May 2011 Medicaid Bulletin

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

Attention: All Providers

Additional Correct Coding Edits

The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), as amended by the Health Care and Education Recovery Act of 2010 (P.L. 111-152), together referred to as the Affordable Care Act (ACA) required state Medicaid programs to be compliant with the National Correct Coding Initiative (NCCI) by March 31, 2011. DMA effectively implemented the mandated NCCI on March 31, 2011, and is compliant with this mandate.

DMA plans to implement additional correct coding guidelines to enhance our current claim processing system. These new correct coding guidelines and edits will be nationally sourced by organizations such as the Centers for Medicare and Medicaid Services (CMS) and The American Medical Association (AMA). These edits will identify any inconsistencies with CPT, AMA, CMS and/or DMA policies and will deny the claim line.

For example, the edits will ensure that:

- The appropriate procedure code is utilized based on age and gender of the patient.
- If a procedure code is submitted that requires a primary procedure code, DMA will verify that the primary procedure code has been submitted.
- Procedure codes are billed in the appropriate place of service as defined by AMA and/or CMS. For example, certain procedure codes are not permitted to be performed outside of an inpatient setting.
- Obstetric services including antepartum care, delivery, and postpartum care are billed appropriately according to CMS guidelines and DMA policy.
- The appropriate Evaluation and Management (E & M) codes are utilized for new patients and established patients.
- Certain services related to a surgical procedure are included in the payment of the global surgery package. These services would include E & M and related surgical procedures performed by the same physician for the same patient.
- Duplicate services are not submitted for the same provider, same patient for the same date of service.

DMA will notify providers through the Medicaid Bulletin when these additional correct coding edits are being implemented.

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

Attention: All Providers

CPT Code 93351

CPT procedure code 93351 (echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision) was a new CPT code effective with date of service January 1, 2009. However, some claims have denied for:

- Invalid place of service when billed with in-patient hospitalization, or
- EOB 3112 (Supply of injectable contrast material for use in echocardiograph, requires echocardiography procedure on the same day.) when billing A9700 with 93351.

If you received a denial for 93351 for invalid place of service or with EOB 3112 on or after January 1, 2009 and the denied claims have been kept timely, please resubmit the denied charges as a new claim (not as an adjustment request) for processing.

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

Attention: All Providers

CPT Code 95830

According to the National Physician Fee Schedule Relative Value File (RVU), CPT code 95830 (insertion by physician of sphenoidal electrodes for electroencephalographic recording) is defined as a physician services procedure and cannot be split into professional (modifier 26) and technical (modifier TC) components. If you have received denials for 95830 when billed without modifier 26 or when billed when the recipient was an in-patient, since January 1, 2009 and filing has been kept timely, please resubmit the denied charges as a new day claim (not as an adjustment request) for processing.

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

Attention: All Providers

Claims for CPT Code 49451 and Modifier 51

Providers are receiving inappropriate denials when billing CPT code 49451 and Modifier 51 "Multiple Procedures."

Effective with DOS January 1, 2008, system changes have been made to correct this issue.

Providers with denied claims for 49451 and Modifier 51 with EOB 0024 or EOB 7996. Correct detail by appending 51 and rebill with proof of timely filing. Please do not send as an adjustment.

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

Attention: All Providers

Correction to CPT Update Bulletin Article

The CPT Update bulletin article was posted January 1, 2011. Please note an incorrect diagnosis for 64568 was posted. The correct diagnoses should be:

Billing Information

CPT Code	Diagnosis Editing
64568	Must be billed with one of the following diagnoses: 332.0, 333.1, **333.6**, 333.71, 333.79, 333.83, 333.90, 345.10 through 345.81, or 996.2.

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

Attention: All Providers

Magnetoencephalography Procedure Codes 95965, 95966, 95967

CPT Codes 95965 (Magnetoencephalography, recording and analysis; for spontaneous brain magnetic activity), 95966 (Magnetoencephalography, recording and analysis; for evoked magnetic fields, single modality), and 95967 (Magnetoencephalography, recording and analysis; for evoked magnetic fields, each additional modality) are no longer covered services by N.C. Medicaid effective with date of service August 1, 2010. Claims billed for these services after August 1, 2010 will deny.

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

Attention: All Providers

Quality Assurance Questionnaire

DMA Provider Services published the first in a series of quality assurance (QA) questionnaires to assist DMA in its efforts to improve customer service to enrolled providers and Medicaid recipients. The QA questionnaires are intended only for DMA's enrolled Medicaid providers. All enrolled providers are encouraged to complete the May 2011 QA questionnaire. Results obtained from the questionnaire will be kept confidential. Completed questionnaires may be submitted by e-mail to ncdma.providerqasurvey@lists.ncmail.net or by fax to 919-715-8548.

DMA, Provider Services
919-855-4050

May 2011 Medicaid Provider Quality Assurance Questionnaire			
	Question	**Response**	
		YES	**NO**
1	Does the annual Medicaid card and web-portal eligibility verification greatly improve your way of doing business?	☐	☐
2	Do you regard your experience as a N.C. Medicaid provider overall to be a positive experience?	☐	☐
3	Do you and your fellow colleagues enrolled in the Medicaid program view their Medicaid as a value added health plan which improves the lives of citizens?	☐	☐
4	Do you find the administrative services and education information provided by DMA on its website, bulletins, and customer service to be adequate in supporting a high level of health care for Medicaid recipients?	☐	☐
5	Do you or your staff ask all Medicaid recipients to present their identification as well their Medicaid card prior to receiving services?	☐	☐
6	Would a more electronically managed Medicaid program improve your ability to provide services (i.e., electronic health records, electronic billing, prior approvals, enrollment applications, etc.) to recipients	☐	☐
7	Does the Medicaid bulletin adequately inform you of important Medicaid recipient, provider, and Medicaid program issues in a timely fashion?	☐	☐
8	Do you believe that the North Carolina clinical policies addressing Medicaid patients are fair and meet the needs of a majority of the patients?	☐	☐
9	Are patients always notified in writing of a non-covered Medicaid service?	☐	☐
10	Do you find your experience in using the provider services line to be timely and at a high professional level?	☐	☐
11	Do you have a formal process to measure Medicaid patient customer satisfaction in your practice?	☐	☐
12	Has your business relationship (i.e., billing, payment, clinical policy, and enrollment) experience with N.C. Medicaid been at a high professional level?	☐	☐
13	Do you or your staff need more training and direction (i.e. billing, payment, clinical policy, and enrollment) from DMA?	☐	☐
14	Would you prefer to handle all enrollment and recertification and other communication with the Medicaid program electronically?	☐	☐
15	Have you supported the development of EHR (Electronic Health Record) and electronic billing with your practice?	☐	☐
16	Is contacting HP (fiscal agent) the first resource you use when you encounter an EOB that you need assistance in finding a resolution?	☐	☐

Please submit your completed questionnaire to DMA Provider Services by e-mail at ncdma.providerqasurvey@lists.ncmail.net or by fax to 919-715-8548.

All responses will be kept confidential.

Attention: All Providers

Radiopharmaceutical Codes

With implementation of the 2010 CPT/HCPCS update effective January 1, 2010, four new radiopharmaceuticals were established and one existing radiopharmaceutical was discontinued.

HCPCS Code	Description	Effective Date	Comments
A9581	Injection, Gadoxetate Disodium, 1 ml	Covered 01/01/2010	A9581 must be billed with CPT codes 74182 or 74183.
A9582	Iodine I-123 Iobenguane, diagnostic, per study dose, up to 15 millicuries	Covered 01/01/2010	n/a
A9583	Injection, Gadofosveset Trisodium, 1 ml	Covered 01/01/2010	A9583 must be billed with CPT code 75561.
A9535	Methylene Blue, 1 ml	End-dated 12/31/2009	Claims billed for this service after this date will deny.
Q9968	Injection, nonradioactive, noncontrast, visualization adjunct (e.g., methylene blue, isosulfan blue), 1 mg	Covered 01/01/2010	n/a

If you received denials when billing for A9581, A9582, A9583, or Q9968 since January 1, 2010 and the denied claims have been kept timely, please resubmit the denied charges as a new claim (not as an adjustment request) for processing.

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

Attention: All Providers

Provider Verification

To comply with industry best practices, CSC's EVC Operations Call Center staff will request the caller to provide the last four digits of the provider's Tax Identification Number Social Security Number (SSN) or Employer's Identification Number (EIN) to confirm that the caller is the actual enrolled provider or an authorized agent of the enrolled provider that he/she is presenting himself/herself to be. If the caller does not have the information available, the CSA (Customer Service Agent) cannot discuss the provider file with you. Once the information is obtained, a CSA will be glad to assist you.

After greeting the caller, the CSA will ask the caller to verify the provider's NPI or MPN, name, the physical site or accounting address. The CSA will also ask for the caller's name, the caller's phone number, and the caller's e-mail address before disclosing any information. Please have your information ready for assistance regarding provider enrollment.

If you have questions regarding this notice, please contact the CSC EVC Operations Center. CSA's are available Monday through Friday, 8:00 a.m. through 5:00 p.m. eastern time, at 1-866-844-1113.

CSC, 1-866-866-1113

Attention: All Providers

Health Check Seminars

Health Check seminars are scheduled for the month of June 2011. Seminars are intended to educate providers on Health Check guidelines.

Pre-registration is required. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the seminars by completing and submitting the online registration form. Please include a valid e-mail address for your return confirmation. Providers may also register by fax (fax it to the number listed on the form). Please include a fax number or a valid e-mail address for your return confirmation. Please indicate the session you plan to attend on the registration form. Providers will receive a registration confirmation. Please bring a copy of the latest version of the Health Check Billing Guide with you to the seminar. Copies will not be provided.

Sessions will begin at 9:00 a.m. and end at 12:00 p.m. Providers are encouraged to arrive by 8:45 a.m. to complete registration. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Seminar Dates and Locations

Date	Location
June 9, 2011	**Greensboro** Clarion Hotel Airport 415 Swing Road Greensboro NC 27409
June 16, 2011	**Morganton** Western Piedmont Community College-Moore Building 1001 Burkemont Avenue Morganton NC 28655
June 21, 2011	**Raleigh** The Royal Banquet and Convention Center 3801 Hillsborough Street Raleigh NC 27607
June 23, 2011	**Greenville** Greenville Hilton 207 SW Greenville Boulevard Greenville NC 27834

HP Enterprise Services

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

Attention: All Providers

Changes in Medicaid Prior Approval Policies and Procedures, Recipient Due Process (Appeals), and Early Periodic Screening, Diagnosis and Treatment (EPSDT) Seminars

In January and February 2011, N.C. Medicaid held Recipient Due Process and EPSDT training for providers. Additional training seminars are scheduled for June 2011.

Seminars are intended to address changes in Medicaid's prior approval policies and procedures and the Medicaid **recipient** appeal process when a Medicaid service is denied, reduced, terminated, or suspended. The seminar will also focus on an overview of EPSDT-Medicaid for Children.

The seminars are scheduled at the locations listed below. Sessions will begin at 9:00 a.m. and will end at 4:00 p.m. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided at the seminars. **Because meeting room temperatures vary, dressing in layers is strongly advised.** Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the Changes in Medicaid Prior Approval Policies and Procedures, Recipient Due Process, and EPSDT seminars online at http://www.ncdhhs.gov/dma/provider/seminars.htm. **Pre-registration is required.** Providers will receive a registration confirmation specifying the training material(s) each provider should bring to the seminar.

Date	Location
June 7, 2011	**Morganton** Western Piedmont Community College – Moore Building 1001 Burkemont Avenue Morganton, NC 28655
June 14, 2011	**Wilmington** Hampton Inn-Medical Park 2320 South 17th Street Wilmington, NC 28401
June 22, 2011	**Raleigh** The Royal Banquet and Convention Center 3801 Hillsborough Street Raleigh, NC 27607

Medicaid Recipient Appeal Process/EPSDT Workshops
June 2011 Seminar Registration Form
(No Fee)

Provider Name and Discipline _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (_____) _____ Fax Number _____

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

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

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

Attention: All Providers

Changes in Medicaid Prior Approval and Recipient Due Process (Appeal Rights) Policies and Procedures

Medicaid adopted new prior approval and recipient due process (appeal) policies and procedures effective May 01, 2011, with the implementation date to be announced in the Special Bulletin. Five live provider training sessions took place in January and February 2011, and additional training is planned for June 2011. Registration information is included in this Bulletin. Medicaid will publish a Special Bulletin and training slides in May 2011. Both may be found on DMA's website at http://www.ncdhhs.gov/dma/provider/epsdthealthcheck.htm**.**

Jane R. Plaskie, RN, MS
DMA, 919-855-4266

Attention: CAP/DA Lead Agencies and CAP/DA Service Providers

The Community Alternative Program for Disabled Adults has launched a self-direction option (Consumer-Directed Care) for CAP/DA participants. Consumer-directed care (CAP-Choice) is now available statewide for new and existing consumers of CAP/DA.

In October 2008, the Centers for Medicaid and Medicare Services (CMS) approved two service categories under the CAP/DA waiver: traditional CAP/DA and CAP/Choice, the new consumer-directed care option. When recipients are eligible to participate in the Community Alternative Program for Disabled Adults, they will have an option to select traditional CAP/DA or CAP/Choice.

Consumer-directed care is an option that allows older and disabled adults the opportunity to direct and have increased control over how, when, and in what amount services/resources are provided. Consumer-directed care allows a recipient to be in charge of the provision of services by selecting the personal assistant, formal services and actively planning and managing these services independently. This program offers recipients more choices, control, flexibility and responsibility over their care.

Consumer-directed care was originally piloted in 2005 in two counties (Duplin and Cabarrus) and because of the success of this self-direction option two additional counties (Forsyth and Surry) were added in 2007. Due to the continued success of the consumer-directed option and CMS's approval of a self-direction option within the CAP/DA waiver, consumer-directed care (CAP/Choice) will be provided to all 100 counties of North Carolina. All recipients must be given the option.

In April 2009, Lead Agencies designated by the Division of Medical Assistance (DMA) were enrolled to provide consumer-directed care (CAP/Choice) to CAP/DA participants. All other currently enrolled CAP/DA service providers who want to provide CAP/Choice services must submit an addendum to amend their provider enrollment package to include CAP/Choice. New service providers may also enroll by completing an enrollment package. All service providers must contact CSC to obtain an addendum or an enrollment package for CAP/DA and CAP/Choice to amend or enroll to provide these services. To amend a CAP/DA provider package, each provider will check all items listed on the addendum that specifically applies to their service specialty and type. To enroll as a CAP/Choice provider, on the addendum form, select all services that you are currently enrolled in as a CAP/DA provider. These services are the same for CAP/DA and CAP/Choice. Carefully follow the instruction of the addendum package or a new enrollment package. Providers can also access the CAP/DA provider addendum via this hyperlink: www.nctracks.nc.gov.

Please direct questions about the consumer-directed-care option to the CAP/DA Unit in the Home and Community Care Section by calling 919-855-4360 or faxing 919-715-2372. Any questions about provider enrollment should be directed to CSC at 1-866-844-1113 or through their website at www.nctracks.nc.gov.

Home and Community Care Section
Community Alternative Program for Disabled Adults
DMA, 919-855-4360

Attention: Critical Access Behavioral Health Agencies

Provider Affiliation Enrollment Verification

The Division of Medical Assistance (DMA) in collaboration with the CSC EVC Call Center is conducting provider outreach to all Critical Access Behavioral Health Agency (CABHA) providers to verify that the provider enrollment information on file with N.C. Medicaid is accurately linked to your CABHA billing provider number. **To ensure that claims adjudicate correctly, it is important to verify that attending provider(s) and service affiliation information has been correctly linked to your CABHA billing provider number.**

CSC will forward via email the CABHA enrollment report for your **immediate** review. The report contains a list of all attending providers and services affiliated with your CABHA billing provider number in the provider enrollment file. Please review the provider affiliation information including the effective and end dates.

To attest to the report's accuracy, simply reply to the email confirming that the information in our enrollment system is accurate. To report any corrections including additions or deletions, please contact the CSC EVC Call Center at 1-866-844-1113. Any attending provider (individual or service) not linked to the CABHA billing provider number that is billed through the CABHA billing provider will result in claim denials.

Note: To avoid any interruption of Medicaid reimbursement for CABHA services, you must respond to the notification by May 15, 2011.

CSC, 1-866-844-1113

Attention: Durable Medical Equipment Providers

Prior Approval Requirement for HCPCS Code W4016 Bath Seat, Pediatric

Effective with date of service March 1, 2011, HCPCS Code W4016, *Bath Seat, Pediatric*, requires prior approval. W4016 is covered when medically necessary for recipient's ages 0 through 20.

A Certificate of Medical Necessity and Prior Approval form must be completed for all items, regardless of the requirement for prior approval. The coverage criteria for this item have not changed. Refer to Clinical Coverage Policy #5A, *Durable Medical Equipment*, on DMA's website (http://www.ncdhhs.gov/dma/mp/) for detailed coverage information. Please refer to the DME Fee Schedule on DMA's website (http://www.ncdhhs.gov/dma/fee/) for the maximum allowable rates for this code and for all of the codes covered by N.C. Medicaid for durable medical equipment.

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

Attention: Federally Qualified Health Centers and Rural Health Clinics

Individual Behavior Change Intervention Services Provided in Federally Qualified Health Centers and Rural Health Centers

Individual behavior change intervention services indicated by the CPT codes listed in the table below are considered to be a core service and are not reimbursable when provided by a federally qualified health center or rural health clinics on the same day that a core service is provided.

CPT Code	Description
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit ; intensive, greater than 10 minutes
99408	Alcohol and/or substance, other than tobacco, abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409	Alcohol and/or substance, other than tobacco, abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes

These individual behavior change intervention services are covered Medicaid services but are not separately billable as a core service or an ancillary service. The services must be rendered as a component of a primary core service visit. Refer to Clinical Coverage Policy 1D-4, *Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics,* on DMA's website at http://www.ncdhhs.gov/dma/mp for additional information.

HP Enterprise Services
1-800-688-6696 or 919-855-8888

Attention: Federally Qualified Health Centers and Rural Health Clinics

Antepartum Care and Postpartum Care Provided in Federally Qualified Health Centers and Rural Health Clinics

Antepartum care and postpartum care are a part of a core service visit. Therefore, federally qualified health centers (FQHCs) and rural health clinics (RHCs) should use HCPCS code T1015 (core service) when billing for each prenatal or postpartum visit. CPT code 59409 (Vaginal delivery only, with or without episiotomy and/or forceps) or CPT code 59514 (Cesarean delivery only) should be used to bill for the delivery. The following CPT codes are not payable to a FQHC or RHC:

Code	Description
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps), and post partum care
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
59425	Antepartum care only; 4-6 visits
59426	Antepartum care only; 7 or more visits
59430	Postpartum care only (separate procedure)
59510	Routine obstetric care including antepartum care, cesarean delivery, and post partum care
59515	Cesarean delivery, including postpartum care

Refer to Clinical Coverage Policy 1D, *Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics*, on DMA's website at http://www.ncdhhs.gov/dma/mp for additional information.

HP Enterprise Services
1-800-688-6696 or 919-855-8888

Attention: Free Standing Non-State Owned Mental Hospital Providers and Specialty Hospitals Providers (LTCHs and Rehab Hospitals)

Interim Billing

Effective dates of service on or after May 1, 2011, Free Standing Non-State Owned Mental Hospitals Providers and Specialty Hospitals Providers (LTCHs, Rehab Hospitals) can file interim claims with Bill Types 112 and 113 with Patient Discharge Status "30". Final claims will be billed with Bill Type 114 with the appropriate discharge/transfer status code. When necessary, replacement claims 117 can be filed for each billing period. Providers can bill interim claims every 30 days.

DHHS/DMA, Hospital Section
919-855-4193

Attention: Health Departments, Nurse Practitioners, and Physicians

Health Departments, Nurse Practitioners, and Physicians
Omalizumab, 5 mg (Xolair, HCPCS Code J2357): Change in Coverage

The bulletin article published on this topic last month has been revised as follows:

Effective with date of service, May 16, 2011, the N.C. Medicaid Program will cover Xolair **ONLY** through the Outpatient Pharmacy Program. Xolair will no longer be covered when billed through the Physician's Drug Program with HCPCS code J2357. **Claims submitted for Xolair with HCPCS code J2357 for dates of service on and after May 16, 2011, will be denied.** This does not include outpatient hospital pharmacy billing through point-of-sale.

Prior authorization (PA) through the Outpatient Pharmacy Program will be required for coverage of Xolair upon completion of the Xolair policy and posting on the DMA website. Based on comments received during the 45-day initial comment period that ended April 15, 2011, a revised version of the Outpatient Pharmacy Program policy for Xolair will be posted for a 15-day additional comment period. At the end of that comment period, the final policy will be posted to the DMA website. Instructions regarding PA will be published at that time. **Until the final policy is posted, no PA is required through the Outpatient Pharmacy Program for Xolair.**

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

Attention: HIV Case Management Providers

Reminders and Updates for HIV Case Management Services

The Carolinas Center for Medical Excellence (CCME) and The Division of Medical Assistance (DMA) are pleased to announce that beginning May 2011 we are offering HIV Basic Training for case managers and supervisors.

Training:

Registration is now open for the following training: HIV Case Management Basic Training. (see schedule below). **This is mandatory training for the following individuals:** HIV Case Managers and Supervisors who are hired on or after May 1, 2011. Providers are reminded of the requirements stated in sub-section 6.4.1 of Clinical Coverage Policy 12 B. "All HIV case managers and case manager supervisors shall complete North Carolina state sponsored, basic policy training within 90 days of their employment date and must be completed prior to any billed case management units." This training is also mandatory for the following: those individuals who were hired on or before April 1, 2010 and have not attended any of the training sessions regarding Clinical Coverage Policy 12 B. This training is limited to those individuals who are currently employed by an agency that is currently certified as an HIV Case Management agency.

Date	Session Topic	Required Attendees
May 16-19, 2011	HIV Case Management Basic Training	HIV Case Managers and HIV Case Manager Program Supervisors who are hired on or after May 1, 2011. In addition those case managers and supervisors who were hired as of April 1, 2010 and did not attend any of the sessions on Clinical Coverage Policy 12 B offered in 2010 and 2011.

All of the trainings will be located at the McKimmon Center in Raleigh, North Carolina (get directions). Information for the March 2011 training is available on CCMEs' HIV Case Management web page.

Updates:
We will announce future sessions of the Potential Provider Inquiry training in future bulletin articles. Information regarding training can also be obtained via CCMEs' web page.

An FAQ document is now available at CCMEs' web page (http://www.thecarolinascenter.org/HIVCM)

DMA, HIV Case Management Program
919-855-4389

Attention: N.C. Health Choice Providers

Prior Approval Criteria Added to N.C. Health Choice Policies

On March 2, 2011, the following N.C. Health Choice policies were removed from public comment. These policies had prior approval criteria added to them.

1. Anterior Cruciate Ligament Allograft
2. Targeted Phototherapy for Psoriasis
3. Arthroscopic Surgery for Femoroacetabular Impingement
4. Cryoablation or Radiofrequency Ablation of Renal Cell Cancer
5. Surgery for Morbid Obesity
6. Monoclonal Antibody Imaging
7. Meniscal Allograft Transplantation
8. Continuous Local Delivery of Anesthesia to Operative Site
9. Reconstructive Eyelid Surgery and Brow Lift

For a complete list of policies that are covered by N.C. Health Choice, refer to the N.C. Health Choice Policies web page at http://www.ncdhhs.gov/dma/hcmp/.

Margaret Watts, N.C. Health Choice
DMA, 919-855-4104

Attention: Personal Care Services Providers

Implementation of In-Home Care (IHC) Services

Effective June 1, 2011, the Division of Medical Assistance (DMA) will no longer provide services under PCS and PCS-Plus and will implement two new services: In-Home Care for Children (IHCC) and In-Home Care for Adults (IHCA). DMA submitted these changes on October 25, 2010 to the Centers for Medicare & Medicaid Services (CMS) in response to Session Law 2010-31 (Senate Bill 897), Section 10.35 (http://www.ncga.state.nc.us/Sessions/2009/Bills/Senate/PDF/S897v8.pdf). CMS approved these changes on April 15, 2011. Clinical coverage polices for the new IHCC and IHCA services will be available on the DMA website (http://www.ncdhhs.gov/dma/mp/index.htm).

The Carolinas Center for Medical Excellence (CCME) will continue to process recipient referrals and conduct independent assessments under the IHC programs. Beginning May 9, 2011, new referrals for personal care services will be processed instead as referrals for IHC services. Current PCS and PCS-Plus recipients' eligibility to transition to the new programs will be determined automatically from the most recent independent assessment. Current recipients and their providers do not need to submit new referrals or other requests to be considered for eligibility under the new IHC programs.

In early May, DMA will send a letter that explains the program changes to all current PCS and PCS-Plus recipients. Prior to the June 1, 2011 IHC program implementation, CCME will then mail a Notice of Decision to each current recipient. CCME will also send a copy to each recipient's PCS provider agency.

To ensure that IHC decision notices are mailed only to your current active PCS clients, please immediately report any recipient discharges you have not reported since the April 1, 2010 implementation of independent assessment. Recipient discharges may be reported via the Provider interface. Providers not yet registered to use the interface may report recipient discharges using Part 2 of the Weekly Summary Form available on the **Independent Assessment website** (http://www.qireport.net).

Notices to recipients who qualify for IHC will indicate the prior authorized service level and period. Recipients who are denied IHC services will receive information on their appeal and maintenance of service rights in the denial notice.

Recipients eligible to transition will be prior authorized to receive services immediately upon implementation of IHC programs. They will be authorized to receive services from their current provider agencies at the same monthly service level that was prior approved under PCS.

Providers should note the following billing code changes:

Service	Code	Modifier	Description	Notes
PCS	S5125	none	Up to 60 hours of PCS per month	End date May 31, 2011
PCS-Plus	99509	none	All claims for recipients authorized to receive greater than 60 hours of PCS per month	End date May 31, 2011
IHCC	S5125	HA	Attendant Care Services; per 15 Minutes	Effective June 1, 2011
IHCA	S5125	HB	Attendant Care Services; per 15 Minutes	Effective June 1, 2011

CCME will offer regional provider trainings on the new IHC services in June. CCME will also continue to maintain the **Independent Assessment website and Provider Interface** (http://www.qireport.net). Please visit the **Information Center** by clicking on the "learn more" link on the QiReport log-in page (http://www.qireport.net). CCME will post additional information about the new IHC programs, upcoming provider trainings, and related forms, educational content, and announcements.

Providers who registered to use the Provider Interface under the PCS program do not need to re-register. The Provider Interface allows home care agencies to receive and respond to IHC recipient referrals, view independent assessments and decision notices, update service area information, and perform other reporting functions using a secure internet-based system. If you would like to register to use the Provider Interface, please complete and submit the QiRePort Provider Registration Form available on the **Independent Assessment website** (http://www.qireport.net).

Questions may be directed to the CCME Independent Assessment Help Line at 1-800-228-3365 and by e-mail to PCSAssessment@thecarolinascenter.org. Please direct questions regarding recipient status or referrals to the Help Line for faster response and to avoid the transmission of protected health information over e-mail.

CCME, 1-800-228-3365

Attention: Pregnancy Medical Home Providers

Registering for Obstetrical Ultrasounds

An **ordering** provider who has signed a contract with the local Community Care of N.C. network to be a Pregnancy Medical Home (PMH) provider with N.C. Medicaid is exempted from medical necessity review for OB ultrasound through the MedSolutions program. The **ordering** provider is responsible for registering the ultrasound with MedSolutions by providing the necessary demographic information for the recipient, ordering provider, rendering facility, ICD9 and CPT codes. The PMH provider is allowed up to five business days after the date of service to register the OB ultrasound with MedSolutions. The registration can be made with MedSolutions via the web (http://www.medsolutionsonline.com), telephone (1-888-693-3211) or fax (1-888-693-3210). Please remember that all other prior authorization requirements for imaging studies remain in effect for PMH providers.

The **rendering** facility does not have to be a PMH provider however the facility must have been approved through the MedSolutions accuracy assessment process for the OBUS imaging services or the registration approval will not be granted. Please remember, the ultrasound must be registered with MedSolutions and uploaded to Medicaid before the **rendering** facility's claim can be processed for payment.

A registration confirmation fax will be sent to the **ordering** and **rendering** providers. Recipients will not receive notice of registration. In addition, the **rendering** facility and the reading providers need to work with the ordering providers regarding when they will be submitting the registrations to MedSolutions. If the ordering provider chooses to batch their registrations every 5 days, the rendering and the reading providers cannot bill the procedures on the date of service. Please allow at least 10 days after the date of service before submitting claims. This time is needed to allow the ordering provider 5 days to batch and register the procedure and then time for the registration to be in the Medicaid claims processing system. All the providers must work together to work out a process for any unique situations at the local level.

The **ordering** provider and the **rendering** facility must be enrolled in N.C. Medicaid and follow the provider requirements found in Clinical Coverage Policy 1K-7, *Prior Approval for Imaging Procedures,* available on DMA's website at http://www.ncdhhs.gov/dma/mp/.

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

Attention: Radiology Providers

CPT Code 74300

CPT Procedure Code 74300 (cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation) is allowed once per day unless billed with the appropriate modifiers -76 (repeat diagnostic procedure by the same physician) or -77 (repeat diagnostic procedure by another physician). However, some claims have denied with EOB 5201 or 5202 (diagnostic procedure allowed once per DOS without modifier -76 or -77) or denied for inappropriate procedure code / modifier combination. If you received a denial for any of the reasons stated when billing 74300 since December 1, 2008 and the denied claims have been kept timely, please resubmit the denied charges as a new day claim (not as an adjustment request) for processing.

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

Attention: Radiology Providers

Mammography / Computer-Aided Detection

CPT Codes 77051 (computer-aided detection with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography) and 77052 (computer-aided detection for screening mammography) are add-on codes and must be billed with a primary code for screening mammography (G0202 or 77057) or diagnostic mammography (G0204, G0206, 77055 or 77056). However, some claims have denied with EOB 5223 (add-on code must be billed with primary code). If you received a denial with EOB 5223 for 77051 or 77052 when billed with G0202, G0204, G0206, 77055, 77056, or 77057 since January 1, 2010, please resubmit the denied charges as a new claim (not as an adjustment request) for processing.

Mammography / Screening Mammography Time Limit
One screening mammography CPT code 77057 or HCPCS procedure code G0202 is allowed once per year. However, some claims have denied when performed after 365 days of the previous screening mammography date of service with EOB 1798 (service already paid within allotted time). If you received a denial with EOB 1798 for 77057 or G0202 since January 1, 2010, and it has been 365 days from the previous screening mammography, please resubmit the denied charges as a new claim (not as an adjustment request) for processing.

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

Attention: Radiation Oncology Providers

Radiation Management Follow-up

Policy 1K-6 *Radiation Oncology Policy*, states follow-up examination and care are "included in the radiation treatment management during the course of the treatment and for 90 days following completion of the treatment." The follow-up examination and care codes and the radiation treatment management codes are all listed in the policy posted at http://www.ncdhhs.gov/dma/mp/1k6.pdf. However, some claims have denied with EOB 9800 (follow-up care is included in radiation management) when billing these procedure codes before radiation treatment management. If you received a denial with EOB 9800 when billing any of the follow-up examination and care codes before radiation treatment management codes since October 1, 2009 and the denied claims have been kept timely, please resubmit the denied charges as a new claim (not as an adjustment request) for processing.

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

Attention: Durable Medical Equipment, Home Health, Private Duty Nursing, Community Alternatives Program Providers

Reimbursement Rates and Addition of New Pull-On Codes

The new reimbursement rates for select incontinence supplies and the addition of new Pull-On codes will not be implemented on May 1, 2011. Please refer to the N.C. Division of Medical Assistance's website at http://www.ncdhhs.gov/dma for future updates and information on the N.C. Medicaid Incontinence program.

Durable Medical Equipment Program
DMA, 919-855-4310

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

Employment opportunities with DMA are advertised on the Office of State Personnel's website at http://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," and then click on "HHS Medical Assistance." If you identify a position for which you are both interested and qualified, complete a **state application form** (http://www.osp.state.nc.us/jobs/applications.htm) and submit it to the contact person listed for the vacancy. If you need additional information regarding a posted vacancy, call the contact person at the telephone number given in the vacancy posting. General information about employment with North Carolina State Government is also available online at http://www.osp.state.nc.us/jobs/gnrlinfo.htm.

Proposed Clinical Coverage Policies

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

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

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

2011 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
May	4/28/11	5/3/11	5/4/11
	5/5/11	5/10/11	5/11/11
	5/12/11	5/17/11	5/18/11
	5/19/11	5/26/11	5/27/11
June	6/2/11	6/7/11	6/8/11
	6/9/11	6/14/11	6/15/11
	6/16/11	6/23/11	6/24/11
	6/30/11	7/6/11	7/7/11

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

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

Melissa Robinson
Executive Director
HP Enterprise Services