



April 2015 Medicaid Bulletin

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***Providers are responsible for informing their billing agency of information in this bulletin.
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Attention: All Providers**NCTracks Updates****Temporary Change to Claim Edit for Rendering Provider Location**

In NCTracks, claims have pending status when the provider location does not match the information on the provider file. The majority of claims pended for this edit were due to invalid rendering provider location.

On March 2, 2015, the system was enhanced to search for **any** active location on the provider record for which the rendering taxonomy code on the claim is valid and process the claim using that location. An Informational (pay and report) Edit 04528 **rendering provider location code set based on taxonomy** is posted along with Explanation of Benefits (EOB) 04528 on the Remittance Advice (RA), alerting providers to update the rendering provider location on the provider record.

EOB 04528 states:

“Unable to determine rendering provider location code based on the submitted address. Location code has been set based on the rendering provider taxonomy only. Contact the rendering provider and ask them to complete a manage change request adding the service facility on this claim as an active service location.”

This approach should significantly reduce the number of claims pended for invalid rendering provider location. Claims already pended for invalid rendering provider location have been reprocessed after the edit change was made on March 2, 2015. No further action is required by providers.

If no active location can be found on the provider record for the rendering taxonomy code, the claim will be pended for invalid rendering provider location. For more information regarding how to correct these pended claims, see the [May 27, 2014 announcement](#) on the NCTracks Provider Portal.

Note: Claims with invalid billing or attending provider locations will continue to pend. This is a temporary change to allow providers time to update their records with the correct rendering provider location.

More information about updating provider locations can be found in the User Guide titled, *How to Change the Primary Physical Address in NCTracks*, which can be found under the heading **Provider Record Maintenance** on the [Provider User Guides and Training page](#) of the NCTracks Provider Portal. An announcement will be posted on the NCTracks Provider Portal before this **temporary** change is discontinued.

Paying Claims for Lesser Intensity Procedures with Radiology PA from MedSolutions

According to N.C. Division of Medical Assistance (DMA) Clinical Coverage Policy 1K-7, *Prior Approval for Imaging*, claims for specific CPT codes for CAT Scans (CTs), Magnetic Resonance Imaging (MRIs) and Magnetic Resonance Angiograms (MRAs) must automatically pay for a less intensive procedure if prior approval (PA) was obtained from MedSolutions for a higher intensity procedure within the same contrast family. However, these claims were previously denying for “no PA” in NCTracks.

For example, approval is received for a CT with contrast, but the radiologist determined that a CT without contrast was sufficient. Previously, the provider would have to call the MedSolutions Intake line (1-888-693-3211) to update the authorization because services rendered were different than those authorized.

As of March 2, 2015, that claim would process and pay against the approved PA request for the higher intensity procedure since it was within the same contrast family. However, if the billed procedure was of a greater intensity than the authorized procedure code, the claim would be denied.

This change applies to all relevant radiology claims, regardless of date of service. So, as of March 2, 2015, providers no longer need to call MedSolutions to update authorizations for a lesser intensity procedure. Radiology claims previously denied for “no PA” must be resubmitted. No automated reprocessing of claims is planned.

For more information, refer to DMA’s clinical coverage policy *1K-7, Prior Approval for Imaging Policy* at www.ncdhhs.gov/dma/mp/.

Increase in NCTracks Recredentialing Period

Note: Recredentialing applies to providers who are enrolled for an indefinite period of time. It does not apply to any time-limited enrolled providers such as Out-of-State (OOS) providers. OOS providers must continue to complete the enrollment process every 365 days.

Effective February 18, 2015, DMA has changed the length of time required before a provider must recredential in NCTracks from three years to five years.

NCTracks is adding two years to the due dates for recredentialing of existing providers. For example, if a provider’s current due date for recredentialing is October 1, 2015, his new due date will be October 1, 2017. For new providers who enroll in NCTracks, the due date for recredentialing will automatically be set to five years.

Providers who are currently recredentialing will complete the process already underway. The due date for their next recredentialing will be set to five years from the approval date.

Providers who have received a letter notifying them that recredentialing is due soon, but have not yet started the recredentialing process, can disregard the letter. Their recredentialing due date will be extended by two years.

Changes in Payment of Medicare Crossover Claims for QMB Cost Sharing

As described in the [CMS Informational Bulletin, Payment of Medicare Cost Sharing for Qualified Medicare Beneficiaries \(QMBs\)](#) dated June 7, 2013, Medicaid is legally obligated to reimburse providers for cost sharing that is due for a QMB according to the state's CMS-approved Medicare cost-sharing payment methodology. QMBs (those Medicare recipients qualified under the Medicare Catastrophic Coverage Act of 1988), include recipients with the following Program Aid Categories with Q classification:

- Medicare Qualified Beneficiary with Cost sharing (MQBQ)
- Medicaid/Medicare Aid to the Aged with Cost Sharing (MAAQ)
- Medicaid/Medicare Aid to the Blind with Cost Sharing (MABQ)
- Medicaid/Medicare Aid to the Disabled with Cost Sharing (MADQ)
- Special Assistance Aid to the Aged with Cost Sharing (SAAQ)
- Special Assistance Aid to the Disabled with Cost Sharing (SADQ)

According to federal requirements, NCTracks must adjudicate and reimburse providers for QMB cost sharing:

“without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan, i.e., not covered by NC Medicaid.”

As of March 1, 2015, NCTracks will pay the entire Medicare cost-sharing amount (deductible, coinsurance and copayment) on claim detail lines for dates of service (DOS) during the time when a recipient is identified as QMB.

The “lesser of logic” to which most Medicare crossover claims are subject will no longer be applied to claims for QMB recipients. This includes Medicare crossover claims for services not covered by Medicaid, claim detail lines that were denied by Medicare during the time when a recipient is identified as QMB, and Medicare Part C claims.

This change affects claims subject to QMB cost sharing regardless of how they are submitted, e.g., whether they automatically crossover from Medicare or when the secondary claim is submitted directly to NCTracks by the provider.

Medicare crossover claims subject to QMB cost sharing that were processed by NCTracks prior to March 1, 2015, will be reprocessed to reimburse providers for the entire Medicare cost sharing amount. The schedule for claim reprocessing has not yet been determined. More information will be posted on the NCTracks Provider Portal when it is available.

For information regarding how pharmacy claims are impacted by QMB cost sharing, see the February 13, 2015 announcement titled [Upcoming Changes in NCPDP D.0 Claims for QMB Cost Sharing](#) on the NCTracks Provider Portal.

Medicaid Coverage for Former N.C. Foster Care Children

The Patient Protection and Affordable Care Act (ACA) requires states to cover former foster care children up to the age of 26 if certain criteria are met. As of January 1, 2014, children who turn age 18 and are terminated from North Carolina foster care continue to receive Medicaid under eligibility category MFC (Medicaid to Former Foster Care Children), if they do not fall into any other Medicaid eligibility category.

On March 2, 2015, NCTracks implemented changes related to MFC. As of March 2, 2015, providers will see MFCGN or MFCNN as the category of eligibility on the eligibility verification responses for these recipients. The new category of eligibility information will be available via the 271 X12 transaction, the NCTracks secure provider portal, and the Automated Voice Response System (AVRS).

Designating Individual Provider Participation in Carolina ACCESS

In NCTracks, individual providers can affiliate with one or more groups or organizations that bill for services on their behalf. **As of March 2, 2015**, there is a new question on the provider enrollment application. When an individual provider affiliates with a group or organization, if the affiliated group or organization participates in Community Care of North Carolina/Carolina ACCESS (CCNC/CA), the individual provider will be presented with the question:

“The group that you have selected is a CCNC/CA provider. Do you wish to participate in CCNC/CA under this group at this location?”

This question will only be presented when the individual provider is eligible to be a CCNC/CA provider (for example, the question will not be presented to a dentist.) This information will be used to create the Carolina ACCESS Provider Directory. Providers who select “Yes” will be listed in the directory as a participating provider under the group’s practice.

For existing individual providers already affiliated with a group or organization participating in CCNC/CA, the assumption was that the individual provider will participate in CCNC/CA under the group. If the individual provider does **not** wish to participate in CCNC/CA, the Office Administrator for the individual provider can submit a Manage Change Request in NCTracks and change the designation by answering “No” to the question, “Do you wish to participate in CCNC/CA under this group at this location?”

In addition, if an individual provider who participates in CCNC/CA changes their response to the question “Are you rendering/attending only?” from No to Yes, when submitting a Manage Change Request, a warning message will be displayed:

“This change will result in the termination of your CCNC/CA participation and your recipients will be reassigned. If you have questions, please contact your local Managed Care Consultant.”

For more information about CCNC/CA, contact your regional Managed Care Consultant, as designated in http://www.ncdhhs.gov/dma/ca/mcc_051214.pdf.

For step-by-step instructions regarding submission of a Manage Change Request to update affiliations, review the User Guide “*How to Affiliate an Individual Provider Record to a Group-Organization in NCTracks*” under the heading “Provider Record Maintenance” on the [Provider User Guides and Training page](#) of the NCTracks Provider Portal.

Streamlined 271 Response

As of **March 8, 2015**, the X12 271 Eligibility Response was streamlined to combine:

- Service Type Codes in 2110C loop
- EB03 segment based on the Plan Coverage Description in 2110C loop
- EB05 segment, and,
- Copay amount in EB07 segment.

The new 271 response was further modified so that each 2110C, EB segment will have a date. This update does **not** change the Recipient’s eligibility information returned in the eligibility response. It is an effort to provide better readability of the X12 271 Eligibility Response. Click [here](#) for details on the streamlined 271 response.

Update on 2014 IRS 1099 Tax Forms

The 2014 IRS 1099 tax forms were printed and mailed on Tuesday, January 27, 2015. Providers receive one 1099 per Tax ID per payment source (e.g., Division of Medical Assistance (DMA), Division of Public Health (DPH), etc.)

- If a provider has multiple NPIs associated with the same Tax ID and only serves DMA recipients, they will receive only one 1099.
- If they serve DMA and DPH recipients, they will receive two 1099s, etc.

The 1099s were sent to the “Pay To” location currently on file. The “Pay To” address is found in location 001 on the provider record.

Note: If there are multiple NPIs using the same Tax ID, the 1099 will be sent to the address associated with the most recently updated provider record.

An updated list of Frequently Asked Questions (FAQ) regarding 1099s can be found on the NCTracks Provider Portal at <https://www.nctracks.nc.gov/content/public/providers/faq-main-page/faqs-for-1099s.html>. Consult this FAQ before contacting the Call Center with questions regarding a 1099.

Providers who did not receive a 1099 can notify NCTracks by using the “Contact Us” link found in the footer of every NCTracks web page. Instructions for submitting the notification are included in the FAQ page.

Issue Resolved - Quarterly Nursing Facility Rates Loaded

As reported on January 9, 2015, there was an issue with loading of the Quarterly Nursing Facility Rates into NCTracks. **As of February 13, 2015**, the issue was resolved and the rates are loaded in NCTracks. A reprocessing of previously paid claims to apply the new rates will be performed, but a target date has not yet been determined. More information will be provided on the NCTracks Provider Portal as it becomes available.

Issue Resolved With Radiology PAs from January 16-18

Beginning February 16, 2015, providers who obtained a valid authorization from MedSolutions from January 16-18, 2015 – but had their radiology claims denied for no prior approval on those dates – can resubmit their claims. Providers with questions related to radiology PA can call MedSolutions client services at 800-575-4517 and select option 3.

CSC, 1-800-688-6696

Attention: All Providers**Allergy Immunology Update**

The revised Clinical Coverage Policy 1N-2, *Allergy Immunotherapy*, will be posted by May 3, 2015. The following unit limitations are included in this version and **will be effective May 3, 2015**.

Allergy Immunotherapy Limits

Codes	Testing Limitations
95115	One unit per date of service
95117	One unit per date of service
95180	12 units per date of service
95144	10 units per date of service
95145	One unit per date of service
95146	One unit per date of service
95147	One unit per date of service
95148	One unit per date of service
95149	One unit per date of service
95165	180 units per 365 days
95170	One unit per date of service

Clinical coverage policies can be found on the N.C. Division of Medical Assistance (DMA) website at www.ncdhhs.gov/dma/mp/.

Clinical Policy and Programs

DMA, 919-855-4260

Attention: All Providers**Respiratory Therapy Providers**

The N.C. Division of Medical Assistance (DMA) has proposed revisions to Clinical Coverage Policy 10D, *Respiratory Therapy Providers Independent Practitioners*. The draft policy is available for public comment through April 18, 2015 at www.ncdhhs.gov/dma/mpproposed/.

Clinical Policy and Programs

DMA, 919-855-4260

Attention: All Providers**R**esults of the Payment Error Rate Measurement (PERM) Audit in North Carolina

The Centers for Medicare & Medicaid Services (CMS), measures improper payments in Medicaid and Children's Health Insurance Programs (CHIP) and produces error rates for each program on a three-year cycle through the Payment Error Rate Measurement (PERM) audit.

- The error rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review
- CMS considers the error rate a measurement of payments made to the state that did not meet statutory, regulatory or administrative requirements
- The federal share of payments made for erroneous claims must be returned to CMS
- Eligibility errors may subject the state to a disallowance of Medicaid funds
- Following the completion of the PERM audit cycle, a report is provided to Congress of each states errors and associated error dollars.

Note: N.C. Health Choice (NCHC) is North Carolina's CHIP program.

North Carolina was one of 17 states required by CMS to participate in the PERM audit for federal fiscal year 2013 (October 1, 2012 through September 30, 2013). North Carolina ranked 6 out of the 17 states sampled in the *Medicaid* PERM audit, with an error percentage of 6.7 percent compared to the national error rate of 8.2 percent

For Medicaid FFS medical record reviews, **the sole source of projected dollars found in error was due to no documentation provided to support the billed claims.**

For CHIP FFS medical record reviews, the **largest sources of projected dollars in error were due to insufficient documentation and no documentation provided to support billed claims.**

All providers who were found through the PERM audit to have received erroneous payments have been notified by DMA Program Integrity of the potential recoupment amounts and their appeal rights.

North Carolina will be participating in the federal fiscal year 2016 PERM audit cycle, which will encompass a review of claims and medical records for the period October 1, 2015-September 30, 2016.

To prevent future medical record errors, providers are reminded of Social Security Act (SSA) requirements – listed in SSA Section 1902(27)(a) and [42 CFR 431.107](#) – to retain any records disclosing the extent of services provided to individuals and – when requested – to provide information regarding any payments for medical services rendered.

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 clinical coverage policies are available on the Division of Medical Assistance (DMA) website at www.ncdhhs.gov/dma/mp/:

- [1K-7, Prior Approval for Imaging Services](#) (1/1/15)
- [10A, Outpatient Specialized Therapies](#) (4/1/15)
- [10B, Independent Practitioners \(IP\)](#) (4/1/15)

These policies supersede previously published policies and procedures.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers**Maintaining the Security and Accessibility of Records after Expiration or Termination of Provider Agreement**

Notice to Providers: This article was first published in the [September 2014 Medicaid Bulletin](#).

N.C. Medicaid and N.C. Health Choice (NCHC) providers must maintain custody of records and documentation related to Medicaid and NCHC service provision and reimbursement a minimum of six years after the expiration or termination of the Provider Participation Agreement. This provision is specified in [10A NCAC 22F.0107](#) and the N.C. Department of Health and Human Services (DHHS) [Provider Administrative Participation Agreement](#) (Section 7), which is part of the Medicaid and NCHC provider enrollment application.

Providers are required to maintain clinical service records, billing and reimbursement records, and records to support staff qualifications and credentials (personnel records). **This includes documentation required to meet federal, state, Medicaid and NCHC billing guidelines.**

Clinical service records include:

- Diagnostic testing results (x-rays, lab tests, psychological assessments, etc.)
- Records from other providers used in the development of care plans
- Nurses' notes or progress notes
- Service orders that authorize treatment
- Treatment service or treatment plans
- Beneficiary demographic information (for billing and reimbursement records)

Failure to protect consumer or staff privacy by safeguarding records and ensuring confidentiality of protected health information is a violation of the [Health Insurance Portability and Accountability Act \(HIPAA\)](#) and [NCGS § 108A-80](#), and may be a violation of the [North Carolina Identity Theft Protection Act](#). Violations will be reported to the Consumer Protection Section of the N.C. Attorney General's Office, the Medicaid Investigations Unit of the N.C. Attorney General's Office and/or the U.S. DHHS Office of Civil Rights.

The following sanctions, penalties, and fees may be imposed for HIPAA violations:

- Mandatory investigation and penalties for noncompliance due to willful neglect
- Willful neglect may result in a fine ranging from \$50,000 to \$1.5 million (\$10,000 up to \$250,000 if corrected within 30 days)
- Enforcement by the State Attorney General along with provisions to obtain further damages on behalf of the residents of North Carolina in monetary penalties, plus

attorney fees and costs as provided for by the Health Information Technology for Economic and Clinical Health (HITECH) Act.

A provider's obligation to maintain records is independent of ongoing participation in the N.C. Medicaid or NCHC programs and extends beyond the expiration or termination of those agreements or contracts (see [10A NCAC 22F.0107](#) and Section 8 of the [DHHS Provider Administrative Participation Agreement](#)). Provider records may be subject to post-payment audits or investigations after a health facility closes.

Failure to retain required documentation of services provided may result in recoupment of payments made for those services, termination or suspension of the provider from participation with the N.C. Medicaid or NCHC programs, and/or referral to the U.S. DHHS Office of Inspector General for exclusion or suspension from federal and state healthcare programs.

If a new provider assumes the functions of a closing entity, maintenance of records for the applicable beneficiaries may be transferred to the new provider, if the new provider agrees to accept custody of such records in writing and a copy of this agreement is provided to N.C. Division of Medical Assistance (DMA) upon request.

When custody of records is not transferred, the expiring/terminating providers must send copies of transitional documentation to the provider who will be serving their beneficiaries for continuity of care. Beneficiary authorization must be obtained as necessary. Copies of records may be provided to the beneficiary directly for coordination of care.

DMA must be notified of changes in provider enrollment status, including changes in ownership and voluntary withdrawal from participation in the N.C. Medicaid and NCHC programs, as explained in the NCTracks manual titled *How to Select a Billing Agent and Other Claims Submission Options in NCTracks* on the [Provider User Guides and Training page](#). Providers who anticipate closure are required to develop and implement a records retention and disposition plan. The plan must indicate:

- How the records will be stored;
- The name of the designated records custodian;
- Where the records will be located;
- The process to fulfill requests for records;
- How beneficiaries will retrieve necessary contact information and the process to request their records;
- Retention periods and the records destruction process to be used when the retention period has expired; and

- Affirmations that there are no outstanding litigation, claim, audit or other official actions pending.

The plan must be on file with the records custodian.

Program Integrity
DMA, 919-814-0122

Attention: All Providers

Medicaid Payment for Services Provided Without Charge (Free Care)

The purpose of this article is to make Local Management Entities-Managed Care Organizations (LME-MCOs), Community Care of North Carolina/Carolina Access (CCNC/CA), and other Medicaid-enrolled providers aware of recent changes to the Centers for Medicare & Medicaid Services (CMS) policy regarding Medicaid payments for services provided without charge (including services that are available without charge to the community at large, or “free care”).

In the past, providers could not bill Medicaid for services which they provided at no cost to other patients. Therefore, if providers billed Medicaid for a specific service, they also had to bill patients who had private insurance. If that service wasn’t covered by their private insurance policies, those patients were subject to an out-of-pocket expense, which could not be waived under the CMS rules. With this change, providers can choose to bill only Medicaid, and provide the service free to those who don’t have alternative coverage.

The new ruling by the Departmental Appeals Board revises the previous policy and states that:

“Medicaid reimbursement is available for covered services under the approved state plan that are provided to Medicaid Beneficiaries, regardless of whether there is any charge for the service to the beneficiary or the community at large.”

This change should allow for greater access to quality healthcare services.

To read the entire CMS publication regarding third-party liability and Federal Financial Participation (FFP) for Medicaid services provided without charge, visit www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf.

Behavioral Health
919-855-4290

Attention: Adult Care Home, Family Care Home, Home Health and PCS Providers and Supervised Living Homes Billing PCS Services

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).

Personal Care Services (PCS) Clinical Coverage Policy 3L

Clinical Coverage Policy 3L, *Personal Care Services* is being amended to reflect PCS program enhancements. The 45-day public comment period is tentatively scheduled to start April 1, 2015. All PCS stakeholders may review the proposed policy amendments and provide comments and suggestions through the N.C. Division of Medical Assistance (DMA) proposed clinical coverage policies web page at www.ncdhhs.gov/dma/mpproposed/.

PCS Provider Regional Training Sessions

PCS spring regional training sessions will be conducted May 5-18, 2015. Training topics and materials will be available to all registered participants prior to May 5, 2015. Providers with questions may contact DMA at 919-855-4360 or Liberty Healthcare Corporation-NC at 1-855-740-1400 or www.nc-pcs.com.

Registration is required.

- **Tuesday, May 5, 2015 – Fayetteville**
Doubletree by Hilton, *Grand Ballroom*
- **Wednesday, May 6, 2015 – Raleigh**
Jane S. McKimmon Conference and Training Center – NC State University
- **Thursday, May 7, 2015 – Greenville**
City Hotel and Bistro - *Ballroom*
- **Wednesday, May 13, 2015 – Asheville**
Doubletree by Hilton – Biltmore, *Burghley Room*
- **Thursday, May 14, 2015 – Charlotte**
Great Wolf Lodge Convention Center, *White Pine 1 & 2 Room*
- **Monday, May 18, 2015 – Greensboro**
Embassy Suites Greensboro Airport, *Timberlake Room*

**Facility, Home, and Community Based Services
DMA, 919-855-4340**

Attention: CAP-DA, Home Health, MFP, PACE and Skilled Nursing Facility Providers

DMA/DAAS Partnering on National Study of Aging and Disabled Adults

The N.C. Division of Medical Assistance (DMA) and N.C. Division of Aging Adult Services (DAAS) have partnered with the University of North Carolina at Chapel Hill (UNC) to participate in the National Core Indicators – Aging and Disabled (NCI-AD) survey. NCI-AD will enable North Carolina to track quality measures and outcomes for elderly and disabled populations and compare them to those of other states. For more information about NCI-AD, visit www.nasuad.org/initiatives/national-core-indicators-aging-and-disabilities.

UNC will conduct approximately 1,000 surveys of Medicaid beneficiaries using a random sampling of participants in the following Medicaid programs:

- Skilled Nursing Facilities;
- Community Alternative Program for Disabled Adults (CAP-DA);
- Program for All-Inclusive Care of the Elderly (PACE); and
- Money Follows the Person (MFP).

In mid-May, selected beneficiaries will receive an introductory letter from the N.C. Department of Health and Human Services indicating they have been selected to participate in the survey and will be contacted for additional information. UNC staff will follow-up with beneficiaries directly and prepare to begin interviews in June.

Participation in the survey is voluntary and selected beneficiaries may decline to participate at any time.

Direct questions to Joe Breen, Chief of Planning, Budget and Support Services, N.C. DAAS at 919-855-3435.

**N.C. Division of Aging and Adult Services
919-855-3435**

Attention: HIV Case Management Providers

HIV Case Management Training Notices

Two three-day training sessions for the HIV case management provider community (managers/supervisors, and the official agency/program administrator; i.e., the agency owner or director) have been scheduled as follow:

Dates:

- April 20, 21 and 22, 2015
- May 20, 21 and 22, 2015

Location:

Wake County Cooperative Extension
Agriculture Extension Service
4001 Carya Drive, Suite E
Raleigh, North Carolina 27610

Time:

9 a.m. to 4 p.m.

All HIV Case managers and supervisors must attend 20 hours of continuing education related to HIV case management. This annual requirement is mandated for all participating providers to certify/recertify their agencies. Providers will also be contacted about training opportunities by email and U.S. mail. An application packet will accompany each notification.

Those with questions can contact Betty Jones, N.C. Division of Medical Assistance (DMA) HIV Program Manager at 919-855-4279, betty.jones@dhhs.nc.gov or Tamara Derieux at 919-855-4364, tamara.derieux@dhhs.nc.gov.

**Betty “BJ” Jones or Tamara Derieux
DMA, 919-855-4364**

Attention: LME-MCO and Providers of Residential Treatment Services (Levels I – IV)

Billing Codes for Residential Treatment Services for Are Being Updated

Billing codes for residential treatment services – covered in Medicaid Clinical Coverage Policy 8D-2, *Residential Treatment Services* – are being updated in compliance with federal Medicaid regulations. The Local Codes (Y-Codes), which have been used for prior authorization (PA) to differentiate services on the payment system, are being replaced with National HCPCS Codes.

Effective May 3, 2015, the National Codes – and modifiers where indicated – for residential treatment services will be implemented on the NCTracks system. These codes are as follows:

Code	Modifier	Description	Taxonomy	Local Code being End Dated
H0046	##	Level I Therapeutic Foster Care	251S00000X	Y2347
S5145	##	HRI Level II Therapeutic Foster Care	251S00000X	Y2362
S5145	HA	Intensive Alternative Family Treatment	251S00000X	Y2364
H2020	##	HRI Level II Group	320800000X 251S00000X	Y2363
H0019	HQ	HRI Level III Residential 4 Beds or Less	320800000X 251S00000X	Y2348
H0019	TJ	HRI Level III Residential 5 Beds or more	320800000X 251S00000X	Y2349
H0019	HK	HRI Level IV Residential 4 beds or less	320800000X 251S00000X	Y2360
H0019	UR	HRI Level IV Residential 5 beds or more	320800000X 251S00000X	Y2361

For reimbursement claims and PA requests submitted for dates of service beginning May 3, 2015, a national code, and modifier where indicated, will be required.

For N.C. Health Choice (NCHC) beneficiaries, ValueOptions must modify existing or new PA records so the effective end date is May 2, 2015 and create a new record beginning May 3, 2015 with the corresponding national code. For example, if an existing PA record has code Y2347 for effective dates March 1, 2015 thru June 30, 2015. The existing record would be

modified with new effective end date of May 2, 2015 and new record submitted for May 3, 2015 through June 30, 2015 with national code of H0046/##.

Any PA submitted with a local code for a date of service equal to or later than May 3, 2015 will deny. The reject report for ValueOptions will indicate these rejections with the code of B6.

Those with question should contact Katherine Nichols by email at katherine.nichols@dhhs.nc.gov or by phone at 919-855-4290.

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

Attention: Nurse Practitioners, Physician Assistants and Physicians**Prothrombin complex concentrate (human) vial (Kcentra™) HCPCS code J3590: Billing Guidelines**

Effective with date of service March 1, 2015, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover prothrombin complex concentrate (human) vial (Kcentra™), for use in the Physician's Drug Program (PDP) when billed with Healthcare Common Procedure Coding System (HCPCS) code J3590 Unclassified biologics. Kcentra™ is currently commercially available in 500 and 1000 unit vials.

Prothrombin complex concentrate (human) vial (Kcentra™) is indicated for urgent reversal of acquired coagulation factor deficiency induced by Vitamin K antagonist (VKA, e.g., warfarin) therapy in adult patients with acute major bleeding or need for an urgent surgery or other invasive procedure.

The recommended dosage for prothrombin complex concentrate (human) vial (Kcentra™) must be individualized based on the patient's baseline International Normalized Ratio (INR) value, and body weight. Administer Vitamin K concurrently to patients receiving Kcentra™ to maintain factor levels once the effects of Kcentra™ have diminished. The safety and effectiveness of repeat dosing have not been established and it is not recommended.

For Medicaid and NCHC Billing

- The ICD-9 diagnosis code required for billing prothrombin complex concentrate (human) vial (Kcentra™) is 286.7 Acquired coagulation factor deficiency.
- Providers must bill Kcentra™ with HCPCS code J3590 Unclassified biologics.
- Providers must indicate the number of HCPCS units.
- One Medicaid and NCHC unit of coverage for Kcentra™ is one international unit. The maximum reimbursement rate per one unit is \$2.0610. One 500 or 1000 unit vials contains 500 or 1000 billable units, respectively.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDCs for Kcentra™ 500 or 1000 unit vials are 63833-0386-02 and 63833-0387-02.
- The NDC units for prothrombin complex concentrate (human) vial (Kcentra™) must be reported as "UN1".
- For additional instructions, refer to the January, 2012 Special Bulletin, *National Drug Code Implementation Update*, at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf.

- Providers must bill their usual and customary charge for non-340-B drugs.
- The PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have registered with the Office of Pharmacy Affairs (OPA) at <http://opanet.hrsa.gov/opa/Default.aspx>. Providers billing for 340-B drugs must bill the amount that is reflective of their acquisition cost. Providers must indicate that a drug was purchased under a 340-B purchasing agreement by appending the “UD” modifier on the drug detail.
- The fee schedule for the PDP is available on DMA’s fee schedule web page at www.ncdhhs.gov/dma/fee/.

CSC, 1-800-688-6696

Attention: Physicians, Physician Assistants and Nurse Practitioners

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

Notice to Providers: This is an update to the guidelines for J9035 published in the [May 2012 Medicaid Bulletin](#).

Effective with date of service October 14, 2014, the N.C. Medicaid and N.C Health Choice (NCHC) programs now cover the following ICD-9-CM diagnoses codes for Avastin, Healthcare Common Procedure Coding System (HCPCS) J9035, in accordance with updated FDA guidelines.

- One of the following diagnosis codes must be billed with **V58.11** (encounter for chemotherapy):
 - **180.0, 180.1, 180.8, 180.9** (Malignant neoplasm of endocervix, Malignant neoplasm of exocervix, Malignant neoplasm of other specified sites of cervix, Malignant neoplasm of cervix uteri unspecified site)
 - **158.8, 158.9, 183.0, 183.2** (Malignant neoplasm of specified parts of peritoneum, Malignant neoplasm of peritoneum unspecified, Malignant neoplasm of corpus uteri except isthmus, Malignant neoplasm of ovary).

CSC, 1-800-688-6696

Attention: Nurse Practitioners, Physician Assistants and Physicians**A**lemtuzumab (Lemtrada™) HCPCS code J3590: Billing Guidelines

Effective with date of service March 1, 2015, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover alemtuzumab (Lemtrada™), for use in the Physician's Drug Program (PDP) when billed with Healthcare Common Procedure Coding System (HCPCS) code J3590 Unclassified biologics. Lemtrada™ is currently commercially available in 12 mg/1.2 ml vials.

Alemtuzumab (Lemtrada™) is indicated for multiple sclerosis.

The recommended dosage for alemtuzumab (Lemtrada™) includes two treatment courses.

- First treatment course: 12 mg/day on five consecutive days.
- Second treatment course: 12 mg/day on three consecutive days 12 months after first treatment course ends.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis code required for billing alemtuzumab (Lemtrada™) is 340 Multiple sclerosis.
- Providers must bill Lemtrada™ with HCPCS code J3590 Unclassified biologics.
- Providers must indicate the number of HCPCS units.
- One Medicaid and NCHC unit of coverage for Lemtrada™ is one mg. The maximum reimbursement rate per one mg is \$1777.50. One 12 mg/1.2 ml vial contains 12 billable units.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Lemtrada™ 12 mg/1.2 ml vial is 58468-0200-01.
- The NDC units for alemtuzumab (Lemtrada™) must be reported as "UN1".
- For additional instructions, refer to the January, 2012 Special Bulletin, *National Drug Code Implementation Update*, at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf.
- Providers must bill their usual and customary charge for non-340-B drugs.
- The PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have registered with the Office of Pharmacy Affairs (OPA) at <http://opanet.hrsa.gov/opa/Default.aspx>. Providers billing for 340-B drugs must bill the amount that is reflective of their acquisition cost. Providers must indicate that a drug was

purchased under a 340-B purchasing agreement by appending the “UD” modifier on the drug detail.

- The fee schedule for the PDP is available on DMA’s fee schedule web page at www.ncdhhs.gov/dma/fee/.

CSC, 1-800-688-6696

Attention: Psychiatric Residential Treatment Facilities (PRTFs)

New Medicaid and NCHC Billing Requirements

Effective July 1, 2015, all Institutional (UB-04/837-I) claims for Psychiatric Residential Treatment Facility (PRTF) services must include the name and National Provider Identification (NPI) of the *beneficiary’s attending psychiatrist and billing provider* for reimbursement.

If the attending psychiatrist’s NPI is not entered on the claim, the claim will deny with Explanation of Benefit (EOB) Code **03101**, “THE TAXONOMY CODE FOR THE ATTENDING PROVIDER IS MISSING OR INVALID.”

The attending physician must:

- Be the psychiatrist who has overall responsibility for the beneficiary’s medical care and treatment
- Be actively enrolled in the N.C. Medicaid and N.C. Health Choice (NCHC) programs
- Have a psychiatric taxonomy in compliance with N.C. Medicaid Clinical Coverage Policy 8D-1, *Psychiatric Residential Treatment Facilities for Children under the Age of 21*, [N.C. Administrative Code 10A-27G.1902](#), and the [North Carolina State Medicaid Plan 4.19-A](#).

Clinical Coverage Policies are posted on the Division of Medical Assistance (DMA) website at www.ncdhhs.gov/dma/mp/.

Through this action, N.C. Medicaid and NCHC billing practices for PRTS will be brought into compliance with federal requirements from the Centers for Medicare & Medicaid Services (CMS).

Questions can be directed to Catharine Goldsmith at 919-855-4290.

Behavioral Health Policy Section
DMA, 919-855-4290

Proposed Clinical Coverage Policies

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

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 substantively revised as a result of the initial comment period. If the adoption of a new or amended medical coverage policy is necessitated by an act of the General Assembly or a change in federal law, then the 45 and 15-day time periods will instead be 30 and 10-day time periods.

2015 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
April	4/02/15	4/07/15	4/08/15
	4/09/15	4/14/15	4/15/15
	4/16/15	4/21/15	4/22/15
	4/23/15	4/28/15	4/29/15
	4/30/15	5/05/15	5/06/15
May	5/07/15	5/12/15	5/13/15
	5/14/15	5/19/15	5/20/15
	5/21/15	5/27/15	5/28/15
	5/28/15	6/02/15	6/03/15

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

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

Paul Guthery
Executive Account Director
CSC