# June 2012 Medicaid Bulletin

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## Attention: All Providers

# Changes in N.C. Medicaid Prior Approval Policies and Procedures, Recipient Due Process (Appeals), and Early Periodic Screening, Diagnosis and Treatment (EPSDT) Seminar

N.C. Medicaid will hold a **Prior Approval, Recipient Due Process, and EPSDT** seminar for providers on June 19, 2012.

The seminar will address changes in N.C. Medicaid's prior approval policies and procedures, and the **recipient** appeal process when a Medicaid service is denied, reduced, terminated, or suspended. The seminar will also provide an overview of Early Periodic Screening, Diagnosis and Treatment (EPSDT)-Medicaid for Children.

The seminar is scheduled from 9 a.m. to 4 p.m. at the location listed below. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided. **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 seminar online. **Pre-registration is required.** Providers will receive a registration confirmation specifying the training material(s) they should bring to the seminar.

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|---|---|
| June 19, 2012 | **Raleigh**<br>Wake Tech Community College<br>Student Service Building Conference Center<br>Second Floor, Rooms 213 & 214<br>9191 Fayetteville Road<br>Raleigh NC 27603<br><br>get directions |

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

## Attention: All Providers

# Electronic Health Records and Meaningful Use Training

The N.C. Medicaid Electronic Health Record (EHR) Incentive Program makes incentive payments available to eligible hospitals and providers to adopt, implement or upgrade certified EHR technology, as well as meaningfully use that technology.

The federal government, through American Recovery and Reinvestment Act (ARRA) funding, is offering educational programs to provide Health Information Technology training to meet the workforce growth that is anticipated with the implementation and maintenance of EHRs.

Physician office staff can take advantage of this EHR, Meaningful Use and IT training. The training is online with federal assistance offered.

Some of the topics covered in the training include:

- Configuring EHRs
- Working with Health IT Systems
- Quality Improvement
- Installation and Maintenance of Health IT Systems
- Networking and Health Information Exchange
- Health Workflow Process/Analysis/ Redesign

Participants have to enroll before October to take full advantage of the tuition assistance.

For more information about North Carolina's education opportunities, please go to http://hitregiond.pittcc.edu and sites.google.com/site/regiondhitech/. For more information about the national program, please go to healthit.hhs.gov/communitycollege.

For more information about the EHR program, please read the June 2012 Special Bulletin about the EHR Incentive Program.

**Kay Gooding**
**Pitt Community College, 252-493-7361**

## Attention: All Providers

# Clinical Coverage Policies

The following new or amended clinical coverage policies are available on the N.C. Division of Medical Assistance (DMA) Website at http://www.ncdhhs.gov/dma/mp/:

- *11A-12, Non-Myeloablative Allogeneic Stem Cell Transplant (Mini-Transplant, Mini-Allograft Reduced Intensity Conditioning) for Treatment of Malignancies (Date of Termination 4/30/12)*
- *11A-13, High Dose Chemotherapy, Bone Marrow or Peripheral Stem Cell Transplant for Ovarian Cancer and Germ Cell Tumors Arising in the Ovaries (Date of Termination 3/1/12)*
- *11D, Biventricular Pacemaker for the Treatment of Congestive Heart Failure (Date of Termination 4/30/12)*
- *11E, Implantable Cardioverter Defibrillator (Date of Termination 4/30/12)*
- *11F, Extracorporeal Membrane Oxygenation/Extracorporeal Life Support (Date of Termination 4/30/12)*
- *11G, Photophoresis for Solid Organ Rejection Autoimmune Disease and GVHD (Date of Termination 3/1/12)*
- *11H, Bone Morphogenic Protein-2 (Date of Termination 3/1/12)*

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

- *1A-3, Noninvasive Pulse Oximetry (3/12/12)*
- *1A-4, Cochlear and Auditory Brainstem Implants (3/12/12)*
- *1A-5, Case Conference for Sexually Abused Children (3/12/12)*
- *1A-6, Electrical Osteogenic Stimulators (3/12/12)*
- *1A-9, Blepharoplasty/Blepharoptosis (Eyelid Repair) (3/12/12)*
- *1A-19, Transcranial Doppler Studies (3/12/12)*
- *1A-25, Spinal Cord Stimulation (3/1/12)*
- *1A-38, Special Services: After Hours (3/12/12)*
- *1B, Physician's Drug Program (3/12/12)*
- *1C-2, Medically Necessary Routine Foot Care (5/1/12)*
- *1D-3, Tuberculosis Control and Treatment Provided in Health Departments (3/1/12)*
- *1K-1, Breast Imaging (3/12/12)*
- *1K-7, Prior Approval for Imaging Services (3/12/12)*
- *1M-2, Childbirth Education (3/12/12)*
- *1M-3, Health and Behavior Intervention (3/12/12)*
- *1M-4, Home Visit for Newborn Care and Assessment (3/12/12)*
- *1M-5, Home Visit for Postnatal Assessment and Follow-up Care (3/12/12)*
- *1M-6, Maternal Care Skilled Nurse Home Visit (3/12/12)*
- *1N-1, Allergy Testing (3/12/12)*

- *1N-2, Allergen Immunotherapy (3/12/12)*
- *1-O-1, Reconstructive and Cosmetic Surgery (3/12/12)*
- *3B, PACE (Program of All-Inclusive Care for the Elderly) (3/12/12)*
- *3H-1, Home Infusion Therapy (3/12/12)*
- *3K-2, Community Alternatives Program for Disabled Adults and Choice Option (CAP/DA-Choice) (3/12/12)*
- *9, Outpatient Pharmacy Program (5/1/12)*
- *10A, Outpatient Specialized Therapies (3/12/12)*
- *10B, Independent Practitioners (IP) (3/12/12)*
- *11C, Ventricular Assist Device (3/12/12)*
- *12B, Human Immunodeficiency Virus (HIV) Case Management (3/12/12)*

The following new or amended NCHC policies are now available on the DMA Website at http://www.ncdhhs.gov/dma/hcmp/:

- *11A-13, High-dose chemotherapy, Bone Marrow or Peripheral Stem Cell Transplant for Ovarian Cancer and Germ Cell Tumors Arising in the Ovaries (Date of Termination 3/1/12)*
- *Ambulance (Date of Termination 4/30/2012)*
- *Anesthesia (Date of Termination 4/30/2012)*
- *Biofeedback (Date of Termination 4/30/2012)*
- *Bone Marrow Transplant for Breast Cancer (Date of Termination 4/30/2012)*
- *Bone Marrow Transplant for Miscellaneous Tumors In Adults (Date of Termination 4/30/2012)*
- *Brachytherapy Treatment of Breast Cancer (Date of Termination 4/30/2012)*
- *Cardiac and Coronary Artery Computed Tomography (CT) and Computed Tomographic Angiography (CTA) (Date of Termination 4/30/2012)*
- *Cataract Lenses For Aphakia (Date of Termination 4/30/2012)*
- *Dietary Supplements (Date of Termination 4/30/2012)*
- *Genetic Testing for Colon Cancer (Date of Termination 4/30/2012)*
- *Hyperalimentation (Total Parenteral Nutrition/TPN) (Date of Termination 4/30/12)*
- *Hyperthermia Therapy (Date of Termination 4/30/2012)*
- *Immunizations (Date of Termination 4/30/2012)*
- *Nonmyeloablative Allogenic Transplants of Hematopoietic Stem Cells (Date of Termination 4/30/2012)*
- *Positron Emission Tomography (PET) (Date of Termination 4/30/2012)*
- *Pre-Admission Certification & Length of Stay (Date of Termination 4/30/2012)*
- *Radiosurgery Stereotactic Approach (Date of Termination 4/30/2012)*
- *Sexual Dysfunction Treatment, Female (Date of Termination 4/30/2012)*

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

# N.C. Health Choice Providers with Outstanding Medical Claims with Dates of Services Prior to October 1, 2011

Effective February 29, 2012, providers should **only** mail outstanding N.C. Health Choice (NCHC) paper claims which have dates of service prior to October 1, 2011 to:

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

Providers were previously notified by Blue Cross and Blue Shield of North Carolina (BCBSNC) to mail all outstanding claims to BCBSNC before February 29, 2012 to ensure timely processing of claims with dates of service prior to October 1, 2011. The N.C. Division of Medical Assistance (DMA) will try to resolve any claims received after February 29, 2012 with dates of service prior to October 1, 2011 in a timely fashion, but it cannot guarantee payment.

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

## Attention: All Providers

# Prior Approval for Procedure Codes 41010, 41115 and D7960

Effective with Date of Service July 1, 2012, no prior approval is necessary for procedure codes 41010 [Incision of lingual frenum (frenotomy)], 41115 [Excision of lingual frenum (frenectomy)] and D7960 [Frenulectomy (frenectomy or frenotomy)] for a child that is 1 year of age or younger when the procedure is performed in a physician or dentist office only. The diagnosis of Tongue tie (Ankyloglossia) must describe the condition of the infant.

The N.C. Division of Medical Assistance (DMA) will continue to pay for newborns with ankyolglossia and feeding difficulties in the hospital without prior approval as long as the procedure is performed prior to discharge. Prior approval must be obtained if the procedure will be performed in any other place of service.

Clinical coverage policy 1A-16, Surgery of the Lingual Frenulum can be accessed at http://www.ncdhhs.gov/dma/mp/index.htm.

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

## Attention: All Providers

# Recredentialing for the N.C. Medicaid Program

As the Enrollment, Verification, and Credentialing (EVC) vendor for the N.C. Medicaid Program, CSC must recredential existing Medicaid providers a minimum of every three years to ensure that all provider information is accurate and current. Effective November 1, 2011, the EVC Operations Center began recredentialing providers as part of a one-month ramp-up project and will continue recredentialing providers going forward. This process includes a thorough examination of a provider's background, credentials, and qualifications to ensure the provider continues to meet N.C. Medicaid Program participation guidelines. It also reduces fraud by ensuring a provider's record is current and that the State is aware of any adverse actions taken against the provider.

The EVC Operations Center electronically generates and distributes contract renewals for all enrolled N.C. Medicaid providers 75 days prior to the three-year anniversary date of enrollment or the date of the last contract renewal. To simplify this process, CSC has pre-populated a Recredentialing application with the information it currently has on file for each provider. Within 30 days of receiving the invitation letter, providers must verify their N.C. Medicaid Provider information and provide any additional information requested via the online Recredentialing application. **Recredentialing applications will not be mailed.**

It is critical that providers verify and provide all information required in the Recredentialing application. Consequences for failing to complete the Recredentialing application within 30 days of the date of the letter include denial of claim payments and possible termination from the N.C. Medicaid Program. Providers can follow the instructions below to access their online Recredentialing application.

1. Visit the North Carolina Identity Management (NCID) Website to apply for a NCID password and then go to the NCTracks Website.
2. On the left navigation menu, select Provider Services and then Provider Enrollment.
3. Scroll down to the Recredentialing section and select Start/Resume the Recredentialing Process Now.
4. Enter your NCID and password on the NCTracks Secure Login Page and select **Log In**.
5. On the Recredentialing Management page, enter your **Recredential ID** in all capital letters, for example **ABCDEFG**.
6. Enter your Medicaid Provider Number and your Tax ID to access the Recredentialing application.

For additional help, please refer to the Recredentialing 101 section under the Recredentialing section on the NCTracks Provider Enrollment Website for more information.

In accordance with N.C. Session Law 2009-451, Section 10.58.A, CSC must charge a recredentialing fee of $100. CSC will notify providers by mail with instructions on paying the recredentialing fee.

Please contact the EVC Operations Center at 866.844.1113 or by e-mail at NCMedicaid@csc.com if you have any questions. Remember to visit the NCTracks Website for other important updates.

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

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## Attention: All Providers and Vendors

## HIPAA ASC X12 4010 A1 and 5010 837 - Discretion Period Cutoff Date June 30, 2012

On March 15, 2012, the U.S. Centers for Medicare & Medicaid Services' (CMS) Office of E-Health Standards and Services (OESS) announced that it will **not** initiate enforcement action to comply with the updated transaction standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA): ASC X12 Version 5010 and National Council for Prescription Drug Programs (NCPDP) Versions D.0 and 3.0, for an additional three months through June 30, 2012.

Given this OESS notice, the N.C. Division of Medical Assistance (DMA) decided to continue the dual processing of 4010A1 and 5010 837 transactions only through June 30, 2012. **Beginning July 1, 2012, the 4010A1 837 transactions will no longer be accepted**.

Providers can contact the ECS unit of HP Enterprise Services, at 1-800-688-6696 or 919-851-8888 and press option 1 for questions or assistance regarding information about the ASC X12 5010 implementation.

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

## Attention: All Providers

## Office Relocation: Program Integrity, Finance Management, Hearings

As of May 21, 2012, the Program Integrity, Finance Management and Hearings units of the N.C. Division of Medical Assistance (DMA) have moved to 333 East Six Forks Road, Raleigh, North Carolina 27609. The mailing addresses and new contact information are listed below:

**DMA Program Integrity**
**New Central Phone Number (919) 814-0000**
**New Fax Number (919) 814-0035**

Mailing Addresses – Remain the Same:
Division of Medical Assistance – Program Integrity
2501 Mail Service Center
Raleigh, NC 27699-2501

Division of Medical Assistance – Program Integrity
Third Party Recovery Section
2508 Mail Service Center
Raleigh, NC 27699-2508

Overnight Delivery Address:
Division of Medical Assistance – Program Integrity
333 East Six Forks Road, **3rd** Floor
Raleigh, NC 27609

**DMA Finance Management**
**New Central Phone Number (919) 814-0000**
**New Fax Number (919) 814-0031**

Mailing Address – Remains the Same:
Division of Medical Assistance – (Rate Setting or Audit)
2501 Mail Service Center
Raleigh, NC 27699-2501

Overnight Delivery Address:
Division of Medical Assistance – (Rate Setting or Audit)
333 East Six Forks Road, **2nd** Floor
Raleigh, NC 27609

**DMA Hearings**
**New Central Phone Number (919) 814-0000 / (919) 814-0090**
**New Fax Number (919) 814-0032**

Mailing Address – Remains the Same:
Division of Medical Assistance – Hearings
2501 Mail Service Center
Raleigh, NC 27699-2501

Overnight Delivery Address:
Division of Medical Assistance – Hearings
333 East Six Forks Road, **2nd** Floor
Raleigh, NC 27609

**Program Integrity/Finance/Hearings**
**DMA, (919) 814-0000**

## Attention: All Providers

## Delay of Required Enrollment for Physician Assistants and Nurse Practitioners

The N.C. Division of Medical Assistance (DMA) announced in the May 2012 Medicaid Bulletin that Nurse Practitioners (NP) and Physicians Assistants (PA) must enroll in the N.C. Medicaid Program and all services rendered by those healthcare providers must be filed with N.C. Medicaid using their National Provider Identifier (NPI) as the rendering (or attending) provider.

**The purpose of this notice is to announce that the mandatory implementation of this change will be delayed to address administrative procedures and to allow more time to do outreach to affected provider communities.**

As a reminder, 42 CFR, subpart E, 455.410 (b) requires:

> "the state Medicaid agency must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers."

Both NPs and PAs should continue their current billing method. NPs and PAs not enrolled with N.C. Medicaid should begin the enrollment process and may continue billing "incident to" until further notice. DMA will monitor the enrollment of NPs and PAs and will notify providers when they should begin using the NPI as the rendering/attending provider number. The effective date of any change to the current "incident to" policy will be communicated to providers via bulletin articles, Website updates, and provider e-mail blasts.

**Clinical Policy**
**DMA, 919-855-4320**

## Attention: All Providers

# Outpatient Specialized Therapies: Adult Therapy

Effective June 1, 2012, diagnosis codes V54.23 and V54.89 are being added to the list of diagnosis codes to be used to bill for two evaluations and 10 visits for adult therapy. Additionally diagnosis category 438 and codes V54.17, V54.19 and V54.27 are being added to the diagnosis codes to be used to bill for three evaluations and 30 visits. Refer to Clinical Coverage policy 10A, for a complete list of diagnosis codes, as well as other requirements for providing adult therapy services.

All limits are hard limits. Prior approval is required for all treatment visits. As is currently done, adult prior approvals will not span two calendar years. A new prior approval will be required for each calendar year.

When completing the prior approval request, providers should submit sufficient medical history to support an exception to the three visit limit, including, but not limited to, appropriate medical or surgical diagnosis and discharge date from inpatient services. Relevant qualifying information can be added in the designated diagnosis fields or in the Additional Medical History or other text fields.

**Pharmacy and Ancillary Services**
**DMA, 919-855-4310**

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## Attention: All Providers

# Outpatient Specialized Therapies: Reminder of Documentation Requirements

Service documentation is a required component of providing care. Service documentation should include the duration of service (length of assessment and/or treatment session in minutes), the signature and credentials of the person providing each service, and a "Description of Services" for each date of service.

The "Description of Services" supports the medical necessity of provided services and reflects the knowledge, skills, and judgment of the licensed therapist providing care. It should include the following:

1. all skilled interventions provided by the therapist, including treatment techniques/modalities/approaches, caregiver education, fitting and training with equipment, and any variations to the interventions that were implemented as the client progressed. The "Description of Services" should describe what the therapist did to help the client.
2. the outcome or client's response to the intervention, that is, how the client (and caregiver, if appropriate) progressed due to the treatment.

If changes to the documentation are necessary, either create a new entry outlining the information that has changed, or draw a line through the incorrect information and sign and date the change. Any addendum should include the date the change was entered into the record, the name and signature of the person making the change, and the reason for the change. Documentation must comply with policy requirements for reimbursement.

For policy requirements, refer to the N.C. Medicaid Program's Clinical Coverage Policy 10A Outpatient Specialized Therapies.

**Pharmacy and Ancillary Services**
**DMA, 919-855-4310**

## Attention: All Providers

## Correct Coding Edits: Implementation of Additional Edits for Professional Duplicates

As announced in previous N.C. Medicaid bulletins, the N.C. Division of Medical Assistance (DMA) is implementing additional correct coding guidelines. These new correct coding guidelines and edits are nationally sourced by organizations such as the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA). These edits identify any inconsistencies with CPT, AMA, CMS and/or DMA policies and generate denials at the claim-detail level. Additional correct coding edits for Professional Duplicates will be implemented on August 1, 2012 for dates of service on or after August 1, 2012.

**Duplicates – Professional Claims**

N.C. Medicaid and N.C. Health Choice (NCHC) programs will be implementing edits that detect where duplicate submissions of a service were submitted on separate claims. The analytics examine codes that cannot be billed more than once on the same date of service – either within a defined date range or over the lifetime of the patient for CPT and HCPCS codes.

The following are examples of Professional Duplicate edits:

**Same Day Duplicate edits**: These errors occur when the same provider submits a procedure on separate claims for the same date of service and the procedure code description does not support multiple submissions.

| Procedure | Claim | Description | Analysis |
|---|---|---|---|
| 11200 | XX159 | Removal of skin tags, up to 15 | Allow |
| 11200 | XX256 | Removal of skin tags, up to 15 | Deny |

**Date Range Duplicate edits** – These errors occur when the same provider submits the same procedure more than once on separate claims within a defined time period.

| Procedure | Claim | Description | Analysis |
|---|---|---|---|
| 94774 | XX622 | Pediatric home apnea monitoring per 30 days | Allow |
| 94774 | XX489 | Pediatric home apnea monitoring, performed within 30 days of previous monitoring | Deny |

**Lifetime Duplicate edits** - These errors occur when a procedure is billed more than once in a patient's lifetime on separate claims (e.g. appendectomy, autopsy).

| Procedure | Claim | Description | Analysis |
|---|---|---|---|
| 58200 | XX115 | Total abdominal hysterectomy | Allow |
| 58200 | XX419 | Total abdominal hysterectomy (billed two years later) | Deny |

When clinically appropriate, a modifier may be appended to the claim detail to override the edit.

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

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## Attention: Ambulatory Surgical Centers

## National Correct Coding Initiative – Billing Guidance

Ambulatory Surgical Centers that received an Explanation of Benefit (EOB) 9954, "Payment of procedure code is denied based on correct coding standards editing," when billing for a date of service that was within a global surgical period should now resubmit their claims.

Effective immediately, providers who have had claims denied and have kept the claims timely, can resubmit the denied charge as a new claim **(not as an adjustment request)** for processing.
Providers can contact the Provider Services unit of HP Enterprise Services, at 1-800-688-6696 or 919-851-8888; press option 3 for assistance.

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

## Attention: Adult Care Home (ACH) Providers

# Special Medicaid Bulletin on Transition to 1915(i) Personal Assistance Services

A Special Medicaid Bulletin for Adult Care Home providers and physicians who refer for ACH personal care services will be forthcoming in June. The Bulletin will provide critical information on the December 31, 2012 sunset of Adult Care Home (ACH) Personal Care Services and the January 1, 2013 implementation of a consolidated 1915(i) Home and Community Based Services (HCBS) Personal Assistance Services benefit for licensed home residents and recipients in their private homes. The Special Bulletin for ACH providers and physicians and practitioners who make AHC referrals will include an overview of licensed home provider and recipient eligibility requirements, and plans for upcoming transitional activities, including required practitioner Medical Attestation, provider training and independent assessments of current licensed home residents.

**Clinical Policy**
**DMA, 1-919-855-4260**

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## *Attention: CAP/C Providers*

# CAP Assure Website changes

The Carolinas Center for Medical Excellence (CCME) has developed a Website to allow case manager and provider interface with the Community Alternative Program for Children (CAP/C) claim review process. The Website address is www.thecarolinascenter.org/capassure**.** Pre-registration began on May 15, 2012.

As of June 1, 2012, those who are registered can view the status of a claim to determine if it has been received, reviewed and faxed. If the claim states it has "missing information," that means there is no valid service authorization covering all the dates on that claim. If it states "pending," it means it was sent back because more information was needed.

On July 1, 2012, the site will be fully functional. At that time, providers and case managers will use the site to access, download and print their claim review summaries. They will also be able to print out respite reports, and missing information letters as needed.

**Clinical Policies and Programs**
**DMA, 919-855-4380**

## Attention: Physicians, Nurse Practitioners, Physician Assistants and Pharmacists

## Prescribing and Documenting Brand Medically Necessary Drugs

Providers are reminded that effective January 1, 1999 and in accordance with the Outpatient Pharmacy Program Clinical Coverage Policy No. 9, the N C. Medicaid Outpatient Pharmacy Program is required by federal regulations to utilize a federal Maximum Allowable Cost (MAC) – also referred to as the Federal Upper Limit (FUL) – for some multiple source drugs. In addition, N.C. Medicaid also utilizes a State MAC list for generic and multi-source brand drug products. The State MAC list contains products with A-rated equivalents and, in the great majority of cases, products marketed by at least two labelers.

It is possible to override either the federal or the state MAC limitations if a prescriber certifies that a specific brand of drug, which has a MAC limitation, is medically necessary for a particular recipient. This certification must fall under federal and state regulations, which specify that the certification "Medically Necessary" must be in the prescriber's own handwriting and signed by the prescriber. This can be written directly on the face of the prescription, or on a separate document which must be attached to the original prescription.

The prescriber is **not** allowed to indicate "Medically Necessary" over the telephone for the pharmacist to document on the prescription if the drug is a MAC drug. If the drug is not a MAC drug, the pharmacist may receive oral authorization not to substitute from the prescriber, write "Medically Necessary" on the prescription, and initial it. If a telephone prescription requiring brand only is accepted, the prescriber must send a new prescription within 72 hours with "Medically Necessary" written on the prescription in the prescriber's own handwriting.

The following are **unacceptable** practices:

- a prescriber's signature over a printed statement indicating "Dispense as Written" or "Medically Necessary" with a check or X in a box on the prescription indicating "Dispense as Written."
- a handwritten statement transferred to a rubber stamp and then stamped on the prescription.
- the abbreviation "DAW" on the prescription by the prescriber.

If a prescriber has properly authorized for the dispensing of a brand name drug product when that drug product is a MAC drug, the pharmacist may bill Medicaid for reimbursement based on the lesser of the usual and customary charge or the Medicaid reimbursement rate of the brand name drug plus the dispensing fee.

Documentation of medical necessity must be present on the prescription at the time of billing. **Obtaining documentation of medically necessity after the Medicaid**

**payment is made is not acceptable and the payment will be subject to post-payment recoupment.** Please note that in addition to receiving proper authorization from the prescriber, the Division on June 5, 2012 will begin imposing prior authorization requirements on brand-name drugs for which the phrase "medically necessary" is written on the prescription.

**Program Integrity**
**DMA, 919-647-8022**

## Attention: Nurse Practitioners, Physician Assistants and Physicians

## Billing Guidelines - Revised: Pralatrexate (FOLOTYN, HCPCS code J9307)

As previously published, effective with date of service January 1, 2011, the N.C. Medicaid Program covers pralatrexate injection (FOLOTYN) for the treatment of recipients with relapsed or refractory peripheral T-cell lymphoma through the Physician's Drug Program. The ICD-9-CM diagnosis codes are being updated for J9307.

One of the following ICD-9-CM diagnosis codes is required for FOLOTYN, effective with date of service January 1, 2011:

- 200.60-200.68 (anaplastic large cell lymphoma); or
- 202.70-202.78 (peripheral T-cell lymphoma); or
- 202.80-202.88 (other lymphomas)

Providers who have had denials for one of the diagnosis codes above may refile as a new day claim.

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

## Attention: Dialysis Providers

# Billing Guidelines: Peginesatide (Omontys, HCPCS codes J3490 and Q2047)

Effective starting with date of service March 29, 2012, the N.C. Medicaid Program covers peginesatide injection (Omontys) for use by dialysis facilities that bill through the Physician's Drug Program. Omontys must be billed with HCPCS code J3490 (Unclassified Drugs) with dates of service ranging from March 29, 2012 June 30, 2012. Providers will use HCPCS code Q2047 for Omontys from date of service July 1, 2012 forward. Omontys is currently available in 1 and 2 ml **multiple-dose vials** containing 10 mg/ml. Omontys is indicated for the treatment of anemia due to chronic kidney disease (CKD) in adult patients **18 years of age and above on dialysis.**

Omontys is not indicated and is not recommended for use:

- in patients with CKD who are not on dialysis;
- in patients receiving treatment for cancer and whose anemia is not due to CKD;
- as a substitute for RBC transfusions in patients who require immediate correction of anemia.

Omontys has not been shown to improve symptoms, physical functioning, or health-related quality of life.

The recommended starting dose for the treatment of anemia in patients who are not currently treated with an erythropoiesis-stimulating agent (ESA) is 0.04 mg/kg body weight administered as a single intravenous or subcutaneous injection once monthly. Treatment with Omontys should be initiated when the hemoglobin level is less than 10 g/dL. Hemoglobin levels should be monitored at least every two weeks until stable, then monitored at least monthly. When adjusting therapy, the hemoglobin rate of rise, rate of decline, ESA responsiveness and hemoglobin variability should be considered.

It is possible to begin treatment with Omontys when a patient is already on another ESA. Please refer to the package insert for detailed information and for the exact dosage calculations when stopping another ESA and converting to Omontys.

**For Medicaid Billing**

- The ICD-9-CM diagnosis code required for billing Omontys is:
  - 585.6 (End Stage Renal Disease, on dialysis); plus
  - 285.21 (anemia in chronic kidney disease) must be included on the claim.
- **Revenue code 250** must be billed for Omontys.
- For **dates of service from March 29, 2012 through June 30, 2012**, providers must bill Omontys with HCPCS code J3490 (Unclassified Drugs). One

Medicaid unit of coverage is 1 mg. The maximum reimbursement rate per unit is $112.53.

- For **dates of service on and after July 1, 2012**, providers must bill Q2047 [Injection, peginesatide, 0.1 mg (for ESRD on dialysis)]. One Medicaid unit of coverage is 0.1 mg. The maximum reimbursement rate per unit will be published on the Physician's Drug Program fee schedule on the N.C. Division of Medical Assistance (DMA) Website at: www.ncdhhs.gov/dma/fee/.
- Providers must indicate the number of HCPCS units. **Omontys is currently available only in multiple-dose vials; therefore, providers must bill only the amount administered to the recipient, and not bill Medicaid for wastage.**
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Omontys should be reported as "ML." For example, to bill for 2.8 mg (0.28 ml) of Omontys from the 1 ml multi-dose vial, report the NDC units as "ML0.28"
- If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's Website (www.ncdhhs.gov/dma/bulletin/pdfbulletin/0309SpecialBulletin.pdf) for additional instructions.
- Providers must bill their usual and customary charge.
- The fee schedule for the Physician's Drug Program is available on DMA's Website at: www.ncdhhs.gov/dma/fee/

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

## Attention: HIV Case Management Providers

# HIV Case Management Under the N.C. Health Choice Program

Effective May 1, 2012, HIV Case Management agencies may serve eligible Health Choice (NCHC) recipients. Clinical Coverage Policy 12B now governs the provision of this service for both the N.C. Medicaid and NCHC populations. Providers are advised to review the policy for changes.

Information regarding NCHC (Title XXI State Children's Health Insurance Program) is available in Section 3 of the **Basic Medicaid and NCHC Billing Guide** at the following link: www.ncdhhs.gov/dma/basicmed/. Additional information regarding this health insurance plan is located on **the N.C. Division of Medical Assistance (DMA) Website** at www.ncdhhs.gov/dma/.

This is a new service population for HIV Case Management agencies. Providers are advised to familiarize themselves with this plan's requirements.

**HIV Case Management Program**
**DMA, 919-855-4389**

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## Attention: All N.C. Health Choice Providers

# Billing for Immunizations for American Indian and Alaska Native N.C. Health Choice Recipients

The October 2011 *Medicaid Bulletin* included N.C. Health Choice (NCHC) provider guidance for administering vaccines to NCHC recipients under the federal Vaccines for Children (VFC) program. **This Bulletin article supersedes the October 2011 Bulletin article.**

One group of recipients eligible for the VFC program is American Indian or Alaska Native (AI/AN), as defined by the Indian Health Care Improvement Act (25 U.S.C. § 1603). The Indian Health Care Improvement Act defines AI/AN recipients as those who are members of either federally or State-recognized tribes. The federal VFC program requires providers to screen recipients at each immunization visit. However, the VFC program does not require parents or guardians to verify self-declared AI/AN status for the child receiving the immunization.

In North Carolina, the agency responsible for administering the VFC program is the N.C. Division of Public Health's Immunization Branch. The (federal) Centers for Disease Control and Prevention (CDC) **National Center for Immunization and Respiratory Diseases (NCIRD)** and the N.C. Immunization Branch have had a longstanding policy of allowing VFC recipients (or their parents or legal guardians)

to self-declare VFC eligibility, including that of AI/AN status — for federally recognized *and* State-recognized tribes — during an immunization visit.

When an individual applies for NCHC program eligibility, MIC-A and MIC-S classifications are assigned to members of federally recognized tribes only, pursuant to 42 C.F.R. § 457.10. The NCHC program eligibility screening does not rely on self-declared AI/AN status. It requires parents or guardians of applicants to present documentation that verifies membership in a federally recognized tribe.

There is a distinction between screening for eligibility for all NCHC program benefits and screening for eligibility for the VFC Program. The State Children's Health Insurance Program (SCHIP) regulation definition of AI/AN individuals applies to eligibility screening for all NCHC program benefits; the Indian Health Care Improvement Act statute definition of AI/AN individuals applies to eligibility screening for the VFC Program.

**Therefore, NCHC providers may administer state-supplied vaccines to a self-declared AI/AN NCHC recipient even when the recipient does not have a MIC-A or MIC-S eligibility group classification in the N.C. Division of Medical Assistance (DMA) Eligibility Information System.**

When the NCHC recipient, or the recipient's parent or guardian, self-declares that the recipient is AI/AN and the provider administers the state-supplied vaccine, the provider must file a claim with the state-supplied vaccine CPT code and a charge of $0.00 reported. However, the provider may bill for the vaccine administration costs. NCHC providers should follow this same billing procedure when they administer a state-supplied vaccine to a recipient with a MIC-A or MIC-S eligibility group classification in DMA's Eligibility Information System.

Please go to http://cdc.gov/vaccines/spec-grps/ai-an.htm to see the federal VFC Program eligibility standards, and www.immunize.nc.gov/ to learn more about the N.C. Division of Public Health's Immunization Branch oversight of the VFC Program in North Carolina.

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

## Attention: Hospital Outpatient Clinics

## Clarification of April 2012 Article on Hospital Outpatient Therapies

The example provided in the April 2012 Medicaid Bulletin article about billing Outpatient Specialized Therapies needs further clarification. For the current claims processing system, Outpatient Hospital Providers should bill for therapy services (physical, occupational, speech) with the appropriate Revenue Code and one (1) unit per visit. The CPT code for the service should not be entered at this time. For example, on a day when two physical therapy services and one occupational therapy service was provided, the outpatient hospital claim would be filed with 1 Unit RC420 and 1 Unit RC430 without any CPT codes.

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

## Attention: DME Providers

# Roche Provider Rebates

Effective July 1, 2012, all claims for diabetic supplies that meet the requirements for the Roche provider rebate that process and pay with dates of service on or after July 1, 2012, will receive an automated rebate payment in conjunction with their reimbursement from N.C. Medicaid. **There will be no action required of providers to receive the provider rebate.** Providers should no longer submit provider rebates to Roche for reimbursement for claims with dates of service on or after July 1, 2012.

The rebate payment will be paid one checkwrite after the claim payment is generated and these claims will appear on the Remittance Advice (RA) with an ICN region starting with 81. If a claim is later reversed or adjusted, the rebate claim will also be adjusted in the checkwrite following the claim recoupment (this will appear as a region 90 adjustment for both pharmacy and DME providers). Pharmacy providers will not see this payment on their POS transaction, but the payment will be included on the RA.

If you are not currently enrolled in the Roche rebate program, please log on to https://rxvp.accu-chek.com no later than Friday , June 15, 2012 to enroll. With your enrollment, Roche will process your eligible N.C. Medicaid claims for June 2012. Below are the Roche provider rebates that will be paid by NDC:

| Product | Size | NDC # | 2012 Roche Provider Rebate Amount |
|---|---|---|---|
| ACCU-CHEK AVIVA STRIPS 50’s | 50 | 65702-0103-10 | $26.23 |
| ACCU-CHEK AVIVA PLUS STRIPS 50’s | 50 | 65702-0407-10 | $26.23 |
| ACCU-CHEK COMPACT 51's | **51** | 50924-0988-50 | $27.64 |
| ACCU-CHEK SMARTVIEW STRIPS (NANO) | 50 | 65702-0492-10 | $26.23 |
| SOFTCLIX LANCING DEVICE KIT (BLUE) | 1 | 50924-0957-01 | $5.08 |
| MULTICLIX LANCING DEVICE KIT | 1 | 50924-0446-01 | $5.08 |
| SOFTCLIX LANCING DEVICE KIT (BLACK) | 1 | 65702-0400-10 | $5.08 |

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

## Attention: DME Providers

# Certificates of Medical Necessity and Obtaining Override Requests

This information will help providers file a Certificate of Medical Necessity/Prior Approval (CMN/PA) form or obtain a Carolina Access Emergency Authorization/Override Number for Durable Medical Equipment (DME) supplies.

**Certificate of Medical Necessity/Prior Approval (CMN/PA) Forms:**

- Providers may obtain CMN/PA Forms by contacting HP Enterprise Services (HPES) at 1-800-688-6696 or 919-851-8888, option No. 3
- CMN/PA forms that were in use prior to 2005 that did not contain the height and weight requirement will no longer be accepted after June 1, 2012
- Providers may obtain CMN/PA Forms by contacting HPES at 1-800-688-6696 or 919-851-8888, option No. 3

**CCNC/Carolina Access number Override Requests for DME claims:**

- Issuance of Carolina Access Emergency Authorizations/Overrides by the N.C. Division of Medical Assistance (DMA) or its fiscal agent, HPES, is not automatic. Each request will be given careful consideration.
- Providers should always verify recipient eligibility before providing services.
- If the recipient is linked to a Carolina Access Personal Care Provider (PCP), as applicable, always contact the Carolina Access PCP on record to request authorization before providing services.
- If the Carolina Access PCP provides his/her Carolina Access Authorization Number (NPI #), proceed with providing the service and filing the claim.
- If the Carolina Access PCP denies your request, see step 3.
- Providers may opt not to provide the service or providers may call 919-855-4780, option 8 to request a Carolina Access Override Number which are issued by the DMA-Recipient & Provider Services-CCNC Team when:
    - the patient is in the provider's office being seen or waiting to be seen, or
    - the service date is the **same date or a future date** of service.
- Providers should complete a Carolina Access Override Request Form if:
    - the service is for a **past date** of service(s) and,
    - provider has received claim denials with EOB: 270 or 286.
- Providers should follow the instructions noted on the Carolina Access Override Request Form including faxing the form to the DMA fiscal agent, HPES
- Providers should allow 45 days for faxed Carolina Access Override Requests to be processed.
- Providers may call 919-855-4780, option 8 to inquire about their Override Request if they do not receive a response within 45 days.

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

## Attention: Institutional Billers

# New Submission Address for Medicare HMO Claims

In the April 2012 and previous versions of the *Basic Medicaid Billing Guide*, providers were instructed to mail Medicare Health Maintenance Organization (HMO) claims for institutional services on the UB-04 claim form to the N.C. Division of Medical Assistance (DMA) Third Party Recovery. ***Starting on July 1, 2012***, providers will mail Medicare HMO UB-04 claims to DMA's fiscal agent, HP Enterprise Services (HPES), at this address:

**HP Enterprise Services**
**P. O. Box 30968**
**Raleigh, NC 27622**
**Attn: UB Medicare HMO**

With the exception of the address change for institutional claims, all other guidelines for submitting Medicare HMO claims stated in the April 2012, *Basic Medicaid Billing Guide, section 10 page 19-20* will remain in effect. Refer to the DMA Website for updates to policies and procedures. Questions regarding claim submission should be directed to the HP Enterprise Services Provider Services Unit at 1-800-688-6696, menu option 3. "UB Medicare HMO" must be clearly written on the envelope and the envelope must contain only UB Medicare HMO claims.

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

## Attention: Institutional Billers

# UB-04 Claim Forms for Medicare HMOs

In order for N.C. Medicaid to consider payment for Medicare HMO, providers are requested to bill all institutional charges on the UB-04 claim form. The claims should not be altered for processing purposes. **The claim should be billed to Medicaid as it was billed to Medicare HMO. Medicaid liability is only for the Medicare HMO cost share, which includes copayment, coinsurance, and/or deductible.**

The following information is required for claim processing:

- The claims must be submitted with a Medicare EOB attached to the claim. If the EOB is on multiple pages, submit all of the pages of the EOB with the claim.
- All charges should be reflected on the UB-04 claim form. Do not combine or destroy the integrity of the claim by combining the charges into one revenue code.
- If the recipient has patient monthly liability or deductible, the information should be reflected on inpatient stays, if applicable

**Claim Codes**

- FL47 – Indicate the total charges
- FL 50 – Two digit payer code
- FL54 – Indicate HMO payment
- FL55 – Indicate the cost share amount

**Note:** The amounts listed in FL55 should reflect the Medicare HMO cost share amount only

- FL56 – Enter your NPI
- FL57 **–** Enter your Medicaid Provider Number
- FL80 – Write **—**This is a Medicare HMO claim

Attached is an example of UB-04 Claim Form, HMO EOB

**Third Party Recovery,**
**DMA, 919-647-8100**

### 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 agency.governmentjobs.com/northcarolina/default.cfm. To view the vacancy postings for DMA, click on "Agency," then click on "Department of Health and Human Services". If you identify a position for which you are both interested and qualified, complete a **state application form online** and submit it to the contact person listed for the vacancy. If you need additional information regarding a posted vacancy, call the contact person at the telephone number given in the vacancy posting. General information about employment with North Carolina State Government is also available online at 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 www.ncdhhs.gov/dma/mpproposed/. To submit a comment related to a policy, refer to the instructions on the Website. Providers without Internet access can submit written comments to the address listed below.

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

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

### *2012 Checkwrite Schedule*

| Month | Checkwrite Cycle Cutoff Date | Checkwrite Date | EFT Effective Date |
|---|---|---|---|
| **June** | 6/7/12 | 6/12/12 | 6/13/12 |
| | 6/14/12 | 6/19/12 | 6/20/12 |
| | 6/21/12 | 6/28/12 | 6/29/12 |
| **July** | 7/5/12 | 7/10/12 | 7/11/12 |
| | 7/12/12 | 7/17/12 | 7/18/12 |
| | 7/19/12 | 7/26/12 | 7/27/12 |

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

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

**Melissa Robinson**
**Executive Director**
**HP Enterprise Services**