March 2013 Medicaid Bulletin

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Attention: All Providers

NC Medicaid Provider Direct Enrollment and Screening – REVISED

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

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

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

- Low
- Moderate
- High

Provider types and specialties that fall into the moderate- and high-risk categories are subject to a pre-enrollment site visit, unless a screening and site visit has been successfully completed by Medicare or an appropriate State agency within the previous 12 months. Session Law 2011-399 §108C-3 further defines provider types that fall into each category.

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

This requirement does not apply to the following providers:

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

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

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

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

This training is completely Web-based and will be available online.

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

ATTENTION: BEHAVIORAL HEALTH PROVIDERS:
As a reminder, NCHC providers must still enroll directly with DMA/CSC, regardless of whether or not these providers accept Medicaid. This also applies to providers billing Medicaid for children aged 0-3, as children these ages are not covered by the LME-MCO waiver at this time. Most new behavioral health providers are considered Moderate or High risk and should expect pre-screening. More information will be forthcoming regarding procedures for providers enrolling both through DMA/CSC and the LME-MCOs.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Enrollment and Application Fees – REVISED

Note to Providers: The original version of this article was published in December 2012. This is a revised version which was originally published in February 2013.

Affordable Care Act (ACA) Application Fee

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

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

This requirement does not apply to the following providers:

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

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

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

North Carolina Enrollment Fee

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

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

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

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

Provider Services
DMA, 919-855-4050

Attention: All Providers

Termination of Inactive N.C. Medicaid and N.C. Health Choice Provider Numbers

Note to Providers: This article was originally published in September 2011, but the last sentence was added in February 2013.

The N.C. Division of Medical Assistance (DMA) wants to remind all providers of its policy for terminating inactive providers to reduce the risk of fraudulent and unscrupulous claims billing practices. DMA's updated policy was announced in the *July 2011 Medicaid Bulletin*.

N.C. Medicaid and N.C. Health Choice (NCHC) provider numbers that do not reflect any billing activity within the previous 12 months will be terminated. Unless providers **can** attest that they have provided services to N.C. Medicaid or NCHC recipients in the previous 12-month period, their provider numbers will be terminated. A new enrollment application and agreement to re-enroll must be submitted to CSC for any provider who is terminated. **As a result, a lapse in the provider's eligibility may occur.**

Termination activity occurs on a quarterly basis, with provider notices being mailed out on April 1, July 1, October 1, and January 1 of each year with termination dates of May 1, August 1, November 1, and February 1, respectively. These notices are sent to the current mailing address listed in the provider's file. **Providers are reminded to update their contact and ownership information in a timely manner.**

Terminated providers who wish to re-enroll can reach CSC by phone at 1-866-844-1113 or by email at NCMedicaid@csc.com. Providers who re-enroll must pay all appropriate application fees.

Provider Services
DMA, 919-855-4050

Attention: All Providers

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

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

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

The Webinar is not intended to address billing questions.

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

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

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

Attention: All Providers

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

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

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

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

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

Attention: All Providers

NC Medicaid EHR Incentive Program Updates

EHR Incentive Program Deadline for 2012 Attestations is Fast Approaching

The N.C. Medicaid Electronic Health Records (EHR) Incentive Program would like to remind eligible professionals (EPs) that the last day to submit an attestation for a 2012 payment during the attestation tail period is **April 30, 2013**.

Clinical Quality Measure Submission for Eligible Professionals

For Stage 2 Meaningful Use, EPs shall electronically submit clinical quality measures to the N.C. Department of Health and Human Services (DHHS) via the state agency for Health Information Exchange (HIE), the NC HIE. EPs participating in North Carolina's EHR Incentive Program will be able to connect with the state-designated entity for HIE to submit clinical quality measures at no cost to them. Additional guidance will be coming soon to providers.

N.C. Medicaid EHR Incentive Program's Provider Webinar Series

The N.C. Medicaid EHR Incentive Program launched its provider Webinar series in late January. Those who were unable to attend a Webinar can listen to a recorded podcast on the EHR Website at www.ncdhhs.gov/dma/provider/ehr.htm.

Providers can also join us for one of the following sessions in March:

- March 6: Audits: What to Expect
- March 13: Meaningful Use 101: What is MU?
- March 20: Meaningful Use 102: Looking Ahead to Stage 2 and Beyond
- March 27: Q&A with DMA
- April 3: Hospitals and the NC Medicaid EHR Incentive Program

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

Attention: All Providers (not in an MCO Network)

Medicaid Beneficiary Fee-for-Service (Dental, Behavioral Health, Medical) Authorizations Following an Office of Administrative Hearings Decision

All providers were notified in the *February 2013 Medicaid Bulletin* that the Centers for Medicare & Medicaid Services (CMS) approved the transfer of the final agency decision from the N.C. Department of Health and Human Services (DHHS) to the Office of Administrative Hearings (OAH) effective July 1, 2012. CMS announced this decision on December 27, 2012. **This means that any decision made by OAH is the decision that the provider and beneficiary can act upon and that a final agency decision by DHHS is no longer required.** OAH will mail a copy of the decision via trackable mail (e.g., certified mail, registered mail, USPS trackable mail) to the parties identified on the appeal request form.

Medicaid has previously apprised fee-for-service (dental, behavioral health, medical) providers and published instructions about how service authorizations would be issued following a final agency decision made by DHHS/Medicaid. These same policies and procedures shall apply to authorizations following an OAH decision and are stated below.

Instructions from the N.C. Division of Medical Assistance (DMA) can be viewed in full in the Medicaid Beneficiary Due Process Rights and Prior Approval Policies and Procedures and seminar presentation found at www.ncdhhs.gov/dma/mp/index.htm.

Decisions That Uphold Agency Action

An OAH decision that upholds the agency action shall be implemented no later than three business days from the date the OAH hearing decision is mailed to the petitioner or representative at the addresses provided on the beneficiary appeal request form. If the provider was not named as a party on the appeal request form, it is important for the provider to ask the beneficiary or representative about the outcome of the hearing.

Decisions that Reverse the Agency Action (Utilization Review [UR] Contractor Decision) in Part or in Full

- If the OAH decision or a mediated settlement holds that all or part of the requested services were medically necessary, payment for those services as approved in the OAH decision or settlement will be authorized by Medicaid or its UR contractor within three business days of receipt of the decision. This authorization will remain in effect for 20 prospective calendar days after the date of the decision.

- If the provider believes that it is medically necessary for the beneficiary to continue the service that has been under appeal, the provider shall submit a prior

approval request to the appropriate UR contractor within 15 calendar days of the date of the OAH decision in order to avoid an interruption in services. Upon receipt by the UR contractor of a request for service authorization within the 15 calendar days of the OAH decision, a determination to approve, deny, reduce, or terminate the request will be made within 15 business days – or in accordance with the contractor's contract with Medicaid. If the request cannot be approved as submitted, authorization for payment will remain in effect without interruption for at least 10 calendar days following the mailing of the notice of decision on the new request for prior approval.

- If the request is denied or reduced, it will be treated as a timely request for reauthorization and maintenance of service (MOS) pending appeal will apply.

Appeals
DMA, 919-855-4350

Attention: All Providers

Program Integrity Prepayment Claims Review

A provider's claims may be manually reviewed prior to payment when the N.C. Division of Medical Assistance (DMA) has evidence of inappropriate billing, program abuse, or both [10A NCAC 22F.0104(c)].

On October 29, 2009, the Carolinas Center for Medical Excellence (CCME) was awarded a contract with DMA to provide prepayment claim review services for enrolled Medicaid providers. DMA's Program Integrity (PI) section will inform providers that their claims are being placed on prepayment claims review. CCME will supply information on the review process requirements, and work with the providers, DMA, and DMA's fiscal agent throughout the claims submission and review process. CCME will advise the providers where and how to submit its claims for review, and will address provider questions regarding the prepayment review process.

Prepayment claim review is a process whereby a provider's claims are temporarily held in the payment system pending review of the provider's supporting documentation. CCME will review the provider's documentation to determine whether the claim is appropriate for Medicaid payment based on criteria including, but not limited to, documentation which establishes that:

1. Services were provided according to DMA policy requirements;
2. Billed services were medically necessary, appropriate, and not in excess of the beneficiary's need pursuant to physician order, etc. as documented in policy or service standards;
3. Providers and beneficiaries were Medicaid-eligible on the date the services were provided;
4. Prior approval was obtained if required by policy;
5. Providers and their staff were qualified as required by Medicaid policy; and;
6. Providers possessed the proper licenses, certifications, or other accreditation requirements specific to the provider's scope of practice, Medicaid policy, and conditions of participation with the N.C. Medicaid Program at the time the services were provided to the beneficiaries.

Pursuant to N.C. Session Law 2011-399, N.C.G.S. § 108C-7(b) and federal regulation, providers are not entitled to payment prior to claims review by the N.C. Department of Health and Human Services (DHHS).

DHHS makes the decision to place agencies on prepayment claims review because of:

1. Receipt by DHHS of credible allegations of fraud or;
2. Identification of aberrant billing practices as a result of investigations or;
3. Data analysis performed by DHHS.

Note: Providers must achieve a minimum of 70% accuracy in claim submission as reported to DMA by CCME for three consecutive months after prepayment review. Providers may be allowed up to six months to achieve the three-month consecutive accuracy rate. If the minimum performance benchmark rate is not met, the provider will be terminated from participation with the N.C. Medicaid Program.

To date, the following trends have been identified:

Personal Care Services/In-Home Care (PCS/IHC):

- Providers and their staff were not qualified to supply the services billed;
- Examples include inappropriate levels of certification, lack of policy-required background checks and failure to meeting staff training requirements, among other things;
- Lack of service documentation, for example missing signatures;
- Plan of Care was not followed and any deviation from the Plan of Care was not documented;
- Supervision was not conducted per clinical policy requirements.

Durable Medical Equipment/Prosthetics, Orthotics and Supplies (DME/POS):

- No evidence of product or service delivery in the record submitted for review, as per policy requirements;
- Certificates of Medical Necessity were missing;
- Required documentation was lacking or outdated;
- No evidence of beneficiary training provided, as per policy requirements.

Community Alternative Program (CAP):

- Failure to follow the service authorization from the case manager.
- Providers and their staff were not qualified to supply the services billed. Examples include but are not limited to: inappropriate levels of certification, lack of policy-required background checks, and failure to meet staff training requirements.

Outpatient speech therapy:

- Services provided did not follow the written Plan of Care for the date of service billed;
- Service documentation does not meet policy requirements. Examples include but are not limited to: illegible signatures on documentation or no documentation of skilled interventions provided on the date of service billed.

Program Integrity
DMA, 919-814-0001

Attention: All Providers

Clinical Coverage Policies

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

- *1A-12, Breast Surgeries (1/15/13)*
- *1A-20, Sleep Studies and Polysomnography Services (2/1/13)*
- *1A-36, Implantable Bone Conduction Hearing Aids (BAHA) (2/1/13)*
- *1S-4, Cytogenetic Studies (2/1/13)*
- *1T-2, Special Ophthalmological Services (1/15/13)*
- *5A, Durable Medical Equipment and Supplies (2/1/13)*
- *9, Outpatient Pharmacy (1/31/13) and (2/7/13)*
- *9B, Hemophilia Specialty Pharmacy Program (1/31/13)*
- *13B, Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement and Repair (2/1/13)*
- *NCHC Genetic Testing for Breast and Ovarian Cancer (Date of termination 12/31/2012)*

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

NCTracks – The new multi-payer system for N.C. DHHS coming on July 1, 2013

NCTracks is a multi-payer system that will consolidate several claims processing platforms into a single solution for multiple divisions within the N.C. Department of Health and Human Services (DHHS), including the Division of Medical Assistance, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the Division of Public Health, and the Office of Rural Health and Community Care. The new NCTracks system will go live on July 1, 2013. There are a number of things that providers can do to prepare for the transition, including taking advantage of upcoming training opportunities.

For more information, go to the website ncmmis.ncdhhs.gov/communication.asp and sign up to receive the *NCTracks Connections* newsletter.

NCTracks Communications Team
N.C. Office of MMIS Services (OMMISS), 919-647-8300

Attention All Providers

Cancellation: Implementation of Password Management Changes for NCECS Web Tool and Secure FTP Users

On March 1, 2013, N.C. Medicaid implemented new software for self management of access passwords. The implementation affects NCECS Web Tool and Secure FTP connectivity. All NCECS Web Tool and Secure FTP users were to enroll in the NCECS Web Tool and Secure FTP Password Management Capability by April 1, 2013.

This initiative has been cancelled. Click here for more information.

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

Attention: All Providers

2013 New CPT/HCPCS Codes

The current rates for the newly covered 2013 Medicaid CPT/HCPCS codes are based on the 2012 Centers for Medicare & Medicaid Services (CMS) conversion factor. Rates for the 2013 N.C. Medicaid covered CPT/HCPCS codes will be revised in accordance with the 2013 Medicare Physicians Fee Schedule (MPFS) Conversion Factor, reflecting the zero percent (0%) update for calendar year 2013 adopted by section 601(a) of the American Taxpayer Relief Act of 2012.

Previously paid claims for dates of service on or after January 1, 2013 will be recouped and repaid by HP Enterprise Services (HCPS). If providers do not want to wait for the automated recoup/repay, they may submit an adjustment claim to HPES. Providers whose usual and customary charge is less than the 2013 Medicaid fee schedule will be paid at the lesser of the billed charge of the Medicaid fee schedule.

Revised fee schedules for the 2013 newly covered CPT/HCPCS codes will be available on the N.C. Division of Medical Assistance (DMA) Website at www.ncdhhs.gov/dma/fee/fee.htm and were effective as of January 1, 2013. Providers must continue to bill their usual and customary charges.

Financial Management
DMA, 919-814-0070

Attention: All Providers

CPT Provider Update

Providers are having claims denied for services provided by nurse practitioners, nurse midwives and physician assistants because their provider type/specialty are not listed for those codes. Provider type/specialty 085/061(nurse practitioners), 086/063 (nurse midwives) and 130/210 (physician assistants) were added to the following codes effective November 1, 2011.

51727	51728	51729	51784
91122	97032	97750	

System changes have been made to correct this issue.

Providers who have received a claim denial with EOB 353 (this service is not payable to your provider type or specialty in accordance with Medicaid guidelines) and have kept claims timely may resubmit as a **new claim** (not as an Adjustment Request) for processing.

Clinical Policy and Programs
DMA, 252-208-1950

Attention: Hospice Providers

RAC Hospice Reviews

On September 16, 2011, the Centers for Medicare & Medicaid Services (CMS) published the Final Rule for Medicaid Recovery Audit Contractors (RAC). Mandated by the Affordable Care Act (ACA), the Medicaid RAC Final Rule required states to implement their Medicaid RAC programs by January 1, 2012, or they would lose federal funding for the program.

Under the Medicaid RAC program, states must contract with a RAC to perform post payment audits in order to identify Medicaid payments that may have been underpaid or overpaid. They must follow federal and state guidelines to recover overpayments or to inform the N.C. Division of Medical Assistance (DMA) of underpayments.

On February 17, 2011, the Division received approval of Medicaid State Plan Amendment NC 10-037 to establish one or more RACs. Effective January 1, 2012, DMA partnered with its current post payment review vendor, Public Consulting Group (PCG), to be one of the NC Medicaid RACs.

Beginning in March 2013, PCG will continue RAC reviews of Hospice providers, specifically evaluating the usage rate of certain non-oncologic diagnoses. DMA and PCG will be working with provider associations to provide further information about the RAC process.

The PCG RAC website can be found at: www.medicaidrecoveryaudits.com/index.html

Additional Information about the Federal Regulations for the Medicaid RAC program can be found at www.gpo.gov/fdsys/pkg/FR-2011-09-16/pdf/2011-23695.pdf.

Program Integrity
DMA, 919-647-8000

Attention: All Providers/Lab providers

Laboratory Audits: Recovery Audit Contract II (RACII)

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

As described in the *October 2012 Medicaid Bulletin*, DMA partnered with HMS to become the second RAC vendor for the State of North Carolina. HMS will perform post-pay audits on inpatient and outpatient hospital, long-term care, **laboratory**, x-ray and specialized outpatient therapy claims. HMS plans to send out the first outpatient lab records requests in spring 2013. Examples of areas for review include unbundling, duplicate billing, correct coding and documentation to support services billed, among others. It is anticipated that specialized therapy services will be the third provider type to undergo review in 2013.

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

For additional questions contact:

Linda Marsh: linda.marsh@dhhs.nc.gov

DMA Program Integrity: 919-814-0000

HMS provider email: NCRACII@HMS.com

Toll free: 1-855-438-6415

Provider Website: www.medicaid-rac.com/ncproviders/

Program Integrity
DMA, 919-647-8000

Attention: Behavioral Health Providers

Referrals for Outpatient Behavioral Health Services

Notice to Providers: This article was originally published in February 2013.

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

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

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

Behavioral Health Section
DMA, 919-855-4290

Attention: NC Innovations Providers, and LME/MCOs

Compensatory Education and Adult Basic Skills Education

In a January 2013 Special Bulletin titled *Extension of CAP-I/DD Waiver*, the N.C. Division of Mental Assistance (DMA) published policy guidance regarding the use of Day Support Services to enable NC Innovations Waiver beneficiaries to access Compensatory Education Classes through the Community College system. In order to do this, beneficiaries must attend an educational setting at a community college site.

The intent of the previous policy guidance was to facilitate the use of Compensatory Education/Adult Basic Skills education programs. Since some beneficiaries who would like to attend Compensatory Education/Adult Basic Skills programs are not enrolled in Day Supports programs, we are issuing further policy guidance. The following NC Innovation services may be used to support attendance at Compensatory Education/ Adult Basic Skills classes:

- **Personal Care** - Personal Care Services under the waiver include support, supervision and engaging participation with eating, bathing, dressing, personal hygiene and other activities of daily living. This service may be appropriate for individuals that need general, non-habilitative support and supervision to attend classes.

- **In Home Skill Building** - In-Home Skill Building provides habilitation and skill building to enable the participant to acquire and maintain skills, which support more independence. This service may be appropriate for an individual who needs active skill building and habilitative support to be successful in the classroom environment. **NOTE:** In Home Skill Building must to start or end in the beneficiary's home.

- **Day Supports** - Day Supports is primarily a group service that provides assistance to the participant with acquisition, retention, or improvement in self-help, socialization and adaptive skills. This service may be appropriate for an individual who needs active skill building and habilitative support to be successful in the classroom environment.

- **Community Networking** - Community Networking provides individualized day activities that support the participant's definition of a meaningful day in an integrated community setting with persons who are not disabled. This service could be appropriate for individuals who are taking Adult Basic Skills education classes through integrated Community College settings .

Benficiaries should work with their Care Coordinators to determine which NC Innovation service best meets their support and habilitation needs.

DMA Behavioral Health Services
919-855-4290

Attention: NC Innovations Providers and LME/MCOs

Supported Employment under NC Innovations

Supported Employment is intended to provide assistance with choosing, acquiring, and maintaining a job for participants for whom competitive employment has not been achieved, has been interrupted or intermittent, or both.

As noted in the Centers for Medicare & Medicaid Services (CMS) *Informational Bulletin*, (September 16, 2011), Federal Financial Participation (FFP) may not be claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment services.

Under NC Innovations, providers are creating positions within their agencies and hiring beneficiaries to whom they provide Supported Employment Services. While it is not prohibited to both employ a beneficiary and provide service to that same beneficiary, it is improper to use Medicaid funds to pay for Supported Employment Services to providers that are subsidizing their participation in providing this service. The following types of situations are indicative of a provider subsidizing its participation in supported employment:

- The job/position would not exist if the provider agency was not being paid to provide the service;
- The job/position would end if the beneficiary chose a different provider agency to provide service; or,
- The hours of employment have a one-to-one correlation with the amount of hours of service that are authorized.

In accordance with the CMS *Informational Bulletin*, (September 16, 2011), providers should not be subsidizing their participation in providing employment to beneficiaries through the provision of Supported Employment Services.

DMA Behavioral Health Policy Section
919-855-4290

Attention: Licensed Residential Facilities under G. S. 131 D (including PCH, ACH, FCH and In-Home Care)

Special Payment to Licensed Residential Facilities

Note: This article does not apply to providers billing for Personal Care Services (PCS) under the Community Alternatives Program (CAP).

In Session Law 2012-142 Section 10.23.A (f), N. C. General Assembly appropriated $39.7 million to the Community Living Fund and designated that amount for the implementation of the State's plan to provide temporary, short-term assistance to adult care home providers. This assistance is available from January 1, 2013 until June 30, 2013 to providers who:

- Continue to provide PCS to residents residing in licensed residential facilities receiving PCS on or before December 31, 2012,
- Have been denied State Plan PCS effective January 1, 2013, and,
- Have been certified by the appropriate Lead Agency **not** to have a safe and timely placement available.

Beneficiaries must have been residing in the licensed residential facility and receiving PCS on or before December 31, 2012 in order for the provider to access these funds. The funds will be paid by dates of service in a biweekly checkwrite process. Follow this link to learn more about the process for accessing the appropriated funds: www.ncdhhs.gov/dma/pcs/Forms/Provider-flow-chart-20130103.pdf

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

Preadmission Screening Resident Review

Beginning January 1, 2013 any individual being considered for admission to an adult care home, regardless of the source of payment, must be screened by an independent screener to determine whether the individual has Serious Mental Illness/Severe and Persistent Mental Illness (SMI/SPMI). The State shall connect any individual with SMI/SPMI to the appropriate Local Management Entity/Managed Care Organization (LME/MCO) for a prompt determination of eligibility for mental health services.

To complete the PASRR process, register at www.ncmust.com.

To learn more, read the article titled, *Adult Care Homes licensed under G.S. § 131D, Article 1 and defined in G.S. § 131D-2.1* in the January 2013 Medicaid Bulletin at this link: www.ncdhhs.gov/dma/bulletin/0113bulletin.htm#ach.

News Alert – Updated website

Visit our revised PCS website at www.ncdhhs.gov/dma/pcs/pas.html

Consolidated PCS Policy and State Plan Amendment

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

PCS Rate Effective January 1, 2013

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

Procedure Code	Modifier	Description	Program Description	Billing Unit	Maximum Allowable
99509	HA	Attendant Care Services	PCS, Beneficiaries Under 21 Years **(Regardless of Setting)**	15 min.	$3.88
99509	HB	Attendant Care Services	PCS, Private Residences, Beneficiaries 21 Years and Older	15 min.	$3.88
99509	HC	Attendant Care Services	PCS, Adult Care Homes	15 min.	$3.88
99509	HH	Attendant Care Services	PCS, Supervised Living Facilities, Adults with MI/SA	15 min.	$3.88
99509	HI	Attendant Care Services	PCS, Supervised Living Facilities, Adults with MR/DD	15 min.	$3.88
99509	HQ	Attendant Care Services	PCS, Family Care Home	15 min.	$3.88
99509	SC	Attendant Care Services	PCS, Adult Care Homes, Special Care Unit	15 min.	$3.88
99509	TT	Attendant Care Services	PCS, Adult Care Homes, Combination Home	15 min.	$3.88

Providers are reminded to bill their usual and customary charges.

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

PCS New Referrals Beginning January 1, 2013

Beneficiaries, who seek admission, are admitted, first receive services in licensed homes, or are seeking in-home services, on January 1, 2013 and after may request new referral assessments through their primary care or attending physicians, nurse practitioners, or physician assistants. The new referral form is available on the DMA Consolidated PCS webpage.

PCS reimbursement will not be available for a beneficiary admitted to a licensed facility on or after January 1, 2013, unless and until the beneficiary has received an independent assessment and Policy 3L qualifying criteria are met.

Change of Status Request Process

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

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

Beneficiary Annual Reassessments

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

Billing for PCS

Effective January 1, 2013, providers billing for PCS must submit claims on the CMS-1500 claim form. All claims must be submitted electronically and can be submitted by utilizing the Web tool at webclaims.ncmedicaid.com/ncecs or by hiring a vendor. To use

the Web tool, providers must have a password and login provided by HP Enterprise Services. To obtain this login information, contact HP at 1-800-688-6696, menu option 1.

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

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

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

Appeals/Maintenance of Service

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

Licensed Residential Facility's (Special Care Unit):

On December 28, 2012, CMS agreed to allow DMA to provide MOS using the current hours for Special Care Unit (SCU) beneficiaries. The approval of 161 hours for SCU beneficiaries applies only to MOS hours issued while the beneficiary goes through the appeal process. The appeal must have been filed by January 30, 2012 for the beneficiary to be entitled to MOS. Once the appeal decision has been made, the highest level of service a beneficiary receiving PCS can receive is 80 hours, regardless of setting.

Provider Interface

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

Fax: 877-272-1942

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

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

Upcoming Provider Trainings

Plans for provider trainings will be announced on the DMA Consolidated PCS Webpage. For additional information about the new PCS program; refer to the DMA Consolidated PCS webpage and to previous and future Medicaid Bulletins.

PCS Available Resources

- **PCS Clinical Coverage Policy 3L: Effective Date January 1, 2013**
  www.ncdhhs.gov/dma/mp/3L.pdf
- **State Plan Amendment (SPA):**
  www.ncdhhs.gov/dma/pcs/NC12013_Approval_Letter_179.pdf
- **House Bill 950 S. L2012-142**
  www.ncleg.net/Sessions/2011/Bills/House/PDF/H950v7.pdf
- **Appeals and QiReport Webinar**
  www.ncdhhs.gov/dma/pcs/011013_PCSWebinar.pdf
- **Technical Assistance Billing Webinar**
  www.ncdhhs.gov/dma/pcs/ACH_011513_transition.ppt

Home and Community Care
DMA, 919-855-4340

Attention: N.C. Health Choice Providers (NCHC)

FQHC and RHC Denial Codes

N.C. Health Choice (NCHC) providers are receiving inappropriate denials when billing certain services. DMA has identified and corrected the system issues and providers may now resubmit claims.

For Federally Qualified Health Centers (FQHCs) and Rural Health Clinic (RHCs)

FQHCs and RHCs that have received denials for the following codes billed for NCHC wellness exams and have kept their claims current may now resubmit.

CPT Code	Description
99385	New Patient Physical Exam: 18 to 39 Years
99395	Established Patient Physical Exam: 18 to 39 Years
90473	Immunization Administration By Intranasal or Oral Route; One Vaccine (Single or Combination Vaccine/Toxoid)

All NCHC providers

Providers who have received an EOB 9 (non-covered service) when billing CPT Code 96365 "Intravenous infusion up to one hour" and have kept their claims current may now resubmit. Due to this denial, providers may have received the additional denial of one of the following add-on codes for lack of a primary code paid. If current, claims for these add-on codes may also be resubmitted.

CPT Code	Description
96366	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis (Specify Substance)
96367	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis (Specify Substance)
96368	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis (Specify Substance)
96375	Therapeutic, Prophylactic, or Diagnostic Injection (Specify Substance or Drug)

N.C. Health Choice (NCHC)
DMA, 919-855-4260

Attention: N.C. Health Choice Providers

Health Choice Wellness Exam Components and Reimbursement

Since October 2011, the N.C. Division of Medical Assistance (DMA) has developed and posted 163 combined template clinical coverage policies for Medicaid-equivalent coverage of health benefits for N.C. Health Choice (NCHC) beneficiaries. No provider reimbursement discrepancies exist for these services between the Medicaid and NCHC programs.

One outstanding NCHC benefit reimbursement issue – for which DMA has been working with HP Enterprise Services – is wellness exams. In 2012, DMA communicated with providers about the pending system change in January, May, and August.

Effective April 1, 2013, the claims processing system will implement a change to accommodate a new preventive service billing procedure.

Medicaid providers will follow exam component and billing procedure requirements published in the *Health Check Billing Guide*. NCHC providers will bill for preventive services using the same codes found in the *Health Check Billing Guide*. However, NCHC providers will use a TJ modifier instead of an EP modifier.

Effective April 1, 2013, the new *NC Health Choice Wellness Benefit Billing Guide* will be posted at www.ncdhhs.gov/dma/provider/library.htm.

DMA has developed a draft *NC Health Choice Wellness Benefit Billing Guide* modeled after the Medicaid Health Check Billing Guide. The NCHC publication is currently posted for 45 day public notice and comment at: www.ncdhhs.gov/dma/mpproposed/ .

This draft billing guide includes medical and dental periodicity schedules and preventive service components to make NCHC wellness exams equivalent to Medicaid Health Check wellness exams. NCHC provider reimbursement for the wellness exams will be 100% equivalent to Medicaid provider reimbursement for Medicaid Health Check wellness exams when Health Choice providers complete all service elements outlined in the new Billing Guide.

Billing Instructions:

1. Reimbursement requests require a TJ modifier. Health Choice providers must *not* use an EP modifier.

2. Until the *NC Health Choice Wellness Benefit Billing Guide* becomes available, refer to the billing instructions in the *Health Check Billing Guide* located at www.ncdhhs.gov/dma/healthcheck/FINAL_Health_Check_Billing_Guide.pdf. On or after April 1, 2013, all claims filed for Health Choice wellness exams must 1) include

all service components in the *Billing Guide*; and 2) have been provided on or after July 1, 2012.

3. Providers who have already received payment for these dates of service but want reimbursement under the new methodology may void their earlier claim and file an electronic replacement on or after April 1, 2013.

Health Choice
DMA, 919-855-4107

Attention: Pharmacists and Prescribers

Delay in Non-Enrolled Prescriber Edit

The N.C. Division of Medical Assistance (DMA) communicated in the *December 2012 Medicaid Bulletin* that an edit would be implemented on April 1, 2013 to deny pharmacy claims written by non-enrolled prescribers. This action has been delayed until after the July 1, 2013 transition to the new MMIS system. A new effective date will be communicated in a future Medicaid bulletin.

DMA continues to strongly encourage all physician assistants and nurse practitioners to enroll as Medicaid providers. It is essential that these provider types enroll to ensure continued prescription coverage for their Medicaid and N.C. Health Choice (NCHC) patients when the new pharmacy edit goes into effect. Residents who are not authorized to enroll as Medicaid or NCHC providers – e.g., interns and residents at hospitals, (house staff at teaching hospitals), who order a prescription for a Medicaid beneficiary on behalf of the hospital – could apply the NPI of the hospital or the NPI of the supervising physician to the claim. Either of these prescriber identifiers will be accepted for resident prescribers when this change goes into effect.

Outpatient Pharmacy
DMA, 919-855-4300

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

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

Proposed Clinical Coverage Policies

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

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

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

2013 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
March	02/28/13	03/05/13	03/06/13
	03/07/13	03/12/13	03/13/13
	03/14/13	03/19/13	03/20/13
	03/21/13	03/28/13	03/29/13
April	04/04/13	04/09/13	04/10/13
	04/11/13	04/16/13	04/17/13
	04/18/13	04/25/13	04/26/13

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

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

Melissa Robinson
Executive Director
HP Enterprise Services