March 2014 Medicaid Bulletin

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Attention: All Providers

Receiving Email Alerts Through NCTracks

Note to Providers: This article was originally published in September 2013.

Providers can subscribe to email alerts through the NCTracks Provider Portal at www.nctracks.nc.gov/. Alerts are sent when there is important information to share between monthly issues of the Medicaid Provider Bulletin. Past email alerts have contained information on these topics:

- Update on 2013 1099s
- Issue with Medicare Code Edit (MCE) 3224 Fixed
- ICD-10 Provider Readiness Assessment Survey from Centers for Medicare & Medicaid Services (CMS)
- Duplicate Management Fees to be Recouped
- Claims With New 2014 Codes to Pend

To receive email alerts and other communications from NCTracks, visit this page https://www.nctracks.nc.gov/content/public/providers/provider-communications.html. Use the link "Click here to join mailing list" under the heading "Sign Up for NCTracks Communications" in the upper right corner of the page. Providers who currently receive email alerts will continue to receive them through NCTracks. No other actions are required.

Email addresses will never be shared, sold or used for any purpose other than Medicaid and N.C. Health Choice email alerts and NCTracks communications.

CSC, 1-800-688-6696

Attention: All Providers

NCTracks Updates

Common Error - Missing Service Location for Rendering Providers

A common error preventing the payment of claims in NCTracks is missing service location(s) for rendering providers. All facilities where providers perform services must be listed as "provider service locations" within the provider record for their National Provider Identification (NPI) in NCTracks. The system uses a combination of NPI, taxonomy code and service location to process claims. If the address where a service was rendered is not listed as a "provider service location" for the rendering provider's NPI, the claim will suspend with Edit 4526 "Rendering locator code cannot be derived." This will delay the completion of claim adjudication and payment.

Rendering providers can add service locations to their provider record by having their Office Administrator complete a "Manage Change Request" in the "Enrollment Status and Management" section of the secure NCTracks provider portal.

Pended claims are reviewed periodically. The system will recognize changes in the provider record which fix Edit 4526 and allow payments to be made.

Note: When adding a new service location, the application will also require that taxonomies and applicable accreditations be added to the new service location.

Visual Aids Prior Approval

Procedure codes are not required when entering requests for visual aids through the Web portal. It is appropriate to leave that field blank.

When entering requests for visual aids via the Web portal, enter "5" for the Service Units under the 'Health Care Services Delivery Information" section.

Before submitting a request for visual aids via the Web portal, be sure the prescription is complete and correctly entered. Be sure to enter the "+" and "-" signs, as the system defaults to "+".

Also be sure pupillary distance (PD) and frame information are entered correctly. PD cannot be changed once the request has been submitted.

Change in Outpatient Hospital Claim Billing

The implementation of NCTracks on July 1, 2013 included a requirement that a HCPCS code be billed with all revenue codes for outpatient hospital claims. That requirement has been changed.

If the revenue code required a HCPCS code prior to July 1, then it will continue to do so. If the revenue code did not require a HCPCS code until after July 1, then it is no longer required. (However, providers are encouraged to use a HCPCS code on claims *when possible* since the N.C. Division of Medical Assistance (DMA) is capturing the data for future use.) All HCPCS codes submitted with revenue codes will need to be valid for the date of service being billed.

Outpatient claims billed with a revenue code – but no procedure code – will still report Edit 00435 "Outpatient hospital claim require HCPCS code to be billed with revenue code" on the Remittance Advice (RA), but it will not cause the claim to deny. The Explanation of Benefits (EOB) will be changed in the near future to remove the word "require." Until then, the current EOB will be displayed **but the line detail will display "paid."**

All claims submitted for dates of service after July 1 which were denied for Edit 00435 can be resubmitted by the provider. For electronic claim submission, providers can submit a replacement claim to the previously denied claim and put the previous Transaction Control Number (TCN) as the replacement claim number, per the 837I billing guidelines.

Update on ACA Enhanced Rate Payments

The Affordable Care Act (ACA) requires that the Medicaid program pay at the Medicare rate for certain primary care services and to reimburse 100% of the Medicare Cost Share for services paid in calendar years 2013 and 2014. Providers who wish to receive the enhanced rate must attest to their qualifications on DMA's Attestation Web portal at www.ncdhhs.gov/dma/provider/ACA_Home.html. Once a provider has successfully attested, it is not necessary to re-attest in calendar year 2014 unless the previous attestation has become invalid.

In September 2013, NCTracks began making the ACA enhanced rate payments to providers who attested and were certified by the state for qualified services billed from that point forward.

Currently NCTracks is being updated to include:

- Health Check,
- Codes that are billed with an EP modifier, and
- Adjustments to the provider's RA.

Once these changes are complete, retroactive reimbursement for claims submitted from July 1, 2013 through present is scheduled to occur in the March 18, 2014 checkwrite. The retroactive ACA enhanced rate payments will be reported in a separate section of the RA to make it easier to identify the payments and post to provider accounting systems. After the reprocessing of claims back to July 1, 2013, NCTracks will begin reprocessing those claims previously processed by HP Enterprise Services (HPES) for dates of service between January 1 and June 30, 2013. No action is required on the part of certified providers to receive retroactive reimbursement.

In December 2013, it was determined that ACA enhanced rate payments are **not** eligible for State Health Insurance Program (SCHIP)/N.C. Health Choice (NCHC) beneficiaries. A system change was implemented to eliminate future ACA enhanced rate payments for SCHIP/NCHC beneficiaries. Prior ACA enhanced rate payments already made to providers for SCHIP/NCHC beneficiaries will be recouped as part of the reprocessing of claims procedure mentioned above.

For more information about enhanced payments under the ACA, including qualifications for reimbursement and a link to the attestation process, see DMA's ACA enhanced payment Web page and the *February 2013 Medicaid Bulletin*.

Shared Savings Plan

As originally announced in the *January 2014 Medicaid Bulletin*, the Shared Savings Plan was enacted by N.C. Session Law 2013-360, Sections 12H.18 (b). Effective **January 1, 2014**, reimbursement rates for the following services rendered to Medicaid and NCHC recipients were be reduced by 3%.

- Inpatient hospital
- Physician (excluding primary care providers who have attested for the enhanced reimbursement until January 1, 2015)*
- Dental
- Optical services and supplies
- Podiatry
- Chiropractors
- Hearing aids
- Personal care services
- Nursing homes
- Adult care homes
- Dispensing drugs

Because of changes required to separate the ACA physicians from the non-ACA physicians, the payments to the non-ACA physicians have not yet been reduced. Once the changes are completed, the previously paid claims for the non-ACA physicians will be adjusted back to January 1, 2014.

DMA is consulting with providers to develop a Shared Saving Plan to implement by July 1, 2014, with provider payments beginning January 1, 2015. The Shared Savings Plan shall offer incentives to provide effective and efficient care that results in positive outcomes for Medicaid and NCHC beneficiaries.

More information is available on DMA's Shared Savings Plan Web page at www.ncdhhs.gov/dma/plan/. Questions, comments and/or recommendations regarding the Shared Savings Plan can be sent to DMA.NCSharedSavings@lists.ncmail.net.

Medicare HMO Paper Claims to be Returned to Providers

In keeping with the mandate for electronic claims submission, the Medicare Health Maintenance Organization (HMO) claims that have been submitted on paper will be returned to providers. Medicare HMO claims are to be resubmitted electronically as secondary claims. Providers do not have to attach any documents to secondary claims, but the claim should reflect the amount paid by Medicare in the "Other Payer Amount." For instructions on filing secondary claims to NCTracks, see the User Guide *How to Indicate Other Payer Details on a Claim in NCTracks and Batch Submissions* on the Provider User Guides and Training page of the NCTracks Provider Portal.

CSC, 1-800-688-6696

Attention: All Providers

NCTracks Tip of the Month: Include NPI with Fax and Email

Documents Without National Provider Identifiers (NPIs) Can Cause Delays in Processing Request

When sending documents to NCTracks, remember to include all provider National Provider Identifiers (NPIs) on the fax coversheet or on the first page of the documentation being faxed. Also, include the NPI in the subject line of emails sent to NCTracks (or in the body of the email) and on any attachment.

If there are multiple attachments, it is helpful to have the NPI on each of the attachments. An example would be supporting documentation related to enrollment or manage change request applications. The NPI is needed to link the documents to the correct provider record. Failure to include the NPI can result in the document being misrouted and cause delays in processing a request. Those who have recently sent documents to NCTracks without including the NPI might wish to resend the documents with the NPI.

CSC, 1-800-688-6696

Attention: All Providers

NC Medicaid EHR Incentive Program: March 2014 Update

Program Year 2013 Attestation Tail Period is Ending April 30, 2014

Eligible Professionals (EPs) must submit their Program Year 2013 attestations no later than April 30, 2014. As of May 1, 2014, the N.C. Medicaid Electronic Health Records (EHR) Incentive Program will **no longer** be accepting Program Year 2013 attestations.

> **Note for Program Year 2013 ONLY:**
>
> Even if providers plan to attest to Stage 1 90-day or 365-day Meaningful Use (MU) during the Jan. 1-April 30, 2014 attestation tail period they must select a continuous 90- or 365-day reporting period **within the 2013 fiscal year** (for eligible hospitals (EHs)) or **2013 calendar year** (for EPs).
>
> *In other words, providers who are attesting for Program Year 2013 in calendar year 2014 must use MU data from calendar year 2013.*

Reminder - 90 Day MU Reporting Period in 2014

In Program Year 2014 **only**, the Centers for Medicare & Medicaid Services (CMS) is allowing a one-time 90-day (for EPs) or fiscal quarter (for EHs) MU reporting period for all participants, regardless of their participation year.

Note: The first day an EP may attest to MU in Program Year 2014 is April 1, 2014.

Providers on track to attest for a 365-day MU reporting period in Program Year 2014 will instead report a 90-day (for EPs) or fiscal quarter (for EHs) MU reporting period, and begin with a 365-day MU reporting period in Program Year 2015.

For more information about reporting periods, visit the N.C. Division of Medical Assistance (DMA) EHR Web page at www.ncdhhs.gov/dma/provider/ehr.htm.

Selecting Patient Volume

The Stage 2 Final Rule dictates that an EP must select patient volume from:

- A consecutive 90-day period in the calendar year **prior** to the program year for which they are attesting, **or**
- A consecutive 90-day period within the 12 months **immediately** preceding the date of attestation.

If a provider is unable to use patient volume during their reporting period, they may either:

- Update the reporting period so it complies with CMS requirements, or
- Attest for Program Year 2014.

For example, if attesting on March 2, 2014 for Program Year 2013, EPs must select between patient volume data from:

- The **2012** calendar year (January 1, 2012 – December 31, 2012), or
- The 12 months immediately preceding the date attestation (March 1, 2013 - March 1, 2014).

Stage 2 Meaningful Use Attestations in Program Year 2014

CMS Stage 2 MU has launched and the N.C. Medicaid EHR Incentive Program is working to reach Stage 2 readiness in Program Year 2014. Providers preparing to attest for Stage 2 should continue to do so, but should note that they will be unable to attest on the N.C. Medicaid Incentive Payment System (NC-MIPS) until further notice. Updates will be posted on DMA's EHR Web page at www.ncdhhs.gov/dma/provider/ehr.htm.

A special bulletin will be released in the coming months with provider guidance for attesting to Stage 2 MU in Program Year 2014.

MU Exclusion for Public Health Data in Program Year 2014

North Carolina is unable to accept electronic submission of public health data, so EPs may continue to claim an exclusion for the MU public health measures.

Note: EHs may **not** take exclusion as they are able to electronically submit syndromic surveillance data to the state to meet the MU public health measures.

Upgrading Certified EHR Technology to 2014 Certification Standards

EPs and EHs planning to attest for an EHR incentive payment in Program Year 2014 will be required to inform the N.C. Medicaid EHR Program that they made upgrades to their computer system to meet 2014 standards. This can be accomplished by taking the following steps:

1. Working with an EHR vendor to upgrade the system so it is compliant with CMS' 2014 EHR certification standards
2. Going to the Office of the National Coordinator's Health IT Product List Website to obtain an updated EHR Certification ID number

3. Visiting the CMS Registration and Attestation (R&A) Portal and updating the EHR Certification ID number in the CMS registration record
4. Waiting at least 24 hours and then visiting NC-MIPS to attest for a Program Year 2014 payment

Note: The first day an EP may attest to MU in Program Year 2014 is April 1, 2014.

N.C. Medicaid Health Information Technology (HIT)
DMA, NCMedicaid.HIT@dhhs.nc.gov; 919-814-0180

Attention: All Providers

Family Planning Waiver and Code J1050

Effective with date of service December 31, 2012, Centers for Medicare & Medicaid Services (CMS) end-dated code J1055 "Injection, medroxyprogesterone acetate for contraceptive use, 150 mg (Use this code for Depo-Provera)" and replaced it with code J1050 "Injection, medroxyprogesterone acetate, 1 mg." The N.C. Division of Medical Assistance (DMA) is aware that claims have been denying for code J1050 for beneficiaries who are enrolled in the Family Planning Waiver (FPW) program.
To solve the problem, system changes have been made to update code J1050.

Denied claims for J1050 for dates of service on or after January 1, 2013, may be resubmitted for reimbursement.

Note: All submitted claims for FPW must be billed using the FP modifier.

Be Smart Family Planning Waiver
DMA, 919-855-4260

Attention: All Providers and N.C. Health Choice Providers

Flu Vaccine Update

The new CPT code, 90685 "Influenza Virus Vaccine, Quadrivalent, Split Virus, Preservative Free, When Administered To Children 6-35 Months Of Age, For Intramuscular Use," was added as a billable code for N.C. Medicaid beneficiaries effective October 1, 2013. This code is covered at a $0.00 rate as it is available to these patients through the Vaccine For Children program. See below for reimbursement guidelines for administration of all flu vaccine.

Each year scientists try to match the viruses in the influenza vaccine to those most likely to cause flu that year. This season's influenza vaccine is comprised of the following three strains:

- A/California/7/2009 (H1N1) pdm09-like virus
- A/Victoria/361/2011 (H3N2)-like virus
- B/Massachusetts/2/2012-like virus

A new quadrivalent flu vaccine will also include the following strain:

- B/Brisbane/60/2008–like virus

For further details on the 2013-2014 influenza vaccine, see the Advisory Committee on Immunization Practices (ACIP) recommendations published in the September 20, 2013, Centers for Disease Control's *Morbidity and Mortality Weekly Report* at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6207a1.htm.

N.C. Medicaid does not expect that providers will be vaccinating beneficiaries with the 2013-2014 influenza seasons' vaccine after date of service June 30, 2014.

N.C. Immunization Program/Vaccines for Children (NCIP/VFC)

The N.C. Immunization Branch distributes all required childhood vaccines to local health departments, hospitals, and private providers under N.C. Immunization Program (NCIP)/Vaccines for Children (VFC) guidelines. According to the NCIP coverage criteria, NCIP/VFC influenza vaccine is available at no charge for children 6 months through 18 years of age who are eligible for the VFC program during the 2013-2014 influenza season. This includes Medicaid-covered children through the age of 18. The current NCIP coverage criteria, and definitions of VFC categories, can be found on NCIP' Coverage Criteria Web page at www.immunize.nc.gov/providers/coveragecriteria.htm.

Children eligible for the VFC program also include American Indian and Alaska Native (AI/AN) N.C. Health Choice (NCHC) beneficiaries. These beneficiaries are identified as MIC-A and MIC-S on their NCHC Identification Cards. However, the

NCIP/VFC program allows beneficiaries/parents to declare their VFC eligibility status. When an NCHC beneficiary self-declares their status as AI or AN, the provider should administer VFC vaccine. The provider must report the CPT vaccine code with $0.00 and may bill NCHC for the administration costs. **All other NCHC beneficiaries are considered insured, and must be administered privately purchased vaccines.** Refer to the June 2012 general Medicaid article, *Billing for Immunizations for American Indian and Alaska Native N.C. Health Choice Recipients* at www.ncdhhs.gov/dma/bulletin/0612bulletin.htm#AI for further details.

For NCIP/VFC vaccines, providers will only report the vaccine code but may bill for the administration fee for Medicaid and eligible AI/AN NCHC beneficiaries.

Providers wishing to immunize children who are **not** VFC-eligible – including all NCHC children who are not AI/AN, and adult patients who do not meet the eligibility criteria for NCIP influenza vaccine – must purchase vaccine for those groups. Because of new federal restrictions, the NCIP/VFC vaccines will not be expanded universally.

Billing/Reporting Influenza Vaccines for Medicaid Beneficiaries

The following tables indicate the vaccine codes that can be either reported (with $0.00 billed) or billed (with the usual and customary charge) for influenza vaccine, depending on the age of the beneficiaries and the formulation of the vaccine. The tables also indicate the administration codes that can be billed, depending on the age of the beneficiaries.

Note: The information in the following tables is **not** detailed billing guidance. Specific information on billing all immunization administration codes for NCHC beneficiaries can be found in the July 2013 NC Medicaid Special Bulletin, *Health Check Billing Guide 2013* at www.ncdhhs.gov/dma/healthcheck/HC-Billing_Guide_2013.pdf

Table 1: Influenza Billing Codes for Medicaid Beneficiaries Less Than 19 Years of Age Who Receive VFC Vaccine

Vaccine CPT Code to Report	CPT Code Description
90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90672	Quadrivalent Influenza virus vaccine, live, for intranasal use (FluMist)

Vaccine CPT Code to Report	CPT Code Description
90685	Influenza virus vaccine, quadravalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90471EP	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **1 vaccine** (single or combination vaccine/toxoid)
+90472EP (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **each additional vaccine** (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note**: Providers *may* bill more than one unit of 90472EP as appropriate.
90473EP	Immunization administration by intranasal or oral route; **1 vaccine** (single or combination vaccine/toxoid). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.
+90474EP (add-on code)	Immunization administration by intranasal or oral route; **each additional vaccine** (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.

Table 2: Influenza Billing Codes for Medicaid Beneficiaries 19 and 20 Years of Age

Use the following codes to bill Medicaid for an influenza vaccine purchased and administered to beneficiaries **19 through 20 years of age.**

Note: For the 2013-2014 flu season, the NCIP will **not** provide Live Attenuated Influenza Vaccine (LAIV) (CPT code 90672 FluMist) for adults ages 21 and over.

Vaccine CPT Code to Report or Bill	CPT Code Description
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90672(purchased vaccine only)	Quadrivalent Influenza virus vaccine, live, for intranasal use (FluMist)

Vaccine CPT Code to Report or Bill	CPT Code Description
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90471EP	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **1 vaccine** (single or combination vaccine/toxoid)
+90472EP (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **each additional vaccine** (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure
90473EP	Immunization administration by intranasal or oral route; **1 vaccine** (single or combination vaccine/toxoid). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.
+90474EP (add-on code)	Immunization administration by intranasal or oral route; **each additional vaccine** (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.

Note: The influenza vaccine is one of four vaccines for which Medicaid will reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). These providers may bill the appropriate CPT code for the vaccine used (90656, 90658 or 90672) along with the appropriate administration code (90471 through 90474). For beneficiaries 6 months through 20 years of age, if the vaccine was provided through the NCIP, the center/clinic may bill only for the administration costs under the C suffix provider number.

Table 3: Influenza Billing Codes for Medicaid Beneficiaries 21 Years of Age and Older

Use the following codes to report the **injectable** influenza vaccine provided by NCIP or to **bill** Medicaid for an **injectable** influenza vaccine **purchased** and administered to beneficiaries **21 years of age and older.**

Note: For the 2013-2014 flu season, the NCIP will not provide LAIV (CPT code 90672, FluMist) for adults. Medicaid does NOT reimburse for purchased LAIV for beneficiaries 21 years of age and older.

Vaccine CPT Code to Report or Bill	CPT Code Description
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **1 vaccine** (single or combination vaccine/toxoid)
+90472 (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **each additional vaccine** (single and combination vaccine/toxoid) (List separately in addition to primary procedure)

For beneficiaries 21 years of age or older receiving an influenza vaccine, an evaluation and management (E/M) code **cannot** be reimbursed to any provider on the same day that injection administration fee codes (e.g., 90471 or 90471 and +90472) are reimbursed, unless the provider bills an E/M code for a separately identifiable service by appending modifier 25 to the E/M code.

Billing/Reporting Influenza Vaccines to Medicaid for NCHC Beneficiaries

The following table indicates the vaccine codes that can be either reported (with $0.00) or billed (with the usual and customary charge) for influenza vaccine, depending on a NCHC beneficiary's VFC eligibility and the formulation of the vaccine. The table also indicates the administration codes that may be billed.

Table 4: Influenza Billing Codes for NCHC Beneficiaries 6 through 18 Years of Age Who Receive VFC Vaccine (MIC-A and MIC-S Eligibility Categories or Beneficiaries in Other Categories who Self Declare AI/AN Status) or Purchased Vaccine (All Other NCHC Eligibility Categories)

Vaccine CPT Code to Report/Bill	CPT Code Description
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90672	Quadrivalent Influenza virus vaccine, live, for intranasal use (FluMist)
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **1 vaccine** (single or combination vaccine/toxoid)
+90472 (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **each additional vaccine** (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note**: Providers *may* bill more than one unit of 90472 as appropriate.
90473	Immunization administration by intranasal or oral route; **1 vaccine** (single or combination vaccine/toxoid). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.
+90474 (add-on code)	Immunization administration by intranasal or oral route; **each additional vaccine** (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.

Note: The EP modifier should NOT be billed on NCHC claims.

For FQHCs and RHCs, for AI/AN NCHC beneficiaries 6 through 18 years of age, if the vaccine was obtained through NCIP/VFC, the clinic may bill only for the administration costs under the C suffix provider number. The vaccine CPT code must be reported and $0.00 should be billed.

For influenza vaccine and administration fee rates, refer to the Physician's Drug Program fee schedule on the DMA Website at www.ncdhhs.gov/dma/fee/ .

CSC, 1-800-688-6696

Attention: All Providers

Sterilization Consent Forms and Hysterectomy Statement Reminders

Providers of OB/GYN services have been receiving numerous Sterilization Consent Form and Hysterectomy Statement denials. Many of the denials are due to the absence of several key requirements for approval, specifically:

1. **N.C. Division of Medical Assistance (DMA) Clinical Coverage Policies (CCP) and Medicaid Bulletin guidelines and regulations are not being followed**. The Sterilization Procedures policy (1E-3) and Hysterectomies policy (1E-1) are located on the DMA Clinical Policy Web page at www.ncdhhs.gov/dma/mp/.

2. **All signatures** on both Sterilization Consent Forms and Hysterectomy Statements must be legible. **Signatures that are illegible should have a printed version of the person's name above or below the signature. If there is any question of legibility of a signature, insure there is a printed name on the consent form prior to submitting it to CSC for review.**

3. **It is the responsibility of the surgeon to send Sterilization Consent Forms and Hysterectomy Statements to CSC.** Hospitals, Anesthesia, Pathology Services, and other ancillary providers, **should never** send Sterilization Consent Forms and Hysterectomy Statements to CSC. Therefore, **the National Provider Identifier (NPI) of the rendering provider (surgeon) shall be the only acceptable NPI for Sterilization Consent Forms and Hysterectomy Statements.** Rendering providers (surgeons) should submit Sterilization Consent Forms and Hysterectomy Statements within 30 days of the procedure for review and approval.

4. **Sterilization Consent Forms and Hysterectomy Statements should not be submitted electronically with the claim at this time.** All Sterilization Consent Forms and Hysterectomy Statements shall be **mailed** to:

   CSC
   P.O. Box 30968
   Raleigh, NC 27622

Questions regarding Sterilization Consent Forms and Hysterectomy Statements should be directed to CSC at 1-800-688-6696.

Clinical Policy,
DMA, 919-855-4260

Attention: Community Care of NC/Carolina ACCESS (CCNC/CA) Providers

Community Care of NC/Carolina ACCESS Overrides

Note to Providers: This article was previously published in February 2014.

A Community Care of NC/Carolina ACCESS (CCNC/CA) Primary Care Provider (PCP) is the only medical provider who can provide services to a CCNC/CA beneficiary without authorization. **All other medical providers must obtain authorization from the beneficiary's CCNC/CA PCP of record prior to rendering treatment *unless* the specific service is exempt from CCNC/CA authorization.**

For a listing of exempt services, see the Provider Claims and Billing Assistance Guide at https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html.

Medical providers should not direct beneficiaries to request overrides from the N.C. Division of Medical Assistance (DMA), CSC (NCTracks), or local departments of social services.

When services are rendered to a CCNC/CA beneficiary without first obtaining authorization from the CCNC/CA PCP and the PCP refuses to authorize retroactively, medical providers may request an override.

CCNC/CA overrides are authorizations issued by the NCTracks Customer Support Center for CCNC/CA enrolled beneficiaries.

- Override requests will only be considered if extenuating circumstances – beyond the control of the parties involved in the claim – affected the beneficiary's access to medical care.
- Overrides will **not** be considered for current, future, or past dates of service unless the CCNC/CA PCP of record has been contacted and refused to authorize treatment.

Medical providers needing a Carolina ACCESS override must submit a DMA CA Override Request Form to the NCTracks Customer Support Center.

There are two preferred methods for submitting an Override Request:

- **Telephone** – The provider can call NCTracks to request an override for future dates of service or if the patient is in the doctor's office waiting for treatment. The NCTracks number is 1-800-688-6696.
- **Fax** – The provider can fax the Override Request Form to NCTracks. The fax number is 1-855-710-1964.

A copy of the DMA CA Override Request Form may be found on DMA's CCNC/CA Web page at www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm.

Those with questions regarding Carolina ACCESS may contact their Regional Consultant. Contact information for Regional Consultants is available at www.ncdhhs.gov/dma/ca/MCC_0212.pdf.

CCNC/CA, Managed Care
DMA, 919-855-4780

Attention: Nurse Practitioners, Physician Assistants, and Physicians

Denosumab, 1mg (Xgeva or Prolia), HCPCS code J0897): New Indication

Note: The process for adding new drugs and products – or new indications for drugs or products that are already covered through PDP – is not automated. Therefore, there is always a delay between the effective date of coverage or change to the NCTracks system and the announcement of the change in the Medicaid Bulletin.

Effective with date of service June 13, 2013, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover a new indication of treatment within the Physician's Drug Program (PDP) for adults and skeletally mature adolescence with giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity. Denosumab injection (Xgeva or Prolia) is now covered when billed with HCPCS code J0897 (Injection, denosumab, 1mg). The new ICD-9 code that can be included with a J0897 claim is 238.0.

Refer to the fee schedule for the Physician's Drug Program on N.C. Division of Medical Assistance (DMA) Website at www.ncdhhs.gov/dma/fee/ for the latest available fees.

CSC, 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants, and Physicians

Eculizumab, 10mg (Soliris), HCPCS code J1300): New Indication

Note: The process for adding new drugs and products – or new indications for drugs or products that are already covered through PDP – is not automated. Therefore, there is always a delay between the effective date of coverage or change to the NCTracks system and the announcement of the change in the Medicaid Bulletin.

Effective with date of service September 23, 2013, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover a new indication of hemolytic-uremic syndrome for eculizumab injection (Soliris) for use in the Physician's Drug Program when billed with HCPCS code J1300 (Injection, eculizumab, 10mg). The new ICD-9 code that can be included with a J1300 claim is 283.11.

Refer to the fee schedule for the Physician's Drug Program on N.C. Division of Medical Assistance (DMA) Website at www.ncdhhs.gov/dma/fee/ for the latest available fees.

CSC, 1-800-688-6696

Attention: OB/GYN Providers

Coverage of Tdap During Pregnancy

Notice to Providers: This article updates information published in the *January 2014 Medicaid Bulletin*.

The Advisory Committee on Immunization Practices (ACIP) recommends healthcare personnel should administer a dose of the combined Tetanus, Diphtheria and Pertussis Vaccine (Tdap) during each pregnancy, regardless of the patient's prior history of receiving Tdap. To maximize the maternal antibody response and passive antibody transfer to the infant, optimal timing for Tdap administration is between 27 and 36 weeks gestation – although Tdap may be given at any time during pregnancy. For women not previously vaccinated with Tdap, if Tdap is not administered during pregnancy, Tdap should be administered immediately postpartum. For more information, visit the February 22, 2013, Centers for Disease Control's *Morbidity and Mortality Weekly Report* at www.cdc.gov/mmwr/preview/mmwrhtml/mm6207a4.htm.

The N.C. Division of Medical Assistance (DMA) has reviewed the current obstetric policy and made a recommendation regarding Tdap vaccine during pregnancy and the postpartum period. The interpretation of the current obstetric policy is to cover Tdap administration according to ACIP guidelines.

Effective for dates of service on or after November 21, 2013, providers may file claims for Tdap vaccine to DMA's fiscal agent for reimbursement. Questions should be directed to CSC at 1-800-688-6696.

OB/GYN Services
DMA, 919-855-4320

Attention: All Personal Care Services Providers

Personal Care Services Program Highlights

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

PCS Expedited Assessment Process

The N.C. Division of Medical Assistance (DMA) has approved an expedited assessment process to provisionally approve beneficiaries for Medicaid PCS. To qualify for the expedited assessment process beneficiaries must be:

1. Medically stable,
2. Eligible for Medicaid or pending Medicaid eligibility, and
3. In the process of either:
    a. Being discharged from hospitalization following a qualifying stay,
    b. Being under the supervision of Adult Protective Services (APS), or
    c. Seeking placement after discharge from a skilled nursing facility.

Beneficiaries seeking admission into an Adult Care Home licensed under G.S. 131D-2.4 must have a Preadmission Screening and Resident Review (PASRR) number on file to qualify for PCS through the expedited assessment process.

The expedited assessment process is used for provisional determination of PCS eligibility for beneficiaries who live in:

1. A private residence, or
2. A residential facility licensed by the State of North Carolina as an:
    a. Adult care home,
    b. Combination home as defined in G.S. 131E-101 (1a), or
    c. Group home licensed under Chapter 122 C of the General Statues and defined under 10A NCAC 27G as a supervised living facility for two or more adults whose primary diagnosis is mental illness, developmental disability, or substance abuse dependency.

PCS provisional approval through the expedited assessment process is subject to the standard PCS assessment process within 14 business days of authorization. A beneficiary approved through the expedited assessment process may receive up to 60 hours of services during the provisional period, not to exceed a 60-day period.

Beneficiaries who qualify for the expedited assessment process will receive a telephone assessment from Liberty Healthcare Corporation-NC (LHC-NC) to determine final PCS eligibility.

Beneficiaries will not receive PCS authorization without active Medicaid eligibility. If a beneficiary is provisionally approved for PCS through the expedited assessment process, but is determined not to be Medicaid eligible, LHC-NC will hold the authorization for 60 days. If after 60 days Medicaid eligibility is not approved, the beneficiary will receive a technical denial for PCS.

How to Initiate the PCS Expedited Assessment

Hospital discharge planners/staff, Division of Social Services case workers and skilled nursing facility discharge planners/staff may request an expedited assessment for beneficiaries by contacting LHC-NC at 1-855-740-1400. The DMA-3051 Request for Services form must be completed by a beneficiary's primary care or attending physician on a beneficiary's behalf and accompany the request for the expedited assessment.

If it is determined that a beneficiary qualifies for PCS, the hospital discharge planner, skilled nursing facility discharge planner, or adult protective services (APS) must communicate the beneficiary's choice of provider and his/her intended admission date both to the selected provider and to LHC-NC.

For additional information regarding the PCS expedited assessment process, contact LHC-NC at 1-855-740-1400 or DMA PCS program at 919-855-4340. To learn more about the PASRR, visit the N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services' Transition to Community Living Web page at www.ncdhhs.gov/mhddsas/providers/dojsettlement/.

Home and Community Care
DMA, 919-855-4340

Proposed Clinical Coverage Policies

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

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

The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is revised as a result of the initial comment period. If the adoption of a new or amended medical coverage policy is necessitated by an act of the General Assembly or a change in federal law, then the 45 and 15-day time periods shall instead be 30 and 10-day time periods.

Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
March	03/06/14	03/11/14	04/12/14
	03/13/14	03/18/14	04/19/14
	03/20/14	03/25/14	04/26/14
	03/27/14	04/01/14	04/02/14
April	04/03/14	04/08/14	04/09/14
	04/10/14	04/15/14	04/16/14
	04/17/14	04/22/14	04/23/14
	04/24/14	04/29/14	04/30/14

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.

Sandra Terrell, MS, RN
Acting Director
Division of Medical Assistance
Department of Health and Human Services

Paul Guthery
Executive Account Director
Computer Sciences Corp. (CSC)