April 2012 Medicaid Bulletin

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Attention: All Providers

Session Law 2011-399 Senate Bill 496 - § 108C-7 Prepayment Claims Review

In order to ensure that claims submitted by a provider for payment by the Division of Medical Assistance (DMA) meet the requirements of federal and state law criteria, a provider may be required to undergo prepayment claims review by DMA or its vendors. DMA will process all "clean" claims submitted for prepayment review within 20 calendar days of receipt of documentation submitted by the provider. If the provider fails to initially provide any of the requested supporting documentation that is necessary to determine if a claim is "clean", DMA will notify the provider in writing and detail the lacking or deficient information within 15 calendar days of receipt of the claim.

DMA shall have an additional 20 calendar days from the day records are received to process the claim. **The provider shall remain subject to the prepayment claims review process until the provider achieves three consecutive months with a minimum seventy percent (70%) clean claims rate. Providers are advised that it is inappropriate to shift clients to other service locations in order to avoid prepayment review of claims.** If the provider does not meet this standard within six months of being placed on prepayment claims review, DMA may implement sanctions, including termination of the applicable Medicaid Administrative Participation Agreement, or continuation of prepayment review for an additional six-month period.

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Provider Self-Audit Protocol

The North Carolina Division of Medical Assistance (DMA) Program Integrity Unit relies upon the health care industry to assist in the identification and resolution of matters that adversely affect the Medicaid and Health Choice Programs. A cooperative effort serves as common interest to protecting the financial integrity of the Medicaid and Health Choice Programs while ensuring proper payments to providers. DMA recommends that providers conduct periodic, **voluntary self-audits** to identify instances where services reimbursed by the Medicaid and Health Choice Programs are not in compliance with the Programs' requirements.

This protocol does not affect the requirements of the Single Audit Act or other independent audit requirements. The **self-audit** protocol facilitates the resolution of matters that in the provider's reasonable assessment, potentially violate State or federal administrative law, regulation or policy governing the Medicaid and Health Choice Programs, or matters exclusively involving overpayments or errors that do not suggest violations of law. Upon review of information submitted by the provider or upon further investigation, DMA may determine that the matter implicates state criminal or federal law. In such instances, DMA will refer the matter to the appropriate state or federal agency.

Voluntary Self-Audit Package information is located at:
http://www.ncdhhs.gov/dma/program%20integrity/SelfAuditPackagePISA0001.pdf

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Bevacizumab (Avastin, HCPCS Code J9035)—Update to Billing Guidelines

This article provides new billing guidance regarding N.C. Medicaid's coverage of the drug Avastin. Effective with date of service on and after April 1, 2012, the N.C. Medicaid program discontinued coverage of Avastin under the Physician's Drug Program for recipients who are newly diagnosed and/or beginning treatment for breast carcinoma. Medicaid continues to reimburse for Avastin for those recipients who were already receiving Avastin treatment for breast carcinoma prior to date of service April 1, 2012. Unless a recipient was started on Avastin treatment prior to April 1, 2012, the last date of service providers may bill for Avastin for recipients with breast carcinoma is March 31, 2012. Claims paid for Avastin on and after April 1, 2012, for breast carcinoma recipients not already on Avastin treatment prior to April 1, 2012, may be recouped.

For dates of service April 1, 2012, and after, providers must bill for recipients **who have already been receiving Avastin for breast carcinoma** and are continuing treatment for breast carcinoma by **appending the EJ modifier ("Subsequent claims for a defined course of therapy") to HCPCS code J9035**. For all other recipients who do not have breast carcinoma diagnoses, providers should continue to bill as usual.

Effective with date of service April 1, 2012, and after, **one** of the following ICD-9-CM diagnoses must be billed with J9035 (**with EJ modifier**) for those recipients with **breast carcinoma who are continuing on Avastin treatment:**

- 174.0 – 175.9 malignant neoplasm of breast
- 198.2 secondary malignant neoplasm of skin of breast
- 198.81 secondary malignant neoplasm of breast
- 238.3 neoplasm of uncertain behavior of breast

Note: ICD-9-CM diagnosis code V58.11 **must** be billed with one of the diagnoses above.

Effective with date of service April 1, 2012, and after, **for recipients other than those with breast carcinoma**, one of the following ICD-9-CM diagnoses must be billed with J9035:

- 153.0 – 154.8 malignant neoplasm of colon, rectum, rectosigmoid junction and anus;
- 162.2 – 162.9 malignant neoplasm of lung;
- 189.0 – 189.1 malignant neoplasm of kidney;
- 191.0 – 191.9 malignant neoplasm of brain; or
- 362.52 wet age-related macular degeneration.

Note: ICD-9-CM diagnosis code V58.11 **must** be billed with one of the diagnoses above **except for 362.52.**

HP Enterprise Services
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/:

- *3K-2, Community Alternatives Program for Disabled Adults and Choice Option (CAP/DA-Choice) (3/1/12)*
- *11A-8, Hematopoietic Stem-Cell Transplantation For Multiple Myeloma and Primary Amyloidosis (3/1/12)*
- *11A-9, Allogeneic Stem-Cell & Bone Marrow Transplantation for Myelodysplastic Syndromes & Myeloproliferative Neoplasms (3/1/12)*
- *11A-10, Hematopoietic Stem-Cell & Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors & Ependymoma (3/1/12)*
- *11A-11, Hematopoietic Stem-Cell & Bone Marrow Transplant for Non-Hodgkin's Lymphoma (3/1/12)*
- *11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells (3/1/12)*
- *11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood (3/1/12)*
- *11A-16, Hematopoietic Stem-Cell Transplantation for Chronic lymphocytic leukemia (CLL) and Small lymphocytic lymphoma (SLL) (3/1/12)*

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

- *1A-11, Extracorporeal Shock Wave Lithotripsy (3/1/12)*
- *1A-17, Stereotactic Pallidotomy (3/1/12)*
- *1A-25, Spinal Cord Stimulation (3/1/12)*
- *1B-2, Rituximab (Rituxan) (3/1/12)*
- *1B-3, Intravenous Iron Therapy (3/1/12)*
- *1D-3, Tuberculosis Control and Treatment Provided in Health Departments (3/1/12)*
- *1E-2, Therapeutic and Non-therapeutic Abortions (3/1/12)*
- *1L-1, Anesthesia Services (3/1/12)*
- *1-O-5, Rhinoplasty and/or Septorhinoplasty (3/1/12)*
- *9A, Over-the-Counter Products (3/1/12)*
- *10C, Local Education Agencies (LEAs) (3/1/12)*
- *10D, Independent Practitioners Respiratory Therapy Services (3/1/12)*
- *A7, Off Label Antipsychotic Safety Monitoring in Recipients 18 and Older (3/20/12)*

The following new or amended NC Health Choice policies are now available on DMA's website at http://www.ncdhhs.gov/dma/hcmp/:

- *Hematopoietic Stem-Cell Transplantation For Multiple Myeloma and Primary Amyloidosis (3/1/12)*
- *Allogeneic Stem-Cell & Bone Marrow Transplantation for Myelodysplastic Syndromes & Myeloproliferative Neoplasms (3/1/12)*
- *Hematopoietic Stem-Cell & Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors & Ependymoma (3/1/12)*
- *Hematopoietic Stem-Cell & Bone Marrow Transplant for Non-Hodgkin's Lymphoma (3/1/12)*
- *Placental and Umbilical Cord Blood as a Source of Stem Cells (3/1/12)*
- *Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood (3/1/12)*

- *Hematopoietic Stem-Cell Transplantation for Chronic lymphocytic leukemia (CLL) and Small lymphocytic lymphoma (SLL) (3/1/12)*
- *Cytogenetic Studies (3/1/12)*
- *Medically Necessary Routine Foot Care (3/1/12)*
- *Podiatry Services (3/1/12)*
- *Enhanced Mental Health and Substance Abuse Services (3/1/12)*
- *Inpatient Behavioral Health Services (3/1/12)*
- *Psychiatric Residential Treatment Facilities (3/1/12)*
- *Residential Treatment Services (3/1/12)*
- *Intellectual and Developmental Disabilities Targeted Case Management (3/1/12)*
- *Mental Health/Substance Abuse Targeted Case Management (3/1/12)*

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

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Radiology Unlisted Procedure Codes

Providers can bill modifiers 26 (professional component) and TC (technical component) with the following unlisted procedure codes:

CPT Code	Description
77299	Unlisted procedure, therapeutic radiology clinical treatment planning
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices
77799	Unlisted procedure, clinical brachytherapy
78099	Unlisted endocrine procedure, diagnostic nuclear medicine
78999	Unlisted miscellaneous procedure, diagnostic nuclear medicine
79999	Radiopharmaceutical therapy, unlisted procedure

If you received a denial when billing procedure codes with modifiers -26 or –TC, please resubmit the denied charges as a new claim (not as an adjustment request) for processing.

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

Attention: All Providers

Medicaid Providers Must Screen for Individual & Entity Exclusion

The HHS Office of Inspector General (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 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 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 they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician/pharmacist or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider/pharmacist, practitioner or supplier that is not excluded in accordance with 42 CFR Section 1001.1901(b).

Providers can look for excluded individuals and entities on the HHS-OIG List of Excluded Individuals and Entities (LEIE) database, which is accessible to the general public and displays 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. Providers can also access the video podcast "How to Use the Exclusions Database" located on the HHS-OIG website at: http://go.usa.gov/5no%20. This video explains how to easily and effectively use the Exclusions Database.

To further protect against payments for items and services furnished, prescribed or ordered by excluded individuals and/or entities, the Division of Medical Assistance (DMA) is advising all current providers and providers applying to participate in the Medicaid program to take the following steps:

- Provider has an **obligation** and must screen all employees and contractors to determine whether any of them have been excluded.
- DMA requires this obligation as a condition of enrollment into the Medicaid program.
- The provider must immediately report to the appropriate Regional Office of the OIG Office of Investigations or DMA any exclusion information discovered.

DMA understands that providers share our commitment to combating fraud, waste and abuse. Working together will strengthen efforts to identify excluded parties, improve the integrity and quality of the Medicaid program and benefit the Medicaid recipients and North Carolina taxpayers, therefore this form of defense in combating fraud, waste and abuse must be conducted accurately, thoroughly and routinely.

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Enrollment Application Status Inquiries

Providers can inquire about the status of their enrollment applications or change requests: via telephone (866.844.1113) and via e-mail (NCMedicaid@csc.com). Customer Service Agents (CSAs) are available at the CSC EVC Operations Center Monday through Friday, from 8 a.m. until 5 p.m. Eastern Time to respond to inquiries. A CSA will respond to all inquiries within 48 hours.

When a provider calls the toll-free number, select from the following options to direct the call:
- Option 1 for currently enrolled providers inquiring about recredentialing or expired licenses and/or certifications
- Option 2 for EHR incentive payments, NC-MIPS, or NCID
- Option 3 for all other questions
- 0 to speak with an agent

The Call Center staff requires the caller to provide:
- the last four digits of the provider's Tax Identification Number
- either the Social Security Number (SSN) or
- the Employer Identification Number (EIN)

If the caller cannot verify this information, the CSA cannot discuss the provider file with the caller. After providing the required information, the CSA will ask for:
- the provider's National Provider Identifier (NPI) for a new enrollment; the provider's Medicaid Provider Number (MPN) for re-enrollment; or the Reference ID for an online application
- the provider's name
- the physical site or accounting address
- the caller's name, phone number, and e-mail address

Once the correct provider record is located and verified, the CSA will research the provider's inquiry and provide a status update. If a provider is not satisfied with the service or answer provided, the provider may ask to speak with a Call Center supervisor. The provider also has the option to leave a message for the manager on the Manager Voicemail Line. All calls will be returned within 24 hours.

EVC Operations Center
CSC, 866-844-1113 or email NCMedicaid@csc.com

Attention: All Providers

Change to Medicaid Identification (MID) Card

During a transition process over the next year, Medicaid-funded mental health, substance abuse, and intellectual/developmental disability services (MH/SA/IDD) will be administered by one of eleven Local Management Entities (LMEs) operating Medicaid Managed Care Organizations (MCOs) as DMA vendors.

Beginning in early April 2012, all new, replacement and annual MID Cards issued for recipients in LME-MCO counties will have the LME-MCO information on the left side of the card below the **Annual Medicaid Identification Card** statement.

The roll-out schedule for enrolled in the LME-MCO networks is printed in the Special March 2012 Medicaid Bulletin.

Medicaid Eligibility Unit
DMA, 919-855-4000

Attention: All Providers

Ultrasounds Removed from the PA Requirement

Effective with the date of service April 1, 2012, the following procedure codes no longer require prior approval:

Code	Description
76510	Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter
76511	Ophthalmic ultrasound, diagnostic; quantitative A-scan only
76512	Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)
76513	Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy
76514	Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)
76516	Ophthalmic biometry by ultrasound echography, A-scan
76529	Ophthalmic ultrasonic foreign body localization
76831	Saline infusion sonohysterography (SIS), including color flow Doppler, when performed
76873	Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)

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

Attention: All Providers

HCPCS Procedure Code Changes for the Physician's Drug Program

The following Healthcare Common Procedure Coding System (HCPCS) procedure code changes have been made to comply with the Centers for Medicaid and Medicare Services (CMS) HCPCS procedure code changes for January 1, 2012.

End dated Codes with No Replacement Code

The following HCPCS code was deleted by CMS effective with date of service December 31, 2011. There are no replacement codes.

HCPCS Code	Definition
J7130	Hypertonic saline solution, 50 or 100 meq, 20 cc vial

HCPCS Procedure Codes
The following HCPCS codes were added to the list of covered codes for the Physician's Drug Program effective with date of service January 1, 2012. These codes did not replace another code.

New HCPCS Code	Description	Unit
J0257*	Injection, alpha 1 proteinase inhibitor (human) (Glassia)	10 mg
J1557	Injection, immune globulin (Gammaplex) intravenous, non-lyophilized	500 mg

* Glassia was previously billed under J0256.

End-Dated Codes with Replacement Codes
The following HCPCS codes were end-dated effective with date of service December 31, 2011, and replaced with new codes effective with date of service January 1, 2012. Claims submitted for dates of service on or after January 1, 2012, using the end-dated codes will be denied.

End-Dated HCPCS Code	Description	Unit	New HCPCS Code	Description	Unit
Q2041	Injection, Von Willebrand factor complex (human) Wilate, 1 IU	1 IU	J7183	Injection, von Willebrand factor complex (human) Wilate, 1 IU	1 IU
Q2042	Injection, hydroxyprogesterone caproate (Makena)	1 mg	J1725	Injection, hydroxyprogesterone caproate (Makena)	1 mg
Q2044	Injection, belimumab (Benlysta)	10 mg	J0490	Injection, belimumab (Benlysta)	10 mg

New Codes That Were Previously Billed with the Miscellaneous or Unclassified Drug Codes

Effective with date of service January 1, 2012, the N.C. Medicaid Program covers the individual HCPCS codes for the drugs listed in the following table. Claims submitted for dates of service on or after January 1, 2012, using the unlisted drug codes J3490, J3590, J7199 or J9999 for these drugs will be denied. An invoice is not required.

Old HCPCS Code	Description	Old Unit	New HCPCS Code	Description	New Unit
J3590	Injection, alglucosidase alfa (Lumizyme)	10 mg	J0221	Injection, alglucosidase alfa (Lumizyme)	10 mg
J3490	Injection, ceftaroline fosamil (Teflaro)	200 mg	J0712	Injection, ceftaroline fosamil (Teflaro)	10 mg
J3590	Injection, denosumab (Xgeva or Prolia)	1 mg	J0897	Injection, denosumab (Xgeva or Prolia)	1 mg
J3590	Injection, pegloticase (Krystexxa)	8 mg	J2507	Injection, pegloticase (Krystexxa)	1 mg
J9999	Injection, cabazitaxel (Jevtana)	60 mg/1.5 ml single-dose kit	J9043	Injection, cabazitaxel (Jevtana)	1 mg
J9999	Injection, eribulin mesylate (Halaven)	1 mg	J9179	Injection, eribulin mesylate (Halaven)	0.1 mg
J9999	Injection, ipilimumab (Yervoy)	1 mg	J9228	Injection, ipilimumab (Yervoy)	1 mg
J7199	Injection, factor XIII (antihemophilic factor, human) (Corifact)	1 IU	J7180	Injection, factor XIII (antihemophilic factor, human) (Corifact)	1 IU

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

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

Attention: All Providers

National Correct Coding Initiative: Medically Unlikely Edits Denials

National Correct Coding Initiative (NCCI) methodologies require that if units of service exceed the Medically Unlikely Edit (MUE) limits, then the entire claim line must be denied. On September 1, 2010, CMS issued a letter to State Medicaid Directors regarding the implementation of the NCCI, which is available at: http://www.cms.gov/smdl/downloads/SMD10017.pdf. Below is an excerpt from the State Medicaid Director Letter #10-017 Enclosure B (page 13):

"If more units of service are reported for the HCPCS / CPT code on a claim line than the MUE value for the code on that claim line, the entire claim line is denied. The claims processing contractor during the automated processing of the claim should NOT pay any units of service on the claim line, if the MUE is triggered for a claim line. The provider / supplier will have to resubmit the claim, if the Fiscal Agent (or the State-contracted entity that performs claims processing activities on behalf of the State Agency) permits this process, or will have to appeal the claim line denial to receive payment for any units of service denied based on an MUE."

The MUE editing through NC Medicaid MMIS system follows the process described above. There are existing NC Medicaid MMIS edits that cut back the number of units on the detail line presented. However, when the presented unit value exceeds the MUE threshold, the entire line is denied per CMS instructions. Despite this fact, due to the existing MMIS edits, the units on the remittance advice for the denied claim line may appear with the cut back unit value.

For further assistance, providers may contact HP Enterprise Services Provider Services Department at 1-800-688-6696, menu option 3, Monday through Friday from 8:00 a.m. to 4:30 p.m.

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

Attention: All Providers

Replacement MMIS – NCTracks Information

If you are seeking information about the Replacement Medicaid Management Information Systems (MMIS), NCTracks, we recommend you check out the following links:

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

Any questions about NCTracks send an email to: OMMISS.ProviderRelations@dhhs.nc.gov

Provider Relations
OMMISS, 919-647-8446

Attention: All Providers

Reinstatement of CPT Code 80100

In August 2011 the Medicaid bulletin article, *CPT code 80100* (Drug screen, qualitative; multiple drug classes chromatographic method, each procedure) was end-dated with an effective date of service April 1, 2011. The Division of Medical Assistance (DMA) has reviewed providers request for coverage and has reinstated CPT code 80100 with an effective date of April 1, 2011. Providers who received claim denials will need to submit new claims for processing.

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

Attention: All Providers

Incorrect Billing for Therapy Visits

Some Outpatient hospital providers are incorrectly billing therapy visits. Incorrect billing eventually causes denials after the approved number of services has been used. Please see the following examples below:

- Incorrect billing is when a recipient is seen in the outpatient hospital therapy and the provider bills 3 units of the approved Revenue Code (RC) along with a CPT code which is defined with "each 15 minutes," and the session lasted 45 minutes.
- The correct way to bill for this service would be to bill one unit of the RC and the CPT code regardless of how long the session lasted.

Outpatient hospital therapy visits are **1 event which is equal to one unit**. For additional information on Outpatient Specialized Therapies, refer to the Medicaid Bulletin November 2009 ***"Changes to Outpatient Specialized Therapies"*** at http://www.ncdhhs.gov/dma/bulletin/1109bulletin.htm#ost and 10A-***Outpatient Specialized Therapies*** on DMA's website at http://www.ncdhhs.gov/dma/mp/8f.pdf.

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

Attention: All Providers

Visual Evoked Potential

Clinical Coverage Policy 1A-28, (Visual Evoked Potential [VEP]), procedure code 95930, was recently promulgated and can be found at: http://www.ncdhhs.gov/dma/mp/1A28.pdf.

The Division of Medical Assistance (DMA) covers Visual Evoked Potential (VEP) when medically necessary for any of the following indications:

a. to diagnose and monitor multiple sclerosis (acute or chronic phases) or other disease states by identifying conditions of the optic nerve, i.e. optic neuritis;
b. to localize the cause of a visual field defect not explained by lesions seen on Computerized Tomography (CT) or Magnetic Resonance Imaging (MRI), metabolic disorders, or infectious diseases; or
c. to evaluate signs and symptoms of visual loss in recipients who are unable to communicate clearly.

DMA does not cover VEP as a routine screening tool to meet the requirements of vision screening during an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) or NC Health Choice wellness exam. However, if during the exam the physician documents a medical need for additional vision services, (i.e. an abnormality is suspected) the physician is expected to make the appropriate referral for a more formal vision assessment. As explained in the VEP policy, physicians providing children's vision assessments shall follow the American Academy of Pediatrics policy for "Eye Examination in Infants, Children, and Young Adults by Pediatricians." (Refer to http://aappolicy.aappublications.org/cgi/content/full/pediatrics;111/4/902), section 16, Opthalmology.

For the technical portion of the test, providers should bill the appropriate qualifying diagnosis code and a TC modifier. For interpretation of VEP test results, the provider shall have a current active license to practice medicine as a neurologist, physiatrist or as an ophthalmologist.

For additional guidance and assistance in billing for vision screening during an EPSDT or wellness exam, please refer to the North Carolina Health Check Billing Guide found at: http://www.ncdhhs.gov/dma/healthcheck/guide2011.pdf.

As reflected in the documentation requirements set forth in the Basic Medicaid Billing Guide at http://www.ncdhhs.gov/dma/basicmed/index.htm providers are reminded that CPT, HCPCS, and ICD-9-CM codes reported on the health insurance claim form or billing statement must be supported by the documentation in the medical record.

Clinical Policy
DMA, 919 855-4318

Attention: All Providers and NC Health Choice Providers

Basic Medicaid and NC Health Choice Seminars

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

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

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

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

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

Please see the seminar schedule on the next page.

Seminar Dates and Locations

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

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

Attention: All Providers and NC Health Choice Providers

Subscribe and Receive Email Alerts for Medicaid Updates

NC Medicaid allows all providers the ability to sign up for NC Medicaid email alerts. Email alerts send notices to providers on behalf of the NC Division of Medical Assistance (DMA) and NC Health Choice (NCHC) programs. Email alerts are sent to providers when there is important information to share outside of the general Medicaid Provider Bulletins. To receive email alerts, subscribe to the Email alerts at www.hp.com/go/medicaidalert. Providers and their staff members may subscribe to the email alerts. Contact information including an email address and provider type of specialty is essential for the subscription process. You may unsubscribe at any time. **Email addresses are never shared, sold or used for any purpose other than Medicaid email alerts.**

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

Attention: All Providers and NC Health Choice Providers

NC Health Choice Providers with Outstanding Medical Claims with Dates of Services Prior to October 1, 2011

Effective February 29, 2012 providers should **only** mail all outstanding NC Health Choice paper claims for dates of Service **prior to October 1, 2011** to:

DMA-Budget Management
Mail Service Center 2501
1985 Umstead Drive
Raleigh NC 27699-2501

Providers were previously notified by Blue Cross and Blue Shield of NC (BCBSNC) to mail all outstanding claims before 2/29/12 to BCBSNC to ensure timely processing. The Division of Medical Assistance (DMA) will work to try and resolve any claims received after 2/29/12 with dates of service prior to October 1, 2011 in a timely fashion but cannot guarantee payment.

NC Health Choice
DMA, 919-855-4100

Attention: All Community Intervention Services Agencies

Education Related to Trends Identified in Program Integrity Post-Payment Reviews

NC DHHS Division of Medical Assistance is expanding its Program Integrity activities in monitoring and auditing North Carolina Medicaid behavioral health providers to ensure that all Medicaid-reimbursed services are being delivered in compliance with Medicaid policy. There are several thematic issues that DMA and DMA auditors have identified in which providers are out of compliance. DMA is sharing the most common findings to educate behavioral health providers and assist them in providing quality care in compliance with Medicaid policy.

1. Staff Credentialing and Training. Program Integrity (PI) and PI contractor audits have identified instances in which staff does not provide documentation of the required training or credentials. For example, staff may be missing required Person Centered Plan (PCP) Instructional Elements training or Person Centered Training. Staff must receive North Carolina Interventions (NCI) Alternatives to Restrictive Intervention training prior to delivering care, and renew this training annually without allowing it to lapse. Training should be completed within 90 days of the employee's hire and must occur prior to the date that services were delivered. All associate professional and paraprofessional staff also requires a supervisory plan to be in place at the time of employment, which must be reviewed annually.

Training certificates should clearly and specifically document what trainings the employee completed. Specific subjects of the training should be documented, such as Crisis Response, Service Definition, or Person Centered Thinking. Please ensure that all staff maintain required credentials and remain up to date on all of their training requirements.

2. Service Authorizations. Reviewers regularly identify that service authorizations do not cover the recipient and/or service, date of service, or are missing altogether. Obtain and document Service Authorizations for each service, and recipient of that service, that fully covers the period of time when services are to be delivered.

3. Assessments and Entrance Criteria. Clinical Coverage Policy, 8A Enhanced Mental Health and Substance Abuse Services, dictates entrance criteria that must be met to be eligible for each behavioral health service. In many cases, reviewers find that the assessments provided do not indicate that the recipient meets the minimum requirements to receive the service or do not provide enough information to determine a recipient's need(s). Assessments must indicate that the recipient meets the entrance criteria dictated in clinical policy. If an assessment, completed by a qualified clinician, does not document that the Entrance Criteria for a given service are met, a different service may be more appropriate.

4. Person Centered Plans. PCPs must be completed and signed prior to the delivery of service. PCP's should always include the amount of services required and the duration over which they should be delivered.

5. Crisis Plans. Reviewers have identified that Crisis Plans do not always support the level and intensity of services. A Crisis Plan should provide complete guidance in how to support the consumer throughout a crisis. At a minimum, the crisis plan should include any supports or interventions to be used in preventing a crisis, signs and behavioral concerns of the recipient that may trigger the onset of a crisis, and contact lists - with complete names and numbers - in the event of a crisis.

6. Service Notes. For each date of service, a service note must be completed to fully document the services delivered and the time spent delivering those services. Service notes should have a written or typed name to accompany the legible signature.

By complying with these Medicaid policies, your practice will ensure that you are providing high quality services to your recipients in your community.

Kevin Hutchison, Public Consulting Group
DMA Post-Payment Vendor, 919-576-2210

Attention: Durable Medical Equipment and Orthotics & Prosthetics Providers

Webinar Training

The Division of Medical Assistance (DMA) has scheduled training during the month of May 2012 to educate providers on Durable Medical Equipment (DME) and Orthotics & Prosthetics (O&P) billing, clinical policy updates, and resources. The training will be presented in webinar format. For updated clinical policy, please visit DMA's web page at: http://www.ncdhhs.gov/dma/mp/dmepdf.pdf for Durable Medical Equipment and http://www.ncdhhs.gov/dma/mp/5B.pdf for Orthotics & Prosthetics.
Pre-registration is required for the webinars. DME and O & P providers are encouraged to participate in the training. Registration for the webinars will be limited to 75 participants per session.

Webinar Dates/Times

Webinar Dates	Morning Webinar	Afternoon Webinar
Tuesday, May 22, 2012	10:00 a.m. to 12:00 noon	2:00 p.m. to 4:00 p.m.
Thursday, May 24, 2012	10:00 a.m. to 12:00 noon	2:00 p.m. to 4:00 p.m.

Providers may register for **webinars** using the online webinar registration form or may register by fax (fax it to the number listed on the form). Please include a valid e-mail address or fax number for your return confirmation. In addition, please indicate the session you plan to attend on the registration form. For those providers who register, the registration confirmation will include information on how to access and navigate within the webinar setting.

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

Attention: Durable Medical Equipment and Pharmacy Providers

Roche ACCU-CHEK Diabetic Supplies Program – Override Extended Until April 30, 2012

The second phase of the Roche ACCU-CHEK Diabetic Supplies program transition went into effect on March 15, 2012 where both Roche and Prodigy diabetic supplies continue to be covered; however, a one-time override is required for continued use of Prodigy products. **The use of the one-time override will be extended until April 30, 2012.** This extension applies to the durable medical equipment (DME) and pharmacy point-of-sale claims processing systems.

Pharmacy Program
DMA, 919-855-4306

Attention: All Hospital Providers

Coding for Ventricular Assist Devices before New Policy was Published on November 1, 2011

On November 1, 2011, the new VAD policy lists the following Revenue Code (RC) as appropriate RC coding when billing for the device component of the procedures. RC279 is indicated for Medical Surgical Supplies and devices - Other Supply/Implants and RC270 indicates Medical Surgical Supplies and devices -General Classification. For claims submitted prior to the November 1, 2011 policy date RC codes 279 and 270 listed above may be used by in-patient hospital billers as valid RC codes on their claims. After review of the system HP Enterprises does not find any reason that either of these codes would deny on a claim from an in-patient provider prior to the November 1st date.

Clinical Policy Section
DMA, 919-855-4360

Attention: Pharmacists and Prescribers

Medicaid and Health Choice Antipsychotics Programs – Pharmacy POS Override Code Protocol

It is important for pharmacies to be informed about the Point-of-Sale override options available for the Antipsychotics – Keeping It Documented for Safety (A+KIDS) and the Adult Safety with Antipsychotic Prescribing (ASAP) programs. A new override - an "11" in the submission clarification field – applicable to both programs has been created. Differences, however, in the child and adult antipsychotic program make understanding the override protocol imperative. See the North Carolina Medicaid Pharmacy Newsletter, February 2012 for a detailed article about the Off Label Antipsychotic Safety Monitoring in Recipients 18 and older Policy for the ASAP program.

Antipsychotic Override Protocol - Adult Safety with Antipsychotic Prescribing (ASAP)
The ASAP Program is for Medicaid recipients aged 18 years and older.

- Meets PA Criteria – Option for ASAP Program ONLY. Prescriber must write "Meets PA Criteria" in his/her own handwriting on the face of the prescription or enter it in the comment block when e-prescribing. The use of "1" in the PA field or "2" in the submission clarification field when "Meets PA Criteria" is written will be effective with program implementation on March 20, 2012. First phase implementation is for atypical antipsychotics only.
- Claim Denial – No history of exempted diagnosis in SmartPA and/or no safety documentation submitted by prescriber. Use override code "11" in the submission clarification field to override the documentation requirement. A code "11" override is limited to two unique dates of service per 365 rolling days. This will be effective beginning on March 20, 2012. First phase implementation is for atypical antipsychotics only.

Antipsychotics - Keeping It Documented for Safety (A+KIDS)
The A+KIDS Program is for Medicaid recipients aged 0 through 17 and Health Choice recipients aged 6 through 17.

- Claim Denial – No safety documentation submitted by prescriber. Use override code "11" in the submission clarification field to override the documentation requirement. A code "11" override is limited to two unique dates of service per 365 rolling days. This will be effective beginning on March 16, 2012.

Pharmacies should share with the prescriber each POS message that returns for a denied antipsychotic claim. This is important especially when a code "11" override is used to process the claim successfully because of the limited use. As a reminder, pharmacies are able to be reimbursed for a 72 hour emergency supply for recipients who have exhausted the two override opportunities and are waiting for documentation to be provided.

Override Audits - Meets PA Criteria – Override Codes "1" and "2"
The use of override codes "1" and "2" for "Meets PA Criteria" may be audited for appropriate use. A grace period will be extended to allow pharmacies time to adapt to appropriate use of override codes "1" and "2" and "11." The grace period applies to antipsychotic claims only. Use of override codes "1" and "2" for "Meets PA Criteria" by a pharmacy for an antipsychotic claim will be monitored and audited starting with dates of service of July 1, 2012.

No Documentation – Override Code "11"
The use of override code "11 "is not audited.

Pharmacy Program
DMA, 919-855-4306

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

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

Proposed Clinical Coverage Policies

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

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

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

2012 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
April	4/5/12	4/10/12	4/11/12
	4/12/12	4/17/12	4/18/12
	4/19/12	4/26/12	4/27/12
May	5/3/12	5/8/12	5/9/12
	5/10/12	5/15/12	5/16/12
	5/17/12	5/22/12	5/23/12
	5/24/12	5/31/12	6/1/12

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

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

Melissa Robinson
Executive Director
HP Enterprise Services