September 2010 Medicaid Bulletin

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Attention: All Providers

Medicaid Reimbursement Rate Update

DMA has been instructed by the NC DHHS Secretary to reverse the proposed rate reductions that were effective September 1, 2010. Notwithstanding any further directives, the rates in effect as of August 31, 2010 shall remain in effect on September 1, 2010, and thereafter. DMA is in the process of replacing the published September 1, 2010, fees schedules with the previously published fee schedules. The Fiscal Agent has been instructed to continue with the current rates on and after September 1, 2010. If you have any questions, please call the DMA Finance Management Section at 919-855-4180.

Rate Setting
DMA, 919-855-4180

Attention: All Providers

End-Dated Coverage of Panniculectomy: Correction to Procedure Code

The following article, originally published in the August 2010 Medicaid Bulletin, is being republished to correct the procedure code. The CPT procedure code that is being end-dated is **15830.**

Due to legislated budget reductions, effective with date of service October 1, 2010, the N.C. Medicaid Program no longer covers panniculectomy procedure. Clinical Coverage Policy 1A-10, *Panniculectomy*, will be end-dated effective October 1, 2010.

Procedure Code	Description
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy

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

Attention: All Providers

Recipient Notifications

Medicaid and N.C. Health Choice recipients are notified of benefit and coverage changes through monthly mailings. Copies of the notifications are available on DMA's website at http://www.ncdhhs.gov/dma/pub/consumerlibrary.htm.

The notification that was mailed to recipients in August 2010 outlined a number of changes to the N.C. Medicaid Program and to the N.C. Health Choice Program.

Medical Services

Medicaid recipients were notified of the following changes to the N.C. Medicaid Program for medical services:

- Policy changes for coverage of breast surgeries
- Reductions to covered podiatry services
- Elimination of the Maternal Outreach Worker Program
- Limitations to refills for lost prescriptions
- Implementation of a recipient management lock-in program for prescription drugs
- Changes to N.C. Medicaid Preferred Drug List
- Coverage of prescription vitamins and mineral products

For more information about these changes, providers may refer to the August 2010 Medicaid Bulletin (http://www.ncdhhs.gov/dma/bulletin/0810bulletin.htm).

Copayments

Medicaid recipients were also notified that effective November 1, 2010, a copayment of up to $3.00 will be charged for clinic and outpatient services. For non-emergency visits to a hospital emergency room, the copayment amount will be increased to $6.00. Local health department visits and outpatient behavioral health services will also be subject to copayments.

Behavioral Health

Beginning January 1, 2011, only providers certified as a Critical Access Behavioral Health Agency (CABHA) may be reimbursed for the provision of Community Support Team, Intensive In-Home, and Day Treatment services provided to Medicaid and N.C. Health Choice recipients. Recipients were instructed that

- If their provider agency is certified as a CABHA on or before December 31, 2010, they may continue to receive these services from their current provider and nothing will change.
- If their provider agency is not planning to become a CABHA, they are strongly encouraged to consider choosing a new provider agency that is or will be certified as a CABHA before December 31, 2010.

Recipients were also told that

- Community Support Team services are limited to 32 hours every 60 days not to exceed six months per calendar year.
- Prior authorization of outpatient behavioral health services for children is required after the 16th visit. (Previously, prior authorization was not required until after the 26th visit.)
- Community Support Services – Child and Adult will be eliminated on December 31, 2010.

For more information about CABHAs, providers may refer to the CABHA Services web page at http://www.ncdhhs.gov/dma/services/cabha.htm.

Personal Care Services

Medicaid recipients were notified that in-home personal care services (PCS) and PCS-Plus are scheduled to be replaced in 2011 with two new in-home care services. The two new programs are

- In-Home Care for Children (IHCC), which will provide personal assistance to individuals under the age of 21 years who qualify for the services; and
- In-Home Care for Adults (IHCA), which will provide personal assistance to individuals aged 21 years and older who qualify for services.

Dental Services

The August 2010 recipient notice also indicated that effective November 1, 2010, Medicaid will no longer cover the following services for Medicaid recipients under the age of 21 years, unless these services are needed to "correct or ameliorate a defect or physical or mental illness or condition" under EPSDT:

1. A full mouth series of x-rays taken on children under age 6 except when the service is rendered in the hospital or ambulatory surgical center setting.
2. Three bitewing x-rays taken on children under the age of 13 years.

Clinical Policy and Programs
DMA, 919-855-4100

Attention: All Providers

Prosecution for Fraudulent Activities

Heritage Home Care co-owners, Kristie Brake and Kimberly Miles, were found guilty in Federal Court ending an investigation initiated by DMA's Program Integrity Section, and referred to the Medicaid Investigations Unit (MIU), involving submission of over 15, 000 fraudulent Medicaid claims. Brake and Miles submitted fraudulent Personal Care Services (PCS) claims totaling $622,405.89.

The N.C. Attorney General's Office found that Heritage Home Care

- Claimed to provide PCS to a recipient who had died.
- Billed for a recipient who had moved hundreds of miles away from Alleghany County.
- Falsified in-home aides' time sheets.
- Submitted fraudulent nursing assessments.
- Forged physician signatures.
- Paid close relatives of PCS recipients to be their in-home aides.
- Paid bonuses to in-home aides for referrals of PCS clients.

The co-owners of Heritage Home Care were sentenced by the U.S. District Court for Western North Carolina to 46 months imprisonment each, repayment of the $622,405.89, and termination from the N.C. Medicaid Program.

Brenda Jordan-Choate, Program Integrity
DMA, 919-647-8000

Attention: All Providers

Medicare and Medicaid Health Information Technology: Title IV of the American Recovery and Reinvestment Act

Background

On February 17, 2009, President Obama signed the American Recovery and Reinvestment Act of 2009 (Recovery Act), a critical measure to stimulate the economy. Among other provisions, the new law provides major opportunities for the Department of Health and Human Services (DHHS), its partner agencies, and the states to improve the nation's health care through health information technology (HIT) by promoting the meaningful use of electronic health records (EHR) via incentives. On July 13, 2010, the Final Rule implementing the Medicare and Medicaid incentive payments provisions of the Recovery Act was published by CMS. It was also published in the July 28, 2010, Federal Register. A copy of that rule can be found on DMA's website at http://www.ncdhhs.gov/dma/provider/ehr.htm.

The HIT provisions of the Recovery Act are found primarily in Title XIII, Division A, Health Information Technology, and in Title IV, Division B, Medicare and Medicaid Health Information Technology. These titles together are cited as the Health Information Technology for Economic and Clinical Health Act or the HITECH Act. This article focuses on the Medicaid provisions of Title IV only.

Funding

Under Title IV, funding is available to certain eligible professionals (EPs) and hospitals, as described below. Funds will be distributed through Medicaid incentive payments to EPs, physicians, and hospitals who Adopt, Implement or Upgrade a certified EHR system in application year one and who meet "meaningful EHR use" in subsequent years. In addition, federal matching funds are available to states to support their administrative costs associated with these provisions.

Criteria for Qualifying for an Incentive

The qualification criteria for incentives (i.e., meeting specified HIT standards, policies, implementation specifications, timeframes, and certification requirements) were published on July 13, 2010, in the Final Rule. Funds may be distributed through N.C. Medicaid to eligible providers and hospitals as early as January 2011.

Additional Information

Frequently asked question (FAQs) on the Final Rule are available on DMA's website at http://www.ncdhhs.gov/dma/provider/ehr.htm. These questions and answers provide an excellent overview of the main provisions of the Medicaid Providers EHR Incentive Program. Additional FAQs are available on the CMS website at http://questions.cms.hhs.gov/app/answers/list/p/21,26,1058.

James Hazelrigs, MITA Manager
DMA, 919-647-8394
NCMedicaid.HIT@dhhs.nc.gov

Attention: All Providers

Payment Error Rate Measurement in North Carolina

In compliance with the Improper Payments Information Act of 2002, CMS implemented a national Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid Program and the State Children's Health Insurance Program (SCHIP). North Carolina has been selected as 1 of 17 states required to participate in PERM reviews of Medicaid fee-for-service and Medicaid Managed Care claims paid in federal fiscal year 2010 (October 1, 2009, through September 30, 2010). The PERM SCHIP program will not be participating in the 2010 PERM measurement.

CMS is using two national contractors to measure improper payments. The statistical contractor, Livanta, will coordinate 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, will be communicating directly with providers and requesting medical record documentation associated with the sampled claims. Providers will be required to furnish the records requested by the review contractor within a timeframe specified in the medical record request letter.

It is anticipated that A+ Government Solutions will begin requesting medical records for North Carolina's sampled claims in August 2010. Providers are urged to respond to these requests promptly with timely submission of the requested documentation.

Providers are reminded of the requirement listed in Section 1902(a)(27) of the Social Security Act 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 claimed by the provider rendering services.

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Clarification of Bariatric Surgery Requirements

The August 2010 Medicaid Bulletin article titled *Elimination of Coverage for Bariatric Surgery* outlined the conditions that must be met in order to allow a recipient who had met with a surgeon and began participating in the surgeon's surgical preparatory regimen prior to July 1, 2010, to complete the program and obtain the surgery. This instruction has been clarified to indicate that a recipient who began participating in a surgical preparatory regimen but had not yet met with their surgeon prior to July 1, 2010, will be allowed to meet with their surgeon and to complete the program under the conditions outlined in the August bulletin article.

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

Attention: All Providers

Medicaid Integrity Contractors Audit

The Deficit Reduction Act of 2005 created the Medicaid Integrity Program (MIP) and dramatically increased the federal government's role and responsibility in combating Medicaid fraud, waste, and abuse. Section 1936 of the Social Security Act (the Act) requires CMS to contract with eligible entities to review and audit Medicaid claims, to identify overpayments, and to provide education on program integrity issues. Additionally, the Act requires CMS to provide effective support and assistance to states to combat Medicaid provider fraud and abuse.

CMS created the Medicaid Integrity Group (MIG) in July 2006 to implement the MIP. As a result of this action, the Medicaid Integrity Contractors (MIC) audit was developed. Section 1936 of the Act requires CMS to enter into contracts to perform four key program integrity activities:

- review provider actions;
- audit claims;
- identify overpayments; and
- educate providers, managed care entities, beneficiaries, and others with respect to payment integrity and quality of care.

CMS has awarded contracts to several contractors to perform the functions outlined above. The contractors are known as the MICs. There are three types of MICs:

- **The Review MIC.** The Review MIC analyzes Medicaid claims data to identify aberrant claims and potential billing vulnerabilities, and provides referrals to the Audit MIC. Thomson Reuters is the Review MIC for North Carolina.
- **The Audit MIC.** The Audit MIC conducts post-payment audits of all types of Medicaid providers and identifies improperly paid claims. The Audit MIC for North Carolina is Health Integrity.
- **The Education MIC.** Education MICs work with the Review and Audit MICs to educate health care providers, State Medicaid officials, and others about a variety of Medicaid program integrity issues. There are two Education MICs:
  - Information Experts
  - Strategic Health Solutions

The objectives of the MIC audit are to ensure that claims are paid

- for services provided and properly documented;
- for services billed using the appropriate procedure codes;
- for covered services; and
- in accordance with federal and state laws, regulations, and policies.

MIC Audit Process

1. **Identification of potential audits through data analysis.** The MIG and the Review MICs examine all paid Medicaid claims using the Medicaid Statistical Information System. Using advanced data mining techniques, MIG identifies potential areas that are at risk for overpayments that require additional review by the Review MICs. The Review MICs, in turn, identify specific potential provider audits for the Audit MICs on which to focus their efforts. This data-driven approach to identifying potential overpayments helps ensure that efforts are focused on providers with truly aberrant billing practices.
2. **Vetting potential audits with the state and law enforcement.** Prior to providing an Audit MIC with an audit assignment, CMS vets the providers identified for audit with state Medicaid agencies, state and federal law enforcement agencies, and Medicare contractors. Vetting is the process whereby CMS provides a list of potential audits generated by the data analysis mentioned above. If any of these agencies are conducting audits or investigations of the same provider for similar billing issues, CMS may elect to cancel or postpone the MIC audit to avoid duplicating efforts.

3. **Audit MIC receives audit assignment.** CMS forwards the list of providers to be reviewed to the Audit MIC after the vetting process is completed. The Audit MIC immediately begins the audit process. CMS policy is that the audit period, also known as the "look back" period, should mirror that of the state that paid the provider's claims.

4. **Audit MIC contacts provider and schedules entrance conference.** The Audit MIC mails a notification letter to the provider. The notification letter
   - identifies a point of contact within the Audit MIC;
   - gives at least two-weeks' notice before the audit is to begin;
   - includes a records request outlining the specific records that the Audit MIC will be auditing; and
   - asks the provider to send the records to the Audit MIC for a desk audit. For a field audit, the provider must have the records available in time for the Audit MIC's arrival at the provider's office.

   The Audit MIC schedules an entrance conference to communicate all relevant information to the provider. The entrance conference includes a description of the audit scope and objectives.

5. **Audit MIC performs audit.** Most of the audits conducted by the Audit MIC are desk audits; however, the Audit MIC also conducts field audits in which the auditors conduct the audit on-site at the provider's location. Providers are given specific timelines in which to produce records. Because some audits will be larger in scope than others, provider requests for time extensions are seriously considered on a case-by-case basis. The audits are being conducted according to Generally Accepted Government Auditing Standards (http://www.gao.gov/govaud/ybk01.htm).

6. **Exit conference held and draft audit report is prepared.** At the conclusion of the audit, the Audit MIC will coordinate with the provider to schedule an exit conference. The preliminary audit findings are reviewed at this meeting. The provider has an opportunity to comment on the preliminary audit findings and to provide additional information if necessary. If the Audit MIC concludes, based on the evidence, that there is a potential overpayment, the Audit MIC prepares a draft report.

7. **Review of draft audit report.** The draft audit report is shared with CMS for approval and is provided to the state for review and comments. The report is then given to the provider for review and comment. The draft report may be subject to revision based on additional information and shared again with the state.

8. **Draft audit report is finalized.** Upon completion of this review process, the findings may be adjusted, either up or down, as appropriate based on the information provided by the provider and the state. The state's comments and concerns will also be given full consideration. CMS has the final responsibility for determining the final amount of any identified overpayment in any audit. At this point, the audit report is finalized.

9. **CMS issues final audit report to the state, triggering the "60-day" rule.** CMS sends the final audit report to the state. Pursuant to 42 CFR 433.316 (a) and (e), this action serves as CMS' official notice to the state of the discovery and identification of an overpayment. Under federal law, 42 CFR 433.12 (2), the state must repay the federal share of the overpayment to CMS within 60 calendar days, regardless of whether the state recovers or seeks to recover the overpayment from the provider.

10. **The state issues final audit report to provider and begins overpayment recovery process.** The state is responsible for issuing the final audit report to the provider. Each state must follow its respective administrative process in this endeavor. At this point, the provider may exercise whatever appeal or adjudication rights are available under state law when the state seeks to collect the overpayment amount identified in the final audit report.

Ten providers have completed MIC audits in North Carolina. To date, no errors have been reported.

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Basic Medicaid Seminars

Basic Medicaid seminars are scheduled for the month of October 2010 at the sites listed below. These seminars are intended to educate all providers on the basics of billing for N.C. Medicaid and will include the latest budget initiative requirements. The October 2010 *Basic Medicaid Billing Guide* is the primary document that will be referenced during the seminar. In addition, the seminar presentation will be posted on the DMA's website prior to the first seminar date.

You are welcome to print the Billing Guide and/or the slide presentation and follow along as we cover the material. Please note that the seminar presentation addresses the topics to be discussed and does not represent all of the information being presented. If preferred, you may download the Billing Guide and/or the slide presentation to a laptop and bring the laptop to the seminar. Or, you may access the Billing Guide and presentation online using your laptop during the seminar. **However, please note that HP Enterprise Services cannot guarantee a power source or Internet access for your laptop.**

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. Please bring your seminar confirmation with you to the seminar.

Providers may register for the seminars by completing and submitting the online registration form. Please include a valid e-mail address for your return confirmation. Providers may also register by fax using the form below (fax it to the number listed on the form). Please include a fax number or a valid e-mail address for your return confirmation. Confirmations will be sent within two business days of receiving the registration form. Please indicate on the registration form the session you plan to attend.

Sessions will begin at 9:00 a.m. and end at 4:00 p.m. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided at the seminars. However, there will be a scheduled lunch break. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Seminar Dates and Locations

Date	Location
October 12, 2010	**Lenoir** J.E. Broyhill Civic Center Caldwell Community College and Technical Institute 1913 Hickory Boulevard SE Lenoir NC 28645
October 13, 2010	**Greensboro** Clarion Hotel Greensboro Airport 415 Swing Road Greensboro NC 27409
October 19, 2010	**Greenville** Hilton Greenville 207 SW Greenville Boulevard Greenville NC 27834

Date	Location
October 20, 2010	**Raleigh** Wake Tech Community College Student Service Building Conference Center Second Floor, Rooms 212-215 9191 Fayetteville Road Raleigh NC 27603
October 27, 2010	**Charlotte** Crowne Plaza 201 South McDowell Street Charlotte NC 28204 **Note: Parking fee of $6.00 per vehicle for parking at this location.**

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

Registration Form

Basic Medicaid Workshops
October 2010 Seminar Registration Form
(No Fee)

Provider Name and Specialty _____

Medicaid Provider Number _____ NPI Number _____

Mailing Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail _____

Telephone Number (_____) _____ Fax Number _____

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

Please fax completed form to: 919-851-4014

Please mail completed form to:
HP Provider Services
P.O. Box 300009
Raleigh, NC 27622

Attention: All Providers

Medicaid Credit Balance Reporting

All providers participating in the Medicaid Program are required to submit a quarterly **Credit Balance Report** to the DMA Third-Party Recovery Section identifying balances due to Medicaid. Providers must report any **outstanding** credits owed to Medicaid that have not been reported previously on a Medicaid Credit Balance Report. However, hospital and nursing facility providers are required to submit a report every calendar quarter even if there are no credit balances. The report must be submitted no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30, and December 31).

The Medicaid Credit Balance Report is used to monitor and recover "credit balances" owed to the Medicaid Program. A credit balance results from an improper or excess payment made to a provider. For example, refunds must be made to Medicaid if a provider is paid twice for the same service (e.g., by Medicaid and a medical insurance policy, by Medicare and Medicaid, by Medicaid and a liability insurance policy) or if the patient liability was not reported in the billing process or if computer or billing errors occur.

For the purpose of completing the report, a Medicaid Credit Balance is the amount determined to be refundable to the Medicaid Program. When a provider receives an improper or excess payment for a claim, it is reflected in the provider's accounting records (patient accounts receivable) as a "credit." However, credit balances include money due to Medicaid regardless of its classification in a provider's accounting records. If a provider maintains a credit balance account for a stipulated period (e.g., 90 days) and then transfers the account or writes it off to a holding account, this does not relieve the provider of liability to the Medicaid Program. The provider is responsible for identifying and repaying all monies owed the Medicaid Program.

The Medicaid Credit Balance Report requires specific information for each credit balance on a claim-by-claim basis. The reporting form provides space for 15 claims but may be reproduced as many times as necessary to accommodate all the credit balances being reported. Specific instructions for completing the report are on the reverse side of the reporting form.

Submitting the Medicaid Credit Balance Report does not result in the credit balances automatically being reimbursed to the Medicaid Program. **Electronic adjustments are the preferred method of satisfying the credit balances and can be performed through the North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool. Refer to the February 2010 Medicaid Bulletin article, titled *Adjusting North Carolina Medicaid Claims Electronically*, on DMA's website at http://www.ncdhhs.gov/dma/bulletin/ for specific filing instructions.**

In the event, a billing error caused an individual provider to be paid for a service in which a provider group should have been paid, a refund check will need to be sent to HP Enterprise Services to correct the error as it is unlikely the individual provider will have future claims to adjust. In these circumstances only, a check must be made payable to HP Enterprise Services and sent to HP Enterprise Services using the **Medicaid Provider Refund Form** (http://www.ncdhhs.gov/dma/provider/forms.htm). The information on the form must be complete and accurate in order to process the provider refund check.

Submit the Medicaid Credit Balance Report Form to:	Electronic Adjustments using the North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool	Submit Refund Checks to:
Third Party Recovery Section Division of Medical Assistance 2508 Mail Service Center Raleigh NC 27699-2508	**Refer to the February 2010 Medicaid Bulletin article titled, *Adjusting North Carolina Medicaid Claims Electronically*, (http://www.ncdhhs.gov/dma/bulletin/)**	HP Enterprise Services Refunds P.O. Box 30968 Raleigh NC 27622 (**Do not** send these refund checks to DMA or to the Controller's Office.)

Submit **only** the completed Medicaid Credit Balance Report to DMA. **Failure to submit a Medicaid Credit Balance Report to DMA will result in the withholding of Medicaid payment until the report is received.**

Send to DMA:

- The **original** completed Medicaid Credit Balance Report.
- Please circle "Adjustment" at bottom of original credit balance report to indicate an electronic adjustment has been performed. (**Note:** You may circle "Refund" in the event a check must be sent due to the reason stated above).

Send to HP Enterprise Services Refunds Department:

- Always send **live credit balance refund check(s)** to the HP Enterprise Services refunds address listed in this bulletin.
- Enclose a copy of the Medicaid Credit Balance Report associated with the refund.
- Please circle "Refund" at the bottom of the copy of the Medicaid Credit Balance Report.
- Include a completed **Medicaid Provider Refund Request Form** to ensure that HP Enterprise Services can appropriately document individual refund amounts.

A copy of the Medicaid Credit Balance Report form follows this article. The Medicaid Provider Refund Form and the Medicaid Credit Balance Report form are also available on DMA's website at http://www.ncdhhs.gov/dma/provider/forms.htm.

Debbie Odette, Third Party Recovery Section
DMA, 919-647-8100

Instructions for Completing Medicaid Credit Balance Report

Complete the "Medicaid Credit Balance Report" as follows:

- **Full name of facility as it appears on the Medicaid Records**
- **The facility's Medicaid provider number**. If **the facility has more than one provider number, use a separate sheet for each number. DO NOT MIX**
- **Circle the date quarter end**
- **Enter year**
- The name and telephone number of the person completing the report. This is needed in the event DMA has any questions regarding some item in the report

Complete the date fields for each Medicaid balance by providing the following information:

Column 1 – The last name and first name of the Medicaid recipient (e.g., Doe, Jane)

Column 2 – The individual Medicaid identification (MID) number

Column 3 – The month, day, and year of beginning service (e.g., 12/05/03)

Column 4 – The month, day, and year of ending service (e.g., 12/10/03)

Column 5 – The R/A date of Medicaid payment (not your posting date)

Column 6 – The Medicaid ICN (claim) number

Column 7 – The amount of the credit balance (not the amount your facility billed or the amount Medicaid paid)

Column 8 – The reason for the credit balance by entering: "81" if it is a result of a Medicare payment; "83" if it is the result of a health insurance payment; "84" if it is the result of a casualty insurance/attorney payment or "00" if it is for another reason. Please explain "00" credit balances on the back of the form.

After this report is completed, total column 7 and mail to **Third Party Recovery, DMA, 2508 Mail Service Center, Raleigh, NC 27699-2508.**

MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME:_____ CONTACT PERSON: _____
PROVIDER NUMBER: _____ TELEPHONE NUMBER: _____
QUARTER ENDING: (Circle one) 3/31 6/30 9/30 12/31 YEAR: _____

(1) RECIPIENT'S NAME	(2) MEDICAID NUMBER	(3) FROM DATE OF SERVICE	(4) TO DATE OF SERVICE	(5) DATE MEDICAID PAID	(6) MEDICAID ICN	(7) AMOUNT OF CREDIT BALANCE	(8) REASON FOR CREDIT BALANCE
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

Circle one: Refund Adjustment

Return form to: **Third Party Recovery**
DMA
2508 Mail Service Center
Raleigh, NC 27699-2508

Revised 10/07

Attention: All Providers

Urine Drug Screening

In response to CMS Change Request 6852, effective with date of service **April 1, 2010,** DMA end-dated CPT code 80101 and replaced it with HCPCS code G0431 (Drug screen, qualitative; single drug class method [e.g., immunoassay, enzyme assay], each drug class) for initial urine drug screenings. HCPCS code G0431 should be billed without a modifier by those clinical laboratories that do not require a CLIA certificate of waiver. Those clinical laboratories that do require a CLIA certificate of waiver should append modifier QW to the code.

HCPCS code G0430 has also been added. HCPCS code G0430 was created to limit billing to one time per procedure and to remove the limitation on the chromatographic method when it is not being used in the performance of the test. HCPCS code G0430 should be billed without a modifier by those clinical laboratories that do not require a CLIA certificate of waiver for a qualitative drug screening test for multiple drug classes that do not use chromatographic methods. Those clinical laboratories that do require a CLIA certificate of waiver should append modifier QW to the code when billing a qualitative drug screening test for multiple drug classes that do not use chromatographic methods.

Providers should use CPT code 80100 when performing a qualitative drug screening test for multiple drug classes that use chromatographic methods. Providers who received claim denials for CPT code 80101 with EOB 9 (service not covered by the Medicaid Program) from April 1, 2010, will need to resubmit new claims for processing with HCPCS code G0431 or G0431 QW, as appropriate.

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

Attention: All Providers

Enrollment Fee Update

As of September 1, 2009, per Session Law 2009-451, a $100 enrollment fee is collected from providers upon initial enrollment with the N.C. Medicaid Program and at 3-year intervals when providers are re-credentialed. Upon receipt of your enrollment application, an invoice will be mailed to you if the fee is owed. An invoice will only be issued if the tax identification number in the enrollment application does not identify the applicant as a currently enrolled Medicaid provider. **APPLICANTS SHOULD NOT SUBMIT PAYMENT WITH THEIR APPLICATION.**

Payment is due immediately upon receipt of an invoice for the enrollment fee. Payment should be remitted to the address on the invoice and not directly to CSC. Payment is accepted by check or money order made payable to DMA. Please make every effort to remit payment promptly. Applications will not be processed if payment is not received. If payment is not received after 30 days, your application will be voided.

CSC, 1-866-844-1113

Attention: Private Duty Nursing Providers

Code Changes for Hourly Nursing Services

Effective with date of service November 1, 2010, a modifier will be required when billing HCPCS code T1000 for private duty nursing (PDN). The modifier will be used to indicate the respective level of care provided to the recipient, either RN or LPN. The codes and maximum reimbursement rates are indicated below.

Code with Modifier	Description	Billing Unit	Maximum Reimbursement Rate
T1000 TD	In-Home Nurse Care – RN	1 unit = 15 minutes	$ 9.18
T1000 TE	In-Home Nurse Care – LPN	1 unit = 15 minutes	$ 7.81

Effective November 1, 2010, claims submitted for HCPCS code T1000 will be denied if the TD or TE modifier is not appended to the code.

Prior approval by DMA PDN Nurse Consultants and signed physician orders are required per usual protocol.

A new code will be added to the fee schedule for PDN providers to use when billing for congregate (multi-recipient) services. Multi-recipient nursing is defined as a single nurse providing hourly skilled nursing care to two or more Medicaid recipients during the same hours and in the same private primary residence. The code for multi-recipient nursing, G0154, shall be used to bill for services where DMA has authorized congregate nursing care. The modifiers TE or TD, as applicable, are required when billing this code.

Congregate PDN should be provided when more than one hourly nursing recipient (PDN or CAP/C) resides in the same home. Congregate PDN shall be limited to a maximum ratio of one private duty nurse to two individuals who receive hourly nursing services.

Agencies currently providing more than one nurse per recipients' household should contact DMA PDN consultants by November 1, 2010, to develop a transition plan for congregate nursing care. An individual review will be used to determine the medical necessity for each recipient and PDN services will be approved accordingly.

Code with Modifier	Description	Billing Unit	Maximum Reimbursement Rate
G0154 TD	Congregate/Multiple Recipient Care - RN	1 unit = 15 minutes	$ 6.89
G0154 TE	Congregate/Multiple Recipient Care - LPN	1 unit = 15 minutes	$ 5.86

It is the responsibility of the home care provider to ensure appropriate delegation and supervision of nursing activities in accordance with the North Carolina Nursing Practice Act, G.S. Chapter 90, Article 9A, and Home Care Licensure Rules. This includes appropriate acceptance of clients and ensuring that the agency has trained and experienced nursing personnel to meet the nursing needs of the recipient as authorized by the physician.

It is also the responsibility of the home care agency to adhere to the CAP Service Authorization as outlined by the CAP/C case manager with regard to approved hours.

As a reminder, PDN nursing services shall not duplicate other services in the home such as home infusion therapy, home health skilled nursing and respiratory therapy. Refer to Clinical Coverage Policy 10D (http://www.ncdhhs.gov/dma/mp/) for recently published limitations on respiratory therapy services provided by independent practitioners.

Teresa Piezzo, Home and Community Care
DMA, 919-855-4380

Attention: CAP/C Case Managers, CAP/C Service Providers, and Hospice Services

CAP/C Waiver Renewal

CMS has granted approval for N.C. Medicaid's Community Alternatives Program for Children (CAP/C) waiver program for an additional 5 year period beginning July 1, 2010. The new coverage policy for CAP/C, Clinical Coverage Policy 3K-1, will be implemented effective with date of service October 1, 2010. The policy will be available on October 1, 2010, on the CAP/C Services web page at http://www.ncdhhs.gov/dma/services/capc.htm.

The following changes in the CAP/C Program are to be implemented with date of service effective October 1, 2010 (unless otherwise noted):

- Effective July 1, 2010, the age range for CAP/C recipients has been expanded through 20 years of age. Eligibility ends prior to the recipient's 21st birthday.
- CAP/C will have only two levels of care, **nursing facility** (SC) and **hospital** (HC) levels of care. The term intermediate level of care (IC) has been eliminated. The current IC recipients will be renamed as nursing facility (SC) level of care. Effective July 1, 2010, the fiscal agent will only approve nursing facility level of care rather than the distinguishing between "intermediate" and "skilled" levels of care.
- The DMA CAP/C Nurse Consultant will continue to approve the hospital level of care.
- Cost neutrality will be monitored on a statewide "aggregate" budget limit rather than individual monthly budget limits. Each service will have a monetary limit and the cost of care will be monitored closely for utilization based on individual needs.
- There are several new administrative requirements and limitations.
    - ♦ The Continuing Needs Review (CNR) due date will be the recipient's birth month.
    - ♦ A mid-year review will be required for participants who receive in-home nurse aide or nursing care and whose waiver budget exceeds $30,000 per year and $135,000 per year respectively.
    - ♦ Qualifications for case managers and providers have changed.
    - ♦ A new Quality Assurance Framework has been developed for the July 1, 2010, to June 30, 2011, year.

The following services have been added or changed, effective with date of service October 1, 2010, unless otherwise noted. Complete service definitions, including criteria and limitations, can be found in Clinical Coverage Policy 3K-1. The document can be accessed from the CAP/C Services web page at http://www.ncdhhs.gov/dma/services/capc.htm.

Service and Procedure Code	Description	Maximum Reimbursement Rate
CAP/C Pediatric Nurse Aide T1019	Personal care services, per 15 minutes. Not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment	$ 4.74 per 15 minutes
Home Modifications S5165	Home modifications; per service	as quoted within max limits $10,000 over life of waiver

Service and Procedure Code	Description	Maximum Reimbursement Rate
CAP/C Nursing – RN T1000 TD **effective 11/1/2010**	Private duty/independent nursing service(s), licensed, up to 15 minutes	$ 9.18 per 15 minutes
CAP/C Nursing – LPN T1000 TE **effective 11/1/2010**	Private duty/independent nursing service(s), licensed, up to 15 minutes	$ 7.81 per 15 minutes
Respite Care, In-Home RN T1005 TD **effective 11/1/2010**	Respite care services, up to 15 minutes	$ 9.18 per 15 minutes
Respite Care, In-Home LPN T1005 TE **effective 11/1/2010**	Respite care services, up to 15 minutes	$ 7.81 per 15 minutes
In-Home Attendant Care T2027	Specialized childcare, waiver; per 15 minutes	$ 2.37 per 15 minutes
Motor Vehicle Modifications T2039	Vehicle modifications, waiver; per service	as quoted within max limits $15,000 over life of waiver
Adaptive Tricycles T2029	Specialized supply, not otherwise specified, waiver	as quoted within max limits $600 over waiver year
Caregiver Training and Education S5110	Home care training, family; per 15 minutes	$ 8.53 per 15 minutes
Palliative Care – Counseling 99510	Home visit for individual, family, or marriage counseling; per visit	$ 71.04 per visit
Palliative Care – Bereavement Counseling S5111	Home care training, family; per session; per visit, one time only	$ 71.04 per visit
Palliative Care – Expressive Therapy S5108	Home care training to home care client, per 15 minutes	$ 5.51 per 15 minutes
Community Transition Funding T2038	Community transition, waiver; per service	as quoted within max limits
Congregate CAP/C Nursing – RN G0154 TD **effective 11/1/2010**	Services of skilled nurse in home health, or nurse in hospice settings, each 15 minutes	$ 6.89 per 15 minutes
Congregate CAP/C Nursing – LPN G0154 TE **effective 11/1/2010**	Services of skilled nurse in home health, or nurse in hospice settings, each 15 minutes	$ 5.86 per 15 minutes

The following CAP/C procedure codes remain in effect and are unchanged by the new waiver.

Service and Procedure Code	Description	Maximum Reimbursement Rate
CAP/C Case Management T1016	Case management, each 15 minutes	$ 14.43 per 15 minutes
CAP/C Case Management T1016 SC	Case management – extra for CNR/Reauthorization/Crisis/Emergency, each 15 minutes	$ 14.43 per 15 minutes

Service and Procedure Code	Description	Maximum Reimbursement Rate
Attendant Care Services S5125	CAP/C Personal Care Service	$ 3.54 per 15 minutes
Respite Care Institutional H0045	Respite care services, not in the home	$211.20 per diem
Respite care In-Home/Aide Level S5150	Unskilled respite care, not hospice	$ 3.54 per 15 minutes
Disposable Liner/Shield/Guard/Pad/ Undergarment, for Incontinence T4535	Disposable liner/shield for incontinence	$ 0.34 each
Incontinence Product, Diaper/Brief, Reusable, Any Size T4539	Incontinence product, diaper/brief, reusable, any size	$ 21.22 each

Effective November 1, 2010, claims submitted for the following HCPCS codes will be denied:

- T1000, if the TD or TE modifier is not appended to the code
- T1005, if the TD or TE modifier is not appended to the code

Provider Requirements

All CAP providers must apply for and be enrolled as a Medicaid provider with N.C. Medicaid to qualify for reimbursement of CAP services. To qualify for reimbursement for new services, existing CAP/C providers must complete a CAP Addendum to Add Services. Provider enrollment information and the application are available at http://www.nctracks.nc.gov/provider/providerenrollment/index.jsp. Please call the EVC Call Center at 1-866-844-1113 for questions regarding enrollment.

Currently enrolled CAP/C case management providers will need to add Vehicle Modifications, Community Transition Funding, and Caregiver Training and Education to their enrollment package. Hospice providers may enroll as a CAP provider in order to provide Palliative Care Services. Qualified home care providers may add Attendant Care, Pediatric Nurse Aide Care, Congregate Care, and Medical Supplies (PDN providers only) to their CAP enrollment package.

Reimbursement to Providers

The fee schedule for the waiver services is located on DMA's website at http://www.ncdhhs.gov/dma/fee/. Providers are reminded to bill their usual and customary rates for all billing. Do not automatically bill the established maximum reimbursement rate. Payment will be the lesser of either the billed usual and customary rate or the maximum reimbursement rate.

Providers may not directly submit billing for any expense for home modifications, vehicle modifications, community transition funding, or caregiver training and education. All requested items **must** go through the individual's case manager for inclusion in the plan of care, which must clearly state defined goals and outcomes related to use for the item.

Teresa Piezzo, Home and Community Care
DMA, 919-855-4380

Attention: CCNC/CA Providers

Carolina ACCESS Provider Management Reports

DMA's Managed Care Section produces reports to help participating primary care providers (PCPs) manage the care of their enrolled Medicaid patients. Currently, the following reports are printed on paper and mailed to each PCP:

- Referral Report for Carolina ACCESS Primary Care Providers
- Primary Care Providers Emergency Room Management Report
- Carolina ACCESS Quarterly Utilization Report

Effective September 1, 2010, DMA no longer prints and mails these reports. Providers can view and download these reports via a secure web portal. To access the portal, providers must complete and submit the Provider Confidential Information and Security Agreement, which can be found on DMA's website at http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm. The Agreement must be signed with an original signature and mailed to DMA.

At this time, the Carolina ACCESS Provider Enrollment Report will continue to be printed on paper and mailed. Providers can also access their enrollment report via the web portal. For questions about any of the managed care reports, contact your managed care consultant. A list of the consultants and contact information can be found on DMA's website at http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm.

Managed Care
DMA, 919-855-4780

Attention: All Providers

Clinical Coverage Policies

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

- 1M-1, *Child Service Coordination*
- 1M-4, *Home Visit for Newborn Care and Assessment*
- 1M-5, *Home Visit for Postnatal Assessment and Follow-Up Care*
- 1M-8, *Maternity Care Coordination*
- 3K-1, *Community Alternatives Program for Children (CAP/C)*
- 12B, *Human Immunodeficiency Virus Case Management*

These policies supersede previously published policies and procedures. Providers may contact HP Enterprise Services at 1-800-688-6696 or 919-851-8888 with billing questions.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: Pharmacists and Prescribers

Substitution of Preferred Brand Drugs

N.C. General Assembly Session Law 2010-31, Section 10.58. (d)(28) allows the Secretary of Health and Human Services to prevent substitution of a generic equivalent drug, including a generic equivalent that is on the State Maximum Allowable Cost (SMAC) list, when the net cost to the State of the brand-name drug, after consideration of all rebates, is less than the cost of the generic equivalent. Generic drugs are usually considered preferred. However, with the implementation of the next phase of the N.C. Medicaid Preferred Drug List, on September 15, 2010, the following four brand drugs will be considered preferred instead of their generic equivalents:

- Duragesic Patches
- Hyzaar
- Cozaar
- BenzaClin

N.C. Medicaid will remove the SMAC from these drugs when applicable. Prescribers will not need to write "medically necessary" on the face of the prescription for coverage of these drugs. Pharmacists will not need to enter a DAW "1" on the point-of-sale claims when dispensing these drugs.

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

Attention: Pharmacists and Prescribers

Substitution for Duoneb and Insulin Cartridges and Pens

With the implementation of the N.C. Medicaid Preferred Drug List changes on September 15, 2010, Duoneb (combination ipratropium and albuterol nebulizer solution) and some insulin cartridges and pens will have a non-preferred status on the N.C. Medicaid Preferred Drug List. On June 15, 2010, the N.C. Board of Pharmacy agreed that pharmacists may

1. Substitute equivalent strength individual nebulizer dosage forms of albuterol sulfate and ipratropium bromide for Duoneb.
2. Substitute vial-packaged insulin products for cartridge, pen or similarly packaged insulin products.

The pharmacist will not be required to obtain a new prescription in these circumstances when substitution is allowed. The Board reminded pharmacists that patient counseling and education on appropriate usage is very important. A copy of the June 15, 2010, N.C. Board of Pharmacy communication can be found on the DMA website at http://www.ncdhhs.gov/dma/pharmacy.

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

Attention: Pharmacists

Point-of-Sale Overrides for Leukotrienes, Statins, Orally Inhaled Steroids, and Second Generation Anticonvulsants

With the implementation of the N.C. Medicaid Preferred Drug List changes on September 15, 2010, pharmacists will be able to override a point-of-sale message that prior authorization (PA) is required for leukotrienes, statins, orally inhaled steroids, and second generation anticonvulsants (for seizure disorders only). If the prescriber has indicated that the PA criteria have been met, by writing "Meets PA Criteria"on the face of the prescription in his or her own handwriting, the pharmacist will be able to override the PA edit for these drugs. **This information may also be entered in the comment block on e-prescriptions.**

If the prescribed drug in one of these drug classes has a generic version available, "medically necessary" must also be written on the face of the prescription in the prescriber's own handwriting in order to dispense the brand name drug. A "1" in the PA field (461-EU) or a "2" in the submission clarification field (420-DK) will override the PA edit. These overrides will be monitored by Program Integrity.

Providers may also contact ACS at 1-866-246-8505 (telephone) or 1-866-246-8507 (fax) to request PA for these medications. The PA criteria and request form for these drug classes will be available early September 2010, on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com. If the PA is approved by ACS, the POS override codes will not be needed.

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

Attention: Pharmacists and Prescribers

Policies for Emend, Leukotrienes, Lidoderm, Orally Inhaled Corticosteroids, Statins, and Suboxone and Revised Policies for CII Narcotic Analgesics and Second Generation Anticonvulsants

Six new prior authorization (PA) policies and two revised PA policies will be implemented with the N.C. Medicaid Preferred Drug List changes on September 15, 2010. The new PA policies are for Emend, leukotrienes, lidoderm, orally inhaled corticosteroids, statins, and Suboxone. Specific clinical criteria must be met before these drugs can be covered by N.C. Medicaid. In addition, two of the existing PA policies were revised. The revised PA policies are for schedule II narcotic analgesics and second generation anticonvulsants. These new and revised policies will be posted early September 2010 on the N.C. Medicaid Enhanced Pharmacy Program website at http://www.ncmedicaidpbm.com/.

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

Attention: Orthotics and Prosthetics Providers

Changes to HCPCS Code S1040

A rate has been established for HCPCS code S1040. Previously, this code was manually priced.

Refer to Clinical Coverage Policy 5B, *Orthotics and Prosthetics*, on DMA's website (http://www.ncdhhs.gov/dma/mp/) for detailed coverage information.

HCPCS code S1040 will be added to the O&P Fee Schedule effective with date of service September 1, 2010. Providers are reminded to bill their usual and customary rates.

HCPCS Code	Orthotic and Prosthetic Devices Description	Maximum Rate
S1040	Cranial remolding orthotic, pediatric, rigid, with soft interface material, custom fabricated, includes fitting and adjustment(s).	$2,778.00

Consistent with the N.C. Medicaid State Plan, there shall be no retroactive payment for fee changes.

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

Attention: HIV Case Management Providers

Implementation of HIV Case Management Policy

The revised policy for HIV Case Management services will be implemented effective October 1, 2010. Clinical Coverage Policy 12B can be accessed on the DMA website at http://www.ncdhhs.gov/dma/mp/. Many of the functions addressed in the policy will be the responsibility of the new vendor, The Carolinas Center for Medical Excellence (CCME). Implementation of those policy changes that are dependent upon the new vendor being fully operational will be delayed somewhat as we work towards assuring a good transition. Also, please be advised that due to the numerous changes in the requirements for certification, DMA is restructuring the certification process. All providers who are currently certified to provide HIV Case Management and enrolled with DMA will be required to complete a new application and undergo the certification process. Until all changes have been implemented, providers should continue to operate under their current certification. Any existing applications or future applications for new HIV Case Management providers will be reviewed under the new requirements recently approved by CMS and documented in Clinical Coverage Policy 12B. DMA will announce in upcoming Medicaid Bulletin articles when the new application process will begin. Until contact information is provided for CCME, please continue to direct any questions to Victoria Landes, HIV Program Consultant at DMA, 919-855-4389.

Victoria Landes, Clinical Policy
DMA, 919-855-4389

Attention: Nurse Practitioners and Physicians

Denosumab Injection (Prolia, HCPCS Code J3590): Billing Guidelines

Effective with date of service June 5, 2010, the N.C. Medicaid Program covers denosumab (Prolia) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologics). Prolia is available in a 60-mg/1-ml prefilled syringe.

Prolia is indicated for the treatment of osteoporosis in postmenopausal women with a high risk for fracture, defined as a history of osteoporotic fracture, or multiple risk factors for fracture; or male or female patients who have failed or are intolerant to other available osteoporosis therapies.

Prolia should be administered in 60-mg doses as a single subcutaneous injection in the upper arm, upper thigh or abdomen, once every six months. Prolia should be administered by a health care professional.

For Medicaid Billing

- One of the following ICD-9-CM diagnosis codes is required for billing Prolia:
  - 733.00 Osteoporosis, unspecified; or
  - 733.01 Senile osteoporosis, postmenopausal osteoporosis; or
  - 733.09 Osteoporosis, other.
- Providers must bill Prolia with HCPCS code J3590 (unclassified biologics).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage is one 60-mg/1-ml prefilled syringe. The maximum reimbursement rate per 60-mg dose is $858.83.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Prolia should be reported in "MLs." To bill for the entire 60-mg/1-ml injection of Prolia, report the NDC units as "ML1." If the drug was purchased under the 340-B drug pricing program, place a UD modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III,* on DMA's website (http://www.ncdhhs.gov/dma/bulletin/) for additional instructions.
- Providers must bill their usual and customary charge.

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

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

Attention: Pharmacists and Prescribers

Coverage of Over-the-Counter Second Generation Antihistamine and Decongestant Combinations

Effective with date of service September 15, 2010, the N.C. Medicaid Outpatient Pharmacy Program will begin coverage of over-the-counter (OTC) second generation antihistamine and decongestant combination products. Products included are cetirizine-D OTC, loratadine-D OTC 12 hour, and loratadine-D OTC 24 hour. With a valid prescription, a recipient may receive up to a 102-days supply per 12 months.

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

Attention: Critical Access Behavioral Health Agencies

Update on Mental Health/Substance Abuse Targeted Case Management

Mental Health/Substance Abuse Targeted Case Management (MH/SA TCM) was implemented effective with date of service July 1, 2010, with a weekly case rate of $81.25.

The procedure code for MH/SA TCM is H0032 and the billing limit is one unit per week (Sunday through Saturday). Prior approval is required for this service. In order to bill this weekly rate, case managers must provide at least 15 minutes of case management activity (assessment, person centered plan [PCP] development, linkage/referral, monitoring) per week. The case manager is expected to provide all services necessary to meet the case management needs of the recipient. It is the expectation that many recipients will require more than 15 minutes of case management activity per week. With the weekly case rate, a provider may only bill once per week, although a case manager might provide services for a recipient multiple times in a week. Providers should not bill for each 15 minute contact. Providers should not bill over a span of dates. Providers may bill only once (one date) per week when at least 15 minutes of case management activity have been achieved. For example, if a case manager has a 15-minute contact with a recipient on Monday, the provider may bill the weekly rate for that week on Monday. If the case manager provides additional case management services throughout that week, the provider cannot bill again for any date in that same week (Sunday through Saturday). The weekly case rate covers **ALL** case management activities for the week and all dates of service for that week. For audit and rate setting purposes, each contact must be documented and must include the amount of time spent during the contact. Per the service definition, a full service note for each contact, or a full service note for each date of service (if there are multiple contacts within a day), written and signed by the person(s) who provided the service, is required. Please see DMA Clinical Coverage Policy 8L (http://www.ncdhhs.gov/dma/mp/) for the full description of the service, including the full requirements of a service note.

Provider Enrollment Information

CSC will issue a statewide MH/SA TCM Medicaid Provider Number (MPN) to each certified and enrolled CABHA until site-specific enrollment can be achieved (more information on site-specific enrollment will be provided in future communications). CSC will contact those CABHAs that have already enrolled to assist with obtaining a statewide MH/SA TCM MPN. CSC will automatically link the MH/SA TCM MPN to the NPI associated with the CABHA MPN. If an already enrolled CABHA wishes to choose a different NPI for their MH/SA TCM MPN, they will need to submit a Medicaid Provider Change Form and a copy of the NPPES letter for that NPI to CSC. The MH/SA TCM MPN will be used to request prior authorization for the service. When billing, the CABHA NPI will be the billing provider number on the CMS-1500 claim, and the MH/SA TCM NPI will be the attending number on the claim. Unless they have indicated a different NPI for their MH/SA TCM MPN, both NPIs (billing and attending) will be the same on the claim form. CABHAs that have not yet enrolled must indicate on the enrollment application that they will be providing MH/SA TCM by checking "Targeted Case Management for Mental Health and Substance Abuse" on the enrollment application. They will need to indicate the NPI associated with MH/SA TCM in the space provided. This NPI can be the same as the NPI associated with the CABHA NPI or it can be a different NPI. If they do not indicate an NPI, CSC will automatically link their MH/SA TCM MPN to the NPI associated with their CABHA MPN. When a CABHA is issued a CABHA MPN, they will also be issued a statewide MH/SA TCM MPN. The updated downloadable enrollment application is available on the NC Tracks website (http://www.nctracks.nc.gov).

Prior Authorization

CABHAs may begin to request prior authorization for MH/SA TCM once they have received their MH/SA TCM MPN. Submission of authorization requests must follow one of two procedures:

1. CABHAs may submit a MH/SA TCM Attestation Letter (see page 27) for those recipients who were seen under a Community Support (CS) authorization **IF** service provided to those recipients followed all the MH/SA TCM policy guidelines, including those for entry criteria and service provision. Providers must submit an Attestation Letter for each CS recipient. All fields on the Attestation Letter must be completed or ValueOptions (VO) will return the form as "Unable to Process." The Attestation Letter must indicate the "start date" of MH/SA TCM services under the new MH/SA TCM MPN. The earliest "start date" for MH/SA TCM is July 1, 2010. Providers must also indicate the date at which the client should be "discharged" for CS under the Community Intervention Services Agency's (CISA) MPN. The earliest date of "discharge" for CS recipients is June 30, 2010. The Attestation Letter must be signed by the Qualified Professional Case Manager who provides services to the recipient. Upon receipt of the Attestation Letter, VO will end-date the CS authorization under the CISA MPN and begin the MH/SA TCM authorization under the new MH/SA TCM MPN. VO will end-date the MH/SA TCM authorization with the same end-date as the former CS authorization.

   Note: CABHAs may not submit Attestation Letters for recipients receiving CS from a different provider. CABHAs may not provide MH/SA TCM to a recipient receiving CS from another provider.

2. CABHAs may submit prior authorization requests for recipients new to case management services. These would be recipients who are not currently receiving the case management portion of Community Support Services. To request prior authorization for MH/SA TCM, providers must submit the ITR, PCP, and a signed service order. The CABHA should request prior authorization using the MH/SA TCM MPN on the ITR in the "Facility ID#" field. Authorizations will be made to the MH/SA TCM MPN and **NOT** to the CABHA MPN.

Claims Submission

System implementation for payment of the weekly rate for MH/SA TCM is expected to be completed by September 1, 2010. Providers should not submit claims for MH/SA TCM prior to September 1, 2010. In the interim weeks, providers may continue to provide and bill the case management component of CS if authorized for a recipient under the CISA MPN.

MH/SA TCM claims will always be billed using the professional (CMS-1500/837P) claim type. For claims submission, the NPI associated with the CABHA MPN will always be the "billing" number and the NPI associated with the MH/SA TCM MPN will always be the "attending" number. Providers must bill MH/SA TCM claims with dates of service that correspond with MH/SA TCM authorization dates. The billing limit is one unit per week, which runs from Sunday to Saturday. If the claim identifies a span of dates (e.g., August 2-6, 2010), the claim will be denied.

When a claim is submitted for MH/SA TCM, HP Enterprise Services will automatically recoup any payments for CS during any week (Sunday through Saturday) that the MH/SA TCM procedure code is billed. Claims will be recouped from the original CISA billing MPN that provided the service. The weekly unit may not be billed for any week in which there was no contact with the recipient. Services reimbursed will be subject to audit and recoupment if policy requirements were not met for that week.

Behavioral Health Unit
DMA, 919-855-4290

Mental Health/Substance Abuse Targeted Case Management

Letter of Attestation Of Recipient Eligibility

Mental Health/Substance Abuse Targeted Case Management is a service that assists recipients to gain access to necessary care: medical, behavioral, social, and other services appropriate to their needs. Case management is individualized, person centered, empowering, comprehensive, strengths-based, and outcome-focused. The functions of case management include:

- Case Management Assessment;
- Person Centered Planning;
- Referral/linkage; and
- Monitoring/follow-up.

As a current Medicaid TCM provider I attest to the following:

- I fully understand all the requirements of **Mental Health/Substance Abuse Targeted Case Management**, including, but not limited to, all elements of the definition, eligibility criteria, staff training requirements and staff qualifications.
- Further I understand I am solely responsible for ensuring the service is provided as defined and am attesting to my compliance to the service definition for **Mental Health/Substance Abuse Targeted Case Management effective July 1, 2010.**
- I further attest that the Medicaid recipient listed below has been receiving the case management component of Community Support Services from this agency, and meets the eligibility and continued service criteria as defined in the **Mental Health/Substance Abuse Targeted Case Management** service definition.
- I further attest that once the Medicaid recipient listed below no longer meets criteria to receive **Mental Health/Substance Abuse Targeted Case Management**, as indicated by the following: The recipient has met the goals in the goals outlined in the Person Centered Plan that require case management functions, **OR** the recipient no longer meets Continued Service Criteria, **OR** the recipient or legally responsible person no longer wishes to receive Case Management Services, they will be discharged from **Mental Health/Substance Abuse Targeted Case Management** to either step down or step up in services as needed.

Recipient Name: _____
Date of Birth: _____
Medicaid ID Number: _____

CABHA Provider QP Signature: _____
(Print name)_____
Date:_____

CABHA Agency Name: _____
MH/SA TCM Medicaid Provider Number: _____
Requested MH/SA TCM Authorization Start Date: _____

Community Support Agency Name: _____
Community Support Medicaid Provider Number: _____
Community Support Authorization End Date: _____

TCM Letter of Attestation
7-10

1

Attention: Critical Access Behavioral Health Agencies

Top Reasons That Could Cause an Interruption in Payment

Please contact HP Provider Services at 1-800-688-6696 or 919-851-8888, option 3, for assistance with the EOBs listed below.

EOB	EOB Description	Common Resolution
5400	EXACT DUP: SAME ATTD PROV/PCODE/TOS/DOS/MOD/DTL $$/DIFF ICN	A claim with the same dates and services has paid, previously in history. If previous payment is incorrect, submit a replacement claim to address overpayment or underpayment. If payment is correct, no action necessary.
79	THIS SERVICE IS NOT PAYABLE TO YOUR PROVIDER TYPE OR SPECIALTY IN ACCORDANCE WITH MEDICAID GUIDELINES	Provider is most likely billing for a code with the incorrect NPI associated with assigned MPN. Resubmit the claim with the correct NPI.
5111	PROVIDER NUMBER ON CLAIM DOES NOT MATCH PROVIDER NUMBER ON PRIOR AUTHORIZATION RECORD	Provider needs to verify the provider number associated with the authorization number and resubmit the claim with the correct NPI associated with the authorization.
23	SERVICE REQUIRES PRIOR APPROVAL	Claim was received with authorization number omitted from the claim. Provider needs to include authorization on the claim or obtain authorization for the service.
5308	PRIOR AUTHORIZED UNITS EXCEEDED	Units are exceeded. Provider needs to obtain additional authorization.
82	SERVICE IS NOT CONSISTENT WITH/OR NOT COVERED FOR THIS DIAGNOSIS/OR DESCRIPTION DOES NOT MATCH DIAGNOSIS	Provider needs to verify the diagnosis code: Missing-incomplete-invalid diagnosis or condition.
270	BILLING PROVIDER IS NOT THE RECIPIENT'S CAROLINA ACCESS PCP. AUTHORIZATION IS MISSING OR UNRESOLVED. CONTACT PCP FOR AUTHORIZATION OR HP PROV SVCS IF AUTHORIZATION IS CORRECT	Submitted claim requires a referring NPI. The referring NPI is either not found on the claim or is unresolved (cannot map to single MPN). Correct and resubmit the claim.
286	INCORRECT AUTHORIZATION NUMBER ON CLAIM FORM. VERIFY NUMBER AND REFILE CLAIM	Referring NPI on processed claim does not match the CCNC/CA PCP listed on the recipient's eligibility file for submitted date of service. Contact referring PCP, obtain the correct referral information and resubmit claim.

Although the suggested resolution is for common denial cases, each claim may propose a unique processing scenario. For further information or claim research, contact HP Provider Services for claim-specific analysis.

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

Attention: Targeted Case Management Providers for Individuals with Intellectual and Developmental Disabilities

Implementation of New Procedure Code and Rate

DMA has received approval to implement a new procedure code and rate for Targeted Case Management for Individuals with Intellectual and Developmental Disability (TCM-IDD) for direct-enrolled providers. Effective with date of service August 1, 2010, or the date of enrollment, whichever is the later date, direct-enrolled providers may be reimbursed for T1017 HE at the new weekly rate of $62.26. T1017 HE may be billed only by the direct-enrolled providers. HP Enterprise Services will not process any systematic recoupment of T1017 HI and repayment for T1017 HE.

Provider Enrollment Information

The effective date of enrollment for direct-enrolled providers will be the date requested by the provider but no earlier than August 1, 2010, or the date a complete enrollment package is received by CSC, if a date is not requested by the provider.

Until providers are directly enrolled, they may continue to bill TCM-IDD services through the local management entities (LMEs) with T1017 HI and T1017 HI SC, at the current rate of $17.67 per unit. Effective January 1, 2011, LMEs will no longer process TCM-IDD claims.

Prior Authorization

This service must be prior authorized for non-Community Alternatives Program (CAP) waiver recipients prior to submitting claims. (TCM for CAP wavier recipients does not require prior authorization.) Following enrollment, the provider will be able to request authorization for TCM-IDD for new non-CAP waiver recipients in accordance with current procedures and documentation requirements. Providers may fax authorization requests to ValueOptions (VO) at 1-877-339-8754. For current recipients with an existing authorization, providers may request transfer of authorizations from T1017 HI to T1017 HE and transfer of the authorization from an LME to their TCM-IDD Medicaid Provider Number through VO's TCM Provider Change Request Form at http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm. VO will retroactively authorize the new code as requested starting August 1, 2010, or the actual provider enrollment date, whichever is later. There will be no charge to the provider for this transfer of authorizations.

Additional Claims Processing Information

Claims Submission: The billing limit is one unit per week, which runs from Sunday to Saturday. If the claim identifies a span of dates (e.g., August 2-6, 2010), the claim will be denied. In order to bill, providers must provide at least 15 minutes of service per week. However, the expectation is that service will be provided and documented according to the needs of the recipient. Electronic claims for procedure code T1017 HE submitted by direct-enrolled providers prior to the August 19, 2010, cut-off will adjudicate on the August 26, 2010, checkwrite. Claims processed after the August 19, 2010, cut-off will adjudicate according to the current checkwrite schedule.

Note: System audits have been developed to deny claims billed with T1017 HE or T1017 HI if billed during the same calendar week. The first claim processed and paid for a recipient will result in the denial of any other claim for TCM during the same week.

Electronic Funds Transfer: Providers must submit to HP Enterprise Services a completed Electronic Funds Transfer (EFT) Authorization Agreement for Automatic Deposit form specific to TCM-IDD. Claims will suspend if this EFT form is not on file. Although many providers have completed the enrollment process and been issued a Medicaid Provider Number, many have not completed an EFT form needed for payment. You can access the form from DMA's website at http://www.ncdhhs.gov/dma/provider/forms.htm.

Behavioral Health Unit
DMA, 919-855-4290

Attention: Enhanced Behavioral Health (Community Intervention) Service Providers and Critical Access Behavioral Health Agencies

Prior Authorization and Billing for Community Support Team

As indicated in Implementation Updates #63 and #65, and the November 2009 and December 2009 Medicaid Bulletins, DMA is engaged in the re-verification of Notifications of Endorsement Actions (NEA) letters for providers of Community Support Team (CST). CST providers were required to submit the re-verification packet with appropriate credentials, including all current NEAs, to qualify for continued enrollment as a provider of CST services. Further verification has also occurred through the endorsing Local Management Entities.

This process is now complete and new provider enrollment numbers were issued with an effective date of July 1, 2010, for CST using the provider's core Medicaid Provider Number (MPN) with a **V suffix** to provide a unique provider number for CST (H2015 HT) separate from other Community Support services (H0036 HA, HB, and HQ). With this separation, all new and concurrent service authorization requests submitted to ValueOptions for dates of service July 1, 2010 and after must include the **V suffix.**

After July 31, 2010, authorization requests for CST services will be returned as "Unable to Process" if the MPN retains the **B suffix** rather than the **V suffix**. Service authorizations approved prior to July 1, 2010, under the **B suffix** will be honored until these authorizations expire.

Please be attentive to which MPN and suffix is used on the authorization when submitting claims. Providers must use the NPI associated with the MPN and suffix that matches the CST authorization to ensure proper adjudication of claims.

For additional assistance, or further information, contact the CSC EVC Call Center. Customer service agents are available Monday through Friday, 8:00 a.m. through 5:00 p.m., at 1-866-844-1113.

CSC, 1-800-866-844-1113

Attention: Children's Developmental Service Agencies, Health Departments, Home Health Providers, Hospital Outpatient Clinics, Independent Practitioners, Local Education Agencies, Local Management Entities, and Physicians

Post-Payment Validation Review "Helpful Hints"

Please refer to the following helpful hints for post-payment reviews.

- Use CCME's post-payment link accessible from CCME's secure website at https://www2.mrnc.org/paservices/pages/home.aspx to view cases requested and to track case status.
- Submit documentation using the cover sheet provided, one recipient at a time.
- Refer to CCME's post-payment validation (PPV) link for "Documentation Standards" used by reviewers and derived from Medicaid Clinical Coverage Policies 10A, 10B, and 10D (http://www.ncdhhs.gov/dma/mp/). Providers must comply with all policy elements. Requirements include the following:
  - ♦ All documentation should include the recipient's full name and be fully dated, including month, date, and year. Documentation that has been "corrected" will not be accepted for a reconsideration review.
  - ♦ The therapy plan of care should include: defined therapy goals, specific content (i.e., therapy specific intervention), frequency, and length of visits for each therapy service.
  - ♦ Each service documentation (Visit Note) should include: date the service is provided, session length **(documented in minutes regardless of billing code),** clinician signature and designation with co-signature/supervision, as needed, and notation of skilled intervention provided and patient response.
  - ♦ The therapy order should identify the acceptable practitioner (MD, NP, etc.) ordering the therapy services and the therapy ordered. Faxed orders and faxed signatures are permissible and serve the same purposes for documentation as an original signature on an original form or orders sheet. Electronic signatures must be identified as such and follow the requirements outlined in the November 2000 Medicaid Bulletin (http://www.ncdhhs.gov/dma/bulletin/1100bulletin.htm#fax). Backdating of the order is not allowed.

The recoupment chart at the end of the recoupment letter specifies each service date subject to recoupment and includes a "remark" to identify the reason for the recoupment. Be sure to follow all of the timelines outlined in the letter.

Questions about PPV should be directed as follows:

- Contact CCME about review process questions – priorauth@thecarolinascenter.org or 1-800-228-3365, option 8.
- Contact DMA Clinical Policy about clinical policy questions – 919-855-4320.
- Contact Medicaid Program Integrity for questions about the post-payment review process and overpayment notices – 919-647-8000.
- Contact the Hearing Office about the reconsideration process – 919-647-8200.

Recoupment checks should be made payable to DMA Accounts Receivable.

CCME, 1-800-228-3365

Nora Poisella, Clinical Policy and Programs
DMA, 919-855-4310

Attention: Personal Care Services Providers

Independent Assessment Updates and Reminders

PCS Provider Interface

Registration for the new PCS Provider Interface, which is required by PCS Clinical Coverage 3C (http://www.ncdhhs.gov/dma/mp/), will begin September 1, 2010. Refer to the **Independent Assessment website** (http://www.qireport.net) for Provider Interface registration dates, forms, and instructions. To allow adequate time for processing, please submit Provider Interface registration forms to The Carolinas Center for Medical Excellence (CCME) by September 15, 2010. All Provider Interface registration forms must be received by October 1, 2010.

The new Provider Interface is a web-based information tool for exchange of information between CCME and PCS personal care services (PCS) providers. Beginning in October 2010, CCME will use the Provider Interface to electronically send recipient referrals to PCS providers. Providers will use the interface to view their own agency's referrals and recipient assessments, notify CCME of their decision to accept or decline a referral, and view authorization notices that CCME generates after the agency accepts a referral.

Regional Provider Training

CCME will offer provider regional trainings in September and October 2010 at the sites listed below. The trainings will cover the following topics:

- Enrolling and using the provider web interface,
- Interpreting completed independent assessments, and
- Using the new electronic POC tool to develop a plan of care.

Date	Location
September 21, 2010	Raleigh
September 22, 2010	Greenville
September 23, 2010	Fayetteville
September 28, 2010	Charlotte/Concord
September 30, 2010	Asheville/Black Mountain

Registration for these sessions will open on September 1, 2010. Refer to the **Independent Assessment website** (http://www.qireport.net) for additional information and to register for an upcoming training in your region.

Please continue to submit weekly discharge updates to CCME using Part 2 of the Weekly Summary Form (see the **Independent Assessment website,** http://www.qireport.net).

Continue to visit the **Independent Assessment website** (http://www.qireport.net) regularly for PCS forms, reference documents, educational content, announcements, and updates to frequently asked questions.

Questions may be directed to the CCME Independent Assessment Help Line at 1-800-228-3365 and by e-mail to PCSAssessment@thecarolinascenter.org. Please note that the Help Line call center capacity has been increased. Please direct questions regarding recipient status or referrals to the Help Line for faster response and to avoid the transmission of PHI over e-mail.

CCME, 1-800-228-3365

Attention: Behavioral Health Providers in Durham, Duplin, Lenoir, Sampson, and Wayne Counties

Prior Authorization of Medicaid-Funded Mental Health, Developmental Disability, and Substance Abuse Services by The Durham Center and Eastpointe LME

As indicated in the joint Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and DMA Implementation Update #77 and the August 2010 Medicaid Bulletin, as of September 20, 2010, all providers for recipients with eligibility within The Durham Center's catchment area (Durham County) will be required to submit requests for initial and concurrent authorization for mental health, developmental disabilities, and substance abuse services to The Durham Center for prior authorization. All providers for recipients with eligibility within Eastpointe's catchment area (Duplin, Lenoir, Sampson, and Wayne counties) will be required to submit requests for initial and concurrent authorization for mental health, developmental disabilities, and substance abuse services to Eastpointe for prior authorization. This change will apply only to providers delivering services to recipients with eligibility in those catchment areas.

Effective September 20, 2010, all CAP requests must be sent to the appropriate LME UR vendor for processing; recipients with eligibility in The Durham Center's catchment area will be sent to The Durham Center and recipients with eligibility in Duplin, Lenoir, Sampson, and Wayne counties will be sent to Eastpointe. As a point of clarification, revision requests for CAP/MR-DD would include requests for additional units for services that have an existing authorization. When submitting CAP/MR-DD revision requests or provider change requests for CNRs that have been approved by ValueOptions (VO), the targeted case managers are required to submit the following documents:

1. A complete revision request including CTCM forms, cost summary, and signature page, as well as any other documentation required per service definitions.
2. A complete copy of the last CNR packet including cost summary, signature page, and MR-2.
3. Copies of any revisions that were approved by VO after the last CNR and prior to the revision being requested.

Note: All concurrent requests for non waiver Targeted Case Management for Individual with Intellectual and Developmental Disabilities (IDD TCM) must continue to be sent to VO until December 31, 2010. All new non-waiver requests from IDD TCM providers who will continue to request authorization for T1017 HI and bill through an LME, must continue to be sent to ValueOptions. Initial requests for non-waiver IDD TCM made by direct-enrolled providers for new recipients with no prior authorizations on file should be sent to the UR vendor for their county of eligibility (i.e. VO, Eastpointe, or the Durham Center) as of September 20, 2010. The LME UR vendors can only authorize the new weekly code (T1017 HE) for direct-enrolled IDD TCM providers.

For mental health/substance abuse services, providers should submit requests for "additional units" to VO for processing if VO originally approved the initial or concurrent request. In other words, if a recipient with eligibility in the Durham Center or Eastpointe catchment areas needs the authorization of additional units for a mental health/substance abuse services request that was authorized by VO prior to September 20, 2010, that request should be **faxed** to VO for processing (this request **should not** be submitted through ProviderConnect). It is important that the request be clearly labeled as a request for "additional units" to ensure that it is processed appropriately by VO in a timely fashion.

The Durham Center's fax number for inpatient requests is 919-328-6011. Eastpointe LME's fax number for inpatient/PRTF requests is 910-298-7184.

For those certified Critical Access Behavioral Health Services Agencies that have a Community Support authorization and plan to use the Mental Health/Substance Abuse Targeted Case Management (MH/SA TCM) Attestation process outlined in DMH/DD/SAS Implementation Update #77 and on page 25, these attestation letters must be sent to VO for end-dating the CS authorization and starting the MH/SA TCM authorization.

Eastpointe and The Durham Center **WILL NOT** be able to process these attestation requests. VO will retain all Community Support authorizations until December 31, 2010. All initial requests for recipients that do not have a Community Service authorization on file with VO should be sent to the appropriate UR vendor (i.e., VO, Eastpointe, or The Durham Center). Concurrent requests for additional units of TCM MH/SA will be sent to the appropriate UR vendor (i.e., VO, Eastpointe, or The Durham Center) for the recipient's catchment area.

Remember that all N.C. Health Choice service requests throughout the state are to continue to be submitted to VO for prior authorization.

Behavioral Health Unit	**ValueOptions**	**The Durham Center**	**Eastpointe LME**
DMA, 919-855-4290	**1-888-510-1150**	**919-560-7100**	**1-800-913-6109**

Attention: All Providers

Family Planning Waiver Update

N.C. Medicaid's Family Planning Waiver (FPW), initially approved by CMS in November 2004 for a 5-year period, is due to end on September 30, 2010. On March 31, 2010, DMA submitted another application to CMS to renew the FPW program beyond the initial 5-year demonstration program. CMS has consistently approved many similar requests from other states without difficulty for programs that have a demonstrated track record of providing quality services to family planning recipients under the Waiver. If approved, family planning services under the FPW renewal will continue through September 30, 2013.

On July 2, 2010, CMS submitted guidance on additional options available to states with FPW programs, which was based on federal health care reform legislation. The *State Eligibility Option for Family Planning Services* would allow states to provide family planning services through an amendment to the Medicaid State Plan, without the formal process of routinely needing to seek approval for a waiver. The State of North Carolina has not made a decision regarding which option it will pursue; however, CMS will extend the State's current FPW program, without any lapse in coverage for recipients. The extension will allow time for the State to determine if pursuing an amendment to the Medicaid State Plan would provide enhanced benefits and an improved quality of family planning services to the citizens of North Carolina, than merely extending the current FPW program.

Therefore, the current FPW program will not end on September 30, 2010. Medicaid Family Planning Waiver applicants will continue to be evaluated for eligibility to enroll in the FPW program, and will receive FPW-covered services. Further, providers will continue to be reimbursed by the State for FPW-eligible covered services. Though the State has not yet made a decision regarding which option it will pursue, please be assured that a process is in place to extend certification and benefits for current eligible recipients for at least 12 months. In addition, Medicaid applications for the program will continue to be processed by the local departments of social services, with no lapse in coverage for approved services and eligible family planning recipients.

The State will continue to keep providers informed of any changes in the FPW program and any decision regarding the option that will be pursued by the State to continue providing family planning services covered under the FPW program. Updates will be published in future Medicaid Bulletins.

Andrea Phillips, FPW Program Manager
DMA, 919-855-4260

Early and Periodic Screening, Diagnosis and Treatment and Applicability to Medicaid Services and Providers

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria stated in this publication **may be exceeded or may not apply to recipients under 21 years of age** if the provider's documentation shows that

- the requested service is medically necessary to correct or ameliorate a defect, physical or mental illness, or health problem; and
- all other Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) criteria are met.

This applies to both proposed and current limitations. Providers should review any information in this publication that contains limitations in the context of EPSDT and apply that information to their service requests for recipients under 21 years of age. A brief summary of EPSDT follows.

EPSDT is a federal Medicaid requirement (42 U.S.C. § 1396d(r) of the Social Security Act) that requires the coverage of services, products, or procedures for Medicaid recipients under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (including any evaluation by a physician or other licensed clinician).

This means that EPSDT covers most of the medical or remedial care a child needs to

- improve or maintain his or her health in the best condition possible OR
- compensate for a health problem OR
- prevent it from worsening OR
- prevent the development of additional health problems

Medically necessary services will be provided in the most economic mode possible, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure that is unsafe, ineffective, experimental, or investigational; that is not medical in nature; or that is not generally recognized as an accepted method of medical practice or treatment.

If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **not** eliminate the requirement for prior approval.

For important additional information about EPSDT, please visit the following websites:

- *Basic Medicaid Billing Guide* (especially sections 2 and 6): http://www.ncdhhs.gov/dma/basicmed/
- *Health Check Billing Guide:* http://www.ncdhhs.gov/dma/healthcheck/
- EPSDT provider information: http://www.ncdhhs.gov/dma/epsdt/

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

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

Proposed Clinical Coverage Policies

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

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

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

2010 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
September	9/2/10	9/8/10
	9/9/10	9/14/10
	9/16/10	9/23/10
October	9/30/10	10/5/10
	10/7/10	10/13/10
	10/14/10	10/19/10
	10/21/10	10/28/10

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

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

Melissa Robinson
Executive Director
HP Enterprise Services