April 2009 Medicaid Bulletin

In This Issue . . . ***Page***

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

Attention: All Providers

Use of the Medicaid Provider Number After National Provider Identifier Implementation

Although providers will not be able to submit Medicaid Provider Numbers (MPNs) on claims after May 1, 2009, they must still use the MPN for the following reasons:

- Prior approval (PA) requests – submit your MPN on all PA requests.
- UB-04 Medicare HMO claims – submit both your NPI and MPN on these claims, even after May 1, 2009.
- Carolina ACCESS override requests – continue to submit your MPN when requesting a Carolina ACCESS override. Do not submit your NPI in place of your MPN on these requests. On your claims, submit the Carolina ACCESS override number.
- Atypical providers – continue to submit your MPN on claims if the billing or referring provider is atypical.
- Automated Voice Response System (AVRS) – certain inquiries (examples: claim status, prior approval) will prompt you to choose from a list of up to 15 MPNs if you have entered an NPI as your provider identifier.
- Requests submitted to finance – anything submitted to finance must include your MPN (examples: refund request, EFT request).
- Medicaid Resolution Inquiry form.
- Medicaid Claim Adjustment Request form.
- Pharmacy Claim Adjustment Request form.

Providers will continue to receive a MPN as part of the enrollment process. In addition, providers will continue to see the MPN on paper Remittance and Status (RA) reports.

Please have your MPN accessible when contacting N.C. Medicaid.

NPI – Get it! Share It! Use It! Getting one is free – Not having one can be costly!

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

Attention: Community Alternatives Program Providers and Personal Care Services Providers

Recommended Taxonomy Code for National Provider Identifier Mapping

For providers who have one National Provider Identifier (NPI) that represents both a Community Alternatives Program (CAP) and a Personal Care Services (PCS) Medicaid Provider Number (MPN), submit taxonomy code 3747P1801X on all claims. If the recipient is eligible for CAP, the claim will map to the CAP provider number. Otherwise, it will map to the PCS provider number. Do not use taxonomy code 251E00000X, which indicates a home health agency, in this scenario. Claims billed with a taxonomy code other than 3747P1801X may not map to the correct MPN and may, therefore, result in a denied claim.

NPI – Get it! Share It! Use It! Getting one is free – Not having one can be costly!

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

Attention: All Providers

Are You Ready for National Provider Identifiers?

Providers have only one more month to prepare for National Provider Identifier (NPI) implementation. Are you ready? As a reminder, after May 1, 2009, Medicaid Provider Numbers (MPNs) will no longer be allowed on paper or electronic claims, with only a few exceptions. (Refer to *Use of the Medicaid Provider Number after National Provider Identifier Implementation* on page 1 for details). The following checklist will assist you with NPI preparation:

- Verify your information on file with N.C. Medicaid. This includes the NPI and site and billing addresses for each of your provider numbers. Providers can verify information by visiting the DMA NPI and Address Database: http://www.ncdhhs.gov/dma/WebNPI/default.htm.
- Make sure you are submitting the correct taxonomy code for your provider type and specialty. If you have a recommended taxonomy code, you should submit that taxonomy code on all claims. See the recommended taxonomy code list at: http://www.ncdhhs.gov/dma/NPI/taxonomy.htm.
- If you use a software vendor or clearinghouse, make sure the information they are submitting for you is correct and that as of May 1, 2009, they are prepared to submit NPI and taxonomy only.
- Submit a few claims now without your MPN, even if you have not received a ready letter.

NPI – Get it! Share It! Use It! Getting one is free – Not having one can be costly!

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

Attention: All Providers

Medicaid Recipient/Applicant Due Process Appeals for Medical, Dental, and Behavioral Health Services

North Carolina S.L. 2008-118, s. 3.13, effective July 1, 2008, eliminated Medicaid **informal** appeals with the Department of Health and Human Services (DHHS) Hearing Office as a hearing option for Medicaid recipients and applicants beginning October 1, 2008. Only a **formal or fair hearing** before the Office of Administrative Hearings (OAH) is required for adverse decisions made about a Medicaid recipient's or applicant's medical, dental, or behavioral health service requests. The law specifies deadlines (see appeal timeline on page 5) throughout the formal hearing process that must be met by OAH and DHHS. The fair or formal hearing process, exclusive of a request for judicial review, must be completed within 90 days of the recipient's/applicant's filing with OAH and the DHHS General Counsel.

Since the law was enacted, OAH, the Mediation Network of North Carolina, and DMA have been working cooperatively to develop policies and procedures to implement the appeal process. DMA has created new notices and a recipient appeal request form and distributed them to staff and vendors for implementation. Additionally, DMA has developed an electronic system that will manage all appeal documents, track the status of individual appeals, and collect data regarding the efficiency, effectiveness, and cost effectiveness of the new appeal process. Lastly, DMA has trained its staff, vendors, and mediators regarding the new appeal process.

A brief overview of the hearing process appears below. This overview is not meant to provide an in-depth explanation of all hearing procedures. DMA expects to publish a detailed Special Bulletin on the appeal process once policies and procedures have been completed with OAH.

- Whenever an adverse decision is made by Medicaid to deny, reduce, terminate, or suspend a Medicaid applicant's or recipient's medical, dental, or behavioral health services and in compliance with federal requirements and North Carolina S.L. 2008-118, s. 3.13, due process or appeal rights are implicated. Written notice of the adverse decision must be provided to the recipient/applicant and, if appropriate, his/her legal representative, as well as the service provider. The notice must include a clear statement of the decision, the citation that supports the decision made, and appeal rights for a fair or formal hearing. The effective date of the decision appears in the notice.
- The Recipient Hearing Request Form is only included in the recipient's mailing. The recipient's notice is sent by trackable mail with return receipt requested to the last address provided to the county Department of Social Services. The provider's mailing is sent by first class mail via the U.S. Postal System to the address furnished by the provider and on file with DMA's Provider Services.
- Providers may assist the recipient or his/her legal representative with the appeal process as allowed by the recipient.
- The information sheet (see page 4) is included in the recipient's notice, and it provides an overview of the appeal process.

The next phase of implementation of North Carolina S.L. 2008-118 is provider training and recipient notification about the new appeals process. Questions about the appeal process may be directed to either OAH or DMA's Appeals Unit.

Appeals Unit
DMA, 1-800-662-7030 or 919-855-4260

FOR YOUR INFORMATION ONLY
DO NOT SEND THIS PAGE WITH A COMPLETED HEARING REQUEST FORM.

GENERAL INFORMATION ABOUT THE HEARING PROCESS

UNDERSTANDING THE APPEAL PROCESS: If you choose to appeal, you may represent yourself during the appeal process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for you. Your case will begin as soon as the completed recipient hearing request form that you were sent in this mailing is **received and filed** with the Office of Administrative Hearings (OAH) **AND** the Department of Health and Human Services (DHHS). You will be contacted by the Office of Administrative Hearings or the Mediation Network of North Carolina to discuss your case and to be offered an opportunity for mediation in an effort to resolve your appeal. If mediation resolves your case, your hearing will be dismissed, and services will be provided as specified by the Mediation Network of North Carolina. If you do not accept the offer of mediation or the results of mediation, your case will proceed to hearing and will be heard by an administrative law judge with the Office of Administrative Hearings. You will be notified by mail of the date, time, and location of your hearing. The administrative law judge will make a decision and will send that decision to Medicaid for a final agency decision. You will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision. If you do not agree with Medicaid's final agency decision, you may ask for a judicial review in superior court. The hearing process must be completed within 90 days of receipt of your completed Recipient Hearing Request Form. For more information about the hearing process, visit the websites indicated below.

- **Adults:** http://www.ncdhhs.gov/dma/medicaid/abd.pdf
- **Children:** http://www.ncdhhs.gov/dma/medicaid/famchld.pdf.

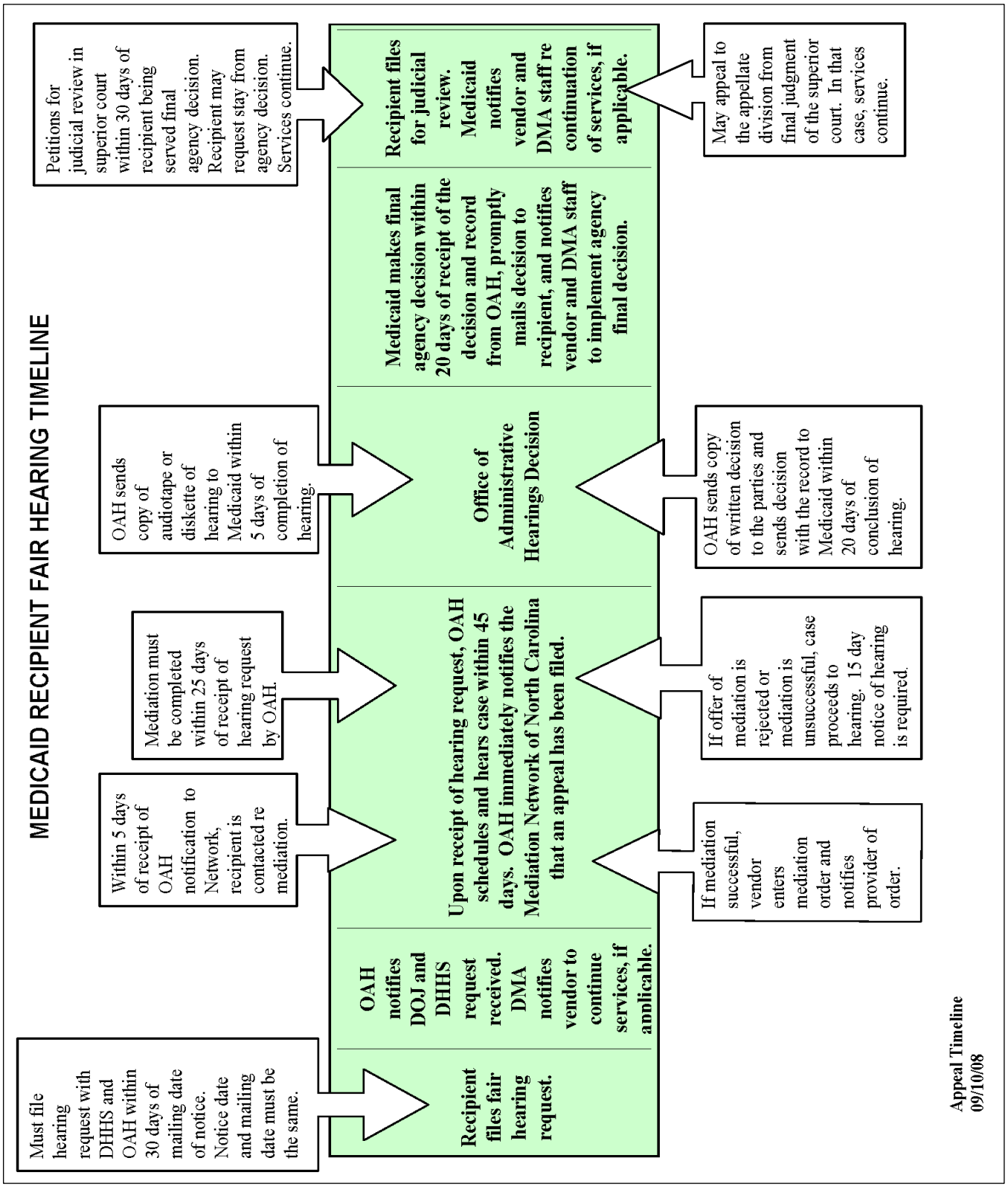
SERVICES DURING THE APPEAL PROCESS: If a **continuing** request for services is denied and you submit a request for hearing within **30 days of the date the notice was mailed** and as long as you remain otherwise Medicaid eligible, unless you give up this right, you are entitled to receive services during the pendency of the appeal. **This right to receive services applies even if you change providers.** The service will be provided at the same level you were receiving the day before the decision or the level requested by your provider, whichever is less. The services that continue must be based on your current condition and must be provided in accordance with all applicable state and federal statutes and rules and regulations. If you lose your appeal, you may be required to pay for the services that continue because of the appeal.

FILING A RECIPIENT HEARING REQUEST FORM WITH OAH AND DHHS: Complete the enclosed Recipient Hearing Request Form if you decide to appeal Medicaid's decision to deny, terminate, reduce (change), or suspend the services requested by your provider. Hearing requests must be served on **BOTH** OAH and DHHS. The request must be filed by mail or fax within **30 days of the date the notice was mailed**. The mailing addresses and telephone and fax numbers for OAH and DHHS appear below.

For questions concerning the decision Medicaid made about your provider's request for service, please contact Medicaid. Should you have questions about the appeal process, please contact OAH. You may also contact the Appeals Unit, Division of Medical Assistance (Medicaid) if you have questions.

AGENCY	MAILING ADDRESS	OFFICE NUMBER	FAX NUMBER
Office of Administrative Hearings (OAH)	Clerk 6714 Mail Service Center Raleigh, NC 27699-6714	919-431-3000	Clerk 919-431-3100
NC Department of Health and Human Services (DHHS)	General Counsel 2001 Mail Service Center Raleigh NC 27699-2001	919-733-4534	General Counsel 919-715-4645
Division of Medical Assistance (Medicaid)	Appeals Unit Clinical Policy and Programs 2501 Mail Service Center Raleigh NC 27699-2501	919-855-4260 Toll-free: 1-800-662-7030 Ask for your call to be transferred to the DMA Appeals Unit, Clinical Policy and Programs.	Appeals Unit 919-733-2796

DMA 2003
09/08/05
REV 09/24/08


MEDICAID RECIPIENT FAIR HEARING TIMELINE
Must file hearing request with DHHS and OAH within 30 days of mailing date of notice. Notice date and mailing date must be the same.
Recipient files fair hearing request.
OAH notifies DOJ and DHHS request received. DMA notifies vendor to continue services, if applicable.
Within 5 days of receipt of OAH notification to Network, recipient is contacted re mediation.
Mediation must be completed within 25 days of receipt of hearing request by OAH.
Upon receipt of hearing request, OAH schedules and hears case within 45 days. OAH immediately notifies the Mediation Network of North Carolina that an appeal has been filed.
If mediation successful, vendor enters mediation order and notifies provider of order.
If offer of mediation is rejected or mediation is unsuccessful, case proceeds to hearing. 15 day notice of hearing is required.
OAH sends copy of audiotape or diskette of hearing to Medicaid within 5 days of completion of hearing.
Office of Administrative Hearings Decision
OAH sends copy of written decision to the parties and sends decision with the record to Medicaid within 20 days of conclusion of hearing.
Medicaid makes final agency decision within 20 days of receipt of the decision and record from OAH, promptly mails decision to recipient, and notifies vendor and DMA staff to implement agency final decision.
Recipient files for judicial review. Medicaid notifies vendor and DMA staff re continuation of services, if applicable.
Petitions for judicial review in superior court within 30 days of recipient being served final agency decision. Recipient may request stay from agency decision. Services continue.
May appeal to the appellate division from final judgment of the superior court. In that case, services continue.
Appeal Timeline
09/10/08

Attention: All Providers

Provider Exclusions, Fraud, and Abuse

CMS requires every state to remind providers to screen their employees and contractors for excluded persons. The information below outlines this requirement and also gives specific instructions to providers on how to access the list of individuals excluded by the Health and Human Services Office of Inspector General (HHS-OIG).

The HHS-OIG excludes individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all federal health care programs [as defined in section 1128B(f) of the Social Security Act (the Act)] based on the authority contained in various sections of the Act, including sections 1128, 1128A, and 1156.

When the HHS-OIG has excluded a provider, federal health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities [Section 1903(i)(2) of the Act; and 42 CFR section 1001.1901(b)]. This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity, and extends to

- all methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system;
- payment for administrative and management services that are not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and
- payment to cover an excluded individual's salary, expenses, or fringe benefits, regardless of whether he or she provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

The following list sets forth some examples of the types of items or services that are reimbursed by Medicaid that, when provided by excluded parties, are not reimbursable:

- services performed by excluded nurses, technicians, or other excluded individuals who work for a hospital, nursing home, home health agency, or physician practice, where such services are related to administrative duties, preparation of surgical trays, or review of treatment plans if such services are reimbursed directly or indirectly (such as through a pay-per-service or a bundled payment) by a Medicaid program, even if the individuals do not furnish direct care to Medicaid recipients;
- services performed by excluded pharmacists or other excluded individuals who enter prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by a Medicaid program;
- services performed by excluded ambulance drivers, dispatchers, and other employees involved in providing transportation reimbursed by a Medicaid program to hospital patients or nursing home residents;
- services performed for program recipients by excluded individuals who sell, deliver, or refill orders for medical devices or equipment being reimbursed by a Medicaid program;
- services performed by excluded social workers who are employed by health care entities to provide services to Medicaid recipients, and whose services are reimbursed, directly or indirectly, by a Medicaid program;
- services performed by an excluded administrator, billing agent, accountant, claims processor, or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Medicaid program;

- items or services provided to a Medicaid recipient by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Medicaid program; and
- items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of recipients and reimbursed, directly or indirectly, by a Medicaid program.

To protect against payments for items and services furnished or ordered by excluded parties, DMA advises all current providers, and providers applying to participate in the N.C. Medicaid Program, to take the following steps to determine whether their employees and contractors are excluded individuals or entities:

- Screen all employees and contractors to determine whether any of them have been excluded.
- Search the HHS-OIG website using the name of each individual or entity.
- Search the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search.
- Immediately report to DMA any exclusion information discovered.

Compliance with this obligation is a condition of participation for N.C. Medicaid and DMA will notify the HHS-OIG promptly of any administrative action taken against a provider who fails to comply with these screening and reporting obligations.

Civil monetary penalties may be imposed against Medicaid providers and managed care entities (MCEs) who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients.

Where Providers Can Look for Excluded Parties

The HHS-OIG maintains the List of Excluded Individuals/Entities (LEIE) as a database that is accessible to the general public. The database provides information about parties excluded from participation in Medicare, Medicaid, and all other federal health care programs. The LEIE website is located at http://www.oig.hhs.gov/fraud/exclusions.asp and is available in two formats. The online search engine identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match using a Social Security Number (SSN) or Employer Identification Number (EIN). The downloadable version of the database may be compared against an existing database maintained by a provider. However, unlike the online format, the downloadable database does not contain SSNs or EINs.

Monica T. Jones, Provider Services
DMA, 919-855-4050

Attention: All Providers

Computer Sciences Corporation to Assume N.C. Medicaid Provider Enrollment, Credentialing, and Verification Activities

DMA is pleased to announce that Medicaid provider enrollment, credentialing, and verification functions will be transferred from DMA Provider Services to Computer Sciences Corporation (CSC) in late April 2009. This change will result in timelier processing of provider enrollment applications and will increase the support available to providers in need of assistance with enrollment and maintenance activities.

Please note that EDS will continue to perform all other provider support functions. Providers will continue to call EDS for claim status, checkwrite information, billing problems, etc., just as they do today. At this time, CSC will assume responsibility for only provider enrollment, credentialing, and verification activities.

Effective April 20, 2009, providers will mail all Medicaid enrollment forms, including applications, agreements, Medicaid Provider Change Forms, and Carolina ACCESS applications and agreements, to CSC at the address shown in the chart below. Providers accessing the DMA website for enrollment information after April 20, 2009, will be redirected to the CSC website to obtain provider enrollment forms.

CSC will operate a dedicated Medicaid Provider Enrollment, Verification, and Credentialing (EVC) Call Center for providers to inquire on the status of their Medicaid applications or change requests. The EVC Call Center hours of operation will be 8:00 a.m. to 5:00 p.m., Monday through Friday, except for State approved holidays. The toll-free CSC telephone and fax numbers are shown in the chart below.

Calls to the EVC Call Center will be answered by representatives who specialize in provider enrollment and credentialing functions. CSC will log and track information captured during the call in order to ensure consistent quality of all inquiry responses. CSC's goal is to resolve inquiries in the initial call. If additional research or escalation is necessary, a response and resolution will be provided within 48 hours of receipt of the call.

The EVC Call Center will be staffed with experienced health care professionals who will provide support in the following areas:

- Enrollment and credentialing processing
- Change request processing
- Enrollment, verification, and credentialing status
- Obtaining appropriate forms and instructions
- Assistance with forms completion
- Website support for downloading forms and instructions

CSC will accommodate many methods of provider communication including telephone, e-mail, fax, and written correspondence. All correspondence coming through the EVC Call Center will be maintained in a central repository to allow easy access to and quick retrieval of provider inquiries.

Beginning in April, CSC will also initiate a process to verify information for currently enrolled Medicaid providers. In accordance with CMS requirements for Medicaid participation (42 CFR.455.100 through 106), CSC will initiate credentialing activities for those enrolled providers who have not been credentialed in the last 14 months. CSC will notify providers when verification and credentialing activities will begin for their provider types.

DMA and CSC will continue to inform providers of various events and changes through the general Medicaid Bulletin, the DMA website, and the CSC website to ensure a smooth and seamless transition of enrollment, credentialing, and verification activities.

Beginning April 20, 2009, the CSC website can be accessed at http://www.nctracks.nc.gov. In addition to enrollment forms and enrollment/credentialing information, the website will also include instructions for completing forms, frequently asked questions, and other information to ensure that providers are well informed in advance of submitting applications.

EVC Call Center Contact Information

Enrollment, Verification, and Credentialing Call Center Toll-Free Number	866-844-1113
EVC Call Center Fax Number	866-844-1382
EVC Call Center E-Mail Address	NCMedicaid@csc.com
CSC Mailing Address	N.C. Medicaid Provider Enrollment CSC PO Box 300020 Raleigh NC 27622-8020
CSC Site Address	N.C. Medicaid Provider Enrollment CSC 2610 Wycliff Road, Suite 102 Raleigh NC 27607
CSC Website Address	http://www.nctracks.nc.gov

Refer to DMA's website at http://www.ncdhhs.gov/dma/provider/mmis.htm for more information about CSC and the development and implementation of the Replacement Medicaid Management Information System (MMIS).

Linda Pruitt
DMA, 919-855-4106

Attention: All Providers

Undeliverable Mail

Currently, if a Remittance and Status Report (RA) or check cannot be delivered due to an incorrect billing address in the provider's file, all claims for the provider number are suspended and the subsequent RAs and checks are no longer printed. Automatic deposits are also discontinued.

Effective April 20, 2009, **any correspondence,** including RAs or checks, that is returned to DMA, CSC or EDS as undeliverable due to an incorrect billing address will result in the suspension of the provider number.

Once a suspension has been placed on the provider number, the provider has 90 days to submit an address change. After 90 days, if the address has not been corrected, suspended claims will be denied and the provider number will be terminated. Once terminated, a provider must complete a new application and agreement to re-enroll and may have a lapse in eligibility as a Medicaid provider.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Top 10 List of Helpful Hints When Billing National Drug Codes

#10: Report Epogen and Procrit National Drug Code (NDC) units as milliliters.

#9: Do not use HCPCS procedure code J2405 (injection, ondansetron HCl, per 1 mg) to bill for ondansetron tablets. J2405 is for injections only.

#8: Rule of thumb: If the drug is in powder form in the vial, report the number of vials of powder administered for the NDC units. An example of NDC in powder form is ceftriaxone 500-mg vial.

#7: Rule of thumb: If the drug is in liquid form in the vial, report the number of milliliters administered for the NDC units. An example of NDC in liquid form is promethazine 25 mg/ml.

#6: When billing HCPCS procedure codes J1055 (injection, for contraceptive use, per 150 mg) or J1051 (injection, per 50 mg) for medroxyprogesterone acetate (Depo-Provera), bill the number of milliliters administered, not the number of milligrams.

Note: For professional claims, bill J1055 with the FP modifier.

#5: The correct HCPCS procedure codes for methylprednisolone sodium succinate (Solu-Medrol) are J2930 and J2920. Be sure the HCPCS code billed corresponds to the NDC of the steroid administered.

#4: When billing more than one NDC for a HCPCS code, be sure that the NDC units correspond to the dose being reported for the HCPCS units. The HCPCS units and the total NDC units, when reviewed separately, should report the same dose.

Example: A patient receives a 150-mg dose of Eloxatin. Report 300 units for J9263 (injection, oxaliplatin 0.5 mg). For Eloxatin 100 mg/20 ml report NDC units as 20 ml; for Eloxatin 50 mg/10 ml report NDC units as 10 ml (30 ml equals a 150-mg dose).

#3: Use HCPCS procedure codes J0560, J0570, and J0580 to bill for penicillin G benzathine (Bicillin LA). Use HCPCS procedure codes J0530, J0540, and J0550 to bill for the combination product, penicillin G benzathine and penicillin G procaine (Bicillin CR).

#2: Morphine, promethazine, and penicillin G benzathine have specific HCPCS codes. It is not correct to bill multiple unrelated NDCs under J3490 unless billing for a compound. In the future, claim details will be denied when miscellaneous HCPCS codes (J3490, J3590, and J9999) are billed with NDCs that have an assigned HCPCS code.

#1: "Milligram" is not a valid unit of measure for NDC units. Do not report the number of milligrams administered as the NDC units. The four required units of measure quantity codes are

- F2 (international unit)
  Example: blood products
- GR (gram)
  Example: ointment, creams
- ML (milliliter)
  Example: liquids (oral, vials, ampules)
- UN (unit)
  Example: number of tablets, number of vials (when powder is the original state)

Remember to use the specific code for the procedure or service performed. Refer to HCPCS coding guidance and the narrative description of the codes to identify the appropriate code for the service performed. If there is not a specific code that accurately identifies the service, use the appropriate unlisted service code. For example,

- If an injection of lidocaine is not administered as an intravenous infusion, do not bill HCPCS procedure code J2001 (Injection, lidocaine HCl for intravenous infusion, 10 mg).
- If an oral non-chemotherapeutic drug is billed on an outpatient hospital claim, use the specific code for the oral drug administered. Do not use J8499 (prescription drug, oral nonchemotherapeutic, NOS) if a specific code is available.

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

Attention: All Providers

Denials for Endovascular Graft Repair of Thoracic Aortic Aneurysm

Effective with date of service December 1, 2006, N.C. Medicaid has covered endovascular graft repair of thoracic aortic aneurysm (see Clinical Coverage Policy #1A-21). However, providers have continued to receive denials related to EOB 9 (service not covered by the Medicaid program).

System updates have now been completed to correct this issue. Providers who received claim denials related to EOB 9 and have kept their claims timely for CPT codes 33880, 33881, 33883, 33884, 33886, 33889, and 33891, and associated radiology codes 75956, 75957, 75958, and 75959, may submit new claims (not adjustments) for processing following time limit procedures.

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

Attention: All Providers

Clinical Coverage Policies

The following new or amended clinical coverage policies are now available on DMA's website at http://www.ncdhhs.gov/dma/mp/:

- 1N-1, *Allergy Testing*
- 1N-2, *Allergen Immunotherapy*
- 1S-4, *Cytogenetic Studies*

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

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Medicaid Fraud and Abuse – Confidential Online Complaint Form

Background

DMA's Program Integrity Section is devoted to ensuring that Medicaid payments are accurate and that fraud, waste or program abuse are **identified** and **reported.** To assist Program Integrity and to better serve the citizens of North Carolina to prevent Medicaid fraud, waste or program abuse, we have created a new confidential **Online Complaint Form.**

How to Report Suspected Medicaid Fraud, Waste and Program Abuse

DMA's Program Integrity Section has a new confidential Online Complaint Form that will now allow you to promptly report suspected Medicaid fraud, waste or program abuse. Everyone is encouraged to report matters involving Medicaid fraud, waste and program abuse. Anyone that reports suspected Medicaid fraud, waste or program abuse via this confidential online complaint form may remain anonymous by indicating this on the form. All complaints of misconduct are kept confidential and are protected from disclosure according to the N.C. State Administrative Procedure Act, Sections 10A NCAC 21A.0403. Program Integrity will not reveal the identity of the complainant to any person, **except as required by law.**

Where to Find Program Integrity Confidential Online Complaint Form

DMA's Program Integrity confidential Online Complaint Form is available on the Program Integrity webpage at http://www.ncdhhs.gov/dma/pi.htm. Everyone now has the ability to complete and submit this form electronically online.

Other Ways to Report Suspected Medicaid Fraud, Waste or Program Abuse

Other options to report suspected Medicaid fraud, waste or program abuse is to contact the North Carolina Division of Medical Assistance, by calling the CARE-LINE Information and Referral Service (http://www.ncdhhs.gov/ocs/) at 1-800-662-7030 (English or Spanish) and request to speak with someone in DMA's Program Integrity Section.

Manny Baksh, Program Integrity
DMA, 919-647-8000

Attention: All Providers

Corrected Diagnosis List for CPT Codes 93228 and 93229

In the January 2009 Medicaid Bulletin, the diagnosis list for CPT codes 93228 (wearable mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; physician review and interpretation with report) and 93229 (technical support for connections and patient instructions for use, attended surveillance, analysis and physician prescribed transmission of daily and emergent data reports) was incorrect.

The correct diagnoses required when billing these codes are listed below and in Clinical Coverage Policy #1R-4, *Electrocardiography, Echocardiography, and Intravascular Ultrasound*, on DMA's website at http://www.ncdhhs.gov/dma/mp/.

Ambulatory Cardiac Event Recorders—Primary Diagnosis Allowed CPT Procedure Codes 93228, 93229, 93268 through 93272	
ICD-9-CM Code	**Description**
410.00 through 410.92	Acute myocardial infarction
411.1	Intermediate coronary syndrome
413.0 through 413.9	Angina pectoris
414.8	Other specified forms of chronic ischemic heart disease
414.9	Chronic ischemic heart disease, unspecified
426.0 through 426.9	Conduction disorders
427.0 through 427.9	Cardiac dysrhythmias
780.2	Syncope and collapse
780.4	Dizziness and giddiness
785.0	Tachycardia, unspecified
785.1	Palpitations
786.00 through 786.59	Chest pain
V67.51	Following completed treatment with high-risk medications, not elsewhere classified

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

Attention: Dental Providers and Health Department Dental Centers

Transfer of Dental Records

Providers are reminded to provide records of diagnostic quality when transferring dental records to another provider or directly to a recipient. Since bitewing radiographs are allowed once a year and panoramic films and intraoral complete series are allowed once every five years, it is imperative that the films/images that are transferred are of diagnostic quality so the provider receiving the radiographs can make a proper diagnosis regarding treatment.

Rules of the North Carolina State Board of Dental Examiners state "*A dentist shall, upon request by the patient of record, provide original or copies of radiographs and a summary of the treatment record to the patient or to a licensed dentist identified by the patient. A fee may be charged for duplication of radiographs and diagnostic materials. The treatment summary and radiographs shall be provided within 30 days of the request and shall not be contingent upon current, past or future dental treatment or payment of services."* [21 NCAC 16T.0102]

Medicaid policy does not prohibit a dentist from charging a record duplication fee to a Medicaid recipient, provided the same fee is charged to private-pay patients. Board rules do not set a maximum level for this duplication fee. When DMA or EDS requests records (to verify medical necessity or accuracy of billing), providers do not receive compensation.

Dental Program
DMA, 919-855-4280

Attention: Nurse Practitioners and Physicians

Bendamustine (Treanda, HCPCS Procedure Codes J9999 and J9033) – Additional Diagnosis Codes

Effective with date of service November 1, 2008, to align with FDA approval, the N.C. Medicaid Program covers bendamustine (Treanda) for the treatment of indolent B-cell non-Hodgkin's lymphoma that has progressed during or within six months of treatment with rituximab or a rituximab-containing regimen. This is in addition to the existing coverage of treatment for chronic lymphocytic leukemia.

Effective with date of service January 1, 2009, providers must bill for Treanda using HCPCS procedure code J9033 (Injection, bendamustine HCl, 1 mg).

For Medicaid Billing

Refer to the tables below for guidance on the ICD-9-CM diagnosis codes required for billing Treanda.

Dates of Service	HCPCS Procedure Code	ICD-9-CM Diagnosis Code	ICD-9-CM Diagnosis Code Description
March 1, 2008, through September 30, 2008	J9999	V58.11 **AND** 204.10 through 204.11	Encounter for antineoplastic chemotherapy Lymphoid leukemia, chronic, without mention of remission, in remission
October 1, 2008, through October 31, 2008	J9999	V58.11 **AND** 204.10 through 204.12	Encounter for antineoplastic chemotherapy Lymphoid leukemia, chronic, without mention of remission, in remission or in relapse
November 1, 2008, through December 31, 2008	J9999	V58.11 **AND** 204.10 through 204.12 **OR** one of these non-Hodgkin's lymphoma diagnosis codes: • 200.00 through 200.88 • 202.08 through 202.98	Encounter for antineoplastic chemotherapy Lymphoid leukemia, chronic, without mention of remission, in remission or in relapse Lymphosarcoma and reticulosarcoma and other specified malignant tumors of lymphatic tissue Other malignant neoplasms of lymphoid and histiocytic tissue

Dates of Service	HCPCS Procedure Code	ICD-9-CM Diagnosis Code	ICD-9-CM Diagnosis Code Description
January 1, 2009, and after	J9033	V58.11 **AND** 204.10 through 204.12 **OR** one of these non-Hodgkin's lymphoma diagnosis codes: • 200.00 through 200.88 • 202.08 through 202.98	Encounter for antineoplastic chemotherapy Lymphoid leukemia, chronic, without mention of remission, in remission or in relapse Lymphosarcoma and reticulosarcoma and other specified malignant tumors of lymphatic tissue Other malignant neoplasms of lymphoid and histiocytic tissue

The Physician's Drug Program Fee Schedule is available on DMA's website at http://www.ncdhhs/dma/fee/.

Providers who received claim detail denials related to the diagnosis of non-Hodgkin's lymphoma for dates of service November 1, 2008, and after may resubmit the denied charges as new claims (not as adjustment requests) for processing.

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

Attention: Nurse Practitioners and Physicians

Plerixafor Injection (Mozobil, HCPCS Procedure Code J3490) – Correction to Reimbursement Rate

Effective with date of service December 1, 2008, the N.C. Medicaid program covers plerixafor injectable (Mozobil) for use in the Physician's Drug Program when billed with HCPCS procedure code J3490 (unclassified drug). The maximum reimbursement rate published in the March 2009 general Medicaid bulletin was incorrect. The correct maximum reimbursement rate for 1 mg of Mozobil is $292.97.

The fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: Nurse Practitioners and Physicians

Testosterone Pellets (Testopel, HCPCS Procedure Code S0189) – Billing Guidelines

Effective with date of service November 5, 2008, N.C. Medicaid covers testosterone pellets (Testopel) for use in the Physician's Drug Program when billed with HCPCS procedure code S0189 (testosterone pellet, 75 mg). Testopel is available as 75-mg pellets.

Testopel is indicated as an androgen replacement therapy in the treatment of delayed male puberty and male hypogonadism (primary or hypogonadotropic). Implantable testosterone pellets are considered experimental and investigational for other indications. Although Testopel is indicated for male use only, androgens are contraindicated in men with carcinomas of the breast or with known or suspected carcinomas of the prostate.

Testopel is administered as a subcutaneous implantation every 3 to 6 months. The recommended dose for Testopel is 150 mg (2 units) to 450 mg (6 units).

For Medicaid Billing

- The ICD-9-CM diagnosis codes required for billing Testopel are
  - ♦ 253.4 (Pituitary hypogonadism)

    OR
  - ♦ 257.2 (Testicular hypogonadism)
- Providers should bill Testopel with HCPCS procedure code S0189 (testosterone pellet, 75 mg).
- One Medicaid unit of coverage is 75 mg. The maximum reimbursement rate per 75 mg is $67.50.
- Providers must bill National Drug Codes (NDCs) and NDC units. Medicaid covers only rebatable NDCs. For each pellet administered, report the NDC units as "each." Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III* (on DMA's website at http://www.ncdhhs.gov/dma/bulletin/ for instructions.
- Providers must indicate the number of HCPCS procedure code units used in block 24G on the CMS-1500 claim form.
- Providers must bill their usual and customary charges.

The fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

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

Attention: All Providers

Registration for Health Check/EPSDT Seminars

Health Check/EPSDT seminars are scheduled for May 2009. Information presented at the Health Check/EPSDT seminars is applicable to all providers who provide early and regular medical and dental screenings for Medicaid recipients under the age of 21.

Registration information, a list of dates, and site locations for the seminars are listed below. Seminars will begin at 9:00 a.m. and will end at 12:00 noon. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided at the seminars. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Due to limited seating, registration is limited to two staff members per office. Pre-registration is required. Unregistered providers are welcome to attend if space is available. Providers may register for the seminars by completing and submitting the registration form online at http://www.ncdhhs.gov/dma/provider/seminars.htm. Providers may also complete the Seminar Registration Form on the following page and fax it to the number listed on the form. Please indicate the session you plan to attend on the registration form.

The April 2009 Special Bulletin, *Health Check Billing Guide 2009*, will be used as the primary training document for the seminar. Please review and print the Special Bulletin and bring it to the seminar. The April 2009 Special Bulletin, *Health Check Billing Guide 2009*, is available on DMA's website at http://www.ncdhhs.gov/dma/bulletin/.

Raleigh **May 12, 2009** Wake Technical Community College Student Services Building 9101 Fayetteville Rd. Raleigh NC 27603	**Wilmington** **May 14, 2009** Holiday Inn Wilmington 5032 Market St. Wilmington NC 28405	**Morganton** **May 20, 2009** Western Piedmont Community College Moore Hall Auditorium 1001 Burkemont Ave. Morganton NC 28655

Directions to the Health Check/EPSDT Seminars

RALEIGH

Wake Technical Community College, Student Services Building

Take I-440 to US 401 South/S. Saunders Street (exit 298). Stay to the right to continue on US 401 South/Fayetteville Road. Continue to travel on US 401 South/Fayetteville Street towards Fuquay-Varina. The college is located on the left approximately one mile from the intersection with NC 1010. Turn left onto Chandler Ridge Circle. Visitor parking is on the left.

WILMINGTON

Holiday Inn Wilmington

Traveling East on I-40: Take exit 8 (Market Street). Turn left at the light. The hotel is located on the left, 0.5 mile from the intersection.

Traveling South on US 17: Follow US-17 South into Wilmington. The hotel is located on the left 0.5 mile from the intersection of US 17 and I-40.

Traveling North on US 17/ East on NC 74/76: Follow US 17 North into Wilmington. The hotel is located on the right approximately 4 miles after entering Wilmington.

MORGANTON

Western Piedmont Community College, Moore Hall Auditorium

Traveling West on I-40: From Hickory, take Exit 103 and turn right onto Burkemont Avenue (US 64). Western Piedmont Community College is on the right.

Traveling East on I-40: From Asheville, take Exit 103 and turn left onto Burkemont Avenue (US 64). Cross the bridge over I-40. Western Piedmont Community College is on the right.

Traveling on NC 18 from Lenoir: Turn left onto S. Sterling Street. Turn right at Burger King onto W. Fleming Drive. At the N.C. School for the Deaf, turn left onto Burkemont Avenue. Western Piedmont Community College is on the left at the second traffic light.

Traveling on NC 64 from Rutherfordton: Driving into Morganton, cross over I-40. Western Piedmont Community College is on the right, 1 block beyond I-40.

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

Health Check/EPSDT Workshops
May 2009 Seminar Registration Form
(No Fee)

Provider Name _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (____) _____ Fax Number _____

1 or **2** person(s) will attend the seminar at _____ on _____
(circle one)

Please fax completed form to: 919-851-4014
Please mail completed form to:
EDS Provider Services
P.O. Box 300009
Raleigh, NC 27622

Attention: All Providers

New Contact Information for Rate Setting Staff

The Professional Services and Behavioral Health section of DMA Rate Setting has relocated to One Bank of America Place. The new contact information is below.

Last Name	First Name	Phone
Davis	Mishawn	919-647-8179
Davis	Natasha	919-647-8189
Gaffney	Tschaina	919-647-8176
Hunike	Aydlett	919-647-8188
Ibrahim	Kimberly	919-647-8183
Jean-Baptiste	Muriel	919-647-8186
Johnson	Sherrill	919-647-8182
Kelly	Christal	919-647-8178
McDonald	Geraldine	919-647-8187
Martin	David	919-647-8172
O'Neal	Patricia	919-647-8181
Oates	Deidra	919-647-8177
Main Line		919-647-8170
Fax		919-715-2209

For regular **U.S. Mail** the address remains unchanged:

Division of Medical Assistance
Rate Setting Section
2501 Mail Service Center
Raleigh NC 27699-2501

For **FedEx** and **UPS**, please use the following physical address:

Division of Medical Assistance
Rate Setting Section
One Bank of America Plaza
421 Fayetteville Street, 9th Floor
Raleigh NC 27601

We apologize for any inconvenience this may have caused you in reaching our section. Please note all changes for future correspondences.

Rate Setting
DMA, 919-647-8170

Early and Periodic Screening, Diagnosis and Treatment and Applicability to Medicaid Services and Providers

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria stated in this publication **may be exceeded or may not apply to recipients under 21 years of age** if the provider's documentation shows that

- the requested service is medically necessary to correct or ameliorate a defect, physical or mental illness, or health problem; and
- all other Early and Periodic Screening, Diagnostic and Treatment (EPSDT) criteria are met.

This applies to both proposed and current limitations. Providers should review any information in this publication that contains limitations in the context of EPSDT and apply that information to their service requests for recipients under 21 years of age. A brief summary of EPSDT follows.

EPSDT is a federal Medicaid requirement (42 U.S.C. § 1396d(r) of the Social Security Act) that requires the coverage of services, products, or procedures for Medicaid recipients under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (including any evaluation by a physician or other licensed clinician).

This means that EPSDT covers most of the medical or remedial care a child needs to

- improve or maintain his or her health in the best condition possible OR
- compensate for a health problem OR
- prevent it from worsening OR
- prevent the development of additional health problems

Medically necessary services will be provided in the most economic mode possible, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure that is unsafe, ineffective, experimental, or investigational; that is not medical in nature; or that is not generally recognized as an accepted method of medical practice or treatment.

If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **not** eliminate the requirement for prior approval.

For important additional information about EPSDT, please visit the following websites:

- *Basic Medicaid Billing Guide* (especially sections 2 and 6): http://www.ncdhhs.gov/dma/basicmed/
- *Health Check Billing Guide:* http://www.ncdhhs.gov/dma/healthcheck/
- EPSDT provider information: http://www.ncdhhs.gov/dma/epsdt/.

Proposed Clinical Coverage Policies

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

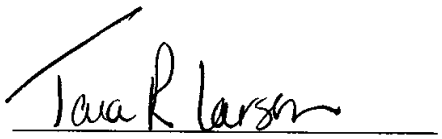
Loretta Bohn
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh NC 27699-2501

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.

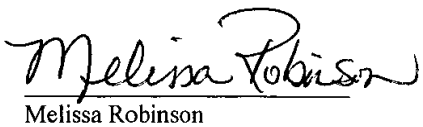
2009 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
April	4/2/09	4/7/09
	4/9/09	4/14/09
	4/16/09	4/23/09
	4/30/09	5/5/09
	4/2/09	4/7/09
May	5/7/09	5/12/09
	5/14/09	5/19/09
	5/21/09	5/28/09

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.



Tara Larson
Acting Director
Division of Medical Assistance
Department of Health and Human Services



Melissa Robinson
Executive Director
EDS, an HP Company