July 2011 Medicaid Bulletin

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Attention: All Providers

Clinical Coverage Policies

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

- **1A-8, Hyberbaric Oxygenation Therapy**
- **1A-27, Electrodiagnostic Studies**
- **1C-1, Podiatry Services**
- **3D, Hospice Services**
- **5A, Durable Medical Equipment**
- **8N, Intellectual and Developmental Disabilities Targeted Case Management**

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

Upcoming Changes

Recent bills were passed and signed into law, which impact the North Carolina Medicaid Program. You may view the bills at www.ncga.state.nc.us/session2011. Providers will receive more detailed information in upcoming bulletins.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Changes to Medicare Recovery Process

Section 6404 of the Patient Protection and Affordable Care Act (PPACA), implemented October 4, 2010, amends Medicare timely filing requirements for submission of Medicare fee-for-service claims. The maximum time period to file a Medicare claim was reduced to one calendar year after the date of service. Prior to PPACA, the regulations stated claims for services furnished during the first nine (9) months of the calendar year were required to be submitted on or before December 31st of the following calendar year. For services rendered during the last quarter of the calendar year, the provider was required to submit the claim on or before December 31st of the next consecutive year.

The previous timely filing period gave DMA time to identify claims with dates of service during a 2-year period that were billed in error to Medicaid. DMA would send a list of these claims to the provider along with the Medicare disallowance notice, allowing the provider 60 days to respond. However, because providers must file claims with Medicare within one calendar year of the date of service, it is no longer possible to allow the 60-day response period.

In order to minimize the financial impact of the Medicare changes on the North Carolina Medicaid program, DMA and its partner, Health Management Systems, Inc. (HMS), have modified the Medicare Recovery Process—the process by which Medicaid recovers funds paid on claims that should have been submitted to Medicare first. To address the new 1-year timely filing requirement, DMA now selects paid claims going back 11 months from the date of the disallowance notice and allows the provider 30 days to submit the refund or the refuting documentation. This process helps safeguard the provider's ability to file the oldest claims with Medicare before the timely filing period expires. Please note that DMA is unable to accept Medicare "denials due to timely filing" as a reason to avoid recoupment of the original Medicaid payments.

Additionally, DMA has increased the frequency at which we will send out disallowance notices. They will be sent to providers every 2 months instead of quarterly. Other than the changes noted in this article, the Medicare Recovery Process itself remains the same. Detailed instructions regarding the process will continue to be included with the disallowance notices issued by HMS.

Program Integrity/TPR
DMA, 919-647-8100

Attention: All Providers

HIPAA 5010 Implementation

In accordance with 45 CFR Part 162 – Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA); Final Rule, HIPAA-covered entities, which include state Medicaid agencies, must adopt modifications to the HIPAA required standard transactions by January 1, 2012. The modifications are to the HIPAA named transactions to adopt and implement ASC X12 version 5010 and NCPDP Telecommunication version D.0.

N.C. Medicaid will be implementing the HIPAA requirements for the 5010 transactions within the MMIS+ claims processing system. DMA will notify providers through upcoming Medicaid bulletins as the HIPAA 5010 implementation efforts progress.
In preparation for 5010 testing and implementation, HP Enterprise Services will begin receiving updated Trading Partner Agreement-Appendix A effective July 1, 2011. Follow the attached link to the 5010 version of Appendix A (link will be attached here). Complete and mail, with original signature, to HP Enterprise Services. You will be e-mailed a letter with instructions on how to proceed with 5010 transaction testing after your Trading Partner Agreement-Appendix A has been processed.

Trading Partners/Vendors will be notified about testing timelines through upcoming Medicaid bulletins as HIPAA 5010 efforts progress.

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

Attention: All Providers

Updated EOB Code Crosswalk to HIPAA Standard Codes

The list of standard national codes used on the Electronic Remittance Advice (ERA) has been cross-walked to Medicaid EOB codes as an informational aid to research adjudicated claims listed on the Remittance and Status Report (RA). An updated version of the list is available on DMA's website at http://www.ncdhhs.gov/dma/hipaa/EOBcrosswalk.htm.

New changes to the format of the crosswalk were added in July 2010. The changes allow for codes to be filtered and sorted in a more efficient manner when multiple codes map to the same Medicaid EOB. In addition, the crosswalk has been divided into separate crosswalks based on claims types – Institutional, Professional, Dental, and Pharmacy. This will eliminate some of the one-to-many mappings.

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

Attention: All Providers

Implementation of Additional Correct Coding Edits: Global Surgery and Evaluation and Management Codes

As previously announced in the May bulletin, DMA will begin implementing additional correct coding guidelines. 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, HCPCS, AMA, CMS and/or DMA policies and will deny the claim line.

Additional correct coding edits for Global Surgery Package (GSP) and Evaluation and Management (E&M) codes will be implemented on August 1, 2011 for dates of service on or after August 1, 2011.

Global Surgery Package (GSP)

GSP edits are defined by CMS as the specific time periods during which certain services related to a surgical procedure, furnished by the physician who performed the surgery, are to be included in the payment of the surgical procedure code. The GSP has two main subcategories:

- Evaluation and Management services billed on the same day as the surgical procedure or during the defined global period for the surgical procedure will be denied by the GSP Surgery/E&M editing if not submitted with an appropriate modifier to indicate a separate unrelated service. The following are examples of Global Surgery E & M Edits:

Procedure	Description	Global Days	Analysis
45385	Colonoscopy with polypectomy	0 Days	Deny E&M day of surgery
36571	Peripheral insertion of central VAD with port	10 Days	Deny E&M day of surgery and 10 days after
44970	Appendectomy	90 Days	Deny E&M day before, day of surgery and 90 days after

- The GSP edits also contain logic that detects additional surgeries or procedures billed within the global period of a previously billed surgery. These edits will deny the subsequent surgery according to DMA Clinical Policy. The use of an appropriate modifier for a separate unrelated surgical service can be appended to the surgery code and will override a GSP Surgery/Surgery edit when appropriate. The following are examples of GSP Surgery/Surgery Edits:

Procedure	Description	Date of Service	Analysis
33510	Coronary artery bypass, vein only, single vessel	01/30/2011	Allow (has 90 day global period)
93510	Left heart catheterization	03/01/2011	Deny

Procedure	Description	Date of Service	Analysis
27275	Manipulation hip joint requiring general anesthesia	2/1/11	Allow (has 10 day global period)
27025	Fasciotomy, hip or thigh, any type	2/7/11	Deny

Evaluation and Management (E&M)
Evaluation and Management (E&M) codes are used to describe the intensity and work associated with a medical encounter as measured by the risks and complexities associated with the history, physical examination, and medical decision-making. The more detailed these components are the higher the level of the E&M service. Correct coding of E&M services stipulates only one E&M code may be reported per day for the same patient/provider. The appropriate use of modifiers complying with DMA policies will allow for appropriate reimbursement. The E & M edits ensure proper coding of these services.

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

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

Attention: All Providers

Suspended Implementation of Place of Service and Inpatient Only Services Correct Coding Edits, Revised Additional Correct Coding Edits Timeline

As previously announced in the May and June bulletin and via email alert to providers, DMA began implementing additional correct coding guidelines June 1, 2011. 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 will identify any inconsistencies with CPT, HCPCS, AMA, CMS and/or DMA policies and will deny the claim line.

Additional correct coding edits for Place of Service and Inpatient Only Services were scheduled for implementation July 1, 2011 for dates of service on or after July 1, 2011. However, this implementation is being suspended to allow for a more thorough review of these edits.

Place of Service edits are based on AMA published criteria indicating where specific types of services may be performed. Procedure codes are billed in the appropriate place of service as defined by AMA and/or CMS. The following are examples of Place of Service edits:

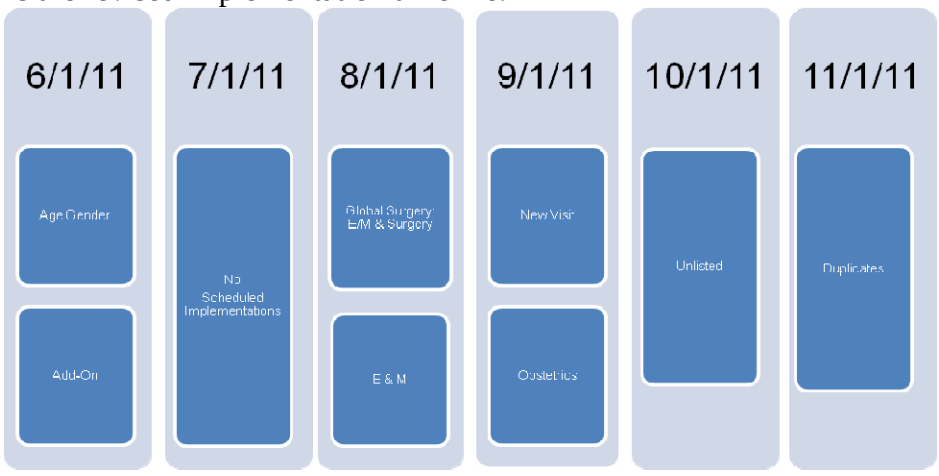
- CPT 99204 (Office Visit for the evaluation and management of a new patient) in the Emergency Room (Place of Service 23) is not acceptable. Therefore, this claim line would be denied by a place of service edit.
- CPT 99238 (Hospital discharge day) in the outpatient setting (place of service 22) is not acceptable. Therefore, this claim line would be denied by a place of service edit.

Inpatient Only edits are based on a CMS policy where specific services may only be performed in an inpatient setting. The following is an example of Inpatient only edits:

- CPT 21196 (Reconstruction of lower jaw) in an office setting (place of service 11) is not acceptable. Therefore, this claim line would be denied by an inpatient only edit.

Revised Timeline for Additional Correct Coding Edits Implementation

The table below is the revised implementation timeline.



Actual Implementation Date					
6/1/11					

For a more information about each group of edits, see "Descriptions of Planned Additional Correct Coding Edits" link on DMA's Correct Coding web page (http://www.ncdhhs.gov/dma/provider/ncci.htm). Providers are encouraged to frequently visit DMA's Correct Coding web page and to review published bulletin articles for information on the project status.

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

Attention: All Providers

Termination of Inactive Medicaid Provider Numbers

In May 2002, DMA began terminating certain Medicaid provider numbers that did not reflect any billing activity within the previous 12 months. This action was necessary to reduce the risk of fraudulent and unscrupulous claims billing practices. Effective July 1, 2011, once a provider is terminated, a new application and agreement to re-enroll must be submitted. As a result, a lapse in eligibility as a Medicaid provider may occur.

The termination activity occurs on a quarterly basis with provider notices being mailed April 1, July 1, October 1, and January 1 of each year and the termination dates being effective May 1, August 1, November 1, and February 1. These notices are sent to the current mailing address listed in the provider's file.

Provider Services
DMA, 919-855-4023

Attention: All Providers

W-9

As part of the enrollment process to become a Medicaid provider in North Carolina, applicants are required to submit a Form W-9 from the IRS. CSC's Credentialing staff has determined that 60 percent of the enrollment applications contain errors related to Form W-9, which increases the amount of time it takes to process an application.

The State of North Carolina has agreed to eliminate the Form W-9 submission requirement provided that CSC add the following section to enrollment applications:

My Taxpayer Identification Number and Name (exactly as shown on my income tax

return) associated with my Medicaid provider number are:

Taxpayer Name_____

Taxpayer Identification Number_____

My Taxpayer Identification Number above is (check only one):

____ Social Security Number

____ Employer Identification Number (EIN)

Under penalties of perjury, I certify that:

1. The payee's TIN is correct.

2. The payee is not subject to backup withholding due failure to report interest.

3. The payee is a U.S. person.

Signature: _____Date:_____

MMIS Financial Operations' review of IRS publications support use of substitute language for applicant (the payee) to certify as to the accuracy of the tax information and name registered with the IRS. Such language will mitigate the potential of "B" notices in the future.

If you have questions regarding the notice, please contact the CSC EVC Operations Center. Customer Service Agents 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: Critical Access Behavior Health Agencies (CABHAs), Local Management Entities (LMEs) and Peer Support Specialists

Peer Support Services Implementation

The Peer Support Services Medicaid policy was approved by CMS and implementation was scheduled for July 1, 2011. Since the approval of the policy, however, there have been several concerns raised about the proposed model of service delivery and the accompanying rate. This feedback comes from providers who are supportive of peer support, train peer support specialists, and currently hire peer support specialists to work on team services such as Assertive Community Treatment Team (ACTT).

PBH has offered a very successful peer support service as a (b)(3) service under the 1915 (b)(c) Medicaid waiver. Medicaid is committed to supporting peer support and ensuring its success and viability. To achieve this goal and in response to the concerns raised by stakeholders, the Peer Support policy previously approved by CMS will not be implemented on July 1, 2011 as planned. With CMS approval, Peer Support as a Medicaid-reimbursable service will be offered to recipients in counties under the 1915 (b)(c) waiver.

Peer Support Specialists may continue to provide services as team members under Community Support Team (CST) and Assertive Community Treatment (ACTT).

Behavioral Health Policy
DMA, 919-855-4290

Attention: Dental Providers

Dental Seminars

Dental seminars have been scheduled for September 2011. Information presented at these seminars will include a review of dental clinical coverage guidelines including prior approval and billing procedures, uses of the N.C. Electronic Claims Submission/Recipient Eligibility Verification Tool, and a review of common problems from provider enrollment to unintended billing errors to fraud, waste, and abuse). The seminar sites and dates will be announced in the August 2011 Medicaid Bulletin.

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

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

Attention: Health Departments, Nurse Midwives, Nurse Practitioners, and Physicians

Makena (Non-Compounded Hydroxyprogesterone Caproate, HCPCS Code Q2042): Billing Guidelines Revised for the Physician's Drug Program

The Division of Medical Assistance **supports and encourages** the use of *compounded* hydroxyprogesterone caproate (known as 17-P) for use in pregnant women with a history of a preterm delivery before 37 weeks gestation but no preterm labor in the current pregnancy. Medicaid covers *compounded* 17-P in the Physician's Drug Program when billed with J3490 since date of service April 1, 2007 and in the Outpatient Pharmacy Program when a rebatable National Drug Code (NDC) is used. Refer to articles in the April 2007, February 2009 and June 2011 general Medicaid bulletins as well as page 16 of this bulletin.

Medicaid began coverage of **Makena**, *non-compounded* hydroxyprogesterone caproate, in the Physician's Drug Program on date of service March 14, 2011, when billed under HCPCS code J3490 (unclassified drugs). Refer to the bulletin article in the April 2011 general Medicaid bulletin. Effective with date of service July 1, 2011, Makena must be billed with **HCPCS code Q2042, instead of J3490. Claim details billed for Makena with HCPCS code J3490 for dates of service on and after July 1, 2011, will deny.** Makena is available in a 5-ml multi-dose vial containing 250 mg/ml (five doses).

The Food and Drug Administration (FDA) has approved Makena injections to reduce the risk of preterm delivery before 37 weeks of pregnancy for women with a history of one spontaneous preterm birth. The drug's approval was based on a 463-patient, randomized, double-blind clinical trial of women 16 to 43 years old, pregnant with a single fetus, and with a history of spontaneous preterm birth (defined as delivery at less than 37 weeks of gestation following spontaneous preterm labor or premature rupture of membranes). The drug was approved through the FDA's accelerated approval program, which approves a drug based on a surrogate endpoint benefit that is likely to predict clinical outcome.

The drug is designed to be given once a week by injection into the hip, beginning at the 16th week and no later than the 21st week of pregnancy, according to the FDA. The recommended dose of Makena is a 250-mg weekly intramuscular injection administered from gestational weeks 16 through 36 or until delivery, whichever comes first.

Progesterone therapy as a technique to prevent preterm labor is considered investigational/not medically necessary for pregnant women who do **not** meet the above criteria or for those with other risk factors for preterm delivery including, but not limited to, multiple gestations, short cervical length or positive tests for cervicovaginal fetal fibronectin. N.C. Medicaid does not cover services that are considered investigational or not medically necessary.

The N.C. Division of Medical Assistance supports the efforts to reduce premature birth and will continue to seek evidence-based, cost-effective alternatives that support the prevention of preterm labor.

For Medicaid Billing of Makena (*non-compounded* hydroxyprogesterone) in the Physician's Drug Program

- The ICD-9-CM **diagnosis code** required for billing Makena is **V23.41** (supervision of pregnancy with history of pre-term labor).
- Providers must verify that the recipient's history includes a singleton preterm birth (prior to 37 weeks gestation). The recipient must be pregnant with a single fetus. Treatment should begin between 16 weeks, 0 days and 20 weeks, 6 days of gestation. Treatment must end before week 37 (through 36 weeks, 6 days). It may be appropriate to start a recipient at a later gestational age if she presented for prenatal care at that time.
- Diagnosis codes must be supported with adequate documentation in the medical record. Documentation must also follow the criteria indicated above.
- Providers must bill Makena with HCPCS code **Q2042** for **dates of service on and after July 1, 2011**.
- Providers must bill Makena, with HCPCS code **J3490 (unclassified drugs) for dates of service March 14, 2011 through June 30, 2011**. Claim details billed with J3490 for Makena on and after July 1, 2011, will deny.
- One Medicaid **unit of coverage** of Makena billed with HCPCS code **J3490 is 250 mg** (one dose). Coverage is limited to one unit (one 250-mg dose) per week (7 days).
- One Medicaid **unit of coverage** of Makena billed under HCPCS code **Q2042 is 1 mg**. Coverage is limited to 250 units or 250 mg per week (7 days).
- Providers must indicate the number of HCPCS units in field 24G on the CMS-1500 claim form, or in the appropriate field on the 837P, 837I or the NCECS Web Tool. Claims must be filed electronically unless they meet one of the ECS-mandated exceptions (http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm).
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for the non-compounded Makena should be reported as "ML." Providers must bill for only the dose administered from the multi-dose vial and report the NDC units as "ML1." 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 (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Providers must bill their usual and customary charge.

"For Medicaid billing of *compounded* hydroxyprogesterone caproate, HCPCS code J3490 must be used. Refer to the article on page 16 of this bulletin.
The fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/."

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

Attention: HIV Case Management Providers

HIV Case Management Training

The Carolinas Center for Medical Excellence (CCME) and The Division of Medical Assistance are pleased to announce that in July 2011 we are offering HIV Basic Training for case managers and supervisors. See the information listed below under training.

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
July 11-14 , 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 July 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)

HIV Case Management Program
DMA, 919-855-4389

Attention: Home Health Agencies

Physician Face to Face Encounter Certification Requirement

Effective with date of service August 1, 2011 Medicaid will require a face to face physician encounter for all recipients receiving home health services. This requirement is in accordance with Section 6407 of the Affordable Care Act. The encounter must occur within the 90 days prior to the start of care or within the 30 days after the start of care.

The physician must certify, in writing, that home health services are appropriate for the recipient's care and that the home is the most appropriate place to provide the care. The physician must document that prior to the certification of appropriateness of home health services, a face to face contact was made with the recipient within the last 90 days. The contact must be with the physician or an allowed non-physician practitioner (NPP) when the NPP is working for or in collaboration with the physician. If there has been no physician face to face contact within the last 90 days, the encounter must be made within 30 days of the start of care.

In rural areas, the law allows the face-to-face encounter to occur via telehealth. Home health agencies are required to establish internal processes to comply with the face-to-face encounter requirements mandated by the Affordable Care Act (ACA) for purposes of certification of a patient's eligibility for Medicaid covered home health services. The encounter must be documented in the recipient's records.

Clinical Policy
DMA, 919-855-4380

Attention: Adult Care Home Providers

DMA Recipient Study

DMA is conducting a study of Adult Care Home, Family Care Home, and Supervised Living Facility recipient populations. On July 1, 2011, DMA will mail a letter to providers of a random sample of 500 recipients at the provider accounting address. The letter will include instructions for mailing to DMA a copy of each of the selected recipient's most current Personal Care Physician Authorization and Care Plan (DMA-3050R), FL-2, or MR-2.

Separate requests will be mailed for each of the 500 recipients in the random sample. If you receive requests for more than one recipient's documents, you may bundle and mail them together to DMA by the requested date.

This request is in accordance with the North Carolina Department of Health and Human Services Provider Participation Agreement. The requested documents must be sent to the address indicated in the letter and postmarked no later than July 15, 2011.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Hospital Providers

Incorrect Denials for Hospital Providers of Laboratory, Radiology and Pharmaceutical Services in the Outpatient Setting

Hospital providers of laboratory, radiology, and pharmaceutical services in the outpatient setting were instructed by DMA to submit NCCI associated modifiers to bypass NCCI edits when medically appropriate. A systematic error in processing outpatient claims that had NCCI associated modifiers appended may have resulted in providers receiving the following denials inappropriately: EOB 9988, "Payment of procedure code is denied based on CCI editing" or EOB 9953 "Payment of procedure code is denied based on MUE editing". Claims affected were for Bill Types 130-135, 137, 138, 140-145, 147 or 148 for dates of service on or after March 31, 2011. The use of modifiers to bypass NCCI edits on outpatient laboratory, radiology, and pharmaceutical claims will not impact claims processing in MMIS and will not display on the remittance advice (RA).

On July 8, 2011, HPES will finalize system changes that will allow submission of any CMS modifier used to bypass NCCI editing when appropriate on the institutional / UB 04 electronic claim format. (Instructions for paper claims will be published in a future bulletin.) Providers that submitted modifier(s) in the institutional / UB 04 claim format beginning with the NCCI implementation for dates of service on and after March 31, 2011 will need to resubmit their claim(s) that denied with EOB 9988 or 9953. Providers are instructed to resubmit each claim with the same Bill Type as the original submission. Please do not resubmit as adjustment.

For additional information contact HP Provider Services 1-800-688-6696, menu option 3.

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

Attention: Local Health Departments, Nurse Midwives, Nurse Practitioners and Physicians

Compounded Hydroxyprogesterone Caproate (known as 17P) continues to be Available in the Physician's Drug Program

With the addition of Makena, the branded version of hydroxyprogesterone caproate (known as 17P), to the marketplace, there has been some confusion on whether or not the compounded version of the drug continues to be covered by N.C. Medicaid. N.C. Medicaid continues to cover the compounded version and the Division of Medical Assistance **supports and encourages** the use of compounded hydroxyprogesterone caproate (known as 17P) for use in pregnant women with a singleton pregnancy and a prior spontaneous preterm birth (before 37 weeks of gestation) due to spontaneous preterm labor or premature rupture of the membranes.

For Medicaid Billing:

- The ICD-9-CM diagnosis code required for billing 17P is V23.41 **(supervision of pregnancy with history of pre-term labor)**.
- Providers must verify that the recipient's history includes a singleton preterm birth (prior to 37 weeks gestation).

The recipient must be pregnant with a single fetus. Treatment should begin between 16 weeks, 0 days and 20 weeks, 6 days of gestation. Treatment should continue until week 37 (through 36 weeks, 6 days) and must end at that time. It may be appropriate to start a recipient at a later gestational age if she presents late for prenatal care.

- Providers must bill 17P with HCPCS procedure code J3490 **(unclassified drugs).**
- One unit of coverage is 250 mg (weekly dose). Providers must bill their usual and customary charge. The maximum reimbursement rate for one unit is $20.00.
- Providers must indicate the number of HCPCS units in field 24G on the CMS-1500 claim form, or in the appropriate field on the 837P, 837I or the NCECSWeb Tool. Claims must be filed electronically unless they meet one of the ECS-mandated exceptions (http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm).
- Providers must use rebatable 11-digit National Drug Codes (NDCs) and appropriate NDC units when billing for 17P.
- If the drug was purchased under the 340B 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 (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Refer to articles in the April 2007 and February 2009 general Medicaid bulletins.

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

Attention: Local Management Entities and Outpatient Behavioral Health Service Providers Employed in a Physician Office/Clinic, Outpatient Hospital Clinics, Local Health Departments, or School-based Health Centers

Outpatient Behavioral Health Providers Billing "Incident to" a Physician

Outpatient behavioral health providers are strongly encouraged to review the October 2008 and March 2009 Medicaid Bulletin for 'Incident To' policy guidelines for licensed, enrolled Outpatient Behavioral Health Providers and for provisionally licensed professionals. These bulletins lay out in great detail the CPT codes that can be billed 'incident to" and the requirements of the individual rendering the service, the physician, and the provider agency. As a reminder, any Outpatient Behavioral Health Provider billing 'incident to' a physician is still required to be enrolled with Medicaid as an Independent Outpatient Behavioral Health Provider and must follow all policy guidelines in DMA Clinical Coverage Policy 8C http://www.ncdhhs.gov/dma/mp/index.htm.

'Incident to' billing is only allowable 'incident to' a physician, not to another licensed professional. The licensed professionals who may bill 'incident to' are listed in DMA Clinical Coverage Policy 8C http://www.ncdhhs.gov/dma/mp/8C.pdf. The licensed professionals listed in this policy should be the only ones providing services through their own MPN and NPI. **Allowing anyone else to use your Medicaid MPN/NPI is considered fraud and individuals doing so may run the risk of losing his or her license in addition to losing the ability to provide Medicaid services.**
Outpatient Behavioral Health Providers are encouraged to read the July 2009 and the March, April, and June 2011 Medicaid bulletins which give helpful guidance on prior authorization, NCCI, and unmanaged/managed visits.

As a reminder, please contact Medicaid directly with any questions regarding NC enrollment or billing questions in order to ensure accurate receipt of information.

Behavioral Health
DMA, 919-855-4290

Attention: Ophthalmology Providers

CPT Procedure Code 76519

CPT Procedure Code 76519 (ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation) no longer requires prior authorization for N.C. Medicaid recipients through MedSolutions or Medicaid. If you received a denial with EOB 2201 (procedure code billed requires prior authorization from MedSolutions) for 76519 since date of service 11/23/2010, please resubmit the denied charges as a new day claim (not as an adjustment request) for processing.

Clinical Policy
DMA, 910-355-1883

Attention: Outpatient Behavioral Health Providers in Integrated Care Practices

Clarification of National Correct Coding Initiative and Enrollment Guidelines

As a reminder, per 8C policy (http://www.ncdhhs.gov/dma/mp/8C.pdf) all licensed professionals listed (i.e. LCSW, LMFT, LPC, LPA, PhD) must be enrolled with Medicaid, even if billing 'incident to' a physician. All components of this policy (*8C Outpatient Behavioral Health Services Provided by Direct Enrolled Providers*) must be followed by any licensed outpatient behavioral health provider listed in the policy, regardless of practice setting. Outpatient Behavioral Health Providers can only provide and bill the psychiatric CPT codes listed in 8C, even if practicing 'incident to." To enroll as an Independent Outpatient Behavioral Health Provider with NC Medicaid, provider must fill out the Individual, In-State/Border Application found at NC Tracks http://www.nctracks.nc.gov/.

Recently, we have had many questions about the impact of the National Correct Coding Initiative (NCCI) on integrated care practices. Per NCCI, only one office code (E&M or psych CPT code) can be billed for attending provider, per recipient, per date of service. In order to ensure that both the medical office visit and the behavioral health CPT code both pay on the same date of service, the claim must be submitted with different attending provider NPIs.

In order to accomplish this, licensed, enrolled behavioral health providers (listed in 8C) operating in integrated care practices must also enroll as an Outpatient Behavioral Health Group, which may be mapped to the tax ID number of the physician group practice. All enrolled, licensed outpatient behavioral health providers in the integrated care practice would enroll as part of the Outpatient Behavioral Health Group practice. The integrated care practice must have at least 1 active, enrolled licensed Outpatient Behavioral Health provider in order to apply for the Outpatient Behavioral Health group number. The Physician Group enrollment is a separate enrollment from the Outpatient Behavioral Health group enrollment, although both may be mapped to the same tax ID number for billing purposes. To enroll as an Outpatient Behavioral Health Group with NC Medicaid, providers must fill out the Organization In-State/ Border Application found at NC Tracks http://www.nctracks.nc.gov/. Please see pages 18 through 23 of the *Provider Qualifications and Requirements Checklist* for full information on Outpatient Behavioral Health Provider enrollment.

The Medicaid provider enrollment process includes the completion of the Internal Revenue Service's (IRS) W-9 form. The N.C. Medicaid Program must collect this information in order to correctly report income paid to the provider. The W-9 form is retained by the N.C. Medicaid Program and is not sent to the IRS. The instructions that the IRS provides with the W-9 form explain that payments you receive may be subject to backup withholding if you do not report your correct tax identification number (TIN). The instructions further explain that the TIN provided must match the name given on Line 1. Failure to provide your correct TIN may result in a penalty. (The W-9 form and instructions for completing the form are available at http://www.irs.gov.)

Provider Earnings reported on the 1099 form are based on the provider number associated with the National Provider Identifier entered on the claim form. If incorrect earnings are reported it may be because claims are incorrectly filed without the group number, which results in income being reported to the individual (attending) provider number entered on the claim. Incorrect earnings are **NOT** reported

based on the W-9. It is important that all providers carefully review the Financial Section of their Remittance and Status Report (RA) to verify that the claim is submitted properly and income is reported to the correct TIN. Please see the July 2009 Bulletin for additional information.

Please note that ALL behavioral health services should be billed under the Outpatient Behavioral Health Group Billing NPI and the Outpatient Behavioral Health Individual Attending NPI, including both unmanaged and managed visits. Unmanaged visits should NOT be billed 'incident to' a physician if the attending provider can bill independently. Outpatient Behavioral Health Providers are encouraged to read the July 2009 and the March, April, and June 2011 Medicaid bulletins which give helpful guidance on prior authorization, NCCI, and unmanaged/managed visits.
As a reminder, please contact DMA directly with any questions regarding NC enrollment or billing questions in order to ensure accurate receipt of information.

Behavioral Health
DMA, 919-855-4290

Attention: Physicians

Physicians Billing for CPT Procedure Codes 15832-15837

It has come to DMA's attention that physicians are receiving denials when billing for additional units for the following CPT procedure codes:

- 15832 [Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh],
- 15833 [Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg],
- 15834 [Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip],
- 15836 [Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm],
- 15837 [Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand].

System updates have been completed to correct this issue. Physicians who received denials with EOB 5327 (unit cutback exceeds maximum units allowed per day) or EOB 7747 (exceeds one procedure per day limitation) may resubmit claims that meet timely filing criteria for processing (not as an adjustment).

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

Attention: Physicians

Physicians Billing for CPT Procedure Code 16035

Effective January 1, 2008, Relative Value Units (RVUs) changed the post operative period for CPT procedure code 16035 [Escharotomy; initial incision] from a 90 day global period to 000 global days. This change was not put into the claims processing system until recently which has caused inappropriate denials.

System updates have been completed to correct this issue. Providers who received these denials with EOB 5500 (follow-up are included in global surgery package) and have kept claims timely may resubmit as a new day claim.

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

Attention: Nurse Practitioners and Physicians

Belimumab Injection (Benlysta®, HCPCS code J3590, 10 mg and HCPCS Code Q2044, 10 mg): Billing Guidelines

Effective with dates of service March 29, 2011 through June 30, 2011, the NC Medicaid Program covers belimumab (Benlysta) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologicals). Effective with dates of service on and after July 1, 2011, Benlysta will be covered under HCPCS code Q2044. Benlysta is available in 120 mg and 400 mg single-dose vials.

Benlysta is a B-lymphocyte stimulator (BLyS)-specific inhibitor indicated for the treatment of **adult patients** with active, autoantibody-positive, systemic lupus erythematosus who are receiving standard therapy. Benlysta should be administered as a one-hour intravenous infusion of 10 mg/kg at two-week intervals for the first three doses and at four-week intervals thereafter..

For Medicaid Billing

- Providers must bill Benlysta with HCPCS code J3590 (unclassified biologicals) for dates of service March 29, 2011, through June 30, 2011.
- Providers must bill Benlysta with HCPCS code Q2044 effective with dates of service on and after July 1, 2011.
- ICD-9-CM diagnosis code 710.0 (lupus erythematosus) must be billed with Benlysta.
- Providers must indicate the number of HCPCS units.
- For HCPCS code J3590, one Medicaid unit of coverage is 10 mg. Refer to the fee schedule for the Physician's Drug Program on DMA's website at http://www.ncdhhs.gov/dma/fee/ for the current rate. Providers may bill for an entire single-dose 120 mg or 400 mg vial.
- For HCPCS code Q2044, one Medicaid unit of coverage is 10 mg. Refer to the fee schedule for the Physician's Drug Program on DMA's website at http://www.ncdhhs.gov/dma/fee/ for the current rate.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Benlysta should be reported as "UN." To bill for the entire 120 mg vial of Benlysta, report the NDC units as "UN1." To bill for the entire 400 mg vial of Benlysta, report the NDC units as "UN1." 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 (http://www.ncdhhs.gov/dma/bulletin/) 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: http://www.ncdhhs.gov/dma/fee/.

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

Attention: Nurse Practitioners and Physicians

Oxaliplatin (Eloxatin, HCPCS Code J9263): Updated Billing Guidelines

The N.C. Medicaid program updated the diagnosis codes covered for Eloxatin, J9263, to the following list of ICD-9-CM diagnosis codes:

For Medicaid Billing

The ICD-9-CM diagnosis codes required for billing Eloxatin are:

- V58.11 (encounter for antineoplastic chemotherapy)

  AND

One of the following:

- 150.0 through 150.9 (malignant neoplasm of esophagus)
- 151.0 through 151.9 (malignant neoplasm of stomach)
- 152.0 through 152.9 (malignant neoplasm of small intestine)
- 153.0 through 153.9 (malignant neoplasm of colon)
- 154.0 through 154.8 (malignant neoplasm of rectum, rectosigmoid junction, and anus)
- 155.0 through 155.2 (malignant neoplasm of liver, not specified as primary or secondary)
- 156.0 through 156.9 (malignant neoplasm of gall bladder and extrahepatic bile ducts)
- 157.0 through 157.9 (malignant neoplasm of pancreas)

The fee schedule for the Physician's Drug Program is available on DMA's website at http://www.ncdhhs.gov/dma/fee/fee.htm.

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

Attention: Nurse Practitioners and Physicians

Peginterferon Alfa-2B Injection (Sylatron™, HCPCS code J3590): Billing Guidelines

Effective with date of service April 15, 2011, the NC Medicaid Program covers peginterferon alfa-2B injection (Sylatron) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologicals). Sylatron is available in 296 mcg, 444 mcg and 888 mcg vials.
Sylatron is indicated for the treatment of melanoma. It should be administered subcutaneously as a 6 mg/kg/wk dose for 8 doses, followed by 3 mcg/kg/wk subcutaneously for up to 5 years.

For Medicaid Billing:

- Providers must bill Sylatron with HCPCS code J3590 (unclassified biologicals).
- An ICD-9-CM diagnosis code in the range of 172.0 through 172.0 (malignant melanoma of skin) must be billed with Sylatron™.
- Providers must indicate the number of HCPCS units. An entire single-dose vial may be billed.
- One Medicaid unit of coverage is 1 mcg. The maximum reimbursement rate per unit is $3.2508.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Sylatron should be reported as "UN." To bill for an entire vial of Sylatron, regardless of the size of the vial, report the NDC units as "UN1." 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 (http://www.ncdhhs.gov/dma/bulletin/) 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: http://www.ncdhhs.gov/dma/fee/.

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

Attention: Podiatrists

Podiatrists Billing for New Patient Office Visit CPT Procedure Codes 99201-99205

It has come to our attention that podiatrists are receiving denials for new patient office visit CPT procedure codes:

99201 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components):

- A problem focused history;
- A problem focused examination;
- Straightforward medical decision making

99202 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components):

- An expanded problem focused history;
- An expanded problem focused examination;
- Straightforward medical decision making.

99203 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components):

- A detailed history;
- A detailed examination;
- Medical decision making of low complexity.

99204 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components):

- A comprehensive history;
- A comprehensive examination;
- Medical decision making of moderate complexity.

99205 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components):

- A comprehensive history;
- A comprehensive examination;
- Medical decision making of high complexity.

System updates have been completed to correct this issue. Physicians who received denials with EOB 1647 (the primary or secondary diagnosis code billed does not meet the Medicaid billing requirements for this provider type and specialty) may resubmit claims that meet timely filing criteria for processing (not as an adjustment).

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

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
July	6/30/11	7/6/11	7/7/11
	7/7/11	7/12/11	7/13/11
	7/14/11	7/21/11	7/22/11
August	7/28/11	8/2/11	8/3/11
	8/4/11	8/9/11	8/10/11
	8/11/11	8/16/11	8/17/11
	8/18/11	8/25/11	8/26/11

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