titled *Adjusting North Carolina Medicaid Claims Electronically*, on DMA's website at http://www.ncdhhs.gov/dma/bulletin/ for specific filing instructions.**

In the event, a billing error caused an individual provider to be paid for a service in which a provider group should have been paid, a refund check will need to be sent to HP Enterprise Services to correct the error as it is unlikely the individual provider will have future claims to adjust. In these circumstances only, a check must be made payable to HP Enterprise Services and sent to HP Enterprise Services using the **Medicaid Provider Refund Form** (http://www.ncdhhs.gov/dma/provider/forms.htm). The information on the form must be complete and accurate in order to process the provider refund check.

Submit the Medicaid Credit Balance Report Form to:	Electronic Adjustments using the North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool	Submit Refund Checks to:
Third Party Recovery Section Division of Medical Assistance 2508 Mail Service Center Raleigh NC 27699-2508	**Refer to the February 2010 Medicaid Bulletin article titled, *Adjusting North Carolina Medicaid Claims Electronically*, (http://www.ncdhhs.gov/dma/bulletin/)**	HP Enterprise Services Refunds P.O. Box 300011 Raleigh NC 27622-3011 (**Do not** send these refund checks to DMA or to the Controller's Office.)

Submit **only** the completed Medicaid Credit Balance Report to DMA. **Failure to submit a Medicaid Credit Balance Report to DMA will result in the withholding of Medicaid payment until the report is received.**

Send to DMA:

- The **original** completed Medicaid Credit Balance Report.
- Please circle "Adjustment" at bottom of original credit balance report to indicate an electronic adjustment has been performed. (**Note:** You may circle "Refund" in the event a check must be sent due to the reason stated above).

Send to HP Enterprise Services Refunds Department:

- Always send **live credit balance refund check(s)** to the HP Enterprise Services refunds address listed in this bulletin.
- Enclose a copy of the Medicaid Credit Balance Report associated with the refund.
- Include a completed **Medicaid Provider Refund Request Form** to ensure that HP Enterprise Services can appropriately document individual refund amounts.
- Please circle "Refund" at the bottom of the copy of the Medicaid Credit Balance Report.

A copy of the Medicaid Credit Balance Report form follows this article. The Medicaid Provider Refund Form and the Medicaid Credit Balance Report form are also available on DMA's website at http://www.ncdhhs.gov/dma/provider/forms.htm.

Debbie Odette, Third Party Recovery Section
DMA, 919-647-8100

Instructions for Completing Medicaid Credit Balance Report

Complete the "Medicaid Credit Balance Report" as follows:

- **Full name of facility as it appears on the Medicaid Records**
- **The facility's Medicaid provider number**. If **the facility has more than one provider number, use a separate sheet for each number. DO NOT MIX**
- **Circle the date quarter end**
- **Enter year**
- The name and telephone number of the person completing the report. This is needed in the event DMA has any questions regarding some item in the report

Complete the date fields for each Medicaid balance by providing the following information:

Column 1 – The last name and first name of the Medicaid recipient (e.g., Doe, Jane)

Column 2 – The individual Medicaid identification (MID) number

Column 3 – The month, day, and year of beginning service (e.g., 12/05/03)

Column 4 – The month, day, and year of ending service (e.g., 12/10/03)

Column 5 – The R/A date of Medicaid payment (not your posting date)

Column 6 – The Medicaid ICN (claim) number

Column 7 – The amount of the credit balance (not the amount your facility billed or the amount Medicaid paid)

Column 8 – The reason for the credit balance by entering: "81" if it is a result of a Medicare payment; "83" if it is the result of a health insurance payment; "84" if it is the result of a casualty insurance/attorney payment or "00" if it is for another reason. Please explain "00" credit balances on the back of the form.

After this report is completed, total column 7 and mail to **Third Party Recovery, DMA, 2508 Mail Service Center, Raleigh, NC 27699-2508.**

MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME:_____ CONTACT PERSON: _____
PROVIDER NUMBER: _____ TELEPHONE NUMBER: _____
QUARTER ENDING: (Circle one) 3/31 6/30 9/30 12/31 YEAR: _____

(1) RECIPIENT'S NAME	(2) MEDICAID NUMBER	(3) FROM DATE OF SERVICE	(4) TO DATE OF SERVICE	(5) DATE MEDICAID PAID	(6) MEDICAID ICN	(7) AMOUNT OF CREDIT BALANCE	(8) REASON FOR CREDIT BALANCE
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

Circle one: Refund Adjustment

Return form to: **Third Party Recovery**
DMA
2508 Mail Service Center
Raleigh, NC 27699-2508

Revised 10/07

Attention: All Providers

Basic Medicaid Seminars

Basic Medicaid seminars are scheduled for the month of April 2010 at the sites listed below. These seminars are intended to educate all providers on the basics of billing for N.C. Medicaid and will include the latest budget initiative requirements. The April 2010 *Basic Medicaid Billing Guide* will be used as the primary training document for the seminar. Please print a copy of the Billing Guide for review and bring it to the seminar. If preferred, you may download the Billing Guide to a laptop and bring the laptop to the seminar or you may access the Billing Guide online using your laptop during the seminar. **However, please note that HP Enterprise Services cannot guarantee a power source or Internet access for your laptop.**

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, or providers may register by fax using the form below (fax it to the number listed on the form). Please indicate the session you plan to attend on the registration form.

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.**

Date	Location
Tuesday, April 6, 2010	Blue Ridge Community College, Flat Rock Campus Blue Ridge Conference Center 180 E. Campus Drive Flat Rock NC 28731
Wednesday, April 7, 2010	Gaston Community College, Dallas Campus Myers Center Building Auditorium 201 Highway 321 South Dallas NC 28034
Tuesday, April 13, 2010	Hawthorne Inn 420 High Street Winston-Salem NC 27101
Thursday, April 15, 2010	The Royal Banquet and Convention Center 3801 Hillsborough Street Raleigh NC 27607
Tuesday, April 20, 2010	Craven Community College, New Bern Campus Orringer Hall Auditorium 800 College Court New Bern NC 28562

Directions to the Basic Medicaid Seminars

DALLAS
Gaston Community College
Traveling on I-85: Take I-85 to Exit 17 (Highway 321). As you exit the ramp, take a left at the stoplight onto Highway 321 North. You will pass two stoplights and then pass over a bridge. About ¼ mile past the bridge, take the Gaston College exit ramp. At the top of the ramp, turn left and follow the road to the traffic circle. Take the first exit right off the circle to go to the main part of campus.

FLAT ROCK
Blue Ridge Community College, Conference Center
Traveling East on 1-26: Travel east on I-26 to Exit 53, Upward Road. Turn right at the end of the ramp. At the 2nd traffic light, (approximately 0.5 miles), turn right onto South Allen Drive. Travel approximately 0.5 miles to the Blue Ridge Community College sign and turn left onto College Drive. The first building on the right is the Sink Building.

NEW BERN
Craven Community College
Traveling North on US 17: Take US 17 North towards New Bern to NC 43. Turn left onto South Glenburnie Road (NC 43/US 17 Business Route). Turn left onto College Court.

Traveling South on US 264: Take US 264 South towards New Bern to NC 43. Turn right onto South Glenburnie Road (NC 43/US 17 Business Route). Turn left onto College Court.

RALEIGH
The Royal Banquet and Convention Center
Traveling East on I-40: Take I-40 East towards Raleigh. Take Exit 289 for Wade Avenue. Pass the exits for Edwards Mill Road and Blue Ridge Road, then merge right onto I-440 S/US 1 South toward I-40 East/Hillsborough Street/Sanford (the Outer Beltline). Take Exit 3 for NC 54/Hillsborough Street. Turn left at the bottom of the exit ramp onto Hillsborough Street. Turn right at the 3rd stoplight at Meredith College and the Brickhouse Restaurant (the turn is located in front of Quizno's and Ben & Jerry's). Go to the end of the parking lot and turn left to park BEHIND the building or in the covered parking area.

Traveling West on I-40: Take I-40 West towards Raleigh. Take Exit 293 for I-440/US 1/US 64/Raleigh/Wake Forest. The exit will split into two lanes. Stay in the right-hand lane to merge onto I-440/Inner Beltline/Raleigh. Take Exit 3 for NC 54/Hillsborough Street. Turn left at the bottom of the exit ramp onto Hillsborough Street. Turn right at the 3rd traffic light at Meredith College and the Brickhouse Restaurant (the turn is located in front of Quizno's and Ben & Jerry's). Go to the end of the parking lot and turn left to park BEHIND the building or in the covered parking area.

WINSTON-SALEM
Hawthorne Inn
Traveling East on I-40: Take I-40 East to I-40 Business into downtown Winston-Salem. Take Exit 5C for Cherry Street and turn onto High Street. The front entrance of the hotel is immediately on your right.

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

Registration Form

Basic Medicaid Workshops
April 2010 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

Attention: All Providers

HCPCS Code Changes for the Physician's Drug Program

The following HCPCS code changes have been made to comply with CMS HCPCS code changes.

New HCPCS Procedure Codes

The following HCPCS codes were added to the list of covered codes for the Physician's Drug Program effective with date of service January 1, 2010.

New HCPCS Code	Description	Unit
J0598*	C1 Esterase inhibitor (human) (Cinryze, Berinert)	Per 10 units
J2793*	Rilonacept (Arcalyst)	1 mg

*Refer to the February 2010 Medicaid Bulletin (http://www.ncdhhs.gov/dma/bulletin/) for billing guidelines for these drugs.

End-Dated Codes with Replacement Codes

The following HCPCS codes were end-dated effective with date of service December 31, 2009, and replaced with new codes effective with date of service January 1, 2010. Claims submitted for dates of service on or after January 1, 2010, using the end-dated codes will be denied.

End-Dated HCPCS Code	Description	Unit	New HCPCS Code	Description	Unit
J0460	Atropine sulfate	Up to 3 mg	J0461	Atropine sulfate	0.01 mg
J0530, J0540 and J0550	Penicillin G benzathine and penicillin G procaine	Varying units	J0559	Penicillin G benzathine and penicillin G procaine	2500 units
J0835	Cosyntropin	Per 0.25 mg	J0833	Cosyntropin, not otherwise classified	0.25 mg
J0835	Cosyntropin	Per 0.25 mg	J0834	Cosyntropin (Cortrosyn)	0.25 mg
J7322	Hyaluronan or derivative, Synvisc	Per dose	J7325	Hyaluronan or derivative, Synvisc or Synvisc-one	1 mg
J9170	Docetaxel	20 mg	J9171	Docetaxel	1 mg
Q2023	Factor VIII (antihemophilic factor, recombinant) (Xyntha)	Per I.U.	J7185	Factor VIII (antihemophilic factor, recombinant) (Xyntha)	Per I.U.

New Codes That Were Previously Billed with the Miscellaneous Drug Codes J3490, J3590 or J9999

Effective with date of service January 1, 2010, the N.C. Medicaid Program covers the individual HCPCS codes for the drugs listed in the following table. Claims submitted for dates of service on or after January 1, 2010, using the unlisted drug codes J3490, J3590 or J9999 for these drugs will be denied. An invoice is not required.

Old HCPCS Code	Description	Old Unit	New HCPCS Code	Description	New Unit
J3590	Certolizumab pegol (Cimzia)	200 mg	J0718	Certolizumab pegol, 1 mg (Cimzia)	1 mg
J3590	Human fibrinogen concentrate (RiaSTAP)	1 mg	J1680	Human fibrinogen concentrate (RiaSTAP)	100 mg
J3490	Plerixafor (Mozobil)	1 mg	J2562	Plerixafor (Mozobil)	1 mg
J3490	Romiplostim (NPlate)	10 mcg	J2796	Romiplostim (Nplate)	10 mcg
J3490	Degarelix (Firmagon)	80 mg	J9155	Degarelix (Firmagon)	1 mg
J9999	Temozolomide (Temodar)	100 mg	J9328	Temozolomide (Temodar)	1 mg
J3490	Ferumoxytol	510 mg vial	Q0138	Ferumoxytol, for treatment of iron deficiency anemia (non-ESRD use)	1 mg
J3490	Ferumoxytol	510 mg vial	Q0139	Ferumoxytol, for treatment of iron deficiency anemia (ESRD, on dialysis)	1 mg

Refer to the fee schedule for the Physician's Drug Program on DMA's website at http://www.ncdhhs.gov/dma/fee/ for the latest available fees.

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

Attention: All Providers

Health Check/EPSDT Seminars

Health Check/EPSDT seminars are scheduled for May 2010. Registration information, a list of dates, and site locations for the seminars will be published in the April 2010 Medicaid bulletin (http://www.ncdhhs.gov/dma/bulletin/).

Seminars 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 seminars. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

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

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

Attention: All Providers

Amendment Approval to the Family Planning Waiver

On November 4, 2009, CMS approved the coverage of additional procedures/devices under the Medicaid Family Planning Waiver (MAFD). The procedures/devices listed in the following table are now included.

Procedure	Procedure Code	Procedure Code Description
Essure	58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography
	58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants
	74740	Hysterosalpingography, radiological supervision and interpretation
Implanon	J7307	Etonogestrel (contraceptive) implant system, including implant and supplies (Implanon)
	11981	Insertion, non-biodegradable drug delivery implant
	11982	Removal, non-biodegradable drug delivery implant
Thin Prep Pap Smear	88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision
	88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision
Contraceptive Pills	S4993	Contraceptive pills for birth control

Claims for dates of service November 4, 2009, and after, may now be submitted for processing.

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

Attention: All Providers

Human Papilloma Virus (HPV) Vaccine, Quadrivalent (CPT Code 90649, Gardasil): Additional Coverage Guidelines

The Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) recently updated recommendations for the use of quadrivalent HPV vaccine, and approved it for males 9 through 26 years of age. Effective February 4, 2010, the North Carolina Immunization Program (NCIP) added coverage for males 9 through 18 years of ages who are eligible for the Vaccines for Children (VFC) Program. The vaccine was previously recommended and available from NCIP for females only. Gardasil is administered as a 3-dose series.

Effective with date of service February 4, 2010, for males and females who are

- **9 through 18** years of age, the N.C. Medicaid Program covers the **administration fee** for Gardasil.
- **19 through 20** years of age, Medicaid covers the Gardasil **vaccine AND the administration fee.**
- **21 through 26** years of age, Medicaid does **NOT** cover the Gardasil **vaccine or the administration fee.**

Refer to the general Medicaid Bulletin and the Health Check Billing Guide for billing guidelines.

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

Attention: Personal Care Services Providers

Implementation of PCS PACT Reviews and Independent Assessments

Independent assessment of PCS recipients is being implemented in response to Session Law 2009-451 (Senate Bill 202), Section 10.68A.(a)(3) (http://www.ncga.state.nc.us/Sessions/2009/Bills/Senate/PDF/S202v8.pdf). The Carolinas Center for Medical Excellence (CCME) was awarded the contract to conduct PCS independent assessments.

All PACT forms submitted to CCME by January 8, 2010, in response to DMA's November 3, 2009, notice to providers, have been reviewed. Service reduction notifications and prior authorizations based on the PACT Review have been delayed due to a legal challenge by the Association for Home and Hospice Care. Information regarding continuing service denial notifications will be announced as it becomes available.

Continue to conduct new referral assessments, annual reassessments, and change of status reviews, and **complete and submit your weekly assessment and discharge updates to CCME using and following instructions in the Weekly Summary Form (see the PACT Review website at http://www.qireport.net).** Include PACT forms for all newly admitted and reassessed PCS and PCS-Plus recipients.

Implementation of independent assessment of all individuals applying for PCS and PCS-Plus and all reassessments and change of status reviews is scheduled for March 2010. Refer to the PACT Review website (http://www.qireport.net) and future Medicaid bulletin articles for additional information and updates on this change. Questions may be directed to the CCME PACT Help Line at 1-800-228-3365 or by e-mail to PACTreview@thecarolinascenter.org.

CCME, 1-800-228-3365

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

Enhanced Services Policy Updates

Child and Adolescent Day Treatment

The Child and Adolescent Day Treatment service definition has been revised, reviewed by the N.C. Physician's Advisory Group (PAG), offered for public comment, and received final approval. This definition will be implemented effective April 1, 2010, and can be found in DMA Clinical Coverage Policy 8A located at http://www.ncdhhs.gov/dma/mp/. The day treatment endorsement checksheet will be revised to reflect the changes in the service definition and posted to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) endorsement webpage to be utilized to complete the endorsement process for any on site visit effective April 2, 2010. All providers endorsed for this service are expected to be in compliance with the new service definition requirements effective April 1, 2010. All stakeholders, including Local Management Entities (LMEs), providers, and consumers are encouraged to carefully read this definition as it has been substantially modified.

Intensive In-Home and Community Support Team

The DHHS service definition workgroup has reviewed all public comments for the revised Intensive In-Home and Community Support Team service definitions. In general, comments were supportive of the move to adopt Evidence Based Practices (EBPs). Concerns were raised regarding training and implementation during this time of significant system transition. Based on these concerns, the specific models listed will be removed from the current drafts. However, a basic foundation in evidence-based clinical practices is essential in the delivery of these rehabilitative services. As a result, new draft definitions will include specific requirements for training in several clinical best practices. These revised definitions will be re-posted on DMA's website for further comment.

Substance Abuse Intensive Outpatient Treatment (SAIOP) and Substance Abuse Comprehensive Outpatient Treatment (SACOT)

Providers of Substance Abuse Intensive Outpatient Treatment (SAIOP) and Substance Abuse Comprehensive Outpatient Treatment (SACOT) are required to submit a discharge ITR to ValueOptions at the end of a treatment episode or when a consumer leaves the service prior to the end of a treatment episode. This allows ValueOptions to keep an accurate and up-to-date record of treatment days available to the consumer.

Additionally, providers delivering evidence-based models (such as the Matrix Model) should submit the specific EBP model name on the ITR when requesting authorization.

Behavioral Health Section
DMA, 919-855-4290

Attention: CAP/DA Case Managers, CAP/Choice Case Managers, CAP/C Case Managers, Targeted Case Management Case Managers (Waiver and Non Waiver) for Persons with Developmental Disabilities, and Early Intervention Case Managers (Children's Developmental Services Agencies)

Policy Changes for Case Management Services

This article is being republished to correct the instruction to providers to bill with the new procedure code T1017SC if additional hours (up to 6 hours/24 units) are needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation. The correct code to bill for these additional hours **is the procedure code currently submitted for case management services with an informational modifier SC appended to the code.**

Beginning **March 1, 2010,** DMA will change the policies as described below for the following programs: CAP/DA, CAP/Choice, CAP/C, CAP/MR-DD, Targeted Case Management for Persons with Developmental Disabilities, and Early Intervention.

- The maximum number of units for case management services will be limited to no more than three hours (12 units) per calendar month for each recipient. See Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) or Medicaid for Children below. Providers should continue to use the current program case management billing codes.
- No more than six additional hours (24 units) may be available if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation.
    - ♦ It is not necessary to bill all of the additional units on the same claim. These additional units can be used cumulatively within a rolling 365 day period.
    - ♦ Any billing for assessments and crises case management above this annual limit will not be paid for adults 21 years of age and older. For children under 21 years of age, requests will be reviewed under EPSDT. (See EPSDT below.)
    - ♦ These six hours (24 units) are in addition to the three hours per calendar month.
    - ♦ When billing for these additional six hours/24 units, **all programs must use the procedure code currently submitted for case management services and append an informational modifier SC to that detail.** For example:
        - o CAP/C and CAP/DA would bill with T1016SC.
        - o CAP/MR-DD, EI would continue to bill with T1017HI and append a second modifier of SC.
        - o CAP/Choice would bill with T2041SC

Early Intervention (EI)

Effective March 1, 2010, any recipient receiving more than three hours (12 units) per calendar month will have his/her hours reduced to the limit of three hour (12 units). This will not affect the entitlement that is applied under the Early Intervention Program for service coordination as listed in the Individualized Family Service Plan.

Providers may request additional units (additional annual and monthly) by following the EPSDT requirements as outlined on http://www.ncdhhs.gov/dma/epsdt/. If the request exceeds the policy limits described above, the request will be reviewed under the EPSDT criteria. If the request meets all of the EPSDT criteria and the requested amount is necessary to meet the child's needs, the request will be approved. If the request does not meet all of the EPSDT criteria or the request exceeds what is necessary to meet the child's needs, the request will not be approved at the level requested.

Developmental Disability (DD) Case Management (Waiver and Non-waiver)

The following procedures apply to providers of DD case management (waiver and non-waiver):

- Current authorizations with effective dates prior to March 1, 2010, will continue as authorized until the next annual continued need review (CNR). The three hour/12 unit limit policy will be applied at the next annual review.

- Effective March 1, 2010, prior authorization of case management services for adults on the Supports and Comprehensive waivers will not be required. These adults will be eligible for up to three hours/12 units monthly as well as the additional 24 units for assessment, planning, and crisis management annually. Non-waiver adults will continue to require prior authorization and may be authorized for up to three hours/12 units per month and no more than six additional hours/24 units if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation. Should a case manager submit a request for a non-waiver recipient that exceeds the policy limits, the case will be reviewed to determine how many hours/units are necessary to meet the recipient's needs (one, two, or three hours per calendar month and/or six or less additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days).

- Effective March 1, 2010, prior authorization of case management services for children on the Supports and Comprehensive waivers will not be required unless the request exceeds the three hour/12 unit monthly limit or the 24 unit limit for assessment, planning and crisis situations.. Non-waiver children will continue to require prior authorization.

- Waiver and non-waiver children must be evaluated under the EPSDT requirements prior to reducing their current service level at their next annual review and for authorization requests that exceed the three hour/12 unit limit or the 24-unit limits for assessment, planning, and crisis management.. See the section below regarding EPSDT.

The case manager may request the additional six hours/24 units (T1017SC) for these current authorizations even if the current monthly authorization is in excess of the three hour/12 units per month. These requests will be reviewed under the EPSDT criteria.

All Other Programs (CAP/DA, CAP/Choice, CAP/C)

- Case management services for all other affected programs will continue as currently approved until the next CNR, or reauthorization is submitted. At that time, the case management unit limits will be applied as specified in the first paragraph of this article.

- All case management units must be documented on the cost summary. It is **important** to note that the conditions set forth in the CAP waiver concerning the recipient's budget and continued participation in the waiver apply. That is, the cost of the recipient's care, including case management services, must not exceed the waiver cost limits specified in the CAP waiver.

- Children will be evaluated under EPSDT requirements prior to taking any adverse action. See the section below regarding EPSDT.

Documentation for case management billable units is required per respective clinical coverage policies. Lack of supportive documentation for billed units will be referred to Program Integrity for possible recoupment.

EPSDT

While the new limit on case management services has been reduced to no more than three hours (12 units) per calendar month and no more than six additional hours (24 units) if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation, these limits may not apply to children under 21 years of age. Federal law, 42 U.S.C. §1396d(r)(5), requires the State Medicaid agency to provide to Medicaid recipients under 21 years of age "necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the [Social Security] Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State [Medicaid] Plan." For more information about EPSDT and provider documentation requirements for EPSDT requests, please visit http://www.ncdhhs.gov/dma/epsdt/.

Recipient Due Process

Children

As indicated above, all requests for recipients under the age of 21 that exceed policy limits will be reviewed against the EPSDT criteria prior to taking adverse action, and the recipient or his/her legal guardian will receive a written notice explaining the decision. The notice will state the decision and effective date of the reduction, explain the reduction is based on Session Law 2009-451, Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10), DMA policy promulgated pursuant to S.L. 2009-451, Section 10.68A.(c), as well as state the EPSDT criteria not met, and an explanation about how to appeal the decision should the recipient or his/her legal guardian so desire.

Adults

If the decision authorizes case management services to the policy limit (three hours per calendar month and/or six additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days), the recipient or his/her legal guardian will receive a written notice explaining the decision. The notice will state the decision and effective date of the reduction to the policy limit, explain the reduction is based on Session Law 2009-451, Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10) as well as DMA policy promulgated pursuant to S.L. 2009-451, Section 10.68A.(c), and that pursuant to 42 CFR §431.210 and §431.220(b), the recipient is not entitled to appeal this decision.

Should less than three hours (12 units) per calendar month and/or less than six additional hours if needed for completing an assessment, completing a reauthorization or continued need review, or for a crisis/emergency situation within 365 days be authorized, the recipient or his/her legal guardian will receive a written notice explaining the decision, and that he/she is entitled to appeal the decision to authorize less than the policy limit. The notice will state the decision and effective date of the reduction, explain the reduction is based on Session Law 2009-451, Sections 10.68A.(a)(2)(a) and 10.68A.(a)(10), as well as DMA policy promulgated pursuant to S.L. 2009-451, Section 10.68A.(c), and an explanation about how to appeal the decision should the recipient or his/her legal guardian so desire.

Recipient Notice Regarding Reductions in Case Management Services

A notice was sent at the end of January to recipients regarding these changes in case management. See the DMA website (http://www.ncdhhs.gov/dma/pub/consumerlibrary.htm) for a copy of the notice.

Community Care Section
DMA, 919-855-4260

Behavioral Health Section
DMA, 919-855-4290

Attention: Children's Developmental Service Agencies, Health Departments, Home Health Agencies, Hospital Outpatient Clinics, Independent Practitioners, Local Education Agencies, Local Management Entities, and Physicians

Outpatient Specialized Therapies: Prior Authorization and Post-Payment Validation

Effective with date of service **December 1, 2009,** prior authorization (PA) became a requirement for outpatient specialized therapies (occupational therapy, physical therapy, speech therapy, respiratory therapy, and audiology services) provided to recipients **under 21 years of age.**

Effective with date of service **January 1, 2010,** PA became a requirement for outpatient specialized therapies provided to **recipients 21 years of age and older.**

Prior authorization is required for all therapy treatments regardless of place of service. Refer to Clinical Coverage Policy 10A, *Outpatient Specialized Therapies,* on DMA's website at http://www.ncdhhs.gov/dma/mp/ for more information.

Reminders for Obtaining PA

1. Submit prior authorization requests using the recipient's Medicaid identification (MID) number and the billing provider's Medicaid Provider Number.
2. Review the status of your request.
   - If the status of your request is listed as "Incomplete Case," resubmit the request. (Incomplete requests will be automatically rescinded 21 days after the case was initiated.)
   - If the status of your request is listed as "Missing Information," provide CCME with the request information to avoid a technical denial.
3. Follow-up with the Carolinas Center for Medical Excellence (CCME) in a timely manner about any cases that are outstanding after five business days.
4. Refer to the "Training" links on CCME's website for additional information and answers to questions.
5. For all billing issues, contact HP Enterprise Services at 1-800-688-6696 or 919-851-8888.

Post-Payment Validation

CCME will implement post-payment validation on paid outpatient specialized therapy claims with dates of services July 1, 2009, and after. Providers who billed for outpatient therapy services between July 2009 and November 2009 are encouraged to register for secure web access to view information about the post-payment validation process. Registration materials and additional details about this process and an informational webinar will be available on CCME's prior authorization website (http://www.medicaidprograms.org/nc/therapyservices) by March 15, 2010.

CCME may be contacted via e-mail at priorauth@thecarolinascenter.org or via the HelpLine, 1-800-228-3365. Select option 8 to speak with a representative. In e-mail communications, recipients should be referenced using only the following information: first name, last initial and last four characters of the MID number.

CCME, 1-800-228-3365

Attention: Hospital Outpatient Clinics, Independent Practitioners, and Physicians

Outpatient Specialized Therapies Video Conference Seminar

The outpatient specialized therapies video conference seminar is scheduled for April 27, 2010. Information presented at this video conference seminar will include a review of policy and billing for specialized therapy services (speech, occupational, physical and respiratory therapy) and prior approval guidelines. 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 1:00 p.m. and will end at 4:00 p.m. Providers are encouraged to arrive by 12:45 p.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 outpatient specialized therapy seminar online at http://www.ncdhhs.gov/dma/provider/seminars.htm. **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. Select from the locations below to register and attend the facility participating in the video conference seminar.

Seminar Schedule –1:00 p.m. to 4:00 p.m., April 27, 2010

City	Address
Asheville	UNC - Asheville Robinson Hall, Room 136 1 University Heights Asheville NC 28804
Boone	Appalachian State University Anne Belk Hall Ground Floor, Room 023 224 Joyce Lawrence Lane Boone NC 28608
Charlotte	Central Piedmont Community College Harris Conference Center Harris 2 Building Video Conference Room 3216 CPCC Harris Campus Drive Charlotte NC 28208
Charlotte	Mecklenburg County Health Department Multi Purpose Room 249 Billingsley Road Charlotte NC 28211
Greensboro	UNC – Greensboro TeleLearning Center Stone Building, Room 186 110 McIver Street Greensboro NC 27412

City	Address
Raleigh (main location)	Department of Public Instruction (DPI) 301 North Wilmington Street Raleigh NC 27601
Raleigh (secondary location)	ITS Support Center Raleigh Office of Information Tech Services 3900 Wake Forest Road Raleigh NC 29609
Williamston	Martin Community College Building 1, Room 10A 1161 Kehukee Park Road Williamston NC 27892
Wilmington	South East Area Health Education Center (SEAHEC) SEAHEC Building, Pelican Room 2511 Delaney Avenue Wilmington NC 28403

Directions to the Outpatient Specialized Therapies Video Conference Seminar

ASHEVILLE
UNC - Asheville
Traveling South on US 19/23: Take the NC 251/UNC Asheville exit. Turn left at traffic light at bottom of ramp. Proceed approximately ½ mile to the second traffic light; turn left onto W.T. Weaver Boulevard. Proceed approximately 1/3 mile to second left-hand turn for the main entrance road to UNCA campus.

Traveling West on I-40: Take Exit 53B for I-240. Follow I-240 for approximately 4.5 miles. Take Exit 5A for Merrimon Avenue. Turn right at the light at the bottom of the ramp. Proceed approximately 1 mile to the third light. Turn left onto W.T. Weaver Boulevard. Proceed approximately 1/4 mile on Weaver Boulevard to right-hand turn for main entrance road to UNCA campus.

Traveling North or East on I-26 or I-40: Take I-240 towards Asheville. As you cross the river, move into the left-hand lane. Take US 19/23 North. Proceed approximately 1 mile to UNCA exit. Turn right at bottom of exit ramp. Proceed approximately 1/3 mile to second traffic light; turn left onto W.T. Weaver Boulevard. Proceed approximately 1/3 mile to second left-hand turn for the main entrance road to UNCA campus.

BOONE
Appalachian State University
Traveling West on I-40: Take I-40 West to US 421 North. Follow US 421 North for approximately 99 miles and turn left at College Street.

CHARLOTTE
CCPC Harris Conference Center
Traveling on I-85: Take Exit 33, Billy Graham Parkway. Travel approximately 1.6 miles. Turn left onto Morris Field Drive. Turn right onto CPCC Harris Campus Drive.

Traveling on I-77: Take Exit 6B, Woodlawn Road, which becomes Billy Graham Parkway. Travel approximately 3.5 miles. Turn right onto Morris Field Drive. Turn right onto CPCC Harris Campus Drive.

Mecklenburg County Health Department

Traveling South on I-77: Take I-77 South to Charlotte. In Charlotte, take I277 to US 74 East. Follow US 74 East to Wendover Road. (Caution—watch signs closely—ongoing construction around this intersection). Take Wendover Road south to Marvin Road. Turn right onto Marvin Road. and continue for one block. At the first street to the left, turn left onto Billingsley Road. At the 4-way stop sign, continue straight. Continue for ½ mile; turn right at the Social Services/Health Department sign. The Health Department is the one-story white building by the lake.

GREENSBORO

UNC - Greensboro TeleLearning Center

Traveling East on I-40: Approaching Greensboro, I-40 and Business I-40 split. Follow Business I-40 to Exit 212 (Greensboro to Bryan Boulevard). Travel 6.5 miles to Exit 218-B (Freeman Mill Road). Take the exit and quickly merge to the far left lane. Turn left on Coliseum Boulevard. Travel 1.4 miles to the second stoplight (Lee Street). Turn right on Lee Street and move into the left lane. Travel 0.5 miles to the first stoplight (Aycock Street). Turn left onto Aycock Street. Proceed on Aycock and move into the right lane. After the second stoplight (Walker Avenue), move into the right turn lane and after a short distance, you will see the exit for Market Street (Downtown). Take this exit. Travel 0.5 miles to the first stoplight (McIver Street). Turn right onto McIver Street. At the first driveway, turn right and circle around to the entrance of the parking deck.

Traveling West on I-40 or South on I-85: Approaching Greensboro, I-85 splits left and Business 85/I-40 splits right. Follow Business 85-S/I-40-W (Exit 131). Shortly after, Business 85 splits left I-40 splits right. Follow Business I-40-E (Exit 36A – old exit 123). From Business I-40-E, take Exit 218-B (Freeman Mill Road). Take the exit and quickly merge to the far left lane. Turn left on Coliseum Boulevard. Travel 1.4 miles to the second stoplight (Lee Street). Turn right on Lee Street and move into the left lane. Travel 0.5 miles to the first stoplight (Aycock Street). Turn left onto Aycock Street. Proceed on Aycock and move into the right lane. After the second stoplight (Walker Avenue), move into the right turn lane and after a short distance, you will see the exit for Market Street (Downtown). Take this exit. Travel 0.5 miles to the first stoplight (McIver Street). Turn right onto McIver Street. At the first driveway, turn right and circle around to the entrance of the parking deck.

RALEIGH

Department of Public Instruction

Traveling on I-40: Take Exit 298-B, South Saunders Street. South Saunders Street becomes McDowell Street. Follow McDowell Street into downtown Raleigh. Turn right on Morgan Street. Turn left onto Wilmington Street. The Department of Public Instruction is located on the left.

Traveling East on US 70: Follow US 70 into Raleigh. US 70 becomes Glenwood Avenue. Turn left onto Peace Street. Turn right onto Blount Street. Turn right onto North Street. The Department of Public Instruction is located straight ahead.

Visitor parking is available at $1.00 per hour with an $8.00 maximum per day in Visitor Lot #1 (entrances at Jones Street and at Edenton Street) and Visitor Lot #2 (entrances at Salisbury Street and at McDowell Street).

ITS Support Center

Traveling East on I-40: Take I-40 East towards Raleigh. Merge onto I-440 East/US 1 North (inner beltline) toward Wilson/Wake Forest/Rocky Mount. Take Exit 10, Wake Forest Road. Turn left onto Wake Forest Road. The ITS Support Center is located on the right in the one-story building with a red roof just past the Wake County Public Schools System Office.

Traveling West on I-40: Take I-40 East towards Raleigh. Merge onto I-440 East (outer beltline). Take Exit 10, Wake Forest Road. Turn right onto Wake Forest Road. The ITS Support Center is located on the right in the one-story building with a red roof just past the Wake County Public Schools System Office.

WILLIAMSTON

Martin Community College

Traveling East on US 64: Take US 64 West to the intersection at McDonald's in Williamston. Turn left on the US 13/US 17 Bypass. The name will change to Old Highway 64 Bypass. Continue approximately 2.3 miles and turn left on Kehukee Park Road. The college is located on the right approximately 0.5 mile from the intersection.

Traveling West on US 64: Take US 64 East to Exit 512 (Prison Camp Road). (Look for the sign just before Exit 512 for Senator Bob Martin Agricultural Center and Martin Community College.) Turn right on Prison Camp Road. Drive for approximately 0.5 mile and turn left on Kehukee Park Road. The college is located on the right approximately 0.5 mile from the intersection.

Traveling North on US 13/US 17: Take US 13/US 17 South to Williamston. Continue to follow US 13/US 17 until it becomes Old Highway 64 Bypass. Continue driving for approximately 2.5 miles. Turn left on Kehukee Park Road. The college is located on the right approximately 0.5 mile from the intersection.

WILMINGTON

South East Area Health Education Center (SEAHEC)

Traveling East on I-40: Take I-40 east to N. College Road/US 117 South. Take a slight right at US 117 South. Turn right at South 17th Street. Turn right onto Delaney Road. The Health Department is located on the right.

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

Attention: Durable Medical Equipment Providers

Medically Necessary Incontinence, Ostomy, and Urological Supplies

The policy allowing durable medical equipment (DME) providers to seek reimbursement for medically necessary incontinence, ostomy, and urological supplies has been placed on temporary hold. The policy is under budgetary review and there will be no reimbursement to DME provider of the services effective March 1, 2010.

Note: Recipients needing these supplies should be referred to a home health agency in their area to obtain these items. A home care agency that is enrolled with Medicaid to provide private duty nursing (PDN) services can also provide incontinence, ostomy and urological supplies to Medicaid recipients

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

Attention: Adult Care Home Providers, CAP/MR-DD Service Providers, Enhanced Behavioral Health (Community Intervention) Services Providers, Personal Care Services Providers, and Residential Child Care Treatment Facilities

Suspension of Mandatory Cost Reporting for Rate Adjustments

Effective January 1, 2010, mandatory Medicaid cost reports for the above mentioned providers are suspended until rescinded by the Secretary of the N.C. Department of Health and Human Services (DHHS). The official DHHS notification can be found on DMA's website at http://www.ncdhhs.gov/dma/cost/reports.htm. Specific questions may be addressed to the contacts identified in the notification.

It is important to note that any outstanding cost reports from cost reporting periods prior to January 1, 2010, are due and must be filed with the appropriate DHHS Division. All policies and rules for timely submission will continue to be in effect.

Finance Management
DMA, 919-855-4180

Attention: Local Management Entities, Outpatient Behavioral Health Providers, and Provisionally Licensed Providers

Extension of Coverage for Provisionally Licensed Providers Billing Outpatient Behavioral Health Services through the Local Management Entity

The deadline for coverage of provisionally licensed providers delivering outpatient behavioral health services as a reimbursable service under Medicaid and state funds and billed through the Local Management Entity (LME) **has been extended to June 30, 2011.** DMA and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services will continue to pay for services delivered by the provisionally licensed individuals listed above when billed through LMEs under HCPCS procedure codes H0001, H0004, and H0005 until that date.

As outlined in Implementation Update # 32 (http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/), the LME may choose to provide this billing service on behalf of the provisionally licensed professional. If the provisionally licensed professional is employed by an agency, the agency must develop a contract directly with the LME to do this billing for them. If provisionally licensed professionals work independently, they should contact their licensure board prior to developing a contract with the LME to ensure compliance with each profession's scope of practice.

In addition to providing outpatient behavioral health services billed through an LME, there are various other means for provisionally licensed professionals to obtain the clinical experience required by their licensing boards. These include

- providing outpatient services working with a physician using Medicaid's "incident to" policy (see the March 2009 Medicaid Bulletin);
- providing enhanced behavioral health (Community Intervention) services as the Qualified Professional (QP) in order to receive family- and community-based clinical experience; and
- serving as the Licensed Professional in the Intensive In-Home service.

Catharine Goldsmith, Behavioral Health Section
DMA, 919-855-4290

Attention: CCNC/CA Primary Care Providers, Durable Medical Equipment Providers, and Pharmacists

Addition of Pen Needles to Pharmacy Point-of-Sale

Effective with date of service February 26, 2010, pen needles are covered as an over-the-counter product in the N.C. Medicaid Outpatient Pharmacy Program. Recipients must have a prescription for the pen needles and there must be an insulin prescription on file within the last 90 days in order to bill using the pharmacy point-of-sale system. A National Drug Code (NDC) must be used when billing through point-of-sale. Rates apply to pen needles; therefore, no copayments or dispensing fees apply. Medicare Part D continues to cover pen needles for dual eligible recipients.

Pen needles do not have to be purchased at the same pharmacy as the insulin unless the patient is locked into a pharmacy. Recipients identified for the Focused Risk Management (FORM) Program who require more than 11 unduplicated prescriptions each month are restricted to a single pharmacy. In these cases, the pen needles must be purchased at the same pharmacy.

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

Attention: Durable Medical Equipment Providers and Pharmacists

Additional Information on Prodigy Diabetic Supplies

The following additional information is provided regarding the Prodigy Diabetic Supply program:

Transition Period Extended Until April 16, 2010

Effective February 16, 2010, there will be an additional 60 day extension period added to the North Carolina Medicaid Prodigy diabetic supplies transition phase.

- A one-time, per-recipient, per-product override will continue to be allowed for an additional 60 days.
- The transition period will be extended until April 16, 2010.
- No overrides will be allowed after April 16, 2010.

Addition of Safety Syringes and Safety Lancets

Effective February 26, 2010, the following safety syringes and safety lancets will added to the North Carolina Medicaid Prodigy line of products under the pharmacy point-of-sale system. These products will be added to the Durable Medical Equipment (DME) Program effective March 1, 2010.

Covered Product	Package Size	Unit Type	NDC-11
Prodigy Insulin Safety Syringe 29G 12.7 mm ½ (100ct)	100 ct Box	1 Box	08484-9904-80
Prodigy Pressure Activated Safety Lancet 28G 1.8 mm (100ct)	100 ct Box	1 Box	08484-9903-38

Prodigy Diabetes Care, LLC
1-866-540-4816

Durable Medical Equipment Program
DMA, 919-855-4310

Outpatient Pharmacy Program
DMA, 919-855-4300

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/

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.

2010 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
March	2/25/10	3/2/10
	3/4/10	3/9/10
	3/11/10	3/16/10
	3/18/10	3/25/10
April	4/1/10	4/6/10
	4/8/10	4/13/10
	4/15/10	4/22/10

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