



March 2012 Medicaid Bulletin

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Attention: All Providers***Basic Medicaid and NC Health Choice Seminars***

Basic Medicaid and NC Health Choice (NCHC) seminars are scheduled for the months of April and May 2012. Seminars are intended to educate providers on the basics of Medicaid and NCHC billing as well as to provide an overview of policy updates, contact information, and fraud, waste and abuse. The focus of the morning session will be the first seven sections of the revised April 2012 *Basic Medicaid and NC Health Choice Billing Guide*, which is the primary document that will be referenced during the seminar. The afternoon sessions will be broken out by claim type: Professional, Institutional, and Dental/Pharmacy. The remaining sections of the April 2012 Billing Guide will be reviewed during these breakout sessions focusing on claims submission, resolving denied claims, and the uses of [N.C. Electronic Claims Submission/Recipient Eligibility Verification Web Tool](#).

Providers are encouraged to print the Billing Guide, which will be posted on the DMA seminar webpage prior to the first scheduled session. This material will assist providers in following along with the presenters. 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, HP Enterprise Services cannot guarantee a power source or Internet access for your laptop.** Copies of these documents will not be provided.

Pre-registration is required for both the morning session and the afternoon session of your choice. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend, if space is available. Please bring your seminar confirmation with you to the morning and afternoon sessions of the seminar.

Providers may register for the seminars by completing and submitting the [online registration form](#). Providers may attend the morning session only, the afternoon session only, or both morning and afternoon sessions.

The morning session will begin at 9:00 a.m. and end at 12:00 noon. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided; however, there will be a lunch break. The afternoon sessions will begin at 1:00 p.m. and end at 4:00 p.m. Providers are encouraged to arrive at 1:15 p.m. to complete registration. **Because meeting room temperatures vary, dressing in layers is advised. Seminar dates and locations are on the next page.**

Seminar Dates and Locations

Date	Location
April 17, 2012	<p>Fayetteville Cumberland County DSS 1225 Ramsey Street Fayetteville, NC 28301 get directions</p>
April 19, 2012	<p>Charlotte Crowne Plaza 201 South McDowell Street Charlotte, NC 28204 Note: Parking fee of \$5.00 per vehicle for parking at this location. get directions</p>
April 24, 2012	<p>Greenville Hilton 207 SW Greenville Blvd Greenville, NC 27834 get directions</p>
May 1, 2012	<p>Asheville Crowne Plaza Tennis & Gold Resort One Resort Drive Asheville, NC 28806 get directions</p>
May 8, 2012	<p>Greensboro Clarion Hotel Airport 415 Swing Road Greensboro, NC 27409 get directions</p>
May 10, 2012	<p>Raleigh McKimmon Conference & Training Center 1101 Gorman Street Raleigh, NC 27606 Note: Visitors are asked to park in designated visitor parking spaces in order to avoid ticketing. get directions</p>

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

Attention: All Providers**Changes in Medicaid Prior Approval Policies and Procedures, Recipient Due Process (Appeals), and Early Periodic Screening, Diagnosis and Treatment (EPSDT) Seminars**

N.C. Medicaid will hold **Prior Approval, Recipient Due Process, and EPSDT** training for providers during the month of March 2012. The seminar is intended to address changes in Medicaid's **prior approval policies and procedures** and the Medicaid **recipient appeal process** when a Medicaid service is denied, reduced, terminated, or suspended. It will also focus on an overview of **EPSDT-Medicaid for Children**.

The seminar will begin at 9:00 a.m. and will 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. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Providers may register for the Changes in Medicaid Prior Approval Policies and Procedures, Recipient Due Process, and [EPSDT seminars online](#). **Pre-registration is required.** Providers will receive a registration confirmation specifying the training material(s) each provider should bring to the seminar.

Date	Location
March 27, 2012	Raleigh Wake Tech Community College Student Service Building Conference Center Second Floor, Rooms 213 & 214 9191 Fayetteville Road Raleigh, NC 27603

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

Attention: All Providers***E*lectronic Health Record - Meaningful Use Overview**

The Medicaid Electronic Health Record (EHR) Incentive Program requires that participants attest to Meaningful Use requirements in their second participation year. The Meaningful Use requirements for Eligible Professionals (EPs) include both a core set and a menu set of objectives:

- For EPs, there are a total of 25 meaningful use objectives. To qualify for an incentive payment, 20 of these 25 objectives must be met.
 - There are 15 required core objectives.
 - The remaining 5 objectives may be chosen from the list of 10 menu set objectives. One of these 5 must be a public health measure.
 - The CMS website contains additional information about the [Meaningful Use objectives](#).

In addition, there are Clinical Quality Measure (CQM) requirements associated with Meaningful Use.

- A list of 38 CQMs are posted on the [CMS website](#).
- EPs must report on 6 total clinical quality measures
 - 3 required core measures (substituting 3 alternate core measures if necessary) and any 3 additional measures from the list.

An EP's second year of participation requires a 90-day reporting period for Meaningful Use that may begin as early as January 1, 2012 for EPs that successfully attested for a payment in 2011. Medicaid plans to open the NC Medicaid Incentive Payment Solution (NC-MIPS) provider portal to begin accepting Meaningful Use attestations in late spring or early summer of 2012. More information about Meaningful Use is available on our website at: <http://www.ncdhhs.gov/dma/provider/ehr.htm>.

Attention: All Providers***E*lectronic Health Record Incentive Payment Assignments are Voluntary**

The NC Medicaid Electronic Health Record (EHR) Incentive Program provides the opportunity for eligible professionals (EPs) to receive up to \$63,750 in incentive payments over six years for the adoption, implementation, or upgrade to a certified EHR technology and the meaningful use of that technology. The payment in Year One of participation is \$21,250 and requires EPs to adopt, implement, or upgrade to a certified EHR technology. Subsequent years address meaningful use standards and participants receive payments of \$8,500 per year for up to five years.

The payments are linked to professionals and may be assigned to an affiliated organization promoting the adoption and meaningful use of certified EHR technology on a voluntary basis. It is against federal rules and EHR program rules for an organization to require affiliated EPs assign an incentive payment to a practice or organization.

For more information on the NC Medicaid EHR Incentive Program, visit the program website at: <http://www.ncdhhs.gov/dma/provider/ehr.htm>.

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

Attention: All Providers and Vendors

HIPAA ASC X12 4010 A1 and 5010 837 Implementation Update

The North Carolina Division of Medical Assistance (DMA) is allowing the dual processing of 4010A1 and 5010 837 transactions **ONLY until March 31, 2012**. The remaining HIPAA-covered ASC X12 4010A1 transactions and NCPDP 5.1 transactions are no longer being accepted. **On April 1, 2012, ONLY ASC X12 5010 837 transactions will be accepted. All ASC X12 4010A1 transactions will be rejected.**

Providers can contact the ECS unit of HP Enterprise Services, at 1-800-688-6696 or 919-851-8888; press option 1 for questions or assistance regarding this information about the ASC X12 5010 implementation.

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

Attention: All Providers

**Implementation of Additional Correct Coding Edits: Suspended
Implementation of Professional Duplicate Edits**

As announced in previous Medicaid bulletins, the Division of Medical Assistance (DMA) is implementing additional correct coding guidelines. These new correct coding guidelines and edits are nationally sourced by organizations such as the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA). These edits identify any inconsistencies with CPT, AMA, CMS and/or DMA policies and deny at the claim detail level. Additional correct coding edits for Professional Duplicates were scheduled for implementation March 1, 2012 for dates of service on or after March 1, 2012. However, this implementation is being suspended to allow for a more thorough review of these edits. DMA will notify providers of the implementation date in future Medicaid bulletins.

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

Attention: All Providers

**Implementation of Additional Correct Coding Edits: Suspended
Implementation of Facility Duplicate Edits**

As announced in previous Medicaid bulletins, the Division of Medical Assistance (DMA) is implementing additional correct coding guidelines. These new correct coding guidelines and edits are nationally sourced by organizations such as the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA). These edits identify any inconsistencies with CPT, AMA, CMS and/or DMA policies and deny at the claim detail level. Additional correct coding edits for Facility Duplicates were scheduled for implementation in the second quarter of 2012. However, this implementation is being suspended to allow for a more thorough review of these edits. DMA will notify providers of the implementation date in future Medicaid bulletins.

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

Attention: All Providers**P**rocedure Code 93571

CPT procedure code 93571 (intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement during coronary angiography) is an add-on code and must be billed with specified primary procedures. Until December 31, 2010, it was billed with primary procedure code 93556 (imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography). During the 2011 CPT Update, this code was end-dated effective with date of service December 31, 2010. At that time another primary code was not identified causing providers to receive denials with no alternative to bill.

System work has been completed that identifies the primary codes that can be billed with 93571 effective with date of service January 1, 2011. These primary codes are 93451 through 93461 and 93530 through 93533. If you received a denial with EOB 5227 (No payment for add-on code allowed if primary code in series is not paid for the same date of service, same provider) when billing procedure code 93571 since January 1, 2011, resubmit the denied charges as a **new claim** (not as an adjustment request) for processing.)

HP Enterprise Services

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

Attention: All Providers**P**rior Approval for CPT Code 91110

In accordance with Session Law 2011-145 HB200 the Division of Medical Assistance (DMA) is mandated to require providers to submit requests for prior authorizations (PA) for the listed capsule endoscopy procedures with an effective date of service April 1, 2012. PA shall be submitted following the instructions in Section 6. Prior Approval of the Basic Medicaid Billing Guide can be accessed at <http://www.ncdhhs.gov/dma/basicmed/section6.pdf>. Clinical coverage policy # 1A-31, Wireless Capsule Endoscopy can be accessed at <http://www.ncdhhs.gov/dma/mp/index.htm>.

CPT Code	Description
91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report

HP Enterprise Services

1-800-688-6696 or 919-855-8888

Attention: All Providers**Two Women Plead Guilty to Health Care Fraud Conspiracy and Related Offenses**

Two women charged with health care fraud related offenses have pled guilty to the charges, announced Anne M. Tompkins, U.S. Attorney for the Western District of North Carolina. On January 26, 2012, Wendy Gibson (a/k/a Wendy Fitzgerald), 40, of Charlotte, pled guilty to one count of health care fraud conspiracy, one count of paying and receiving illegal kickbacks, and one count of conspiracy to distribute controlled substances. Gibson's co-defendant, Karen Wills (a/k/a Karen Boykin and Karen Jackson), 43, of Salisbury, entered a guilty plea to the same charges and to one additional count of health care fraud conspiracy on January 12, 2012. The defendants were charged by a criminal bill of indictment on August 17, 2011.

According to filed documents and statements made in court, from around 2008 to January 2011, Wills and others participated in a scheme to defraud Medicare and Medicaid by submitting false and fraudulent claims for medical services which were medically unnecessary, not provided, or both, including but not limited to, electromyography ("EMG") and anorectal manometry ("AM") procedures. As a result of this scheme, Medicare and Medicaid paid over \$400,000 in reimbursement payments on the fraudulent claims. Court documents indicate that around August 2008, Wills and others became aware of the investigation into this fraudulent billing scheme. In an effort to conceal the fraud, Wills created several false EMG and AM reports and placed them in patient files. As part of her guilty plea, Willis admitted that the amount of loss intended to be caused by the scheme was in excess of \$400,000 but less than \$1,000,000.

Wills and Gibson also pled guilty to charges of conspiring to pay and receive illegal kickbacks. According to the indictment, from around January 2008 to around 2009, Wills, Gibson, and others engaged in an illegal kickback scheme involving power wheelchairs. According to plea documents, Wills used her position with her employer's company to submit fictitious referrals for patients to receive medically unnecessary power wheelchairs from Gibson's employer's company. In some instances, Wills forged a physician's signature on required qualification documents, while Gibson tracked and directed payment to those referrals. As part of their plea agreements, the defendants admitted to concealing the illegal kickback payments by falsely representing on invoices and checks that the payments were for nursing and billing services. This scheme resulted in payments for the medically unnecessary equipment from Medicare and Medicaid in excess of \$300,000.

Wills and Gibson also pled guilty to charges of conspiracy to distribute controlled substances and to commit health care fraud. In pleading guilty to that charge, Wills admitted that she forged a physician's signature on prescription pads she misappropriated from her employer, and issued fraudulent prescriptions in Gibson's name. The prescriptions were written for controlled substances including oxycodone and hydrocodone/acetaminophen pills. In her plea, Gibson admitted that she used her health insurance prescription benefit program to pay for the fraudulent prescriptions resulting in payments in over \$30,000 for these fraudulent prescriptions. Wills and Gibson obtained and illegally distributed approximately 3,000 oxycodone pills, and approximately 5,000 hydrocodone/acetaminophen pills.

At sentencing, Gibson and Wills face a maximum statutory sentence of 10 years in prison on the health care fraud conspiracy and a \$250,000 fine, and five years in prison and a \$25,000 fine for the illegal

kickbacks charge. They also face 20 years in prison and a \$1 million fine for the conspiracy to distribute controlled substances. Wills also faces a penalty of 10 years of imprisonment and a \$250,000 fine for the additional charge of health care fraud conspiracy. Wills has been in federal custody on these charges since August 2011, and Gibson remains on bond. A sentencing date has not been set.

The investigation into Wills and Gibson was handled by HHS-OIG, MIU, FBI, USSS, NC SBI, CPMD, and Rowan County Sheriff's Office. The prosecution is being handled by Assistant U.S. Attorney Kelli Ferry of the U.S. Attorney's Office in Charlotte.

The investigation and charges are the work of the Western District's joint Health Care Fraud Task Force. The Task Force is a multi-agency team of experienced federal and state investigators and prosecutors, working in conjunction with criminal and civil Assistant United States Attorneys, dedicated to identifying and prosecuting those who defraud the health care system, and reducing the potential for health care fraud in the future. The Task Force focuses on the coordination of cases, information sharing, identification of trends in health care fraud throughout the region, staffing of all whistle blower complaints and the creation of investigative teams so that individual agencies may focus their unique areas of expertise on investigations.

The Task Force builds upon existing partnerships between the agencies and its work reflects a heightened effort to reduce fraud and recover taxpayer dollars. If you suspect Medicare or Medicaid fraud please report it by phone at 1-800-447-8477 (1-800-HHS-TIPS), or E-Mail at HHSTips@oig.hhs.gov.

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Replacement MMIS – NCTracks Information

If you are seeking information about the Replacement MMIS, NCTracks, we recommend you check out the following links:

- OMMISS website - <http://ncmmis.ncdhhs.gov/>
- NCTracks Provider Readiness Bulletin - <http://ncmmis.ncdhhs.gov/updates.asp>
- Frequently Asked Questions (FAQ) - <http://ncmmis.ncdhhs.gov/faq.asp>
- Monthly NCTracks Provider Newsletters - <http://ncmmis.ncdhhs.gov/newsletters.asp>
- Sign up for NCTracks provider communication email distribution list - <http://ncmmis.ncdhhs.gov/contact.asp>

If you have any questions about NCTracks, you may send an email to: OMMISS.ProviderRelations@dhhs.nc.gov

Provider Relations
OMMISS, 919-647-8446

Attention: Ambulatory Surgical Centers, Hospital Outpatient Clinics, Hospitals, and Physicians**Reporting of Never Events and Hospital-Acquired Conditions**

In compliance with CMS billing guidelines, the recently approved State Plan Amendment and N.C. legislative mandates, all claims are required to reflect reporting indicators on diagnosis codes that are identified in the current ICD-9 Hospital Manual related to Health Care Acquired Conditions (HCACs) or never events. Claims with Hospital Acquired indicators will not be approved by the Peer Review Organization (PRO) and are not reimbursable. This policy refers to all reimbursement provisions documented in Section 4.19A of the State Medicaid Plan including Medicaid supplemental or enhanced payments and Medicaid disproportionate share hospital payments to **in-state** as well as **out-of-state** providers and complies with Medicare billing guidelines for HCACs, never events, and present on admission (POA) diagnoses.

Outline of the Legislative Requirements:

In accordance with Federal regulations, Medicaid will make no payment to providers for services related to Health Care Acquired Conditions, incorrect surgical interventions and other provider preventable conditions.

- Section 2702 of the Affordable Care Act requires that the Secretary exercise authority to prohibit Federal payment for certain provider preventable (PPCs) and health care-acquired conditions (HCACs)
- Section 1902(a) (19) of the Act requires that states provide care and services consistent with the best interest of the recipients.
- Section 19802 (a) (30) of the Act requires that State payment methods must be consistent with efficiency, economy and quality of care.

Definitions:

1) Never Events –incorrect procedural intervention that includes one of the following:

- 1) A different procedure than planned altogether;
- 2) The correct procedure but on the wrong body part; or
- 3) The correct procedure but on the wrong patient.

2) Health care-acquired conditions – means a condition occurring in an in-patient hospital setting. These are identified as a Hospital Acquired condition (HAC) by the secretary under section 1886(4) (D) (iv) of the Act for purposes of the Medicaid program identified in the State Plan as described in 1886(4) (D) (ii) and (iv) of the Act; other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement in pediatric or obstetric patients.

3) Other provider preventable conditions (OPPC) means a condition occurring in any health care setting that meets the following criteria:

(i) Is identified in the State Plan.

(ii) Has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.

(iii) Has a negative consequence for the recipient.

(iv) Is auditable.

(v) Includes, at a minimum, wrong surgical, or other invasive procedure performed on a patient; wrong surgical, or other invasive procedure performed on the wrong body part; wrong surgical, or other invasive procedure performed on the wrong patient.

4) Provider preventable condition (PPC) means a condition that meets the definition of a “health care-acquired condition” or an “other provider-preventable condition” as defined in this section.

Procedures to Follow for Reporting Avoidable Errors (Never Events)

Avoidable errors that fall under this policy include:

1. Wrong surgical or other invasive procedure performed on a patient
2. Surgery or other invasive procedure on the wrong body part
3. Surgical or other invasive procedure performed on the wrong patient

Effective with date of processing June 1, 2011, any claim for dates of service January 1, 2011, and after, submitted by inpatient hospital claims for avoidable errors should be submitted on a UB-04 claim form or the 837I claim transaction with type of bill (TOB) 110 indicated on the claim. Outpatient hospital claims for avoidable errors should use TOB 130.

The non-covered claim must have one of the following ICD-9-CM diagnosis codes reported in diagnosis position 2-9:

- E876.5 – Performance of wrong operation (procedure) on correct patient (existing code)
- E876.6 – Performance of operation (procedure) on patient not scheduled for surgery
- E876.7 – Performance of correct operation (procedure) on wrong side or body part

Note: The above codes shall not be reported in the External Cause of Injury (E-Code) field.

Effective with date of processing May 1, 2011, any claim for dates of service January 1, 2011, and after, submitted by ambulatory surgical centers and practitioners using the CMS-1500 claim form or 837P claim transaction, must include the appropriate modifier appended to all lines that relate to the erroneous surgery(ies) or procedure(s) using one of the following applicable National Coverage Determination modifiers:

- **PA** – Surgery wrong body part
- **PB** – Surgery wrong patient
- **PC** – Wrong surgery on patient

Related Claims

- Within 5 days of receiving a claim for a surgical error, DMAs fiscal agent shall begin to review beneficiary history for related claims as appropriate (both claims already received and processed and those received subsequent to the notification of the surgical error). Also, HP Enterprises will need to establish an audit that any claims for the recipient will suspend for review to determine if they relate to identify incoming claims that have the potential to be related to the original Never event claim. When HP Enterprises identifies such claims, it will take appropriate action to deny such claims and to recover any overpayments on claims already processed.
- Every 30 days for an 18-month period from the date of the surgical error, HP Enterprises will continue to review recipient history for related claims and take appropriate action as necessary.

Note: Related services do not include performance of the correct procedure

Present on Admission (POA) and Hospital Acquired/ Health Care Acquired Condition (HAC/HCACs) Claims (Non-Payment for HAC/HCACs):

Effective with date of processing May 1, 2011, any claim for dates of service January 1, 2011, and after, involving inpatient admissions to general acute care hospitals using the UB-04 claim form or 837I claim transaction must file their discharge claims with POA/HAC indicators for all primary and secondary diagnoses. The POA/HAC indicator is placed adjacent to the principle and secondary diagnoses as the 6th character after the ICD-9-CM diagnosis code. The codes that are acceptable as POA/HAC indicators are:

- 1) Y = Yes = present at the time of inpatient admission
- 2) N = No = not present at the time of inpatient admission
- 3) U = Unknown = the documentation is insufficient to determine if the condition was present at the time of inpatient admission
- 4) W = Clinically Undetermined = the provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not
- *5) 1 = Unreported/Not used – Exempt from POA reporting - This code is the equivalent code of a blank on the UB-04, however, it was determined that blanks were undesirable when submitting this data via the 4010A1.

Note: * With the implementation of the 5010 Inpatient Prospective Payment System (IPPS) hospitals will no longer report the POA indicator of ‘1’.

For discharges occurring on or after January 1, 2011, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the DRG would be paid excluding any codes that had a 6th digit code of **N**, or **U** paid as though the secondary diagnosis were not present grouping only codes with the 6th digit of **Y** and **W** as defined in list below.

Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission. <i>Medicaid will pay the complicating condition/major complicating condition (CC/MCC) DRG for those selected Hospital Acquired Conditions (HCACs) that are coded as "Y" for the POA Indicator.</i>
N	Diagnosis was not present at time of inpatient admission. <i>Medicaid will not pay the CC/MCC DRG for those selected HCACs that are coded as "N" for the POA Indicator.</i>
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission. • <i>Medicaid will not pay the CC/MCC DRG for those selected HACs that are coded as "U" for the</i>
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission. <i>Medicaid will pay the CC/MCC DRG for those selected HACs that are coded as "W" for the POA Indicator.</i>
1	Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04, however; it was determined that blanks are undesirable when submitting this data via the 4010A. <i>Medicaid will not pay the CC/MCC DRG for those selected HACs that are coded as "1" for the POA Indicator. The "1" POA Indicator should not be applied to any codes on the HAC list.</i>

At this time, the following hospitals are **EXEMPT** from the POA Indicator:

1. Critical Access Hospitals (CAHs)
2. Long-term Care Hospitals (LTCHs)
3. Maryland Waiver Hospitals
4. Cancer Hospitals
5. Children's Inpatient Facilities
6. Rural Health Clinics
7. Federally Qualified Health Centers
8. Religious Non-Medical Health Care Institutions
9. Inpatient Psychiatric Hospitals
10. Inpatient Rehabilitation Facilities
11. Veterans Administration/Department of Defense Hospitals

However, DMA is requesting that if any of the above providers chooses to list POA/HAC indicators, that HP enterprises capture this information and retain it in a file for report purposes.

General Provisions

- (1) Medicaid will not pay any claims for “provider- preventable conditions” for any recipient who is eligible for Medicaid and Medicare funding.
- (2) No reduction in payment will be imposed on a provider for a provider preventable condition, when the condition defined as a PPC for the particular recipient existed prior to the initiation of the treatment for that recipient by that provider.
- (3) Reductions in Provider payments may be limited to the extent that the following apply:
 - (i) The identified PPC would otherwise result in an increase in payment.
 - (ii) The state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for and to related to, the PPCs.
- (4) FFP will not be available for any state expenditures for PPC’s. A state plan must ensure that non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.
- (5) Reporting the state plan must require that providers identify PPCs that are associated with claims for Medicaid payment or with course of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available.

Clinical Policy Section

DMA, 919-855-4360

Attention: In-Home Care (IHC) Providers**Implementation of Federal Court Order Prohibiting Implementation of Policy 3E**

On December 8, 2011, a federal court judge issued an order that prohibits the Division of Medical Assistance (DMA) from implementing Clinical Coverage policy 3E, which was the policy for the In-Home Care for Adults (IHCA) program that went into effect on June 1, 2011. The order requires DMA to approve services for individuals who meet the previous PCS program requirement of unmet need for limited assistance with two Activities of Daily Living (ADLs), and who were denied services under the IHCA policy. The order also eliminates DMA's authority to approve time for recipient errands. Based upon that order, DHHS has reverted to Clinical Coverage Policy 3C, which can be found at: <http://www.dhhs.state.nc.us/dma/mp/index.htm>.

The order does not apply to In-Home Care for Children (IHCC). Policy 3F, assessments, and EPSDT reviews of recipients under 21 years of age are continuing with no change as a result of the order. IHCC prior approvals and recipient notices are being processed and issued as usual.

The following are some of the steps and actions taken by DMA and the Carolinas Center for Medical Excellence (CCME) to fully comply with the order:

1. On January 18, 2012, CCME began sending Notices of Reinstatement of Services to recipients whose assessments showed unmet need for assistance with two limited-assistance ADLs and who were denied transition from Personal Care Services (PCS) to IHCA. Services were restored to May 31, 2011 service levels, and prior approvals were issued to recipients' May 31, 2011 providers.
2. On February 3, 2012, CCME issued Notices of Revised Decision to new program applicants whose assessments showed a need with two limited-assistance ADLs and who were denied services since June 1, 2011. On February 10, 2012, CCME sent referrals to the provider agencies selected by the recipient at the time of assessment. Confirmation notices were sent to recipients and providers upon provider acceptance of the referrals.
3. Beginning the week of February 27, 2012, CCME will refer recipients who were reassessed at the two limited-assistance ADL level and denied services since June 1, 2011 to their previous providers. Confirmation notices will be sent to recipients and providers upon provider acceptance of the referrals.
4. On January 6, 2012, CCME suspended regular program Decision Notices for new referrals and continuing recipients in order to update the computer systems and make changes to decision notices. CCME continues to process recipient assessment referrals as usual, and to schedule and conduct new referral, annual, and change of status assessments. DMA anticipates that CCME will begin to release suspended Decision Notices in the next three to four weeks.
5. DMA anticipates that CCME will begin to issue Notices of Change in Services to any remaining recipients whose services are being reduced as a result of the errands exclusion in the following four to six weeks. Please note that recipients will not be entitled to appeal a reduction in services based solely on elimination of hours previously authorized for errands.

DMA and CCME are scheduling regional provider trainings in March to answer questions about the changes required as a result of the order and other frequently asked questions. Dates, times, and locations for those trainings will be posted on the **Independent Assessment website** (<http://www.qireport.net>).

Please refer to the **Independent Assessment website** (<http://www.qireport.net>) for updates and details on recipient notification timelines and provider guidance related to the federal court order.

Questions may be directed to the CCME Independent Assessment Help Line at 1-800-228-3365.

CCME, 1-800-228-3365

Attention: Personal Care Service Providers

Sunset of Adult Care Homes Personal Care Service and In-Home Personal Care Service

The original sunset date for Personal Care Services (PCS) in In-Home and Adult Care Homes was February 29, 2012. DMA requested an extension of the February 29th sunset date. CMS recently informed North Carolina Division of Medical Assistance that the PCS for In-Home and Adult Care Homes will be granted an April 30th, 2012 extension. CMS and the Department of Health Human Services are working on the implementation details of this decision.

Clinical Policy

DMA, 919-855-4360

Attention: All Providers**Medicaid Recipient Notices and Appeal Request Forms**

Medicaid receives a number of calls requesting duplicate recipient appeal request forms. Most often, adverse notices and appeal request forms are not received because the recipient did not sign for the trackable mail or did not report a change of address.

As a reminder, all adverse notices are mailed to the last known address given by the recipient or his/her legal guardian to the county Department of Social Services or the U.S. Social Security Administration (for SSI recipients). It is the responsibility of the recipient and/or their legal guardian to keep the address information current. If a recipient has a change of address, it would be helpful if providers reminded recipients of this responsibility.

Providers will receive a courtesy copy of the recipient's adverse notice and can assist in this matter by notifying the recipient that their notice and appeal request form will arrive via trackable mail and that a signature will be required for the notice to be delivered. Any recipient who believes that they did not receive notice of a decision on a request for prior approval may contact the Appeals Section, Division of Medical Assistance (DMA) at 919-855-4350 or the Department of Human Services (DHHS) Customer Service Center at 1-800-662-7030, Monday-Friday, 8:00 a.m.-5:00 p.m., and request that the call be transferred to the DMA Appeals Section.

For questions about Medicaid due process, please contact the Office of Administrative Hearings at 919-431-3000 or Jane Plaskie, Manager, DMA Appeals, at 919-855-4350.

All Health Choice Providers: Provider Courtesy Reviews (PCR)

Effective Wednesday, February 29, 2012, Health Choice review procedures will no longer include the Provider Courtesy Review (PCR) process. This action is being taken so that the Division of Medical Assistance (DMA) may more closely align the Medicaid recipient appeal and the Health Choice review processes. Hopefully, this will decrease confusion about the processes among providers and recipients as recipients move between Medicaid and Health Choice eligibility.

Vendors will accept requests for a PCR through February 29, 2012, close of business. All PCR requests received by this deadline will be acted upon by the vendor. Any requests received after this deadline date will be returned to the provider. If recipients and/or legal guardians or authorized representatives disagree with the utilization review decision, a review of the decision may be requested in accordance with notice instructions or providers, with the agreement of the recipient and/or legal guardian or authorized representative, may re-submit the request with any additional information that needs to be reviewed.

Please contact Margaret Watts, Chief, Health Choice, at 919-855-4100, or Jane Plaskie, Manager, DMA Appeals, at 919-855-4350 for questions about the Health Choice review processes.

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

Attention: Durable Medical Equipment and Orthotics & Prosthetics**Webinars**

Durable Medical Equipment (DME) and Orthotics & Prosthetics (O&P) webinars are scheduled for the month of May 2012. Webinars educate providers on DME and O&P Medicaid billing as well as provide an overview of DME and O&P updates and resources. The webinar dates will be announced in the April 2012 Medicaid Bulletin. The DME and O&P Clinical Policy will be used as the training document for the webinars and will be available prior to the webinars on DMA's Medicaid Clinical Coverage Policies and Provider Manuals web page <http://www.ncdhhs.gov/dma/mp/index.htm>. Pre-registration will be required for the webinars and registration will be limited to 50 participants per session.

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

Attention: Physician Assistants**Enrollment Physician Assistants**

All Physician Assistants may enroll with North Carolina Medicaid and all services provided will be filed with Medicaid using their NPI as the rendering (or attending) provider. Physician Assistants may be enrolled effective April 1, 2012.

Applicants must meet all program requirements and qualifications for enrollment before they can be enrolled as a Medicaid provider. Nurse Practitioners may enroll by completing the Medicaid provider enrollment application on www.nctracks.nc.gov. Computer Science Corporation (CSC) is available to assist providers who want to enroll in NC Medicaid at 866-844-1113 or email NCMedicaid@csc.com.

Clinical Policy**DMA, 919-855-4331**

Attention: Nurse Practitioners and Physicians**Aflibercept (Eylea, HCPCS Code J3590): Billing Guidelines**

Effective with date of service November 22, 2011, the North Carolina Medicaid Program covers aflibercept injections (Eylea™) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologics). Eylea is available in 2 mg/0.05 mL single use vials. Each vial should be used for the treatment of a single eye. Eylea is indicated for the treatment of Neovascular (Wet) Age-Related Macular Degeneration (AMD).

Eylea (aflibercept) is a recombinant fusion protein consisting of portions of human VEGF receptors 1 and 2 extracellular domains fused to the Fc portion of human IgG1 formulated as an iso-osmotic solution for intravitreal administration. The recommended dose for Eylea is 2 mg (0.05 mL or 50 microliters) administered by intravitreal injection every 4 weeks (monthly) for the first 12 weeks (3 months), followed by 2 mg (0.05 mL) via intravitreal injection once every 8 weeks (2 months).

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Eylea is:
 - 362.52 – Exudative senile macular degeneration
- Providers may bill for the administration of Eylea with CPT procedure code 67028 [intravitreal injection of a pharmacologic agent (separate procedure)]. Modifier 50 may be appended to CPT procedure code 67028 to indicate a bilateral procedure was performed.
- Providers must bill Eylea with HCPCS code J3590 (unclassified biologics).
- Providers must indicate the number of HCPCS units. One single-use vial may be billed for the treatment of one eye, or two single-use vials may be billed for the treatment of both eyes.
- One Medicaid unit of coverage is 2 mg (0.05 ml). The maximum reimbursement rate per unit is \$1927.87.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. NDC units for Eylea should be reported as “ML” To bill for the entire 2 mg/0.05 mL vial of Eylea, report the NDC units as “ML.05.” To bill for two vials, report the NDC units as “ML.10.”
- If the drug was purchased under the 340-B drug pricing program, place a “UD” modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website (<http://www.ncdhhs.gov/dma/bulletin/>) for additional instructions.
- Providers must bill their usual and customary charge.
- The fee schedule for the Physician's Drug Program is available on DMA's website at: <http://www.ncdhhs.gov/dma/fee/>.

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

Attention: Nurse Practitioners and Physicians**Asparaginase *Erwinia Chrysanthemi* (Erwinaze, HCPCS Code J9999):
Billing Guidelines**

Effective with date of service November 22, 2011, the North Carolina Medicaid Program covers asparaginase *Erwinia chrysanthemi* injection (Erwinaze) for use in the Physician's Drug Program when billed with HCPCS code J9999 (not otherwise classified, antineoplastic drugs). Erwinaze is available in 10,000 IU vials.

ERWINAZE (asparaginase *Erwinia chrysanthemi*) is an asparagine specific enzyme indicated as a component of a multi-agent chemotherapeutic regimen for the treatment of patients with acute lymphoblastic leukemia (ALL) who have developed hypersensitivity to *E. coli*-derived asparaginase. Erwinaze is indicated for the treatment of acute lymphoblastic leukemia (ALL). It may be substituted for pegaspargase (Oncaspar) OR native *E. coli*-derived asparaginase (Elspar).

To substitute for a dose of pegaspargase, the recommended dose for Erwinaze is 25,000 International Units/m² administered intramuscularly three times a week (Monday/Wednesday/Friday) for six doses for each planned dose of pegaspargase (Oncaspar).

If used as a substitute for native *E. coli* Asparaginase (Elspar), the recommended dose is 25,000 International Units/m² administered intramuscularly using the same dosing schedule as the native *E. coli* asparaginase. For each dose of Elspar, one would administer one dose of Erwinaze.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Erwinaze is:
 - 204.00 - 204.02 (Acute lymphoid leukemia)
- Providers must bill Erwinaze with HCPCS code J9999 (not otherwise classified, antineoplastic drugs).
- Providers must indicate the number of HCPCS units. An entire single-dose vial may be billed.
- One Medicaid unit of coverage is 1,000 international units (IU). The maximum reimbursement rate per unit is \$331.25.
- Providers must bill 11 digit National Drug Codes (NDCs) and appropriate NDC units. Erwinaze is available.

In 10,000 IU per vial.

- The NDC units for Erwinaze should be reported as "UN." To bill for the entire 10,000 IU vial of Erwinaze report the NDC units as "UNI."
- If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website (<http://www.ncdhhs.gov/dma/bulletin/>) for additional instructions.
- Providers must bill their usual and customary charge.
- The fee schedule for the Physician's Drug Program is available on DMA's website at: <http://www.ncdhhs.gov/dma/fee/>.

HP Enterprise Services

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

Attention: Outpatient Direct Enrolled Behavioral Health Providers**Upcoming Provider Audit and Investigation Initiative, February 28, 2012 - June 30, 2012**

Starting February 28, 2012, the Program Integrity Unit, Behavioral Health Review Section and its Partners will be conducting unannounced and announced provider audits and investigations for several Outpatient Behavioral Health providers identified through IBM Fraud and Abuse Management System and complaints or referrals. The audits and investigations will span all geographical regions of the State and will involve independent providers and group practices to include Critical Access Behavioral Health Agencies – Outpatient group and independent practices. According to Session Law 2011.399 or North Carolina General Statutes 108C, these Behavioral Health Providers are designated as “high categorical risk”.

There will be four phases during this Audit and Investigation Initiative. Phase I includes attending providers with high dollar claims and the associated group practices, top 50 attending providers with the high dollar claims for a period of 3/1/2009 to 12/31/2011, and providers with complaint/referral allegations. Phase II includes attending providers with paid claims amount greater than or equal to \$300,000 by individual calendar years and their associated billing providers. Phase III includes attending providers with paid claims greater than or equal to \$200,000 to \$299,999 by individual calendar years and their associated billing providers. Phase IV includes attending providers with paid claims greater than or equal to \$100,000 up to \$199,999 and their associated billing providers.

This Initiative is the first of its kind for Outpatient Behavioral Health providers. The first announcement of this Initiative was conveyed by Program Integrity during the November 2011, 8C Training conducted in Asheville, Charlotte, Raleigh, and Wilmington. Providers should review the Program Integrity Web site at <http://www.ncdhhs.gov/dma/pi.htm>, and Special Medicaid Bulletin, <http://www.ncdhhs.gov/dma/program%20integrity/Special%20Bulletin102011.pdf>. There will be several Partners assigned to this Initiative to include DMA Program Integrity, Behavioral Health Review Section, Public Consulting Group (PCG): Advanced Med (Medi-Medi Contractor for the State of North Carolina); Carolina Centers for Medical Excellence (CCME); IBM Technical and Business Support Team; DMA Clinical Policy-Behavioral Health Section, Information Technology unit, and Provider Services Unit; Computer Science Corporation-Enrollment, Verification, and Credentialing unit, and Hewlett-Packard.

Advance Med will focus on Medicare claims associated with each provider’s billing and payments received. PCG is an extension of Program Integrity and will continue to conduct onsite audits and investigations.

Program Integrity identifies provider claims for review and assigns cases to an investigator, analyst, or PCG. The full scale of operations includes but not limited to the following:

- Receive Fraud and Abuse Management and Detection Systems leads, complaints, and/or referrals.
- Determine a time period to review claims and pull a population of claims
- establish a statistically valid claim review sample from the population of claims
- conduct an administrative and/or clinical audit or investigation
- use the RAT-STATS Software 2007 Version 2.0 (Windows-based software approved by the U.S. Office of the Inspector General) to determine the sample size and extrapolated overpayment amount.

Program Integrity's and PCG's responsibilities include:

- Initiating contact with the provider, announced or unannounced
- Informing the provider of the post payment audit or investigation process requirements to include entrance and exit conference
- Working closely with the provider to complete the Audit/Investigation in a timely manner with the least disruption to the provider agency
- Advising the provider who to submit documentation to and establishing points of contact during the onsite
- Addressing provider questions regarding the post payment audit or investigation process
- Comply with hours of operation, unless Owner or Management willing to extend the hours during this time.

Provider's responsibilities:

- According to Session Law 2011.399 or N.C.G.S. 108 C-11, providers shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other program integrity activities conducted by the Department. Providers who fail to grant prompt and reasonable access or who fail to timely provide specifically designated documentation to the Department may be terminated from the North Carolina Medicaid or North Carolina Health Choice Program.
- Establish a convenient workspace for the Program Integrity's or PCG's staff, preferably an office or conference room.
- Access to Managerial, Financial, Administrative, and Clinical Staff, if necessary.
- Refrain from adjusting claims with Hewlett-Packard for the designated period in question
- Participate in entrance and exit conference

If the provider's claims are determined to be out of compliance, a Tentative Notice of Overpayment letter will be sent to the provider in the amount of the overpayment. In accordance with [10A NCAC 22F.0402](#), reconsideration and appeal rights will be offered to the provider if the provider does not agree with the findings of the review. Instructions for the reconsideration review and appeal rights are included with the Tentative Notice of Overpayment letter.

If the preliminary investigation supports the conclusion of possible fraud, as defined in [NCGS 108A-63](#), the case shall be referred to the appropriate law enforcement agency for a full investigation, in accordance with [10A NCAC 22F.0203](#). As a reminder, the False Claims Act (State FCA) legislation was enacted by the N.C. General Assembly on January 1, 2010, in [Session Law 2009-554](#) to deter persons from knowingly causing or assisting in causing the State to pay claims that are false or fraudulent. This legislation applies to any service that is reimbursed with State funds, not just claims for Medicaid services. The legislation stipulates that any person who presents or causes to be presented a false or fraudulent claim is liable for three times the amount of damages sustained by the State; the cost of the civil action brought by the State; and penalties of between \$5,500 and \$11,000.

Review Tool and Guidelines will be posted on the Program Integrity Web site at <http://www.ncdhhs.gov/dma/pileletters.htm> for Provider's convenience and to help providers conduct their own internal Quality Assurance reviews.

Program Integrity
DMA, 919-647-8000

Attention: Pharmacists and Prescribers**A+KIDS Medicaid and North Carolina Health Choice - Unlimited Overrides
End on March 15, 2012**

Effective March 16, 2012, the use of an override for antipsychotic claims processing for the Antipsychotics – Keeping It Documented for Safety (A+KIDS) programs in Medicaid and North Carolina Health Choice (NCHC) will limit to two every 365 rolling days. The A+KIDS registry used to capture safety documentation is supported by the Medicaid policy titled “Off Label Antipsychotic Safety Monitoring in Recipients through Age 17” implemented in April 2011 and the “Off Label Antipsychotic Safety Monitoring In NCHC Recipients” policy implemented in February 2012. The first phase implementation for NCHC effective on February 8, 2012 is for ages 6 through 17 only.

Currently, unlimited override use by a pharmacist is allowed to obtain successful point of sale (POS) processing for an antipsychotic claim when a prescriber has not provided safety documentation for the prescribed antipsychotic therapy. The importance of ensuring recipients did not go without antipsychotic medication related to the novel initiative warranted this liberty. The unlimited override window was created as an extra medication access and availability assurance measure during the period of registry implementation and widespread educational and training effort by Community Care of North Carolina.

Prescribers not registered to submit safety documentation using the A+KIDS registry can go to the website www.documentforsafety.com to complete the registration process. A user identification and pass word are required to access the A+KIDS registry. These are available within five business days of registering.

An alternate method to provide the safety documentation is completion of the “North Carolina Medicaid and NCHC Off Label Antipsychotic Safety Monitoring. In Recipients through Age 17” fax form. The form is found on websites www.documentforsafety.com and <http://www.ncmedicaidpbm.com>. The completed form is faxed to ACS at 866-246-8507. ACS is the DMA prior authorization vendor.

Pharmacies are urged to share with the prescriber the POS message that returns for a rejected anti-psychotic claim when safety documentation is not found. Prescribers are urged to use the A+KIDS registry or the fax form to provide safety documentation to ensure avoidable delays in getting anti-psychotic medications do not occur for their patients. Pharmacies are able to dispense a 72 hour emergency supply for recipients who have exhausted the two override opportunities and are waiting for safety documentation to be provided.

The following resources are available for assistance.

- Registry technical support (M – F, 8am – 5pm) 855-272-6576
- ACS Help Desk 866-246-8505
- DMA 919-855-4300

**Pharmacy Program
DMA, 919-855-4306**

Attention: Pharmacists and Prescribers**Upcoming Policy Implementation: March 20, 2012 Off Label Antipsychotic Safety Monitoring in Recipients 18 and Older**

On March 20, 2012, DMA, partnering with Community Care of North Carolina, will implement a policy that creates a prior authorization process for the off label prescribing of an antipsychotic for a Medicaid recipient age 18 and older. The prior authorization process will collect information to support standards established by the Food and Drug Administration for on label use of antipsychotics. This first phase implementation starting on March 20, 2012 is for atypical (second generation) antipsychotics only. Documentation will be requested when the atypical is prescribed for an indication that is not approved by the federal Food and Drug Administration.

Recipients with any of the following diagnoses are exempt from the requirements of the policy:

- Schizophrenia
- Schizophreniform disorder
- Schizoaffective disorder
- Delusional disorder
- Brief psychotic disorder
- Shared psychotic disorder
- Psychotic disorder NOS
- Bipolar disorder
- Major depressive disorder with psychotic features
- Treatment resistant depression (antipsychotic use for TRD is adjunctive only)
- Tourette syndrome
- Other psychosis

The exemption ensures recipients with these diagnoses are able to obtain antipsychotic medications without documentation. When any of the above diagnoses are present, the prescriber should write on the face of each new and renewal prescription in his/her own handwriting: **“Meets PA Criteria”** to authorize the exemption. **“Meets PA Criteria”** may also be entered in the comment block on e-prescriptions. The pharmacist is authorized to override the documentation requirement when **“Meets PA Criteria”** is written. If an exempted diagnosis is found in the recipient’s most recent 24 months of Medicaid claims data, an atypical claim can process successfully without any action at all by the prescriber.

In accordance with the policy, a documentation request will occur for each atypical antipsychotic medication prescribed for a recipient that meets any of the below criteria. Generally, a dose change or change in strength only will not trigger a documentation request.

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

When documentation is required, the information may be submitted by faxing a completed Adult Safety with Antipsychotic Prescribing (ASAP) form to ACS at 866-246-8507 or by calling ACS with the information at 866-246-8505. The form can be found on the DMA website at <http://www.ncmedicaidpbm.com> and on the Resources page of www.documentforsafety.com. A twelve month approval period is granted when the documentation is provided using the fax form or by phone.

The information requested includes:

- drug and total daily dosage
- primary psychiatric diagnosis
- primary target symptoms
- recipient informed regarding the potential metabolic and neurologic adverse effects with these agents.

Two point of sale (POS) overrides per recipient per 365 rolling days are available for occurrences where the prescriber has not provided documentation or an exempted diagnosis does not exist. Each override will apply to all claims for antipsychotic medication(s) on the same date of service. The message "Safety documentation requested call ACS 866-246-8505" will return to the pharmacy for atypical antipsychotic claims for recipients without documentation. The claim will not process successfully. A POS override can be utilized for these rejected claims if timely provision of information by the prescriber does not occur. If a third override is attempted, the message "Override limit exceeded. Prescriber call ACS 866-246-8505" will return to the pharmacy. This message cannot be overridden and the pharmacy should share it with the prescriber. The alert indicates the prescriber must provide the requested documentation for the recipient in order for successful claims processing to result.

A widespread training effort about the Medicaid antipsychotic initiatives, led by Community Care of North Carolina, has been underway since early 2011. The adult initiative is known as **ASAP (Adult Safety with Antipsychotic Prescribing)**. Objectives of the initiative include improving the use of evidence based treatments, reduction of antipsychotic polypharmacy, and reduction of occurrences where the antipsychotic is prescribed in an amount differing from the FDA approved dosage for an indication.

Pharmacy Program
DMA, 919-855-4306

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

Employment opportunities with DMA are advertised on the Office of State Personnel's website at <http://agency.governmentjobs.com/northcarolina/default.cfm>. 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 to the contact person listed for the vacancy. If you need additional information regarding a posted vacancy, call the contact person at the telephone number given in the vacancy posting. General information about employment with North Carolina State Government is also available online at <http://www.osp.state.nc.us/jobs/gnrlinfo.htm>.

Proposed Clinical Coverage Policies

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

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

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

2012 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
March	3/1/12	3/6/12	3/7/12
	3/8/12	3/13/12	3/14/12
	3/15/12	3/20/12	3/21/12
	3/22/12	3/29/12	3/30/12
April	4/5/12	4/10/12	4/11/12
	4/12/12	4/17/12	4/18/12
	4/19/12	4/26/12	4/27/12

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

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

Melissa Robinson
Executive Director
HP Enterprise Services