



April 2013 Medicaid Bulletin

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Attention: All Providers**P**ayment Error Rate Measurement (PERM) in North Carolina

The first in a series of 2013 Payment Error Rate Measurement (PERM) Provider Education webinar/conference calls will be on:

- Tuesday, May 21, 2013, 3:00 - 4:00 p.m. EST

The webinar, titled “Provider Education Calls,” will allow participants to learn more about the PERM process and provider responsibility. It can be accessed at the following website: www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Provider_Education_Calls.html.

PERM is an audit program that was developed and implemented by the Centers for Medicare & Medicaid Services (CMS) to comply with the Improper Payments Information Act (IPIA) of 2002. PERM examines eligibility determinations and claims payment made to Medicaid and Children’s Health Insurance Programs (CHIP) for accuracy, and to ensure states only pay for appropriate claims. In North Carolina, CHIP is called N.C. Health Choice (NCHC). North Carolina’s next PERM cycle is Federal Fiscal Year 2013 (October 1, 2012 – September 30, 2013).

A+ Government Solutions, the Review Contractor for the Federal FY 2013 PERM cycle, will start requesting documentation from selected providers in June 2013. Throughout the cycle, A+ Government Solutions will be responsible for collecting Medicaid and NCHC policies; conducting data processing reviews; requesting medical records from providers; conducting medical reviews; and hosting the State Medicaid Error Rate Findings (SMERF) website. States can use the website to track medical records requests, view review findings and request difference resolution/appeals on identified errors, and more.

Providers can find more information at the following sites:

- CMS website at www.cms.gov/PERM/.
- CMS PERM “Providers” web page: www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Providers.html.
- Central PERM email for providers: PERMProviders@cms.hhs.gov

The dates for the series of 2013 PERM Provider Education webinar/conference calls are:

- **Tuesday, May 21, 2013**, 3:00 - 4:00 p.m. EST
- **Wednesday, June 5, 2013**, 3:00 - 4:00 p.m. EST
- **Tuesday, June 18, 2013**, 3:00 - 4:00 p.m. EST
- **Tuesday, July 2, 2013**, 3:00 - 4:00 p.m. EST

Program Integrity
DMA, 919-814-0000

Attention: All Providers

Clinical Coverage Policies

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

- *2A-2, Long Term Care Hospital Services (3/1/13)*
- *4A, Dental Services (3/1/13)*
- *5A, Durable Medical Equipment (3/1/13)*

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**CPT Code Update: Sleep Studies**

Effective January 1, 2013, two new sleep study codes were added to distinguish age criteria:

- 95782, polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
- 95783, polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist

Additionally, the descriptions for CPT codes 95810 and 95811 have changed to reflect “polysomnography, age 6 years or older.”

Due to system updates, providers will receive a denial when an electronic claim is submitted for CPT codes 95810 and 95811 with dates of service prior to January 1, 2013 for beneficiaries under the age of 6. Providers must submit the Remittance Advice (RA) indicating the denied claim along with a new claim form to:

Maria Welch
N.C. Department of Health and Human Services
Division of Medical Assistance
2501 Mail Service Center
Raleigh, N.C. 27699-2501

Upon receipt of this information, the fiscal agent will be sent a memorandum instructing them to pay the claim. Allow a minimum of six to eight weeks for the fiscal agent to make the necessary system adjustments.

Clinical Policy and Programs
DMA, 919-855-4318

Attention: All Providers**E**lectromyography Add-on Codes

Provider claims are currently being denied when the following two add-on codes are billed with any recommended primary codes (95907-95913).

- 95885 (Needle electromyography, **each extremity**, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; **limited** (list separately in addition to the code for primary procedure) and,
- 95886 (Needle electromyography, **each extremity**, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; **complete**, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (list separately in addition to the code for primary procedure)

HP is working to link the add-on codes with the new primary codes. Until system updates are completed, providers should continue to keep claims filed in a timely manner.

Questions about claims should be directed to HP Enterprise Services at 1-800-688-6696 or 919-851-8888.

Clinical Policy
DMA, 919-855-4318

Attention: All Providers**NC Medicaid EHR Incentive Program Updates****More than \$100M in EHR Incentives Paid to N.C. Providers**

On February 20, 2013, the N.C. Medicaid Electronic Health Record (EHR) Incentive program surpassed the **\$100 million** mark for incentives payments used by healthcare providers to improve patient care in North Carolina.

To date, 2,673 payments to professionals and 71 payments to hospitals have been disbursed, totaling \$105.2 million. Of those professionals paid, 161 were Meaningful Use incentive payments. The N.C. Medicaid EHR Incentive Program appreciates everyone who helped reach this milestone.

Program Year 2012 Attestation Tail Period Ending April 30, 2013

The N.C. Medicaid EHR Incentive Program would like to remind eligible professionals (EPs) that the attestation tail period for all 2012 attestations is ending soon. EPs must submit their 2012 attestations no later than **April 30, 2013**. Note that as of **May 1, 2013**, the N.C. Medicaid EHR Incentive Program will no longer accept 2012 attestations.

New Phone Number for the NC Medicaid EHR Incentive Program

As of March 25, 2013, the NC Medicaid EHR Incentive Program has changed the main phone number to 919-814-0180. Use this phone number for all program questions and/or comments.

Change in NC-MIPS Help Desk

The NC-MIPS Help Desk will soon move to the N.C. Division of Medical Assistance (DMA). Beginning June 1, 2013, providers should use the phone number, email, and mailing addresses listed below for all correspondence with the EHR Incentive Program, including program and attestation inquiries, sending in signed attestations and supporting documentation.

N.C. Medicaid EHR Incentive Program Help Desk contact information as of June 1, 2013:

Email: NCMedicaid.HIT@dhhs.nc.gov

Phone: 919-814-0180

Mail: N.C. Medicaid EHR Incentive Program
2501 Mail Service Center
Raleigh, N.C. 27699-2501

** Starting June 1, 2013, the NC Medicaid EHR Incentive Program will no longer receive documentation via fax.*

Prior to June 1, 2013, providers should continue to use the following contact information for all correspondence with the EHR Incentive Program:

Email: ncmips@csc.com

Phone: 1-866-844-1113

Mail: NC-MIPS CSC EVC Center
PO Box 300020
Raleigh, N.C. 27622-8020

Fax: 866-844-1382

Recorded Webinar Series Now Available as Podcasts

The EHR Incentive Program will conclude its 11-part provider webinar series on **April 3, 2013**, at 12:30 p.m. with a webinar titled “Hospitals and the N.C. Medicaid EHR Incentive Program.”

Topics covered in previous webinars include: N.C. Medicaid EHR Incentive Program overview; Stage 1 Changes; Preparing for Attestation; Attesting in NC-MIPS; Understanding Patient Volume; Audits: What to Expect; Meaningful Use 101: What is Meaningful Use?; Meaningful Use 102: Looking Ahead to Stage 2 and Beyond; and Question and Answer sessions with DMA.

For those who missed the webinars, they are posted on the EHR website as podcasts. To access the podcasts, visit the EHR website at www.ncdhhs.gov/dma/provider/ehr.htm and click to expand the gray bar titled *NC Medicaid EHR Incentive Program Webinar Series & Podcasts*.

NC PATH Upgrades Existing EHR Solution

The North Carolina Program to Advance Technology for Health (NC PATH) is upgrading the existing EHR solution offered from Allscripts MyWay™ to Allscripts Professional™ Suite (EHR & PM). By upgrading to a more robust EHR solution, NC PATH is able to expand the program beyond physicians in primary care. Through the NC PATH program, eligible providers will receive the Allscripts Professional Suite EHR & PM solution, integration to the North Carolina Health Information Exchange (NC HIE), and training and support resources at a reduced cost.

For more information regarding NC PATH, visit
www.ncdhhs.gov/dma/provider/NCPATH_ProgramUpdate.pdf.

Contact NC PATH Program Manager Kristal Shearin by email (kristal.Shearin@nchie.org) or phone (919-882-0324) with any questions.

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

Attention: All Providers

NCTracks Provider Checklist for Go-Live

NCTracks is the new multi-payer system that will consolidate several claims processing platforms into a single solution for multiple divisions within the N.C. Department of Health and Human Services (DHHS).

The NCTracks system will go live on July 1, 2013.

There are a number of things providers can do to enable a smooth transition to the new NCTracks system. A “Provider Checklist for Go-Live” has been developed to help providers prepare for transition. The checklist includes tasks such as obtaining an NCID (the User ID of the North Carolina Identity Management system) for the Office Administrator and staff to access NCTracks and completing the Currently Enrolled Provider (CEP) NCTracks Registration process. (See the related article on the CEP in this bulletin.)

Providers are encouraged to take advantage of the checklist. Updates to the checklist will be made as more information becomes available. The current checklist is posted under the *Tool Kit* section of the *Communications* page on the OMMISS Website at www.ncmmis.ncdhhs.gov/communication.asp. Questions regarding the checklist should be sent to ommiss.providerrelations@dhhs.nc.gov.

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

Attention: All Providers**NCTracks Currently Enrolled Provider (CEP) Registration Process**

Before the new NCTracks system goes live on **July 1, 2013**, there are several types of information that need to be gathered from all N.C. Department of Health and Human Services (DHHS) providers. This information is either new data associated with NCTracks or existing data that could not be transferred from the legacy systems.

Required information includes:

- Electronic Funds Transfer (EFT) information for claims payment
- Designation of an Office Administrator
- Designation of a Billing Agent information (for providers that use a Billing Agent)
- Trading Partner Agreements from providers who intend to submit batch HIPAA 5010 X12 claims through the NCTracks Provider portal.

A “Currently Enrolled Provider” (CEP) NCTracks Registration process has been developed to enable providers to submit this important information prior to go-live. The CEP process takes about five minutes to complete and is accessed from the current Enrollment, Verification, and Credentialing (EVC) website at www.nctracks.nc.gov.

A letter will be mailed (March 11 through May 1, 2013) to all currently enrolled DHHS providers giving specific instructions for submission of this information. This letter will provide instructions regarding access to the Currently Enrolled Provider (CEP) NCTracks Registration web page and an authorization code to verify the identity of the provider when they login to the application. An NCID (the User ID of the North Carolina Identity Management system) will also be required to complete the CEP process.

Those providers who do not receive a letter by May 1 should contact the EVC Operations Center at 1-866-844-1113. More information about the CEP process can be found in the February 2013 edition of the NCTracks *Connections* newsletter at www.ncmmis.ncdhhs.gov/communication.asp.

NCTracks Communications Team

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

Attention: All Providers**NCTracks: Providers Should Verify Trading Partners NCTracks Certification**

NCTracks, the multi-payer system for the N.C. Department of Health and Human Services, is scheduled for full implementation on **July 1, 2013**. All entities that submit transactions directly and plan to become Electronic Data Interchange (EDI) trading partners with NCTracks must enroll and complete Health Insurance Portability and Accountability Act (HIPAA) compliant ASC X12 transactions certification via the CSC Ramp Management portal.

Providers who are currently using a clearinghouse, billing agent, value added network or medical practice management software vendor, should contact them and confirm their NCTracks certification plans will meet the July 1, 2013 implementation date. **If their HIPAA certification is not completed, they will not be permitted to submit your transactions to NCTracks and this could have a negative impact to your business.**

If you are a Trading Partner and have not received communications from NCTracks, contact us at NCMMIS_EDI_SUPPORT@csc.com. You will then receive an invitation from the Edifecs Ramp Management System to begin your HIPAA Certification testing.

Those who have questions regarding this process, should contact us at NCMMIS_EDI_SUPPORT@csc.com or call us at 1-866-844-1113 option 3. We look forward to working with you.

CSC Electronic Data Interchange (EDI), 1-866-844-1113 Option 3

Attention: All Providers**NCTracks Provider Training Opportunities**

There are several training opportunities for providers on the new NCTracks system. Provider training on NCTracks is being accomplished through two complementary delivery methods:

- Instructor Led Training (ILT) and,
- e-Learning (Computer-Based Training/CBT)

Instructor Led Training (ILT)

ILT will be held at five locations across North Carolina from April 8 through June 20, 2013. There will be approximately two weeks of training at each location, organized by provider type (Institutional, Medical, Dental, and Pharmacy), with between 1.5 and 2.5 days of training for each type.

Within a provider type, topics are scheduled by job function. Therefore, every member of a provider's organization can take only the courses they need. ILT can be attended in person or remotely via conference call or webconferencing. The specific locations and dates for the ILT are:

- Asheville
 - April 8-12 (Institutional/Medical)
 - April 22-24 (Pharmacy/Dental)
- Raleigh
 - April 15-19 (Institutional/Medical)
 - June 10-14 (Dental/Pharmacy)
- Greensboro
 - April 29-May 3 (Institutional/Medical)
 - June 17-20 (Dental/Pharmacy)
- Charlotte
 - May 6-10 (Institutional/Medical)
 - May 28-31 (Dental/Pharmacy)
- Wilmington
 - May 13-17 (Institutional/Medical)
 - May 20-23 (Dental/Pharmacy)

Computer-Based Training (CBT)

In addition to ILT, there will be numerous opportunities for electronic learning (e-Learning). Beginning April 1, 2013, e-Learning courseware will be available and will include such topics as:

- NCTracks Overview
- Contact Guide (Who to Call When)
- How to Read Your Remittance Advice (RA)
- Office Administrator Functions
- Updating Provider Record Data

SkillPort

SkillPort is the Learning Management System (LMS) for NCTracks. Providers can use SkillPort to register for ILT – whether they plan to attend in person or remotely – as well as for e-learning. Providers can access SkillPort prior to go-live using a link on the current Enrollment, Verification, and Credentialing (EVC) website (www.nctracks.nc.gov).*

Access to SkillPort requires an NCID

More information about all of the available courses and how to register for them in SkillPort can be found in the “How to Register for Training” document, located below the link to NCTracks Training on the EVC website at <https://www.nctracks.nc.gov/provider/providerEnrollment/index.jsp>.

* **Note:** After the Go-Live date (July 1, 2013), the link to SkillPort (LMS) will be available from the Provider Portal.

NCTracks Communications Team

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

Attention: All Providers and N.C. Health Choice Providers**S**ubscribe and Receive Email Alerts on Important N.C. Medicaid and N.C. Health Choice Updates

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

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

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

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

Attention: All Providers**T**ermination of Inactive N.C. Medicaid and N.C. Health Choice Provider Numbers

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

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

N.C. Medicaid and N.C. Health Choice (NCHC) provider numbers that do not reflect any billing activity within the previous 12 months will be terminated.

Unless providers can attest that they have provided services to N.C. Medicaid or NCHC recipients in the previous 12-month period, their provider numbers will be terminated. A notice of termination of the Medicaid Provider Number (MPN) will be sent to the accounting address listed in the provider's file. If a provider rendered services to N.C. Medicaid or NCHC beneficiaries in the previous 12 months, the provider may attest and return this letter.

A new enrollment application and agreement to re-enroll must be submitted to CSC for any provider who is terminated, and all appropriate enrollment fees must be paid. **As a result, a lapse in the provider's eligibility may occur.**

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

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

Provider Services
DMA, 919-855-4050

Attention: All Providers

Pre-Enrollment Site Visit: What to Expect

Before the pre-enrollment site visit

Public Consulting Group (PCG) is currently scheduling pre-enrollment site visits to fulfill Federal regulations [42 CFR 455.410](#) and [455.450](#), which require all participating providers to be screened according to their categorical risk level. These screenings will take place both upon initial enrollment and re-enrollment.

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

- Low
- Moderate
- High

Provider types and specialties that fall into the moderate- and high-risk categories are subject to a pre-enrollment site visit, unless a screening and site visit has been successfully completed by Medicare or another state agency within the previous 12 months. [Senate Bill 496 §108C-3](#) further defines provider types that fall into each category.

While PCG also conducts program integrity visits, the pre-enrollment visit is structured – and conducted – differently than a program integrity visit.

To confirm your place on the pre-enrollment site visit, you may contact PCG at 877-522-1057. When there are several providers requiring a pre-enrollment site visit at the same location, PCG can coordinate one appointment with all providers, thus minimizing repeat visits to the same location.

Newly enrolling providers who are also required to complete the online training are encouraged to do so in advance of scheduling an appointment as a resource for success with the pre-enrollment site visit. If completion of an online training is not a pre-enrollment requirement, providers are encouraged to review the [Basic Medicaid Billing Guide](#) and be familiar with the contents of the Provider Administrative Participation Agreement submitted with the application prior to the site visit.

During the pre-enrollment site visit

At a minimum, the pre-enrollment site visit will last two hours. There will be two PCG representatives conducting the pre-enrollment site visit.

Providers will be expected to demonstrate a working knowledge of the North Carolina Medicaid program through responses to a series of questions. The North Carolina Billing Guide (www.ncdhhs.gov/dma/basicmed/index.htm) and the Provider Administrative Participation Agreement are resources for success with the visit.

After the pre-enrollment site visit

Using a system of “pass/fail,” PCG will report the results of the pre-enrollment site visit to CSC. CSC will notify each provider that he or she has either passed or failed, by way of a “Welcome Letter” or an “Incomplete Letter.” CSC call center staff will not have access to any of the details, e.g., which answers were correct versus incorrect. Providers with “fail” results are able to reapply but are strongly encouraged to wait until **AFTER** the incomplete notification has been received. If a provider chooses to reapply all appropriate fees would need to be repaid.

ATTENTION: BEHAVIORAL HEALTH PROVIDERS:

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

Provider Services
DMA, 919-855-4050

Attention: All Providers**E**nrollment and Application Fees – REVISED

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

Affordable Care Act (ACA) Application Fee

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

The Centers for Medicare & Medicaid Services (CMS) set the application fee, which may be adjusted annually. The application fee for enrollment in calendar year 2013 is \$532. The fee is used to cover the cost of screening and other program integrity efforts.

The application fee will be collected **per site location** prior to executing a provider agreement from an initial or re-enrolling provider.

This requirement does not apply to the following providers:

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

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

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

North Carolina Enrollment Fee

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

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

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

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

Provider Services
DMA, 919-855-4050

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

How to Report a Change to Your Carolina ACCESS Practice

Community Care of North Carolina/Carolina ACCESS (CCNC/CA) providers are able to make some changes using the Medicaid Provider Change Form. Changes that can be made using this form include:

- Contact person's name
- After-hours telephone number
- Restriction information
- Enrollment limits
- Counties served

Providers should:

1. Download the Medicaid Provider Change Form from the NCTracks website at www.nctracks.nc.gov/provider/400_Ops_EPF_ChangeForm.pdf
2. Complete Section 1 of the form, remembering to check the **Carolina ACCESS provider block** in Section 1
3. Proceed to Section 3 – Changes for Carolina ACCESS providers only – and make necessary changes
4. Complete Section 5
5. Fax the form to CSC at 1-866-844-1382

If you have any questions regarding making Carolina ACCESS provider changes using this form, contact your Regional Consultant. Contact information for Regional Consultants is available at www.ncdhhs.gov/dma/ca/MCC_0212.pdf.

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

Attention: N.C. Medicaid Health Check and N.C. Health Choice providers

Billing Guidance for NCCI Denials for Health Check and N.C. Health Choice Wellness Claims and Additional Screenings

On January 1, 2013, Centers for Medicare & Medicaid Services (CMS) implemented new National Correct Coding Initiative (NCCI) edits that pair:

- Immunization administration codes (CPT codes 90471 – 90474) with,
- Preventive medicine evaluation and management (E&M) service codes (CPT codes 99381 – 99397) and,
- Additional screening codes allowed with N.C. Health Check wellness visits (CPT 99406 – 99409 and 99420).

The edit prevents inappropriate payment of an E&M service when a beneficiary visits a physician's office for an immunization other than the day of a comprehensive preventive medicine E&M service.

When the only reason for the visit is an immunization, the provider cannot bill an E&M service code in addition to the administration codes.

CMS provided billing guidance to providers to append modifier 25 when applicable to bypass NCCI edits. With the implementation of this new editing, providers that billed for N.C. Health Check wellness exams or additional screenings with the EP modifier, received Explanation of Benefit (EOB) 9988, "Payment of procedure code is denied based on CCI editing."

Since the current claims processing system cannot adjudicate N.C. Health Check wellness claims or additional screenings to bypass NCCI editing with both the EP and 25 modifiers on the same detail, CMS has permitted N.C. Medicaid to deactivate these edits.

Providers who received a denial due to NCCI for Health Check wellness exams or additional screenings can now resubmit their claims to HP Enterprise Services. NCHC wellness exams that were denied should be resubmitted, **but the 25 modifier should *not* be used.**

For additional billing guidance, contact HP Enterprise Services Provider Services Department at 1-800-688-6696, menu option 3.

**Clinical Policy and Programs
DMA, 919-855-4260**

Attention: N.C. Health Choice (NCHC) Providers**H** **Health Choice Wellness Exam Components and Reimbursement - UPDATE**

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

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

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

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

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

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

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

Billing Instructions:

1. Reimbursement requests require a TJ modifier. Health Choice providers must *not* use an EP modifier.
2. Until the *NC Health Choice Wellness Benefit Billing Guide* becomes available, refer to the billing instructions in the *Health Check Billing Guide* located at

www.ncdhhs.gov/dma/healthcheck/FINAL_Health_Check_Billing_Guide.pdf. On or after April 1, 2013, all claims filed for Health Choice wellness exams must:

- a) Include all service components in the *Billing Guide* and the TJ modifier; and,
 - b) Have been provided on or after July 1, 2012.
3. Providers who have already received payment for these dates of service on or after July 1, 2012, but want reimbursement under the new methodology may void their earlier claim and file an electronic replacement on or after April 1, 2013.
 4. Providers who have not yet submitted a claim for dates of service on or after July 1, 2012 must follow the new billing guidance effective April 1, 2013.

Health Choice
DMA, 919-855-4107

Attention: N.C. Health Choice (NCHC) Providers**Nc Health Choice Timely Filing**

Per Session Law (SL) 2011-399 [Chapter 108A-70.20](#) and [Chapter 135-48.52](#), the timely filing limit for N.C. Health Choice (NCHC) is 18 months from the date of service. Timely filing dates for Medicaid and NCHC are as follows:

- **Medicaid Claims** – 365 days to submit claim from date of service
- **NCHC** – 18 months to submit claim from date of service

In order to obtain payment for NCHC claims with dates of service over 365 days, but within 18 months, providers must submit those claims on paper with the Health Choice Resolution Form attached to each claim. The form can be found here:

www.ncdhhs.gov/dma/forms/SCHIPResolutionInquiryForm.pdf.

Mark the box indicating “Time-Limit Override” and mail the form, claim and any attachments to this address:

HP Enterprise Services
Attn: N.C. Health Choice
PO Box 300001
Raleigh, N.C. 27622

The Health Choice Resolution Form can also be found under “Frequently Used Forms” on this web page: www.ncdhhs.gov/dma/provider/forms.htm.

Be sure to use the Health Choice Resolution Form – not the Medicaid Resolution Inquiry Form – or NCHC claims submitted for time limit overrides will not be processed correctly.

Note: This submission procedure does not apply to NCHC claims with dates of service prior to October 1, 2011.

Claims for dates of service prior to the October 1, 2011 transition were also subject to the 18-month timely filing limit and should have been received by the N.C. Division of Medical Assistance (DMA) on or before March 30, 2013.

If you have questions or need further assistance, contact the HPES Provider Services Unit at 1-800-688-6696, menu option 3.

**N.C. Health Choice (NCHC)
DMA, 919-855-4100**

Attention: N.C. Health Choice (NCHC) Providers**I****ntrauterine Copper Contraceptive Denials**

N.C. Health Choice providers (NCHC) received denials with EOB 082, “Service is not consistent with/or not covered for this diagnosis/or description does not match diagnosis” when submitting claims for J7300 (Intrauterine Copper Contraceptive). The diagnosis list for this device has been updated in the system and is now V25.1 through V25.13.

Providers who have kept timely claims may refile each claim as a new claim (not as an adjustment) with HP Enterprise Services.

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

Attention: N.C. Innovations Providers and LME/MCOs**N****C Innovations Residential Supports and State Plan Personal Care**

The N.C. Division of Medical Assistance (DMA) contracts with Carolinas Center for Medical Excellence (CCME) to provide assessments for Personal Care Services (PCS) for those individuals living in licensed facilities and in their private homes.

This is a reminder that adult beneficiaries who are on the N.C. Innovations Waiver and receive Residential Support Services may **not** receive PCS. Residential Supports includes assistance with activities of daily living.

Providers should not refer N.C. Innovations beneficiaries who are receiving Residential Supports Services to CCME for PCS assessments. If an assessment is completed in error, and the provider receives authorization for PCS services, providers should not bill for PCS. Instead they should contact CCME to inform them that the beneficiary receives Residential Support Services through the Innovations waiver.

Behavioral Health Services
DMA, 919-855-4290

Attention: Personal Care Services (PCS) Providers

Personal Care Services (PCS) Program Highlights

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

Upcoming Provider Trainings

Regional trainings for all PCS providers will be conducted in April 2013. Training dates, locations, and registration information will be available on the N.C. Division of Medical Assistance (DMA) Consolidated PCS web page at www.ncdhhs.gov/dma/pcs/pas.html and the Carolina's Center for Medical Excellence (CCME) website at www.thecarolinascener.org.

Plans for additional provider trainings and webinars, as well as general information about the consolidated PCS program, will also be announced on the DMA [Consolidated PCS web page](#), as well as in future Medicaid Bulletins.

Appeals/Maintenance of Service

Beneficiaries who received adverse decision notices for PCS in an Adult Care Home (ACH) and who filed a timely appeal – as defined in the chart below – will be granted Maintenance of Service (MOS). Due to the volume of appeals filed, providers may experience a delay in the processing of MOS.

Providers cannot bill claims for beneficiaries until they have received MOS. MOS will be retroactive from the date the appeal was received by the Office of Administrative Hearings (OAH).

Providers will be notified of MOS through the Provider Interface QiReport. Providers who are not registered with QiReport will receive a fax from CCME. The registration form for the Provider Interface QiReport is available at www.ncdhhs.gov/dma/pcs/QiRePort_Registration_112712.pdf.

Contact the resources specified in the following table for assistance with mediation, appeals or MOS.

Questions Regarding	Resources	Telephone Numbers
Mediation	Mediation Network of North Carolina CCME DMA Appeals Unit	1-336-461-3300 1-800-228-3365 1-919-855-4350
Hearing Process	CCME DMA Appeals Section Office of Administrative Hearings (OAH)	1-336-461-3300 1-800-228-3365 1-919-431-3000
Maintenance of Service	DO NOT CONTACT OAH. OAH DOES NOT ISSUE MOS. CCME DMA Appeals Unit	DO NOT CONTACT OAH. OAH DOES NOT ISSUE MOS. 1-800-228-3365 1-919-855-4350

Maintenance of Service (MOS)

Beginning December 21, 2012, adverse notices were mailed to beneficiaries receiving PCS in the ACH setting. The new consolidated PCS program became effective January 1, 2013. The changes in services stated in the adverse notice became effective January 10, 2013. If beneficiaries filed an appeal with OAH in a timely manner, MOS will be extended as indicated below.

- Appeal filed with OAH within 10 days of the date of the notice:** This means the appeal was filed with (received by) OAH no later than close of business on January 10, 2013. There will be no break in payment for services if the appeal was filed by this date.
- Appeal filed with OAH within 11 days of the date of the notice but no more than 30 days from the date of the notice:** There will be a break in payment of services until the appeal is filed with OAH. Once the appeal is received by OAH, services will be reinstated to the level prior to the issuance of the adverse notice. The effective date of the change in services was January 10, 2013. This means the beneficiary’s services continued at the same level as the day before the notice through January 10, 2013. The change stated in the notice should have been implemented January 11, 2013, unless the beneficiary filed an appeal with OAH by close of business January 10, 2013.

Example: A beneficiary had been receiving 161 hours of service per month. Following the independent assessment, services were reduced to 60 hours per month. To continue services at 161 hours per month without a break in payment, the appeal had to be filed (received by OAH) no later than close of business January 10. The beneficiary did not file the appeal with OAH until January 22, 2013. From January 11-22, the beneficiary’s personal care services will be paid at

60 hours per month. Beginning January 23, 2013, services will be reinstated to 161 hours per month pending the outcome of the appeal.

- **Appeal filed with OAH more than 30 days after the date of the notice:** OAH – **not Medicaid** – will determine whether the late appeal will be accepted. There will be no MOS as the beneficiary did not file the appeal with OAH within 30 days of the date of the notice.

OAH notifies Medicaid when a contested case hearing has been filed. MOS is posted by CCME within five business days of receipt of notification that the beneficiary has appealed. As a large volume of appeals has been filed, it is important for the provider to note the following:

- MOS will be posted retroactive to the date the appeal was filed (received) by OAH.
- It is important to maintain fax confirmation sheets, e-mail confirmations, or certified return delivery receipts.

If a provider has not been notified concerning MOS, contact Facility and Community Care at 919-855-4260. Do **not** contact OAH as they do not issue MOS.

Mediation and Hearing Process

When beneficiaries file appeals, mediators contact the beneficiaries or their authorized representatives. If a beneficiary is unable to make personal health care decisions and someone else (such as a spouse, adult child, parent, friend, legal guardian, etc.) makes decisions on the beneficiary's behalf, give the mediators that person's contact information. Providers are encouraged to participate in the mediation and hearing processes and may represent the beneficiary/authorized representative provided they have written permission to do so. It is best practice is for all parties – beneficiaries (if able to understand the proceedings), spokespersons (as defined above) and providers – to participate in the mediation and hearing processes.

Note: Mediation is legally binding.

Providing Hospice Care in an ACH to beneficiaries receiving PCS

Hospice services can be provided for Medicaid beneficiaries residing in ACHs when beneficiaries elect the hospice benefit. The ACH and the hospice must have a written contractual agreement that describes the services to be provided by each according to the plan of care. The ACH is considered the beneficiary's place of residence and the basic care is provided by the ACH staff.

The hospice has the responsibility for the professional management of the beneficiary's care. The hospice is responsible for the oversight of the beneficiary's medical care and the monitoring of the care provided by the facility. The plan of care includes the services

provided by both the ACH and the hospice provider (e.g., room and board, PCS). The hospice agency is responsible for coordinating all services included in the plan of care. A copy of the hospice plan of care will be provided to the ACH.

For additional information on Hospice Services in ACHs, read the Hospice Services Clinical Coverage Policy 3D at www.ncdhhs.gov/dma/mp/3d.pdf. Hospice services provided in an ACH include services to those residing in Alzheimer's Special Care Units.

ACH Incorrect Billing Modifier Notices

During the PCS Transition process, incorrect billing modifiers were issued for some ACH beneficiaries. On February 12, 2013, CCME issued corrected notices to ACH providers for the identified beneficiaries. The corrected notices were mailed only to ACH providers. The corrected notice allows providers to re-bill for services issued from the date of the initial decision notice. Providers who have additional questions regarding incorrect billing modifiers and who are unable to bill for beneficiaries should contact CCME at 1-800-228-3365.

Enhanced ACH/PCS and Special Care Unit Prior Approval Requests

Effective January 1, 2013, prior approval requests for Special Care Unit beneficiaries are no longer accepted. Special Care Unit beneficiaries receive PCS under Clinical Coverage Policy 3L at www.ncdhhs.gov/dma/mp/3l.pdf. Any prior approval packets submitted to DMA will not be processed. For additional information on the removal of special care unit prior approval processes refer to the [*December 2012 Medicaid Bulletin*](#).

**Home and Community Care
DMA, 919-855-4340**

Attention: Pharmacists and Prescribers**D**elay in Non-Enrolled Prescriber Edit

Note to providers: This article was originally published in March 2013.

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

DMA continues to encourage all physician assistants and nurse practitioners to enroll as Medicaid providers. It is essential that these provider types enroll to ensure continued prescription coverage for their Medicaid and N.C. Health Choice (NCHC) patients when the new pharmacy edit goes into effect. Interns and residents at hospitals (house staff at teaching hospitals) who are authorized to enroll as Medicaid or NCHC providers – who order a prescription for a Medicaid beneficiary on behalf of the hospital – can apply the National Provider Identifier (NPI) of the hospital or the NPI of the supervising physician to the claim. Either of these prescriber identifiers will be accepted for resident prescribers when this change goes into effect.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Pharmacists and Prescribers**ProAir Placed on Preferred Drug List (PDL)**

As of April 1, 2013, ProAir HFA is a preferred agent in the BETA-ADRENERGICS HANDHELD, SHORT ACTING class. In addition, Ventolin HFA will become non-preferred on this date.

This decision was made at the Preferred Drug List (PDL) Panel meeting on September 25, 2012.

Providers can review the PDL at

[www.ncmedicaidpbm.com/downloads/Final+PDL_11142012\[2\].pdf](http://www.ncmedicaidpbm.com/downloads/Final+PDL_11142012[2].pdf)

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Pharmacists and Prescribers**Concurrent Use of Methadone and Benzodiazepines**

The Drug Utilization Review Board evaluated Medicaid data related to the concurrent use of methadone and benzodiazepines. While the Board recognizes there are clinical situations in which it may be necessary to use these drugs together, it recommends alerting Medicaid providers to the potential risk. Co-administration of the two products can potentiate the Central Nervous System (CNS) effects (respiratory depression, hypotension, profound sedation, or coma) of either agent. Patients should use methadone with caution and the prescriber may need to reduce the methadone and/or benzodiazepine dose. More information is available at www.clinicalpharmacology.com.

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Physicians**Affordable Care Act Enhanced Payments to Primary Care Physicians: Attestation Update**

According to Section 1202 of the Affordable Care Act (ACA) – which amends section 1902(a)(13) of the Social Security Act – Medicaid is federally required to pay up to the Medicare rate for **certain primary care services** and to reimburse 100% of the Medicare Cost Share for services rendered and paid in calendar years 2013 and 2014.

The primary care physicians will be able to self-attest through a web portal that they are Board Certified in one of the specialties **OR** that 60% of their paid CPT codes are the eligible codes. Providers can attest to having board certification in a specialty (family medicine, general internal medicine or pediatric medicine) or subspecialty designated in the statute and attest to billing at least 60% for Evaluation & Management (E&M) and vaccine/toxoid codes through a N.C. Division of Medical Assistance (DMA) website portal using their N.C. Medicaid provider numbers.

Primary care physicians were able to begin attesting that they meet the above requirements starting on **Friday, March 15, 2013**.

N.C. Medicaid will systematically reimburse eligible providers retroactively if they have already been paid for dates of service beginning January 1, 2013 or after.

Provider Services
DMA, 919-855-4050

Attention: N.C. Medicaid-enrolled Psychiatric Residential Treatment Facilities, both in-state and out-of-state**Letters of Attestation for Compliance with Federal Seclusion and Restraint Regulations**

Within the next several weeks, Psychiatric Residential Treatment Facilities (PRTF) will receive a letter requesting review of their seclusion and restraint policies and practices to ensure that they are in compliance with [42 CFR 483, Subpart G](#). The letter will also instruct PRTFs on how to submit the required formal Letter of Attestation to DMA stating that the facility is in compliance with all provisions contained in those regulations. The Letter of Attestation must be received by DMA Provider Services by July 21, 2013, and must be submitted annually thereafter by July 21 of each year.

Compliance with provisions in 42 CFR 483, Subpart G, is a federal Condition of Participation for continued enrollment as a PRTF in Medicaid. Noncompliance with policies, procedures, practices, reporting requirements and submission of the Letter of Attestation are grounds for termination of enrollment.

**Behavioral Health Section
DMA, 919-855-4290**

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

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

Proposed Clinical Coverage Policies

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

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

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

2013 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
April	04/04/13	04/09/13	04/10/13
	04/11/13	04/16/13	04/17/13
	04/18/13	04/25/13	04/26/13
May	05/02/13	05/07/13	05/08/13
	05/09/13	05/14/13	05/15/13
	05/16/13	05/21/13	05/22/13
	05/23/13	05/30/13	05/31/13

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

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

Melissa Robinson
Executive Director
HP Enterprise Services