August 2012 Medicaid Bulletin

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Attention: All Providers

HCPCS Procedure Code Changes for the Physician's Drug Program

The following Healthcare Common Procedure Coding System (HCPCS) changes comply with the Centers for Medicare & Medicaid Services (CMS) HCPCS procedure code changes for July 1, 2012.

End-Dated Codes with Replacement Codes

The following HCPCS codes were end-dated effective with date of service June 30, 2012, and replaced with new codes effective with date of service July 1, 2012. Claims submitted for dates of service on or after July 1, 2012 using the codes which were end-dated on June 30, 2012 will be denied.

End-Dated HCPCS Code	Description	Unit	New HCPCS Code	Description	Unit
J1680	Injection, human fibrinogen concentrate, 100 mg (RiaSTAP)	100 mg	Q2045	Injection, Human Fibrinogen Concentrate, 1 mg (RiaSTAP)	1 mg
J9001	Injection, doxorubicin HCL, all lipid formulations, 10 mg	10 mg	Q2048	Injection, doxorubicin hydrochloride, liposomal, Doxil, 10 mg	10 mg
J9001	Injection, doxorubicin HCL, all lipid formulations, 10 mg	10 mg	Q2049	Injection, doxorubicin hydrochloride, liposomal, imported Lipodox, 10 mg	10 mg

New Code that was Previously Billed with a Miscellaneous or Unclassified Drug Code

Effective with date of service July 1, 2012, the N.C. Medicaid Program covers the individual HCPCS code for the drug listed in the following table. Claims submitted for dates of service on or after July 1, 2012, using the unlisted drug code J3590 for this drug will be denied. An invoice is not required.

Old HCPCS Code	Description	Old Unit	New HCPCS Code	Description	New Unit
J3590	Injection, afilbercept, 1 mg (Eylea)	1 mg	Q2046	Injection, aflibercept, 1 mg (Eylea)	1 mg

Refer to the fee schedule for the Physician's Drug Program on the N.C. Division of Medical Assistance (DMA) website at www.ncdhhs.gov/dma/fee/fee.htm for the latest available fees.

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

Attention: All Providers

Basic Medicaid and N.C. Health Choice Seminars

Basic Medicaid and N.C. Health Choice (NCHC) seminars will be held in October 2012. Seminars are intended to educate providers on the basics of N.C. Medicaid and NCHC billing, as well as to provide an overview of policy updates, contact information, and fraud, waste and abuse. The seminar locations and dates will be announced in the *September 2012 Medicaid Bulletin*. The October 2012 *Basic Medicaid and NC Health Choice 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) website at www.ncdhhs.gov/dma/provider/seminars.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

N.C. Health Check Seminars

N.C. Health Check seminars are scheduled for September 2012 to educate providers about N.C. Health Check policies, billing guidelines and fraud, waste and abuse. **Pre-registration is required.** Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

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

Sessions will begin at 10 a.m. and end at 1 p.m. Providers are encouraged to arrive by 9:45 a.m. to complete registration. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Seminar Dates and Locations:

Date	Location
September 12, 2012	**Charlotte** Crowne Plaza 201 South McDowell Street Charlotte, NC 28204 **Note: Parking fee of $5.00 per vehicle for parking at this location.** get directions
September 18, 2012	**Winston-Salem** Marriott Winston-Salem 425 N. Cherry Street Winston-Salem, NC 27101 get directions
September 25, 2012	**Raleigh** Wake Tech Community College Student Service Building Conference Center 9101 Fayetteville Road, Rooms 213 & 214 Raleigh NC 27603 get directions
September 27, 2012	**Fayetteville** Cumberland County DSS 1225 Ramsey Street Fayetteville, NC 28301 get directions

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

Attention: All Providers

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

N.C. Medicaid will hold a **Prior Approval, Recipient Due Process (Appeals), and Early Periodic Screening, Diagnosis and Treatment (EPSDT)** seminar for providers on September 11, 2012. The seminar will address 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 **EPSDT-Medicaid for Children**. The seminar will **not** address billing.

The seminar will run 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.

Those who wish to attend the seminar can register online. **Pre-registration is required.** Providers will receive a registration confirmation specifying the training material(s) each provider should bring to the seminar.

September 11, 2012	**Raleigh** Wake Tech Community College Student Service Building Conference Center Second Floor, Rooms 213 & 214 9191 Fayetteville Road Raleigh NC 27603 get directions

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

Attention: All Providers

National Correct Coding Initiative: Billing Guidance

CPT code 15277 (application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq. cm; first 100 sq. cm wound surface area, or 1% of body area of infants and children) was being inappropriately denied for age due to a system error.

Providers should resubmit their claims for CPT code 15277 if they received an **Explanation of Benefit (EOB) 9954 "Payment of Procedure Code Is Denied Based on Correct Coding Standards Editing"** with this explanation in the provider portal: "The age/gender of the patient is inappropriate for this procedure, based on the CPT/HCPCS code."

Providers with questions 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: 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 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

Attention: All Providers

Payment Error Rate Measurement (PERM) in North Carolina

In compliance with the Improper Payments Information Act of 2002, the federal Centers for Medicare & Medicaid Services (CMS) has implemented a national Payment Error Rate Measurement (PERM) program to determine the extent of improper Medicaid and State Children's Health Insurance Program (SCHIP) payments. North Carolina was selected as 1 of 17 states required to participate in PERM reviews of Medicaid fee-for-service and managed care claims paid in federal fiscal year 2010 (October 1, 2009, through September 30, 2010).

The SCHIP program did not participate in the 2010 PERM measurement.

CMS used two national contractors to measure improper payments. The statistical contractor – Livanta – coordinated efforts with the state regarding the eligibility sample, maintaining the PERM eligibility website, and delivering samples and details to the review contractor. The review contractor – A+ Government Solutions – communicated directly with providers and requested medical record documentation associated with the sampled claims. Providers were required to furnish the records requested by A+ Government Solutions within a timeframe specified in the medical record request letter.

The following are North Carolina PERM medical record documentation errors identified during federal fiscal year 2010:

1. No medical record documentation provided for the review
2. Diagnosis Related Group (DRG) code errors
3. Incorrect number of units of service billed
4. Medicaid policy violations errors (Policy violations included undated prescription and billing for services without a physician order)
5. Administrative/other medical review errors (This included billing for dates of service when services were not provided, and billing for dentures prior to the date of delivery to the recipient.)

The N.C. Division of Medical Assistance (DMA), Program Integrity Section, recouped the overpayments identified by CMS. In addition, provider noncompliance led to a recommendation of Prepayment Review and possible exclusion of providers from the Medicaid program.

Providers are reminded of Social Security Act (SSA) requirements – listed in SSA Section 1902(27)(a) and 42 CFR 431.107 – to retain any records necessary to disclose the extent of services provided to individuals and – upon request – to furnish information regarding any payments for medical services rendered.

North Carolina will be required to participate in federal fiscal year 2013 PERM review of Medicaid fee-for-service, managed care and SCHIP program claims. This is a good time to review medical record documentation to ensure it meets program requirements.

Program Integrity
DMA, 919-814-0000

Attention: All Providers

ICD-10 Web Page Launched

The N.C. Office of Medicaid Management System Services (OMMISS) has launched a new web page for the International Classification of Diseases, 10th Edition (ICD-10) diagnosis and procedure codes project at www.ncmmis.ncdhhs.gov/icd10.asp.

The ICD-10 web page is full of information, educational materials, and other resources to assist with the transition to the ICD-10 code set. The web page also contains announcements, project statuses, and updates. Providers can register to be on the ICD-10 listserv and send questions directly to the project team using the ICD-10 project team's new e-mail address at OMMISS.ICD10@dhhs.nc.gov.

The ICD-10 project team consists of staff from OMMISS, the N.C. Division of Medical Assistance (DMA), the N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), the N.C. Division of Public Health/Office of Rural Health and Community Care (DPH), and Computer Sciences Corporation (CSC), which is the NCTracks fiscal agent.

The ICD-10 project team looks forward to hearing from providers, sharing information, and working with providers toward the ICD-10 compliance deadline.

Office of Medicaid Management System Services (OMMISS)
DMA, 919-647-8300

Attention: All Providers

Reporting Managing Relationship Changes

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

Providers are responsible for notifying the N.C. Division of Medical Assistance (DMA) of any changes to their managing relationships. This notification must be made within thirty (30) calendar days of the change. The changes must be reported by submission of a new Provider Enrollment Packet, found on the NCTracks website at https://nctracks.nc.gov/provider/providerEnrollment/index.jsp.

Providers are encouraged to use the online provider enrollment application. With each submission, the provider must disclose all managing relationships in the Managing Relationship section. The entire Provider Enrollment Packet must be complete and correct upon submission to avoid delays in processing.

Below are two examples of how changes in managing relationships should be reported on the Provider Enrollment Packet:

- **Scenario 1** (**Adding a managing relationship**): Upon enrollment, a provider disclosed that it had four managing relationships. A year later, the provider added one new managing relationship. The provider must complete a new Provider Enrollment Packet. In the Managing Relationship section, the provider must list all five managing relationships.

- **Scenario 2** (**Removing a managing relationship**): Upon enrollment, a provider disclosed that it had 20 managing relationships. Six months later, the provider removed one of its managing relationships. The provider must complete a new Provider Enrollment Packet. In the Managing Relationship section, the provider must list all 19 managing relationships.

Notifying DMA of managing relationship changes will ensure providers that their Medicaid provider files are always current.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Termination of Inactive N.C. Medicaid and N.C. Health Choice Provider Numbers

Note to Providers: This article originally ran in September 2011.

The N.C. Division of Medical Assistance (DMA) wants to remind all providers of its policy for terminating inactive providers to reduce the risk of fraudulent and unscrupulous claims billing practices. DMA's updated policy was announced in the *July 2011 Medicaid Bulletin*.

N.C. Medicaid and N.C. Health Choice (NCHC) provider numbers that do not reflect any billing activity within the previous 12 months will be terminated. If providers **cannot** attest that they have provided services to N.C. Medicaid or NCHC recipients in the previous 12-month period, their provider numbers will be terminated. A new enrollment application and agreement to re-enroll must be submitted to CSC for any provider who was terminated. **As a result, a lapse in the provider's eligibility may occur.**

Terminated providers who wish to re-enroll can reach CSC by phone at 1-866-844-1113 or by e-mail at NCMedicaid@csc.com.

Termination activity occurs on a quarterly basis with provider notices being mailed out on April 1, July 1, October 1, and January 1 of each year with termination dates of May 1, August 1, November 1, and February 1, respectively. These notices are sent to the current mailing address listed in the provider's file. **Providers are reminded to update their contact and ownership information in a timely manner.**

Provider Services
DMA, 919-855-4050

Attention: All Providers

Clinical Coverage Policies

The following new or amended combined N.C. Medicaid clinical coverage policies are available on the DMA website at www.ncdhhs.gov/dma/mp/:

- *5A, Durable Medical Equipment (7/1/12)*

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 www.ncdhhs.gov/dma/mp/:

- *1A-8, Hyberbaric Oxygenation Therapy (3/12/12)*
- *1A-12, Breast Surgeries (6/1/12)*
- *1A-16, Surgery of the Lingual Frenulum (3/12/12)*
- *1A-23, Physician Fluoride Varnish Services (3/12/12)*
- *1A-33, Vagus Nerve Stimulation for the Treatment of Seizures (7/1/12)*
- *1H, Telemedicine and Telepsychiatry (7/1/12)*
- *1N-2, Allergen Immunotherapy (3/12/12)*
- *1R-1, Phase II Outpatient Cardiac Rehabilitation Programs (7/1/12)*
- *1R-4, Electrocardiography, Echocardiography, and Intravascular Ultrasound (7/1/12)*
- *1T-1, General Ophthalmological Services (3/12/12)*
- *3H-1, Home Infusion Therapy (5/1/12)*
- *4A, Dental Services (3/12/12)*
- *4B, Orthodontic Services (3/12/12)*
- *6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21 (7/15/12)*
- *8-O, Services for Individuals with Intellectual and Developmental Disabilities and Mental Health or Substance Abuse Co-Occurring Disorders (3/12/12)*
- *9C, Mental Health Drug Management Program Administrative Procedures (7/1/12)*
- *9D, Off Label Antipsychotic Safety Monitoring in Children through Age 17 (7/1/12)*
- *9E, Off Label Antipsychotic Safety Monitoring in Recipients 18 and Older (7/1/12)*
- *11A-1, Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL) (3/12/12)*
- *11A-2, Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia (3/12/12)*
- *11A-3, Hematopoietic Stem-Cell & Bone Marrow Transplantation for Chronic Myelogenous Leukemia (3/12/12)*
- *11A-5, Allogeneic Hematopoietic & Bone Marrow Transplant for Genetic Diseases and Acquired Anemias (3/12/12)*

- *11A-6, Hematopoietic Stem-Cell & Bone Marrow Transplantation in the Treatment of Germ Cell Tumors (3/12/12)*
- *11A-7, Hematopoietic Stem-Cell & Bone Marrow Transplantation for Hodgkin Lymphoma (3/12/12)*
- *11A-8, Hematopoietic Stem-Cell Transplantation For Multiple Myeloma and Primary Amyloidosis (3/1/12)*
- *11A-9, Allogeneic Stem-Cell & Bone Marrow Transplantation for Myelodysplastic Syndromes & Myeloproliferative Neoplasms (3/1/12)*
- *11A-10, Hematopoietic Stem-Cell & Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors & Ependymoma (3/12/12)*
- *11A-11, Hematopoietic Stem-Cell & Bone Marrow Transplant for Non-Hodgkin's Lymphoma (3/1/12)*
- *11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood (3/1/12)*
- *11A-16, Hematopoietic Stem-Cell Transplantation for Chronic lymphocytic leukemia (CLL) and Small lymphocytic lymphoma (SLL) (3/1/12)*
- *11B-1, Lung Transplantation (3/12/12)*
- *11B-2, Heart Transplantation (3/12/12)*
- *11B-3, Islet Cell Transplantation (3/12/12)*
- *11B-4, Kidney Transplantation (3/12/12)*
- *11B-5, Liver Transplantation (3/12/12)*
- *11B-6, Heart/Lung Transplantation (3/12/12)*
- *11B-7, Pancreas Transplant (3/12/12)*
- *11B-8, Small Bowel and Small Bowel/Liver and Multivisceral Transplants (3/12/12)*

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

- *Durable Medical Equipment and Supplies (7/1/12)*
- *Vagus Nerve Stimulation (Date of termination 6/30/2012)*
- *Dental and Oral Surgery Services (Date of termination 9/30/2011)*
- *Orthognathic Surgery (Date of termination 9/30/2011)*
- *Routine Dental Care (Date of termination 9/30/2011)*

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. Medicaid Provider Direct Enrollment and Screening

Beginning October 1, 2012, the N.C. Division of Medical Assistance (DMA) will implement Federal regulations 42 CFR 455.410 and 455.450 – requiring all participating providers to be screened according to their categorical risk level. These screenings will take place both upon initial enrollment and re-enrollment.

42 CFR 455.450 establishes the following three categorical risk levels for N.C. Medicaid and N.C. Health Choice (NCHC) providers to assess the risk of fraud, waste, and abuse:

- Low
- Moderate
- High

Provider types and specialties that fall into the moderate- and high-risk categories are subject to a pre-enrollment site visit, unless a screening and site visit has been successfully completed by Medicare or another state agency within the previous 12 months.

In addition, 42 CFR 455.410 requires that all ordering and referring physicians – as well as other professionals providing services under the N.C. Medicaid and NCHC programs and those providing such services under a waiver – be enrolled as participating providers. This holds true for anyone in those groupings who orders or refers Medicaid and NCHC beneficiaries for services and seeks reimbursement.

All claims for payment for ordered or referred services or items must include the National Provider Identifier (NPI) of the ordering or referring physician or other professional.

Applications for provider types and specialties that are not currently enrolled in the N.C. Medicaid and NCHC programs, but wish to continue to provide services to beneficiaries, will be available beginning October 1, 2012.

Provider Services
DMA, 919-855-4050

Attention: All Providers

340b Purchased Drugs

Drugs dispensed by a hospital to its patients during an outpatient visit are not considered "retail" pharmacy transactions. Since the patient is registered as a hospital outpatient for services/procedures – and the drugs are incidental to the outpatient services – the cost of the drugs is included in the outpatient settlement.

As such, the drugs must be billed to N.C. Division of Medical Assistance (DMA) at their usual and customary charge, including those drugs used from the 340b stock. To do otherwise would be in conflict with Medicare cost reporting guidelines. Transactions of outpatient hospital services are billed to DMA on a UB-04 or 837i transaction. Those drugs from the 340b stock are billed with a UD modifier to indicate that the drug is a 340b drug and will not be included in the rebate calculation.

Hospital "retail" pharmacy transactions can be billed as either point of sale or on a CMS 1500 or 837p transaction. Since these transactions are not cost settled, a pharmacy would need to bill DMA at the acquisition cost of the 340b drug if 340b inventory is dispensed. The UD modifier is used on the CMS 1500/837p transaction type to indicate a 340b drug and the claim will not be included in the rebate calculation.

The physician drug program and retail pharmacy program should operate the same way – in that the provider would bill DMA at the acquisition cost of the 340b drug if 340b inventory is administered or dispensed. The physician drug program provider would bill DMA using a CMS 1500 or 837p transaction with the UD modifier for a 340b drug. In the retail pharmacy program, the pharmacy provider using the point of sale system can add its applicable dispensing fee to the acquisition cost of the 340b drug, but should not add the same dispensing fee to all claims since DMA policy has different dispensing fees for brands and generics. Generic dispensing fees are also different depending on a pharmacy's generic dispensing rate.

In the retail pharmacy program, if the pharmacy is on the Health Resources and Services Administration (HRSA) Medicaid provider exclusion file, its claims would not be included in the rebate calculation. The Medicaid exclusion file lists 340b entities and their associated Medicaid provider numbers and/or NPIs. The entities listed on the exclusion file have reported to HRSA that they intend to fill Medicaid prescriptions with 340b purchased drugs. The claims for these prescriptions are not eligible for manufacturers' rebates.

Exception: A physician office that is part of a hospital-based clinic (e.g., the clinic is a department of a hospital), would have the drugs billed to DMA on a UB04/837i transaction and as such the hospital-based clinic would bill the usual and customary charge for 340b drugs since those drugs would be included in the hospital outpatient cost settlement. The physician's professional fee would be billed to DMA using a CMS 1500/837i transaction and would not be included in any type of settlement.

Exception: FQHC/RHC facilities are both settled. However, since the cost allocation for drugs is based upon prescriptions filled and not based upon charges, the FQHC/RHC facilities should bill DMA at the 340b acquisition cost and not their usual and customary charge.

Pharmacy
DMA, 919-855-4300

Attention: All Providers

Mirena Return Process for Physicians' Offices

A "Mirena Abandoned Unit" can be returned to CVS Caremark via Genco, a third-party processor. An "Abandoned Unit" is defined as an unopened unit of Mirena shipped by CVS Caremark under the Mirena Specialty Pharmacy Program with a prescription label that includes an individual patient's name.

Note: The prescriber has not paid for this unit. **In no case can a unit that was purchased by the prescriber (e.g., purchase of a wholesale unit) be returned through this program.**

In order to be returnable, the box of Mirena must be sealed and have been shipped in 2010 or later. The Mirena unit must also be in its original packaging (the actual box in which it was received). Furthermore, the original box must be sealed and must have been abandoned for at least 120 days from the date received.

The Mirena unit is considered unreturnable if the box has been opened and the unit removed.

If the abandoned unit is deemed returnable, the physician will receive a return authorization number and a postage-paid UPS label. The Mirena unit must be placed in the original box in which it was shipped from CVS Caremark or another suitable mailing envelope. Physicians' Bayer Sales Consultants will provide them with mailing envelopes if a shipping box is not available.

More than one "Abandoned Unit" can be shipped back at the same time, but each unit must be sent in its original individual packaging with corresponding forms to ensure proper processing.

Please see below the six-step process for returning a Mirena Abandoned Unit:

1. Complete a Mirena Abandoned Unit form for each Mirena unit
2. Fax the form(s) to CVS Caremark for verification
3. Wait for CVS Caremark fax approval
4. Wait for an authorization number and return mailing label from Genco
5. Package the unit in one of the cardboard boxes that the Mirena was initially shipped in or a large envelope
6. Mail the unit

To get started, providers can fill out the "Mirena Abandoned Unit" form that is located on the N.C. Division of Medical Assistance (DMA) Outpatient pharmacy website (www.ncdhhs.gov/dma/pharmacy/Mirena_Abandoned_Unit_Form.pdf) listed under "What's new?"

The form must be filled out completely, signed by the physician, and faxed to CVS Caremark at 1-877-552-3339. Those who have not received a confirmation fax can contact Caremark at 1-888-345-3083. Those who need to contact Genco directly can call 1-800-950-5479.

Remember to send the "Mirena Abandoned Units" to Genco – **NOT** CVS Caremark. Physicians will receive a postage-paid return mailing label via e-mail from Genco. Physicians can use their own envelopes, but they must affix the mailing labels e-mailed to them from Genco.

Those with additional questions regarding Mirena or the process for returning Mirena units should contact their Bayer Sales Consultants.

Outpatient Pharmacy Services
DMA, 919-855-4300

Attention: All Providers

EHR Providers Can Make Attestations under NC-MIPS

As of July 23, providers under the N.C. Medicaid EHR Incentive Program are able to attest for an Adopt/Implement/Upgrade (AIU) incentive payment – or view an attestation status – via the new NC-MIPS Portal. The NC-MIPS Portal is expected to go live for Meaningful Use (MU) attestations on August 20, 2012.

Please note that providers who have received a 2011 AIU incentive payment can't attest for a Year 2 MU incentive payment until August 20, 2012. Please watch for announcements posted on the N.C. Division of Medical Assistance (DMA) EHR Incentive Program website (www.ncdhhs.gov/dma/provider/ehr.htm) or the NC-MIPS Portal (https://ncmips.nctracks.nc.gov/) regarding system availability and updates.

DMA is committed to offering the provider community continued enhancements and system upgrades. We sincerely appreciate your support as we continue to build a better vehicle for attestation.

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

Attention: All Providers

EHR Incentive Program Updates

Success!

The N.C. Medicaid Electronic Health Record (EHR) Incentive Program has recently reached a significant milestone. As of June 27, 2012, the Program has paid **$50.12 million** in incentive payments to 1,142 eligible professionals (EPs) and 30 eligible hospitals (EHs). These numbers represent 33% of professionals and 32% of hospitals projected to be eligible for the Program statewide.

The Program has surpassed its goal to pay more than $50 million to providers by the end of June 2012. This feat would not have been possible without the dedication and hard work of many groups and individuals. On behalf of the N.C. Medicaid EHR Incentive Program - thank you to all who have helped us obtain this accomplishment!

2011 Attestation Updates

The N.C. Medicaid EHR Incentive Program is pleased to announce that, with a few exceptions, the 2011 attestations are complete. As of June 18, 2012, the Program has paid a total of $40.94 million to 1,124 providers. Here is a detailed breakdown of payment by county and payments by type/specialty.

New MU Measures Help

In an effort to help providers as they prepare for meaningful use attestation, the N.C. Medicaid EHR Incentive Program has posted a Meaningful Use (MU) Measures Overview on its website. The MU Overview will show providers the Core, Menu and Clinical Quality Measures needed to successfully attest to MU in participation years two through six. See the NC EHR Incentive Program website for additional trainings, webinars and resources.

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

Attention: All Providers

EHR Incentive Program: Clarifying PA-Led, Practice Predominantly, and "Incident To" Billing

PA Eligibility for the NC Medicaid EHR Incentive Program

Physician Assistants (PAs) are only eligible for the N.C. Medicaid EHR Incentive Program if they furnish services at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a PA, so long as the PA meets all other Program eligibility requirements (Medicaid patient volume requirement, not hospital-based, etc.).

The Final Rule states that a PA would be leading an FQHC or RHC under any of the following circumstances:

1. The PA is the primary provider in a clinic (note: when there is a part-time physician and full-time PA, the PA would be considered the primary provider);
2. The PA is a clinical or medical director at a clinical site of practice; or
3. The PA is an owner of the FQHC or RHC.

PAs wishing to participate in the Program should submit documentation on group letterhead attesting to one of the three requirements mentioned above, along with any supporting documentation. Eligible PAs who attest to practicing predominantly in an FQHC or RHC may be asked to provide additional documentation of encounters with "needy individuals," as defined below.

Needy individuals include:

1. Individuals receiving assistance from Medicaid or the Children's Health Insurance Program (Health Choice);
2. Individuals provided uncompensated care by the EP; and
3. Individuals who received services at no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

Practicing Predominantly, New Providers, and Group Methodology

Eligible Professionals (EPs) who have more than 50% of their total patient encounters at an FQHC or RHC during any continuous six-month period in the **previous** calendar year qualify as "practicing predominately" at an FQHC or RHC. An EP who attests to practicing predominately in an FQHC or RHC may count needy individuals toward the 30% patient volume requirement necessary to receive an EHR incentive payment.

N.C. Medicaid recognizes that this issue has implications for newer FQHC and RHC staff who cannot attest to practicing predominantly during the previous year and who wish to use group methodology when calculating Medicaid patient volume. The following

clarifies some of the circumstances which face such providers when applying for EHR Incentive Payments.

Example 1:

A new provider is hired by an FQHC that attested using group methodology to calculate patient volume and meet the 30% Medicaid patient volume requirement **without using needy individual patient encounters**. The new provider did not practice at an FQHC or RHC for six continuous months during the previous year, and would answer "**No**" to the practices predominantly question. This provider expects to see Medicaid patients in keeping with the FQHC's reported patient volumes from the previous year, and due to his/her current affiliation with the FQHC, s/he **may attest** using the group's pre-calculated patient volume (group methodology) from the previous year.

Example 2:

A new provider is hired by an FQHC that attested using group methodology to calculate patient volume and was able to meet the 30% Medicaid patient volume requirement **by using needy individual patient encounters**. The new provider did not practice at an FQHC or RHC for six continuous months during the previous year, and would answer "**No**" to the practices predominantly question. Although this provider expects to see Medicaid patients in keeping with the FQHC's reported patient volumes from the previous year and has a current affiliation with the FQHC, s/he **may not attest** using the group's pre-calculated patient volume (group methodology) from the previous year. The reason is that the practicing predominantly requirement must be satisfied in order to use needy individuals toward the Medicaid patient volume requirement.

Example 3:

A new provider is hired into an FQHC that attested using group methodology, **either with or without the use of needy individual patient encounters**. The new provider came to the new practice from another FQHC or RHC and can answer "**Yes**" to the practices predominantly question. In this scenario, the provider expects to see Medicaid patients in keeping with the new FQHC's reported patient volumes from the previous year, and due to his/her current affiliation with the FQHC **and** his/her ability to satisfy the practicing predominantly requirement, s/he may attest using the group's pre-calculated patient volume (group methodology) from the previous year.

Note:

In all of the above examples, a provider who practiced elsewhere during the previous year and saw the requisite 30% Medicaid patients may be eligible to attest using individual methodology for calculating patient volume. In this case, providers would calculate their individual patient encounters from the previous practice site(s), as long as the previous practice group did not attest using group methodology for the same 90-day period.

Please note that patient volume methodology and assignment of payment are not related. Providers may attest having used group methodology to calculate patient volume, and assign the incentive payment to themselves or to another practice with whom they are affiliated that promotes the meaningful use of certified EHR technology.

"Incident to" Billing and the EHR Incentive Program

"Incident to" billing is a long-standing practice in N.C. Medicaid. While there will be issues surrounding the validation of Medicaid patient volume under the EHR Incentive Program, there is no requirement to have a billed claim tied to your personal MPN/NPI to be eligible for the Program.

To be clear, providers who bill "Incident to" a physician – and thus have no or few claims billed under their names – are still eligible to receive incentive payments if they meet all other Program requirements.

Providers who have billed "Incident to" in the year prior to attestation should work with EHR Incentive Program staff to identify all MPNs under which their encounters were billed with N.C. Medicaid, and provide documentation to this effect. This will avoid delays in validation and payment.

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

Attention: All Providers

EHR Incentive Program announces NC PATH

It is no secret – Electronic Health Records (EHRs) are expensive; however, qualifying providers in North Carolina can take advantage of a low-cost, hi-tech option to get connected and achieve Meaningful Use.

Blue Cross and Blue Shield of North Carolina (BCBSNC) – in collaboration with the North Carolina Health Information Exchange (NC HIE) and Allscripts – has launched the North Carolina Program to Advance Technology for Health (NC PATH). This program was created to place North Carolina at the forefront of healthcare reform.

NC PATH will equip qualifying providers with Allscripts EHR software and support, and connect health care providers across the state to the NC HIE at a considerable discount. Designed to meet the needs of both providers and patients, NC PATH is designed to move North Carolina into a new era of quality healthcare.

To find out more about NC PATH and how EHRs will impact your practice, visit the NC PATH website at www.allscripts.com/ncpath, or contact HIE's Program Manager, Kristal Shearin, by phone at 919-926-1042 ext. 2250 or by -mail at kristal.shearin@nchie.org.

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

Attention: Hospital Providers

EHR Incentive Program: Eligible Hospital Payment Calculation

The attestation and Electronic Health Record (EHR) payment calculation for Eligible Hospitals (EHs) contains a data field titled *Medicaid HMO Inpatient Days* on Worksheet S-3, Part I of the hospital's N.C. Medicaid cost report (2552-96 / 2552-10). This cost report data field is used to calculate the Medicaid share of the EHR payment. As permitted by Medicare cost reporting regulations, some hospitals have included both inpatient days paid by a North Carolina LME/ PIHP (Prepaid Inpatient Health Plan), and Medicaid eligible days in the *Medicaid HMO Inpatient Days* field.

Hospitals are reminded that 42 CFR §495.310 **permits only inpatient bed days** in the calculation of the Medicaid share of the EHR payment. EHs who submit attestations for EHR payments should identify only those inpatient days from their Medicaid cost report which were paid by a North Carolina LME / PIHP in the *Medicaid HMO Inpatient Days* data field.

The patient days identified by the provider in the EHR attestation are subject to review and/or audit for supporting documentation.

N.C. Medicaid Health Information Technology (HIT)
DMA, 919-814-0030

Attention: All Providers

Update on Bundled Prospective Payment System (PPS) for End Stage Renal Disease

On January 1, 2011, the Centers for Medicare & Medicaid Services (CMS) – in accordance with Section 153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA) – replaced the current basic case-mix adjusted composite payment with a mandated Bundled Prospective Payment System (PPS) for End Stage Renal Disease (ESRD).

The PPS combines the composite rate with separately billable outpatient ESRD-related services for hospital-based and free-standing renal dialysis facilities. The bundled PPS payment is inclusive of all the resources used in providing outpatient dialysis treatment – such as supplies, equipment and staff time used to administer dialysis, drugs, biologicals, laboratory tests, training (as appropriate) and support services.

The N.C. Division of Medical Assistance (DMA) met with stakeholders to determine an efficient way to address CMS' implementation of the PPS. DMA is currently working to revise the reimbursement methodology, as well as clinical coverage policies for Dialysis Services and ESRD providers.

DMA will notify providers as a resolution draws near. Providers are advised to monitor subsequent General Bulletins and Special Medicaid Bulletins for details and updates regarding this topic.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Dialysis Providers

Clarification about Filing to N.C. Medicaid

Effective November 1, 2012, claims filed to N.C. Medicaid when Medicare Part B has made a payment must have the sum of both the coinsurance and the deductible on the UB-04 claim form, Form Locator (Estimated Amount Due) alongside the Class and Carrier code of 'MC' in Form UB-04, FL50.

N.C. Medicaid will begin reimbursing providers **the lesser** of the coinsurance and deductible or the difference between the Medicaid allowable and the Medicare payment.

This change only applies to dates of service on and after November 1, 2012.

As an example, under a scenario in which the payment from Medicare Part B was $50.00, and the coinsurance plus deductable was $100, as follows:

- Medicare payment = $50
- Medicare coinsurance = $75
- Medicare deductible = $25
- Contractual adjustment = $10

In such a case, the UB-04 form would read as follows:

50 Payer	51 Provider No.	52 Rel. Info	53 Sag Ben	54 Prior Payments	55 Est. Amount Due	56 NPI
MB	34XXXX			$50.00		
MC	34XXXXX				$100.00	

Note: Providers do not add the contractual adjustment to the payment listed in UB-04, FL54.

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

Attention: Adult Care Home Providers

Transition Planning for Implementation of Consolidated Personal Care Services

The Carolinas Center for Medical Excellence (CCME) began conducting independent assessments in July 2012 to determine recipient eligibility for the consolidated Personal Care Services (PCS) benefit, which become effective January 1, 2013. Assessments of current residents of licensed care homes (Adult Care Homes, Family Care Homes, 5600a and 5600c Supervised Living Homes, and combination facilities with ACH beds) are expected to continue through November 2012.

CCME is using the facility service address and telephone number on file with N.C. Division of Medical Assistance (DMA) Provider Enrollment to schedule resident assessments. Please ensure that your provider contact information on file with DMA Provider Enrollment is current.

As a reminder, the Medicaid Provider Agreement requires updating any change in site location or business address within 30 days (Paragraph 6.a.vi.). Failure to keep your contact information current with DMA may result in sanctions, up to and including suspension or termination of participation in the program.

To verify and update facility contact information, contact the N.C. Medicaid provider Enrollment, Verification, and Credentialing (EVC) Call Center at 866-844-1113. Select the menu option to speak to a representative about "all other questions." For general planning purposes, refer to the preliminary timeline of estimated assessment dates by facility on the DMA Consolidated PCS web page.

In order to ensure that PCS services continue on January 1, 2013, residents of currently licensed homes must have completed independent assessments demonstrating that they meet PCS qualifications and have submitted completed attestation forms to CCME by the close of the transition assessment period. The attestation form and instructions for completion are available on the DMA Consolidated PCS web page.

Providers are encouraged to initiate completion of Medical attestation forms for all Medicaid residents immediately to ensure the completed form is available at the time of each resident's scheduled assessment.

Completed assessments and attestation forms will be reviewed in relation to program eligibility criteria to determine recipient qualification and authorized service levels effective January 1, 2013. Each recipient will receive a notice in advance of any change in services resulting from the independent assessment, as well as information about appeal rights. In accordance with federal regulation, maintenance of service will be available for recipients who file a timely appeal of a change or denial of services. Timelines for recipient notifications will be announced in future Medicaid Bulletins.

Proposed Clinical Coverage Policy 3L, Personal Care Services**,** is posted for public comment on DMA's Proposed Medicaid Clinical Coverage Policies web page. CCME and DMA will conduct regional provider trainings for licensed home providers between August 6 and August 17, 2012. Trainings will be held in Asheville, Charlotte, Raleigh, Greenville, and Fayetteville, NC. Please visit the Personal Care Services Regional Training Registration web page for dates, times, and locations and to register for the training.

Provider trainings on the consolidated PCS benefit are ongoing. Updates and materials from completed provider trainings are available, and will continue to be added, to the DMA Consolidated PCS web page.

The following table provides an overview and timeline of completed and planned PCS program trainings.

Date	**Description**	**Topic**
June 21, 2012 10:00 – 11:30 a.m.	Webinar Training: Transition Planning for Licensed Adult Care Home Providers	Eligibility, Independent Assessments (Completed)
July 11, 2012 10:00 – 11:30 a.m.	Institutions for Mental Disease (IMD) Training for Licensed Adult Care Home, Family Care Home, & Supervised Living Home (5600a and 5600c) Providers	IMD characteristics and reviews (Completed)
July 26, 2012 10:00 – 11:30 a.m.	Webinar Training: Eligibility, Independent Assessments, and Recipient Notification	(Completed)
August 6 – August 17, 2012	Regional Trainings for Licensed Home Providers	Proposed Policy, Eligibility Assessments, Recipient Decision Notices Providers may register online at www.thecarolinascenter.org/default.aspx?pageid=194
September 20, 2012 10:00 – 11:30 a.m.	Webinar Training	Recipient Appeals
September-October 2012	Regional Trainings for Licensed Home and Home Care Agency Providers	PCS Policy, Billing and Aide Documentation
November 15, 2012 10:00 – 11:30 a.m.	Webinar Training	To be determined

Please refer to the July 2012 *Medicaid Special Bulletin* and future Medicaid Bulletins for additional information on the consolidated Personal Care Services benefit. Licensed home providers and staff may also subscribe and receive e-mail alerts sent by HP Enterprise Services on behalf of DMA. To receive e-mail alerts for licensed care home providers, subscribe to North Carolina Medicaid E-mail Alert and select the Adult Care Home specialty. To subscribe, you must provide contact information including an e-mail address. **E-mail address are not shared, sold, or used for any purpose other than Medicaid email alerts, and you may unsubscribe at any time.**

Questions regarding eligibility assessments for the consolidated PCS program may be directed to the CCME Independent Assessment Help Line at 1-800-228-3365, or to PCSAssessment@thecarolinascenter.org.

Home and Community Care Section,
DMA, 1-919-855-4340

Attention: In-Home Care Providers

Proposed Clinical Coverage Policy 3L Posted for Public Comment

Effective January 1, 2013, N.C. Medicaid Personal Care Services (PCS) for recipients in all settings – including private residences and adult care homes – will be provided under a consolidated PCS benefit. The proposed clinical coverage policy for the new PCS benefit is now posted for public comment on the DMA website at www.ncdhhs.gov/dma/mpproposed.

Recipient eligibility criteria for the new PCS benefit will be the same as the current In-Home Care (IHC) recipient eligibility criteria. All recipients authorized for IHC services on December 31, 2012 will be transitioned to the new consolidated PCS program with no interruption in services. In accordance with N.C. General Assembly Session 2011 House Bill 950, errands will no longer be covered in the consolidated PCS program.

Regional trainings for home care agency and licensed home providers are being planned for September and October 2012. Please refer to future Medicaid Bulletins for additional information about the new PCS program.

Home and Community Care Section,
DMA, 919-855-4340

Attention: Hospice Providers

Hospice Benefit Period Information Accessible on AVR System and NCECSWeb Tool

Effective August 1, 2012, providers may use the Automated Voice Response (AVR) system or NCECSWeb Tool to verify a recipient's hospice benefit period.

For AVR Access:

1. Dial 1-800-723-4337
2. Press 1 for N.C. Medicaid Inquires
3. Press 6 for Eligibility
4. Press 2 for Identification, and enter your Medicaid Provider Number (MPN)
5. Press 2 for Hospice
6. Enter Medicaid ID Number (MID) and Inquiry Date

If Hospice has been reported for the MID entered – and the inquiry date is within the boundaries of a hospice benefit period – the provider will hear the number of the hospice benefit period (first, second, third, etc.) and the starting date of the segment.

If Hospice has been reported for the MID entered – but the inquiry date is not within the boundaries of a hospice benefit period – providers will be told that Hospice Eligibility was found prior to the inquiry date entered. The provider will then be told the hospice benefit period, as well as the starting date of the next most recent benefit period. The provider will also be told that the recipient has not been reported for Hospice on the inquired date.

If Hospice has not been reported for the MID entered, the provider will hear that the recipient has not been reported for Hospice on the inquired date.

For NCECSWeb Tool Access

The NCECSWeb Tool can be accessed at https://webclaims.ncmedicaid.com/ncecs/. Providers need to contact HP Enterprise Services' ECS Department at 1-800-688-6696, menu option 1, if they do not have a login ID and password. If there is Hospice activity for the MID entered, up to nine (9) hospice benefit periods with starting dates will be displayed. If there are more than nine benefit periods, nine will be displayed and a message will indicate that more than nine benefit periods were found.

Home Care Initiatives Unit
DMA, 919-855-4380

Attention: Institutional (UB-04) Billers

New Submission Address for Medicare HMO Claims

In the April 2012 *Basic Medicaid and N.C. Health Choice Billing Guide*, providers were instructed to mail Medicare Health Maintenance Organization (HMO) claims for institutional services submitted on the UB-04 claim form to N.C. Division of Medical Assistance (DMA) Third Party Recovery.

Starting July 1, 2012, providers must 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

Clearly write "Attn: UB Medicare HMO" on the mailing envelope. The envelope must contain **only** UB Medicare HMO claims. Ensure that all information is complete and correct prior to submission, as failure to follow guidelines will affect processing. **Claims that have incorrect, invalid, or missing information will no longer be mailed back to the provider, but will instead be denied on the provider's RA.** Adjudicated Medicare HMO claims will appear in the "Adjusted Claims" section of the RA.

Due to a large backlog of claims to be prepared and processed, it may be August 2012 before claims begin to appear on a remittance and status report (RA). Providers are asked to please avoid inquiring about claim status until the end of August 2012.
With the exception of the address change for institutional claims, all other guidelines for submitting Medicare HMO claims stated in the *Basic Medicaid and N.C. Health Choice Billing Guide* will remain in effect. Those guidelines are as follows:

General Guidelines

- **The claim should not be altered for processing purposes. The claim should be billed to Medicaid as it was billed to the Medicare HMO. Medicaid's liability is only the Medicare HMO cost share, which includes copayment, coinsurance, and/or deductible.**

- The claim must be submitted with a Medicare HMO Explanation of Benefits (EOB) attached to the claim. If the EOB is on multiple pages, submit all of those

pages with the claim. The amount billed to Medicaid on the claim form must equal the cost share amount indicated on the EOB.

- All charges should be reflected on the UB-04 claim form. Do not combine charges or destroy the integrity of the claim by "rolling up" charges into one revenue code.

- If the recipient has a monthly liability or deductible, that information should be reflected on inpatient stays, if applicable.

UB-04 Line Item Explanations

- FL47 – Indicate the total charges

- FL50 – Enter the two-digit payer code (see the December 2008 Medicaid Bulletin article, "New Payer Codes," for the list of acceptable codes)

- FL54 – Indicate HMO payment

- FL55 – Indicate the cost share amount

(**Note:** The amount listed in FL55 should reflect the Medicare HMO cost share amount only. This amount must match the amount indicated on the Medicare EOB.)

- FL56 – Enter your NPI

- FL57 **–** Enter your Medicaid Provider Number

- FL80 – Write "This is a Medicare HMO claim"

Click here to see an example of a completed UB-04 claim form for a Medicare HMO.

The Medicare HMO EOB must be attached. Currently, there is no need to send documentation for a time limit override for Medicare HMO claims; the time limit is being overridden systematically. Any changes to this procedure will be announced through provider communication.

Refer to the DMA website for updates to policies and procedures. Questions regarding claim submission should be directed to the HPES Provider Services Unit at 1-800-688-6696, menu option 3.

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

Attention: North Carolina Health Choice Providers

N.C. Health Choice Well Visits, Immunizations and Vaccines – Update

Providers were previously notified by bulletin and e-mail alert that the N.C. Division of Medical Assistance (DMA) was working with its fiscal agent, HP Enterprise Services, to correct a processing issue that caused N.C. Health Choice (NCHC) wellness exams to be denied when billed in conjunction with vaccines for the same date of service. The resulting denial was EOB 2066 (Immunization Administration and Therapeutic Injections not allowed same day as E/M).

The system update has now been completed. NCHC providers who have received EOB 2066 may now re-file those claims. Providers who elected to hold all claims for preventive services for NCHC until the system was corrected may now file those claims.

In addition, questions have been raised about the reimbursement for the NCHC wellness exam. DMA is in the process of defining a wellness package of services that will be reimbursed as Medicaid reimburses for the Health Check exam. Additional information will be provided when that program is developed. Until that time, for dates of service on or after Oct. 1, 2011, in addition to the preventive medicine codes, providers may bill separately and receive reimbursement for the following services for NCHC recipients – if appropriate.

- Developmental Screening CPT Code 96110
- Hearing CPT Code 92551 or 92552;
  For children 6-10 and then as appropriate, based on risk.
- Autism Screening CPT Code 99420
- Health Risk Assessments, CPT Code 99420
  (GAPS/HEADSSS) and Behavioral/Mental Health Screening (PSC/SDQ/PSQ-A/Beck's);
- CPT 99406-99407
  For Smoking/Tobacco Use Cessation; and
- CPT 99408-99409
  For Alcohol/Substance Abuse Structured Screening and Brief Intervention (CRAFFT)

The preventive medicine codes appropriate for NCHC are listed below, along with their descriptions.

Age	New Patient	Established Patient
5 through 11 years	99383	99393
12 through 17 years	99384	99394
18 through 20 years	99385	99395

E/M CPT codes in the 99201 – 99215 series should not be billed in conjunction with the preventive medicine diagnosis or CPT codes listed above.

Note: Allergy shots require a co-pay of $5.00 for each office visit.

For further assistance, providers can contact HP Enterprise Services Provider Services Department at 1-800-688-6696, menu option 3, Monday through Friday, from 8:00 a.m. to 4:30 p.m.

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

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
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
Sept.	8/30/12	9/5/12	9/6/12
	9/6/12	9/11/12	9/12/12
	9/13/12	9/18/12	9/19/12
	9/20/12	9/27/12	9/28/12

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