July 2012 Medicaid Bulletin

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

Provider Verification for Non-Emergency Medical Transportation (NEMT) Program

Federal regulations specify that all state Medicaid programs assure necessary transportation is available for recipients to travel to and from Medicaid-enrolled providers to receive Medicaid-covered services. Beginning January 1, 2012, revised Non-Emergency Medical Transportation (NEMT) policy requires the transportation coordinators in the county Departments of Social Services (DSS) or their contracted agents to verify that eligible Medicaid recipients are being transported to Medicaid-covered services. (This does **not** mean that Medicaid will actually pay the claim for the service, but that the service is covered under the Medicaid program.)

After a medical service has been rendered to the recipient, the county must verify that the recipient received a Medicaid-covered service by a Medicaid-enrolled provider on the date of the transport. Providers should cooperate with DSS staff, their contracted agent and Medicaid recipients to meet these requirements. Providers may be contacted by telephone, fax, or by a Medicaid recipient and asked for these verifications.

A new form, “DMA-5118 – Medicaid Transportation Verification of Receipt of Medicaid Covered Service,” has been created to expedite the process of verification. However, other forms of documentation (e.g., verification on a prescription or medical provider’s letterhead) are acceptable. All Medicaid-enrolled providers, including pharmacists, are asked to enter their name and sign the DMA-5118 form for any Medicaid recipient who requests this to substantiate that the recipient received a Medicaid-covered service on the date of the transport. **Providers cannot charge Medicaid recipients for providing this information or completing the form when the county has approved the service.**

The county or agent must verify that the service will be provided at the closest appropriate medical provider. When the recipient requests transportation out of the normal medical service area, the referring physician must complete the “DMA-5048 –Medicaid Transportation Exception Verification” form or provide documentation to verify that the service is not available locally.

The section of the HIPPA law that allows these disclosures is located in 45CFR 164.504 (e) (1) Standard Disclosures to business associates (i), which states that a covered entity may disclose protected health information to a business associate and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurance that the business associate will appropriately safeguard the information.

Recipient and Provider Services
DMA, 919-855-4000

Attention: All Providers

Clinical Coverage Policies

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

- *1A-12, Breast Surgeries (3/12/12)*
- *1A-13, Ocular Photodynamic Therapy (3/12/12)*
- *1A-14, Surgery for Ambiguous Genitalia (3/12/12)*
- *1A-15, Surgery for Clinically Severe Obesity (6/15/12)*
- *1A-20, Sleep Studies and Polysomnography Services (3/12/12)*
- *1A-22, Medically Necessary Circumcision (3/12/12)*
- *1A-24, Diabetes Outpatient Self-Management Education (3/12/12)*
- *1A-26, Deep Brain Stimulation (3/12/12)*
- *1A-27, Electrodiagnostic Studies (3/12/12)*
- *1A-28, Visual Evoked Potential (VEP) (3/12/12)*
- *1A-32, Tympanometry and Acoustic Reflex Testing (3/12/12)*
- *1D-1, Refugee Health Assessments Provided in Health Departments (3/12/12)*
- *1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments (3/12/12)*
- *1E-1, Hysterectomy (3/12/12)*
- *1E-4, Fetal Surveillance (3/12/12)*
- *1G-1, Burn Treatment (3/12/12)*
- *1G-2, Bioengineered Skin (3/12/12)*
- *1H, Telemedicine and Telepsychiatry (3/12/12)*
- *1-I, Dietary Evaluation and Counseling (3/12/12)*
- *1L-2, Moderate (Conscious) Sedation (3/12/12)*
- *1-O-2, Craniofacial Surgery (3/12/12)*
- *1-O-3, Keloid Excision and Scar Revision (3/12/12)*
- *1R-1, Phase II Outpatient Cardiac Rehabilitation Programs (3/12/12)*
- *1S-1, Genotyping and Phenotyping for HIV Drug Resistance Testing (3/12/12)*
- *1S-3, Laboratory Services (6/15/12)*
- *2B-1, Nursing Facilities (3/12/12)*
- *3E, In-Home Care for Adults (3/12/12)*
- *3F, In-Home Care for Children (3/12/12)*
- *7, Hearing Aid Services (6/15/12)*
- *8-I, Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments to the under-21 Population (3/12/12)*
- *10A, Outpatient Specialized Therapies (6/1/12)*
- *13A, Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair (3/12/12)*

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

- *Excision of Gynecomastia (Date of termination 5/31/2012)*
- *Mammoplasties (Date of termination 5/31/2012)*
- *Hearing Aids (Date of termination 6/14/2012)*

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

Prior Approval for Procedure Codes 41010, 41115, 41520, D7960 and D7963

Effective with the date of service July 1, 2012, no prior approval is necessary for the following procedure codes for a child who is 1 year of age or younger when the procedure is performed in a physician or dentist office.

- 41010 [Incision of lingual frenum (frenotomy)]
- 41115 [Excision of lingual frenum (frenectomy)]
- 41520 [Frenuloplasty (surgical revision of frenum, e.g., with Z-plasty)],
- D7960 [Frenulectomy (frenectomy or frenotomy)] and,
- D7963 [Frenuloplasty]

The diagnosis of Tongue tie and Ankyloglossia must describe the condition of the infant. Prior approval must be obtained if the procedure will be performed in any other place of service.

Prior approval is not required for:

- Newborns with Ankyloglossia and feeding difficulties prior to discharge from the hospital
- Recipients who are 1 year of age or younger diagnosed with Ankyloglossia and feeding difficulties while in the hospital for another unrelated procedure, as long as the procedure is performed prior to discharge from the hospital.

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

N.C. Medicaid Electronic Health Record (EHR) Incentive Program Audits

The Centers for Medicare & Medicaid Services (CMS) requires U.S. states to conduct audits around Electronic Health Record (EHR) incentive payments received by eligible professionals (EPs) and eligible hospitals (EHs).

N.C. Medicaid is responsible for auditing Adopt/Implement/Upgrade (AIU) and Meaningful Use (MU) incentive payments to EPs and AIU payments to EHs. CMS conducts MU audits for EHs.

To comply with CMS requirements, N.C. Medicaid will soon begin auditing providers who have received incentive payments. Providers will be notified if they have been selected for an audit and about the type of audit that will be conducted. Some audits will be desk reviews while others will be performed on-site. It is important that providers keep documentation that supports the information to which they attest. CMS requires providers to keep all documentation related to the EHR Incentive Program for **six years** post-attestation.

Providers should start preparing for possible audits at the onset of program participation. N.C. Medicaid suggests the following:

- Select the appropriate staff member – or group of staff members – who will be responsible for identifying policies and procedures that meet meaningful use (MU) criteria. This will be invaluable when coordinating MU compliance throughout the attestation process.
- Outline a plan and identify the responsible party/parties for collecting, organizing and maintaining the information needed to meet the criteria for AIU/MU attestation.
- Maintain the documentation required in a central location, for example, in an EHR Incentive Program Notebook. This notebook should be updated as needed, and should include supporting data for each MU objective and clinical quality measure to which each provider attests. Examples of such supporting data include the measurement used to validate the objective, the certified EHR technology being used, and any relevant provider or practice policies, procedures, or staff training modules (if applicable) for maintaining compliance with the objective.
- Review and validate MU and eligibility data to ensure the EHR Incentive Program requirements are met prior to attestation.
- Conduct internal audits, which are the only way to assess compliance with the EHR Incentive Program's eligibility requirements. If internal audits are being considered as a long-term compliance solution, information on the process should be included in the EHR Incentive Program Notebook.

The consequences of being unprepared for an audit can be time-consuming and expensive. Establishing a robust EHR Incentive Program Notebook, or similar resource, to maintain compliance with the EHR Incentive Program will take upfront time and effort. However, it will ensure providers are aware of, and compliant with, all program updates and guidelines.

NC Medicaid EHR Incentive Program's Progress to Date:

- As of June 8, 2012, there were **1,031 N.C. Medicaid providers** participating in the EHR Incentive Program, and **$38.98 million** has been awarded in North Carolina.

- **Breakdown of payments:**

    - $21.21M for 1010 EPs
    - $17.85M for 21 EHs

Check out next month's Health Information Technology (HIT) Team Bulletin update to see the team's continued progress!

Health Information Technology (HIT)
DMA, 919-855-4200

Attention: All Providers

N.C. Medicaid EHR Incentive Program/NC-MIPS Portal Update

Due to significant personnel issues and considerable feedback from user acceptance testing, the N.C. Division of Medical Assistance, Health Information Technology (HIT) team has moved the go-live date for the North Carolina Medicaid Incentive Payment System (NC-MIPS) Portal.

The updated go-live dates are:

- AIU attestation portal - July 23, 2012
- MU attestation portal - August 20, 2012

The HIT team is working diligently to launch an error-free portal as quickly as possible. Please contact the team with any questions at ncmedicaid.hit@dhhs.nc.gov.

Health Information Technology (HIT)
DMA, 919-855-4200

Attention: All Providers

Notice of Rate Adjustment

The N.C. Division of Medical Assistance (DMA) published a notice in the *November 2011 Medicaid Bulletin* notifying providers of rate reductions effective November 1, 2011. To comply with Session Law 2011-145, Section 10.37(a) (6), DMA submitted State Plan Amendments for the purpose of revising rate methodology language to reflect for SFY 2011–2012. Effective November 1, 2011, rates paid to most North Carolina Medicaid services providers will be reduced by approximately 2.67 percent.

The amendment also added rate methodology language to reflect that effective July 1, 2012, rates will be adjusted to the level at which they would have been if the November 1, 2011 rate reduction had taken place July 1, 2011.

Effective July 1, 2012, those rates that were reduced as part of the legislated rate reduction shall have their rates adjusted to comply with Session Law 2011-145, Section 10.37(a)(6).

Those providers whose rates were reduced effective July 1, 2011 – or whose rates were not part of the legislated rate reduction – will not be revised. Revised fee schedules can be found on the DMA Website at http://www.ncdhhs.gov/dma/fee/index.htm .

Finance Management
DMA, 919-814-0070

Attention: All Providers

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

Note to providers: This article originally ran in June 2012

Effective February 29, 2012, providers should mail all outstanding N.C. Health Choice paper claims for dates of services **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 work to try to resolve any claims received after February 29, 2012 with dates of service prior to October 1, 2011 in a timely fashion **but payment cannot be guaranteed.**

It is not necessary for providers to call regarding the status of claims after DMA has confirmed receipt of the claim. Any claim extending 18 months from the date of service will be returned unpaid by DMA.

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

Attention: All Providers

Intrauterine Copper Contraceptive (Paragard, HCPCS Code J7300) – Revised Billing Guidelines

Effective with date of processing August 1, 2012, Paragard intrauterine contraceptive device (IUD), billed with HCPCS code J7300, will require a National Drug Code (NDC) on the claim detail.

If providers have outstanding claims to be submitted – or if adjustments regarding Paragard are outstanding – an NDC must be on the claim for J7300FP if they are processed on or after July 1, 2012, or the claim detail will be denied.

Remember: **Paragard IUD, HCPCS code J7300 REQUIRES the FP modifier also on the detail and if purchased at a 340-B price, a "UD" modifier must be placed on the detail.**

Refer to the fee schedule for the Physician's Drug Program on the N.C. Division of Medical Assistance (DMA) Website at http://www.ncdhhs.gov/dma/fee/fee.htm for the latest available fees. Paragard J7300 is now listed with asterisks (***), indicating an NDC is required.

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

Attention: All Providers

Recipient Eligibility Verification Tools

A N.C. Medicaid or N.C. Health Choice recipient's eligibility status may change from month to month if financial or household circumstances change. For that reason, providers of behavioral health services should verify the recipient's county of eligibility using one of the recipient eligibility verification tools. These tools include the N.C. Electronic Claims Submission/Recipient Eligibility Web Tool (NCECS Web Tool), Automated Voice Response (AVR) system, and the 270/271 transaction (batch and real time). These tools are described on the N.C. Division of Medical Assistance (DMA) Website at: http://www.ncdhhs.gov/dma/provider/RecipEligVerify.htm.

Please note that as of April 2012, the Medicaid card for new recipients and the updated annual card for current recipients includes the name of each recipient's Local Management Entity - Managed Care Organization (LME-MCO), which is based upon their N.C. Medicaid county of eligibility. In addition, the AVR system has been updated to include the recipient's LME-MCO.

Behavioral Health
DMA, 919- 855-4290

Attention: All Providers and Local Management Entities

Clarification of the Division of Health Service Regulation Good Standing Status

The N.C. Division of Health Service Regulation (DHSR) has provided clarification on its definition of good standing status. Effectively immediately, DHSR good standing status is associated with a facility – not an entire agency or an individual associated with an agency or facility. DHSR determines whether facility is in good standing based on current and active administrative actions against the facility.

Actions included in the determination that a facility is **not** in Good Standing include:

- Active Type A or Imposed Type B, based on Provider Penalty Tracking Database [criteria in NCGS 122C-23(e1) – non-compliance in Article 3, Client Rights].
- Current Intent to Revoke – Intent to Revoke is active and has not been rescinded.
- Active Suspension of Admissions – Suspension of Admissions has not been lifted
- Active Summary Suspension – Summary Suspension was issued and has not been lifted.
- Active Notice of Revocation – Notice of Revocation is current, and may be in appeal.
- Revocation in Effect – Notice of Revocation was issued and the final outcome is that the license for this facility has been revoked and is no longer active.

Local Management Entities-Managed Care Organizations (LME-MCOS) will receive a Good Standing Notice to help determine which agencies under the 1915 b/c waiver have received a determination of good standing from the DHSR. If a facility is not in good standing, LME-MCOs can withhold a decision about whether to contract with the specific facility for 90 days. During this 90-day period, LME-MCOs can check back with DHSR to determine if any resolution or changes to the action have occurred prior to making a final decision.

Behavioral Health Section
DMA, 919-855-4290

Attention: All Providers

Health Check/EPSDT Seminars

Health Check/EPSDT seminars are scheduled for the month of September 2012 to educate providers on Health Check/EPSDT guidelines. Seminar sites and dates will be announced in the Augu*st 2012 Medicaid Bulletin*. The *Health Check Billing Guide* will be used as the training document for the seminars and will be available prior to the seminars on the N.C. Division of Medical Assistance (DMA) *Health Check Billing Guide* Webpage at http://www.ncdhhs.gov/dma/healthcheck/index.htm. 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: All Providers

Correct Coding Edits: Implementation of Additional Edits for Professional Duplicates

Note to Providers: This article originally ran in June 2012.

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 page has 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

Attention: All Providers

Correct Coding Edits: Adjusting the Number of Units for Submitted Claims

Note to Providers: This article originally ran in May 2012.

If a provider determines that the number of units billed for a service was incorrect, the original claim should be voided and a replacement claim submitted with the corrected number of units. Providers should not submit another claim with additional units, as this may result in the denial of the claim under NCCI or other correct coding editing. National Correct Coding Initiative (NCCI) methodologies require that if units of service exceed the Medically Unlikely Edit (MUE) limits, then the entire claim line must be denied.

With the implementation of standard claims transactions to comply with The Health Insurance Portability and Accountability Act (HIPAA), adjustments may be filed electronically. Electronic adjustments are the preferred method to report an overpayment or underpayment to N.C. Medicaid or N.C. Health Choice.

There are two options may be used:

1. **Void** – To file a claim to be voided, the provider must mark the claim as a voided claim using the Claim Submission Reason Field (Dental ADA 2006/837D and CMS-1500/837P) and Type of Bill (UB-04/837I) on the 837 electronic claim transaction. The ICN for the original claim to be voided must also be provided. When processed, the claim associated with the original ICN will be recouped from the patient's record and the payment will be recouped from the provider's Remittance and Status Report (RA).

2. **Replacement** – A replacement claim may be filed by completing a corrected electronic claim and marking the claim as a replacement using the Claim Submission Reason Field (Dental ADA 2006/837D and CMS-1500/837P) and Type of Bill (UB-04/837I) on the 837 electronic claim transaction. The ICN for the original claim to be replaced must also be provided. The original claim will be recouped from the patient's record and shown as a recoupment on the RA when the replacement claim is processed without error. If the replacement claim is denied, the entire replacement process will be denied, including the recoupment.

Step by step instructions about using the NCECSWeb Tool are located on page 51 of the December 2011 Medicaid Special Bulletin, "NCECSWeb Tool Instruction Guide," at http://www.ncdhhs.gov/dma/bulletin/NCECSWebGuide.pdf. For further assistance, providers may contact HP Enterprise Services Provider Services Department at 1-800-688-6696, menu option 3, Monday through Friday from 8 a.m. to 4:30 p.m.

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

Attention: Ambulatory Surgical Centers

National Correct Coding Initiative – Billing Guidance

Note to providers: This article originally ran in June 2012

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 with questions can contact the Provider Services unit of HP Enterprise Services, at 1-800-688-6696 or 919-851-8888, menu option 3, Monday through Friday from 8 a.m. to 4:30 p.m.

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

Attention: Behavioral Health Providers

Extension of Coverage for Provisionally Licensed Providers Billing Outpatient Behavioral Health Services through Local Management Entities (LMEs)

Coverage of provisionally licensed providers delivering outpatient behavioral health services under N.C. Medicaid and billed through a Local Management Entity (LME) has been extended to **June 30, 2013**. The HCPCS procedure codes that may be used to bill for such services are H0001, H0004, H0005, and H0031.

Provisionally licensed professionals billing with those HCPCS Codes must use generally accepted guidelines and timeframes for individual outpatient sessions (generally 45-60 minutes) and group outpatient sessions (generally 90 minutes). Overuse of HCPCS Code billing is being monitored by the N.C. Division of Medical Assistance (DMA) Program Integrity (PI) as part of federal Medicaid fraud initiatives. Providers should also review the March 2011 Medicaid Bulletin for guidance on counting unmanaged visits and requesting prior authorization.

Given the recent passage of House Bill 1081 (Provisional Licensure Changes Medicaid), DMA will be submitting State Plan Amendment changes to CMS to enable direct billing for licensed clinical social worker associates, licensed clinical addictions specialist associates, licensed professional counselor associates, licensed marriage and family therapist associates and licensed psychological associates. DMA will publish guidance for enrollment, billing and transition steps in an upcoming Medicaid bulletin.

Behavioral Health Section
DMA, 919-855-4290

Attention: Physicians

Clarification Regarding Psychiatric Billing

Psychiatrists can bill using the physician codes on the physician fee schedule designed for medical doctors or doctors of osteopathy. The following link connects to that fee schedule: http://www.ncdhhs.gov/dma/fee/phy_fee/phy_fee_sch042412.pdf.

As a reminder, many of the evaluation and management (E&M) codes count toward the 22 visit annual limit. The link below provides a list of any codes that count toward the annual visit limit, as well as a list of recipients who are excluded from the annual visit limit, such as children with serious emotional disturbance (SED) and adults with severe and persistent mental illness (SPMI): http://www.ncdhhs.gov/dma/provider/AnnualVisitLimit.htm.

Please remember that all billing must be within the scope of the physician's training and that physicians must bill using codes that accurately reflect the services performed.

As a reminder, under managed care (the 1915 b/c waiver), all psychiatric authorization requests and billing must go to the Local Management Entity-Managed Care Organization (LME-MCO). For additional information, please see the March 2012 Special Medicaid Bulletin at: http://www.ncdhhs.gov/dma/waiver/SpecialMedicaidBulletinMarch2012.pdf.

Behavioral Health
DMA, 919-855-4290

Attention: Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF)

Authorization Requests by Psychiatric Inpatient Acute Care Providers

Note: The following article does not pertain to recipients covered under the 1915 b/c waiver.

Requests for authorization of inpatient start dates must be submitted to the Utilization Review (UR) vendor no more than two business days from the date of admission in order for the authorization to begin on the date of admission.

Requests received after the second business day following the date of admission will be authorized to start no earlier than the date the request was received. For example, if a recipient is admitted on Friday, the request must be received by the end of the day on Tuesday. Requests received on Wednesday will have a start date no earlier than Wednesday (date of receipt).

When making the authorization request in the vendor's Web-based system, a correct "Requested Start Date" is essential; UR vendors review requests beginning with the providers' Requested Start Date and incorrect requests may result in loss of potentially authorized days.

Please note: The ValueOptions ProviderConnect system will default the Requested Start Date to the date of submission if not the start date is not specifically entered by the provider.

Concurrent requests must be submitted prior to the end of the current authorization in order to be reviewed for authorization for the dates of service. A late submission resulting in unauthorized days requires splitting the stay for claims payment purposes.

Retrospective authorization resulting from late submissions is not permitted.

Behavioral Health
DMA, 919-855-4290

Attention: Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTFs)

Certificates of Need (CON) for Free-standing Psychiatric Hospitals Serving People Under the Age of 21 and PRTFs

Effective August 1, 2012, Certificates of Need (CONs) for free-standing psychiatric hospitals (including state facilities) serving people under the age of 21 and Psychiatric Residential Treatment Facilities (PRTFs) **must** be signed and dated on the date of admission. A copy of the CON **must** be submitted to the Utilization Review (UR) vendor as part of the prior authorization request. The UR vendor can only begin the authorization on the date of the **last** signature on the CON.

Federal regulations require a CON form to be completed for admissions of Medicaid recipients under the age of 21 to a psychiatric hospital or PRTF. (Refer to 42 CFR 441.152 and 441.153 for detailed requirements). It is vital that this CON meet all the federal requirements and that the original completed form be maintained with the recipient's medical record for inspection during federal or state audits.

The state-approved CON form is required for psychiatric hospitals and PRTFs. Federal regulations require that the team providing the CON must include, at a minimum, a board-eligible or board-certified psychiatrist and one of the following:

- a psychiatric social worker (licensed clinical social worker);
- a registered nurse with specialized training or one year's experience in treating people with mental illness;
- an occupational therapist who is licensed and has specialized training or one year of experience treating individuals with mental illness;
- a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

For additional information on the composition of the team, refer to 42 CFR 441.156.
Use the following UR vendor links to obtain a copy of the correct CON form.

- **ValueOptions:**
  http:www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm

- **Eastpointe:**
  http://www.eastpointe.net/

- **The Durham Center:**
  http://www.durhamcenter.org/index.php/provider/index/phome

Behavioral Health
DMA, 919-855-4290

Attention: Hospitals

Use of RC Coding for Emergency Room Charges

Until modifications are made to the N.C. Medicaid billing system, code trauma patients as you would any other ER patient. The N.C. Division of Medical Assistance (DMA) Clinical Policy Section is recommending that providers use the RC coding for Emergency Room (ER) charges listed below.

045x Emergency Room

Charges for emergency treatment to those ill and injured persons who require immediate unscheduled medical or surgical care.

SubC	Subcategory Definition	Standard Abbreviation	Unit	HCPCS
0	General Classification	EMERG ROOM	Visit	Y
1	EMTALA Emergency Medical Screening	ER/EMTALA	Visit	Y
2	ER Beyond EMTALA	ER/BEYOND EMTALA	Visit	Y
3-5	RESERVED			
6	Urgent Care	ER/URGENT	Visit	Y
7-8	RESERVED			
9	Other Emergency Room	OTHER EMERG ROOM	Visit	Y

Facilities Services
DMA, 919-855-4260

Attention: N.C. Health Choice Providers

Allergy Shots Are Not Exempt from Recipient Cost Sharing Obligations

As described on page 3-6 of the *Basic Medicaid and N.C. Health Choice Billing Guide* at http://www.ncdhhs.gov/dma/basicmed/BasicMedicaid0412.pdf, the following N.C. Health Choice (NCHC) services are exempt from cost sharing:

- Routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents";
- Laboratory tests associated with well-child routine physical examinations;
- Immunizations and related office visits as recommended and updated by the Advisory Committee on Immunization Practices (ACIP); and,
- Routine preventive and diagnostic dental services (such as oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays) as described in the most recent guidelines issued by the American Academy of Pediatric Dentistry (AAPD).
- Visual aides dispensing.

Please note: Allergy shots are distinct from immunizations and are therefore ***not exempt*** from cost sharing. A NCHC recipient who receives an allergy shot is responsible for the applicable co-pay, as indicated on the NCHC identification card.

This new policy direction is in direct conflict with page 3-6 of the Basic Medicaid and N.C. Health Choice Billing Guide which states "Prior approval is not required for allergy immunotherapy (allergy shot). No copay is required for office visits; however, co-payment(s) may apply to covered prescription drugs and services."

The October 2012 edition of the Basic Medicaid and N.C. Health Choice Billing Guide will reflect these changes.

N.C. Health Choice (NCHC)
DMA, 919-851-4260

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

Employment opportunities with DMA are advertised on the Office of State Personnel's Website at http://www.osp.state.nc.us/jobs/. To view the vacancy postings for DMA, click on "Agency," then click on "Department of Health and Human Services." If you identify a position for which you are both interested and qualified, complete a state application form online and submit it 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. To submit a comment related to a policy, refer to the instructions on the Proposed Clinical Coverage Policies Web page at http://www.ncdhhs.gov/dma/mpproposed/. Providers without Internet access can submit written comments to the address listed below.

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

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

2012 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
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
Aug	8/2/12	8/7/12	8/8/12
	8/9/12	8/14/12	8/15/12
	8/16/12	8/21/12	8/22/12
	8/23/12	8/30/12	8/31/12

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.

Michael Watson
Director
Division of Medical Assistance
Department of Health and Human Services

Melissa Robinson
Executive Director
HP Enterprise Services