September 2011 Medicaid Bulletin

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

Basic Medicaid Seminars

Basic Medicaid seminars are scheduled for the month of October. These seminars are intended to educate all types of providers on the basics of billing for N.C. Medicaid, recent updates and changes, and the latest budget initiatives. The focus of the morning session will be the first seven sections of the revised October 2011 Basic Medicaid Billing Guide, which is the primary document that will be referenced during the seminar. The afternoon sessions will be broken out by claim type: Professional, Institutional, and Dental /Pharmacy. The remaining sections of the October 2011 Billing Guide will be reviewed during these breakout sessions with a focus on claims submission, resolving denied claims, and the uses of N.C. Electronic Claims Submission/Recipient Eligibility Verification Web Tool.

Providers are encouraged to print the Billing Guide, which will be posted on the DMA website at http://www.ncdhhs.gov/dma/basicmed/ prior to the first scheduled session. This material will assist providers in following along with the presenters. If preferred, you may download the Billing Guide to a laptop and bring the laptop to the seminar. Or, you may access the Billing Guide online using your laptop during the seminar. **However, HP Enterprise Services cannot guarantee a power source or Internet access for your laptop.** Copies of the document will not be provided.

Pre-registration is required for both the morning session and the afternoon session of your choice. 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 morning and afternoon sessions of the seminar. Providers may register for the seminars by completing our online registration at www.hp.com/go/medicaid_seminar_NC. Providers may attend the morning session only, the afternoon session only, or both morning and afternoon sessions.
The morning session will begin at 9:00 a.m. and end at 12:00 noon. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided; however, there will be a lunch break. The afternoon sessions will begin at 1:00 p.m. and end at 4:00 p.m. Providers are encouraged to arrive at 12:45 p.m. to complete registration. **Because meeting room temperatures vary, dressing in layers is advised.**

Seminar Dates and Locations

Date	Location
October 5, 2011	**Asheville** Crowne Plaza Tennis & Gold Resort One Resort Drive Asheville NC 28806 get directions
October 11, 2011	**Raleigh** Wake Tech Community College Student Service Building Conference Center Second Floor, Rooms 213 & 214 9191 Fayetteville Road Raleigh NC 27603 get directions
October 13, 2011	**Greensboro** Clarion Hotel Airport 415 Swing Road Greensboro NC 27409 get directions
October 20, 2011	**Charlotte** Crowne Plaza 201 South McDowell Street Charlotte NC 28204 **Note: Parking fee of $4.00 per vehicle for parking at this location.** get directions
October 25, 2011	**Greenville** Hilton 207 SW Greenville Blvd Greenville, NC 27834 get directions
October 27, 2011	**Fayetteville** Cumberland County DSS 1225 Ramsey St. Fayetteville, NC 28301 get directions

HP Enterprise Services

1-800-688-6696 or 919-851-8888

Attention: All Providers

Clinical Coverage Policies

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

- **1A-5, Case Conference for Sexually Abused Children**
- **1B-3, Intravenous Iron Therapy**
- **1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics**
- **1S-2, HIV Tropism Assay**
- **1S-4, Cytogenetic Studies**
- **2A-3, Out-of-State Services**
- **4B, Orthodontics**
- **8A, Enhanced Mental Health and Substance Abuse Services**

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

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Enrolling Medicaid and Health Choice Patients in Community Care of North Carolina (CCNC)/Carolina Access (CA)

What providers can do to assist with enrollment to CCNC/CA:

- Check the recipient's Medicaid card. If the card does not have a primary care physician on it, refer the recipient to the local DSS office to enroll in the CCNC/CA network.
  - The recipient may choose a medical home with a primary doctor. The local County Department of Social Services has a complete list of participating doctors. A medical home can be chosen for each family member. If recipient does not choose a medical home, one will be automatically assigned.

- Give the recipient a Carolina ACCESS member handbook (PDF, 899 KB). This book can be your guide when explaining the benefits and requirements of being a member of CCNC.
  - You can order handbooks by contacting the Division of Medical Assistance, Managed Care Section, at 919-855-4780 or faxing a request to the Managed Care Section at 919-715-0844 or 919-715-5235.
  - It is also located on the DMA website at http://www.ncdhhs.gov/dma/ca/carechandbook.pdf

- Explain the benefits of being a member of CCNC/CA.
  - A medical home with a primary care provider (PCP). The medical home is a place for well check-ups, sick visits, treatment of special health care needs, etc.
  - Medical advice available 24/7. There is no need to go to the ER unless the problem risks life or health without immediate treatment.
  - Coordinated medical services so that patients receive necessary care either by the PCP or by a referral to a specialist. The PCP will help find the right specialist.
  - Arrangements for hospitalizations when necessary. (Inform patient which hospital PCP admits to.)
  - Care management services available through the CCNC/CA network.

- Follow up with the local DSS to ensure the recipient has been enrolled in the CCNC/CA network.

Provider Services
DMA, 919-855-4780

Attention: All Providers

False Claims Act Education

Effective January 1, 2007, Section 6023 of the Deficit Reduction Act (DRA) of 2005 required providers receiving annual Medicaid payments of $5 million or more to educate employees, contractors, and agents about federal and state fraud and false claims laws and the whistleblower protections available under those laws. The Affordable Care Act (Section 6401) and Session Law 2011-399, modified this requirement. The federal rule § 455.23 enacted require **ALL** Medicaid providers, regardless of the amount reimbursed, to attest that they met the minimum business requirements necessary to comply with all federal and state requirements.

Previously, the Division of Medical Assistance (DMA) has notified those providers who received a minimum of $5 million in Medicaid payments during the last federal fiscal year (October 1 through September 30) that they must submit a Letter of Attestation to Medicaid in compliance with the DRA. This minimum amount may have been paid to one N.C. Medicaid provider number or to multiple Medicaid provider numbers associated with the same tax identification number.

In the October Medicaid Bulletin, all providers will receive further guidance on completing and submitting attestations for Medicaid. Providers should review their corporate compliance programs and be prepared to submit the signed attestations since Medicaid payments will be denied for providers who do not submit a signed Letter of Attestation within thirty days of the date of notification.

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

Attention: All Providers

HIPAA 5010 Implementation

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

N.C. Medicaid will implement the HIPAA requirements for the 5010 transactions within the legacy MMIS+ claims processing system. HPES is anticipating beginning Vendor or Trading Partner testing of the 837 transactions in October, 2011. Providers please contact your vendors/trading partners and inform them to update their Trading Partner Agreement – Appendix in preparation for 5010 testing and implementation. HPES is anticipating publishing the 837 and 835 companion guides in early September 2011. HPES is also anticipating dual processing beginning in November, 2011. In addition, if your Trading Partner Agreement has been updated, you will receive both the ASC X12 versions 4010 and ASC 5010 of the 835 transaction beginning in November. DMA will notify providers through upcoming Medicaid Bulletins as the HIPAA 5010 implementation efforts progress.

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

Attention: All Providers

Guidance for Electronic Signatures

Electronic Signatures

Per HIPPAA standards, an electronic signature means the attribute affixed to an electronic document to bind it to a particular party. An electronic signature secures the user authentication (proof of claimed identity) at the time the signature is generated; creates the logical manifestation of signature (including the possibility for multiple parties to sign a document and have the order of application recognized and proven); supplies additional information such as time stamp and signature purpose specific to that user; and ensures the integrity of the signed document to enable transportability of data, interoperability, independent verifiability, and continuity of signature capability. Verifying a signature on a document verifies the integrity of the document and associated attributes and verifies the identity of the signer. If an entity uses electronic signatures, the signature method must assure all of the following features: message integrity (evidence that the document has not been altered); nonrepudiation (strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid); and user authentication (evidence of the identity of the person signing). No specific technology is mandated by HIPAA.

Authenticated/Dated Signatures

There are some instances where a person's signature is critical to the authenticity of a document, whether it is the signature of the service provider, the individual, the legally responsible person, or other individual. In situations when a dated signature is required, as in the case of service orders, Person-Centered Plans [PCPs], or service plans, etc., the signature is authenticated when the person enters the date next to his or her signature. A handwritten signature requires a handwritten date, and an electronic signature shall include a time and date stamp. In either case, entering the date at the time that the signature is written confirms that the signature was made on that date. The date entered is always the date that the person signs the document. The practice of pre- or post-dating signatures in any form or circumstance is prohibited. As previously discussed in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services Records Management and Documentation Manual, for late entries, a dated signature is indicated. When entering corrections in the service record, the staff's initials and date that the correction was made are required.

Electronic Signatures of Staff

For purposes of this policy, the use of the word, "staff" is inclusive of the employees of a governing body, owner(s), individuals under contract with a provider agency, or individual behavioral health practitioners in a private practice.

When an electronic signature is entered into the electronic record by agency staff [employees or authorized individuals under contract with the agency], the following standards shall be followed:

1. When an electronic signature is used, the provider shall be given an opportunity to review the entry for completeness and accuracy prior to electronically signing the entry.
2. Once an entry has been signed electronically, the computer system shall prevent the entry from being deleted or altered. The entry shall include a time and date stamp.
3. If errors are later found in the entry, or if information must be added, this shall be done by means of an addendum to the original entry. The addendum shall be signed electronically and shall include a time and date stamp.
4. Passwords or other personal identifiers shall be controlled to ensure that only the authorized individual can apply a specific electronic signature. Passwords should be changed at specified intervals.

5. Any staff authorized to use electronic signatures shall be required to sign a statement that acknowledges their responsibility and accountability for the use of their electronic signature. The statement must explicitly state that the provider is the only one who has access to and use of this specific signature code/password.
6. An electronic signature shall be under the sole control of the person using it. A provider shall Not delegate their electronic signature authorization to another person.
7. Policies and procedures shall be developed to:
   a. Safeguard against unauthorized use of electronic signatures. The policy shall also address sanctions for improper or unauthorized use of electronic signatures.
   b. Address procedures that staff should follow if the application is unavailable.
   c. Address procedures when a staff member is not available to electronically sign documents.
8. The governing body shall authorize the use of electronic signatures, and a list of all current staff who are authorized to use electronic signatures shall be maintained and kept on file.

If an agency has a governing body, authorization and compliance to this policy shall be documented in the governing body minutes, and the governing body chairperson shall sign and date the authorized list, which should be maintained by the executive director [or designee] of the organization and the designated medical records staff person. In addition, a letter of authorization shall be placed in each staff member's personnel file.

If the agency does not have a governing body, then the executive director or designee, along with the medical records staff person or office manager, shall document compliance to this policy and the authorization of staff to use electronic signatures, in an administrative meeting or supervision. In addition, a letter of authorization shall be placed in each staff member's personnel file.

Evidence of compliance with this policy would be supported by a notarized statement of compliance, maintained by the staff indicated above, as well as filing a letter of authorization in each staff member's personnel file, with the approval date; agreement for use, and other relevant information.

Note: The above electronic signature standards are subject to revision based upon State law and/or HIPAA requirements.

Electronic Signatures of Recipients, Legally Responsible Persons, and Others

The following protocol is specific to electronic signatures obtained from service recipients, parents, legally responsible persons, representatives from other agencies, and other individuals who are not agency staff. This guidance applies when an agency is seeking any non-agency signature[s] on documents such as PCPs, service plans, release of information forms, consent forms, etc.

In all cases, the person whose signature is being sought shall be given ample opportunity to review the document for completeness and accuracy prior to electronically signing the document.

When obtaining electronic signatures of individuals receiving services, legally responsible persons, representatives from other agencies, and others, the only acceptable format is a digitized signature - an electronic image of an individual's handwritten signature reproduced in its identical form using a pen tablet. The signature(s) must include a time and date stamp, and the signature must be entered on the electronic image of the document that they are signing.

Once an entry has been signed electronically, the computer system shall prevent the entry from being deleted or altered. The entry shall include a time and date stamp.

If errors are later found in the entry, or if information must be added, this shall be done by means of an addendum to the original entry. The addendum shall be signed electronically and include a time and date stamp.

Clinical Policy
DMA, 919-855-4294

Attention: All Providers

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

As previously announced in the May bulletin, DMA began implementing additional correct coding guidelines. These new correct coding guidelines and edits are nationally sourced by organizations such as the Centers for Medicare and Medicaid Services (CMS) and The American Medical Association (AMA). These edits identify any inconsistencies with CPT, HCPCS, AMA, CMS and/or DMA policies and will deny the claim line.

In addition to the May article, in the July 2011 Medicaid bulletin, additional correct coding edits for Global Surgery Package (GSP) and Evaluation and Management (E&M) codes were announced for August 1, 2011 for dates of service on or after August 1, 2011.

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

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

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

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

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

Procedure	Description	Date of Service	Analysis
27275	Manipulation hip joint requiring general anesthesia	02/01/2011	Allow (has 10 day global period)
27025	Fasciotomy, hip or thigh, any type	02/07/2011	Deny

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

Procedure Code	Description	Date of Service	Analysis
99238	Hospital Discharge Day Management	08/22/2011	Allow
99233	Subsequent hospital care	08/22/2011	Deny – 99238 includes all services by the physician on the day of discharge
99222	Initial hospital care per day	10/05/2011	Allow
99284	Emergency department visit	10/05/2011	Deny – all E/M services provided on the same date as the admission are considered part of the initial hospital care

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

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

Attention: All Providers

Revised Timeline for the Implementation of Additional Correct Coding Edits: New Visit and Obstetric Care

The additional correct coding edits "New Visit" and "Obstetrics Care" will not be implemented on September 1, 2011 for dates of service September 1, 2011 and greater as previously announced in the August 2011 Medicaid Bulletin. The revised implementation date is October 1, 2011 for dates of service October 1, 2011 and greater. Providers can view the revised timeline on the Correct Coding – NCCI and Additional Edits DMA webpage at http://www.ncdhhs.gov/dma/provider/ncci.htm.

New Visit

New Visit edits are defined by the AMA and CMS. A new patient is defined as a patient, "who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within 3 years." The term "professional services" applies to any face-to-face visit with a provider. This includes surgical procedures as well as Evaluation and Management (E/M) visits. An analysis will be performed on a patient's historical claims data to determine whether a New Visit E/M or another professional service has been paid within a three-year period.

Providers are reminded to review the AMA definitions of new and established patients in Evaluation and Management Service section in the CPT Code book. New patient preventative E&M codes should not be used when the patient has been seen by the provider either inpatient or in the office within the 3 years prior to the current visit.

Procedure Code	Description	Date of Service	Analysis
99205	Office or other outpatient visit for the evaluation and management of a new patient	01/27/2011	Allow
99345	Home visit for the evaluation and management of a new patient	07/11/2011	Deny
59409	Vaginal delivery only	05/25/2011	Allow
99385	Initial comprehensive preventive medicine evaluation and management .... new patient; 18-39 years	10/10/2011	Deny
44950	Appendectomy	04/12/2011	Allow
99205	Office or other outpatient visit for the evaluation and management of a new patient	01/05/2012	Deny

Obstetric Care

Obstetric Care edits are based on guidance per the AMA. Per AMA, the total obstetric package includes the provision of antepartum care, delivery, and postpartum care. The Obstetric Care edits apply

acceptable methods of billing obstetric services, and identify duplicate or conflicting methods of billing obstetric services and/or their components, as well as appropriate and/or inappropriate use of modifiers. The following are examples of Obstetric Care Edits:

Procedure	Description	Date of Service	Analysis
59510	Routine global care, including antepartum, cesarean delivery, and postpartum care	04/19/2011	Allow
59425	Antepartum care, 4-6 visits	03/29/2011	Deny (included in global care)
59510	Routine global care, including antepartum, cesarean and delivery, and postpartum care	04/29/2011	Deny (time-window edit)

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

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

Attention: All Providers

Medicaid Recipient Prior Approval and Appeal Processes (Due Process) and Early and Periodic Screening, Diagnosis and Treatment Seminars

Medicaid **Recipient** Prior Approval and Appeal Processes and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) seminars are scheduled for the month of September and October, 2011. Seminars are intended to address Medicaid **recipient** prior approval and appeal processes when a Medicaid service is denied, reduced or terminated. The seminars will also focus on an overview of EPSDT-Medicaid for Children. **Billing will not be addressed during the presentation**.

The seminars are scheduled at the location listed below. This session will begin at 9:00 a.m. and will 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 seminar. **Because meeting room temperatures vary, dressing in layers is strongly advised.** Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the Medicaid Recipient Prior Approval and Appeal Processes and EPSDT seminars online **or** by fax. **Pre-registration is required.** Providers will receive a registration confirmation outlining the training material(s) each provider should bring to the seminar.

Date	Location
September 15, 2011	**Raleigh** The Royal Banquet and Conference Center Room C 3801 Hillsborough Street Raleigh, NC 27607
October 18, 2011	**Raleigh** The Royal Banquet and Conference Center Room C 3801 Hillsborough Street Raleigh, NC 27607

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

Attention: All Providers

NC Health Choice Claims Processing

Effective with dates of service on and after October 1, 2011, NC Health Choice (NCHC) medical *and* pharmacy claims will be processed by DMA's fiscal agent, HP Enterprise Services instead of BCBS. For questions regarding claims processing with dates of service of 10/1/2011 and after, providers may contact the HP Provider Services Department at 1-800-688-6696, menu option 3. There will be a five-month run-out period for providers to file claims for dates of service through September 30, 2011 to BCBS. The run-out period will begin on October 1, 2011 and end on February 29, 2012. **You must file all claims for dates of service through September 30, 2011 with BCBS by February 29, 2012.**

Active NC Medicaid providers who want to participate in NCHC will not need to take any action for NCHC enrollment. However, any provider that is not currently enrolled in the N.C. Medicaid program and wants to provide care to NCHC recipients will need to complete the Medicaid provider enrollment application at www.nctracks.nc.gov. CSC, DMA's Enrollment, Verification & Credentialing vendor, is available to assist providers who want to enroll in NC Medicaid. CSC contact information is provided below.

EVC Call Center Contact Information

Enrollment, Verification, and Credentialing Call Center Toll-Free Number	866-844-1113
EVC Call Center Fax Number	866-844-1382
EVC Call Center E-Mail Address	NCMedicaid@csc.com
CSC Mailing Address	N.C. Medicaid Provider Enrollment CSC PO Box 300020 Raleigh NC 27622-8020
CSC Site Address	N.C. Medicaid Provider Enrollment CSC 2610 Wycliff Road, Suite 102 Raleigh NC 27607-3073
CSC Website Address	http://www.nctracks.nc.gov

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

Attention: Health Choice Providers

Upcoming Change to NC Health Choice Recipient Co-Payments

Effective October 1, 2011, co-payment changes for NC Health Choice recipients will be in effect. NC Health Choice recipients will receive new ID cards and notification of the co-payment changes in September. Please see the table below for a detailed listing of all applicable co-payments for NC Health Choice recipients.

	Income Level	Cost-Sharing
Class A	≤ 150% of FPL AND Native American OR Alaska Native	• No enrollment fee • No co-pays at all
Class J	≤ 150% of FPL	• No enrollment fee • No provider visit co-pays • Non-emergency ER co-pay $10 • Generic Prescription co-pay $1 • Brand Prescription with NO generic available co-pay $1 • Brand prescription when generic available co-pay $3 • Over-the-counter medication co-pay $1
Class K	151% - 200% of FPL	• $50 enrollment fee, max $100 for 2 or more children • Provider visit co-pay $5 • Non-emergency ER co-pay $25 • Generic Prescription co-pay $1 • Brand Prescription with NO generic available co-pay $1 • Brand prescription when generic available co-pay $10 • Over-the-counter medication co-pay $1
Class S	151% - 200% of FPL AND Native American OR Alaska Native	• No enrollment fee • No co-pays at all
Class L (*Optional extended coverage*)	201% - 225% of FPL	• No enrollment fee • Pay monthly premiums • Provider visit co-pay $5 • Non-emergency ER co-pay $25 • Generic Prescription co-pay $1 • Brand Prescription with NO generic available co-pay $1 • Brand prescription when generic available co-pay $10 • Over-the-counter co-pay $1

Clinical Policy
DMA, 919-855-4100

Attention: Health Choice Providers

Clinical Coverage Policy Update

The NC Physician Advisory Group has recommended that the proposed policies listed below *no longer be covered* under the N.C. Health Choice Program.

Proposed Policy to no longer be covered by NCHC	Date Posted	Comment Period End Date
NCHC Carotic Artery Angioplasty/Stinting	August 15, 2011	September 29, 2011
NCHC Pulmonary Hypertension Drug Management	July 28, 2011	September 11, 2011

The NC Physician Advisory Group has recommended that the proposed policies listed below *be covered* under the N.C. Health Choice Program.

Proposed Policy to be covered by NCHC	Date Posted	Comment Period End Date
NCHC Bone Mass Measurement	August 15, 2011	September 29, 2011

For a complete list of N.C. Health Choice clinical coverage policies, please refer to the N.C. Health Choice Policies web page at http://www.ncdhhs.gov/dma/hcmp/.

Clinical Policy
DMA, 919-855-4100

Attention: Health Choice Behavioral Health Providers

Changes in Behavioral Health Authorizations and Billing for Health Choice

The Division of Medical Assistance is working to align all Behavioral Health clinical coverage policies and service definitions for Health Choice recipients with Behavioral Health Medicaid policies. However**,** the EPSDT Special Provision and the Important Notes on EPDST documented in Medicaid clinical coverage policies **do not** apply to NC Health Choice. The target date for this clinical coverage policy transition is October 1, 2011. All requests for prior authorization submitted to ValueOptions on or after October 1st will therefore use the Medicaid service criteria.

For outpatient treatment services, the count of unmanaged visits will begin anew on October 1, 2011, under the limitation of 16 visits. The count of unmanaged visits will then begin anew *again* on January 1, 2012 and conform to the standard calendar year limitation of 16 visits. These visits are defined by the number of procedure codes paid for services rendered to the recipient and not by the individual units of service provided. The data system counts each procedure code as one visit with the exception of the following codes for group therapy: 90849, 90853, 90857, H0005, and H004 HQ. These five codes are counted as ½ visits for the unmanaged unit counts. When the recipient reaches the maximum number of unmanaged units, any subsequent visits will be denied unless prior approval is obtained. Once prior approval is on file for a recipient, the system considers the unmanaged count as "used" for that calendar year, regardless of the amount of previous services provided.

Claims adjudication for authorized services rendered prior to October 1, 2011 will occur through Blue Cross Blue Shield (BCBS). Claims adjudication for authorized services rendered on or after October 1, 2011 will occur through HP Enterprise Services. It is critical that providers use the October 1st date to separate their claims submissions so that uninterrupted payment may occur.

Behavioral Health Section
DMA, 919-855-4290

Attention: All Providers

Procedures for PA Request for Synagis for RSV Season 2011/2012

The clinical criteria utilized by N.C. Medicaid for the 2011/2012 RSV season are consistent with published guidelines in the *Red Book: 2009 Report of the Committee on Infectious Diseases, 28th Edition*. **Prior approval (PA) is required** for Medicaid coverage of Synagis during the upcoming RSV season. The coverage season is November 1, 2011, through March 31, 2012. An Early and Periodic Screening, Diagnosis and Treatment (EPSDT) medical necessity review will be performed for all Synagis requests.

Requesting PA for Synagis for the upcoming season will be an electronic process. The electronic PA system is designed to capture data succinctly. Prompts, alerts, dropdown choices, attachment capability as well as free text opportunities will allow the provider to submit a request with all information essential to justify medical necessity. When the system offers an opportunity to upload supporting documents, a note documenting the patient's pulmonary or cardiac status should always be submitted as an attachment when available. The electronic system can automatically approve based on criteria submitted and allows the provider to monitor the status of a pending request. The auto approval feature will improve the overall timeliness of reviews especially at the beginning of the season when the volume of requests is the highest.

The electronic PA method will approve up to five monthly doses of Synagis, but each dose will be individually authorized on a monthly basis. After the initial approval, providers will submit very limited information such as the most recent weight of the child and date the prior dose was administered for authorization of subsequent doses. The number of doses requested for authorization by the provider should be adjusted if an infant received the first dose prior to a hospital discharge.

It is important for a pharmacy to have a Synagis authorization notification on hand prior to billing a claim to Medicaid. These notifications must be submitted to the pharmacy by the provider and will include the number of vials approved for the patient. A claim transmitted at POS will be denied if a prior approval request was not submitted by the provider or if the request was not approved. It is the responsibility of the provider to ensure that the pharmacy has a prescription for Synagis.

Maximum of Five Doses

Up to five doses during the season can be authorized for chronic lung disease (CLD) and hemodynamically significant congenital heart disease (HSCHD) for infants and children less than 24 months of age.

CLD

The diagnosis causing the long-term respiratory problems must be specific. Treatment, such as supplemental oxygen, bronchodilator, diuretic or chronic corticosteroid therapy, in the six months before the start of the season is required.

HSCHD

Infants not at increased risk from RSV who generally should **not** receive immunoprophylaxis include those with hemodynamically insignificant heart disease, such as secundum atrial septal defect, small ventricular septal defect (VSD), pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, patent ductus arteriosus (PDA), lesions adequately corrected by surgery unless the infant continues on medication for CHF, or mild cardiomyopathy not requiring medication.

In addition to the two conditions listed above, a premature infant (prematurity must be counted to the exact day) may qualify for five doses as follows:

- Born at an EGA of ≤28 weeks 6 days and DOB is on or after November 2, 2010;
- Born at an EGA of 29 weeks 0 days to 31 weeks 6 days and DOB is on or after May 2, 2011; or

- Born at an EGA of ≤34 weeks 6 days and DOB is on or after November 2, 2010, and also has severe neuromuscular disease that compromises handling of respiratory secretions; **or** congenital abnormalities of the airways that compromises handling of respiratory secretions.

The diagnosis to justify severe neuromuscular disease or congenital airway abnormalities must be specific.

Five Dose Authorization Exceptions

Coverage of Synagis for CLD and HSCHD will terminate when the recipient exceeds 24 months of age AND has received a minimum of three doses during the season. Coverage of Synagis for congenital abnormalities of the airways and severe neuromuscular disease that compromises handling of respiratory secretions will terminate when the recipient exceeds 12 months of age AND has received a minimum of three doses during the season. For these occurrences, coverage will continue always to ensure a medication supply for three doses.

Maximum of Three Doses; Last Dose Administered at Three Months of Age (90 Days of Life)

Infants meeting clinical criteria as follows may be approved for up to three doses of Synagis during the season:

- Born at an EGA of 32 weeks 0 days to 34 weeks 6 days, and DOB is on or after August 2, 2011, and has at least one of the two following defined risk factors:
  - ♦ Attends child care [defined as a home or facility where care is provided for any number of infants or young toddlers (toddler age is up to the third birthday)]. The name of the day care facility must be submitted with the request.
  - ♦ Has a sibling younger than five years of age in the home. A twin sibling does not meet this requirement.

Generally, the following diagnoses do not singularly justify medical necessity for Synagis prophylaxis:

- a positive RSV episode during the current season
- repeated pneumonia
- sickle cell
- multiple birth with approved sibling
- apnea or respiratory failure of newborn

Submitting a Request to Exceed Policy

For doses exceeding policy or for Synagis administration outside the defined coverage period, the provider should use the **Non-Covered State Medicaid Plan Services Request Form for Recipients Under 21 Years of Age** to request Synagis. The form is available on DMA's website at http://www.ncdhhs.gov/dma/epsdt/. A medical necessity review will be done under EPSDT (see http://www.ncdhhs.gov/dma/epsdt/index.htm); if the information provided justifies medical need, the request will be approved.

Pharmacy Distributor Information

Medicaid will allow Synagis claims processing to begin on October 26, 2011, to allow sufficient time for pharmacies to provide Synagis by November 1, 2011. Payment of Synagis claims prior to October 26, 2011, and after March 31, 2012, will not be allowed. POS claims should not be submitted by the pharmacy distributor prior to the first billable date of service for the season. Pharmacy providers should always indicate an accurate days' supply when submitting claims to N.C. Medicaid. Claims for Synagis doses that include multiple vial strengths must be submitted as a single compound drug claim. Synagis doses that require multiple vial strengths that are submitted as individual claims will be subject to recoupment by DMA Program Integrity. Physicians and pharmacy providers are subject to audits of patient records by DMA Program Integrity.

Providers will fax the approval notification to the pharmacy distributor of choice. Single dose vial specific authorizations will be done by DMA up to the maximum number of doses approved for the patient. Please ensure that an authorization notification is received before billing Synagis a claim to Medicaid. The authorizations should be maintained in accordance with required record keeping time frames.

Provider Information

Please refer to the follow up article coming in the October 2011 Medicaid Bulletin for specific details about the electronic PA process. The PA website, fax numbers and help numbers will be provided in the article. Provider registration for the electronic PA process will start in mid to late September. Providers without internet access should contact Charlene Sampson at (919)855-4300 to facilitate submission of a PA request for Synagis.

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

Attention: All Providers

Provider Application Fee

The Section 6401(a) of the Affordable Care Act (ACA), as amended by section 10603 of the ACA, amended section o1866 (j) requires the collection of an application fee to cover costs of screening and to carry out screening and other program integrity efforts. The application fee will be required with the submission of an initial enrollment application, the application to establish a new practice location, or as a part of revalidation. It is essential that the application fee is received with the application. Therefore, application processing for a new or currently enrolled provider or supplier will not begin until the application fee is received.

All institutional providers of medical or other items or services or suppliers are required to pay the application fee. Institutional providers include, but are not limited to: ambulance service suppliers; ambulatory surgical centers; community mental health centers; comprehensive outpatient rehabilitation facilities; durable medical equipment prosthetics, orthotics, and supplies suppliers; end-stage renal disease facilities; federally qualified health centers; histocompatibility laboratories; home health agencies; hospices; hospitals, including but not limited to acute inpatient facilities, inpatient psychiatric facilities, inpatient rehabilitation facilities, and physician-owned specialty hospitals; critical access hospitals; independent clinical laboratories; independent diagnostic testing facilities; mammography centers; mass immunizers (roster billers); organ procurement organizations; outpatient physical therapy/occupational therapy/speech pathology services, portable x-ray suppliers; skilled nursing facilities; radiation therapy centers; religious nonmedical health care institutions; and rural health clinics. Institutional providers also include any institutional entity that bills the State Medicaid program or CHIP on a fee-for-service basis, such as: personal care agencies, non-emergency transportation providers, and residential treatment centers, in accordance with the approved Medicaid or CHIP State plan. The ACA exempts physicians and non-physician practitioners from paying the application fee.

The application fee through December 31, 2011 is $505 as established by Section 1866 (j)(2)C)(i)(I) of the ACA. This amount will be adjusted by the percentage change for the consumer price index for the 12-month period ending June 30 of the prior year.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Reporting Provider Fraud and Abuse

The N.C. Department of Health and Human Services created a poster http://www.ncdhhs.gov/dma/fraud/FraudPoster.pdf asking citizens to report Medicaid fraud and abuse. In a memo http://www.ncdhhs.gov/dma/fraud/FraudMemo.pdf dated June 4, 2010, DHHS Secretary Lanier Cansler asked all health care agencies and private health care providers to print and prominently display the poster in their offices. These efforts continue to be a priority for the Department and the health care industry. Combating fraud/abuse and over use of services is an effective way to reduce health care costs without compromising recipient care.

You are encouraged to report matters involving Medicaid fraud and abuse. If you want to report fraud or abuse, you can remain anonymous; however, sometimes in order to conduct an effective investigation, staff may need to contact you. Your name will not be shared with anyone investigated. (In rare cases involving legal proceedings, we may have to reveal who you are.)

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Termination of Inactive Medicaid Provider Numbers

As previously announced in the July 2011 bulletin, DMA has updated its policy for terminating inactive providers to reduce the risk of fraudulent and unscrupulous claims billing practices. Medicaid provider numbers that do not reflect any billing activity within the previous 12 months will be terminated. Unless the provider can attest that they have provided services to N.C. Medicaid recipients or Health Choice members in the previous 12 month period, the provider number will be terminated. A new enrollment application and agreement to re-enroll must be submitted for any provider terminated. As a result, a lapse in eligibility as a Medicaid provider may occur.

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

Note: Providers are reminded to update contact and ownership information timely.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Update on the NC Medicaid EHR Incentive Payments

NC Medicaid has been working with many federal, state, provider, and vendor stakeholders to launch the Electronic Health Record (EHR) Incentive Payments Program this year.

NC Medicaid Incentive Payment System (NC MIPS) launched the portal for Eligible Professionals (EP) attestation in March 2011 and for Eligible Hospitals (EH) on September 1, 2011. Attestation guides have been created and posted on the portal to assist providers in working through their attestations. The portal is located at https://ncmips.nctracks.nc.gov/. Assistance is available for the portal from the NC-MIPS CSC EVC Center by phone **866-844-1113** or email NCMIPS@csc.com.

The first payments in the incentive program have already been made and more are scheduled to go out as EPs and EHs complete the attestation process and those attestations are validated by the State. As with any new program, there have been a few bumps in the road but we continue to increase the number of payments to providers as we move forward. We appreciate all of the feedback from participants as we develop new processes and procedures that will ensure a vibrant and solid program in the future. Please contact NC Medicaid at NCMedicaid.Hit@DHHS.NC.gov with any feedback or specific questions.

On the horizon, NC Medicaid plans to restart the EHR newsletter, *The Provider Insider* to provide up to date information about the EHR program. Our goal is to effectively communicate updates from NC Medicaid, CMS and other HIT/HIE partners.

NC-MIPS
CSC, 1-866-844-1113

Attention: All Providers

UPDATE: Prior Authorization for Non-emergency Cardiac Imaging Procedures

The N.C. Medicaid Program implementation of a prior authorization (PA) program for non-emergency out-patient cardiac imaging procedures for recipients 21 years of age and older is tentatively set for October 1, 2011. Cardiac catheterization codes have been removed from the list of procedures that will require prior authorizations. A complete list of codes that require PA is listed at the bottom of this article.

The proposed policy, 1K-7, Prior Approval for Imaging Services, is posted for comments until September 26, 2011 at http://www.ncdhhs.gov/dma/mpproposed/index.htm.

As a reminder, imaging procedures performed in the following situations are exempt from the prior approval requirement:

1. During an inpatient hospitalization
2. During an observation stay (this includes labor and delivery observation stay)
3. During an emergency room visit
4. During an urgent care visit (only for urgent care, not primary care)
5. As a referral from a hospital emergency department or an urgent care facility
6. As an emergency procedure

Note: Procedures that are exempt from the prior approval requirement must meet current North Carolina Medicaid policies that define medical necessity criteria and unit limitations for claims payment. Bypassing prior approval by having the procedures performed in the emergency room is not a guarantee of payment.

Services provided to the following recipients **do not** require prior approval (these recipients will be identified as "non-delegated" and the option to create an authorization request will be unavailable):

1. Recipients who are dually eligible (for Medicare and Medicaid)
2. Recipients who are covered by one of the following third-party insurance:
   - (a.) Major Medical Coverage
   - (b.) Indemnity Coverage
   - (c.) Basic Medicare Supplement
3. Recipients enrolled in the following Medicaid programs:
   - (a.) Program of All-Inclusive Care for the Elderly (PACE)
   - (b.) Health Choice
   - (c.) Family Planning Waiver
   - (d.) Health Insurance Payment Plan (HIPP)
   - (e.) Aid to the Aged
   - (f.) Special Assistance for the Blind
   - (g.) Special Assistance to the Aged
4. Refugees
5. Recipients with emergency coverage for approved dates of service
6. Recipients under 21 years of age for the cardiac imaging procedures

The ordering physician or non-physician practitioner is responsible for obtaining prior approval. A rendering facility may request prior approval if the facility has the clinical information necessary to support the requested imaging.

Cardiac Imaging Procedure Codes

The following procedure codes require prior approval for recipients 21 years of age and over, and are subject to the fee schedule reimbursement:

A. Cardiac Computed Tomography (CT) Scans

CPT CODE	DESCRIPTION
75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image post processing, assessment of cardiac function, and evaluation of venous structures, if performed)
75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image post processing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)

B. Cardiac Computed Tomography Angiography (CTA)

CPT CODE	DESCRIPTION
75574	Computed tomography angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image post processing, (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)

B. Cardiac Magnetic Resonance Imaging (MRI)

CPT CODE	DESCRIPTION
75557	Cardiac magnetic resonance imaging morphology and function without contrast material
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast materials (s) and further sequences

C. Cardiac Positron Emission Tomography (PET)

CPT CODE	DESCRIPTION
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation
78491	Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress
78492	Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest or stress

D. Nuclear Cardiac Imaging (NCM)

CPT CODE	DESCRIPTION

78451	Myocardial perfusion imaging, tomographic (SPECT); including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)
78452	Myocardial perfusion imaging, tomographic (SPECT); including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection
78453	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)
78454	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection
78466	Myocardial imaging, infarct avid, planar; qualitative or quantitative
78468	Myocardial imaging, infarct avid, planar; with ejection fraction by first pass technique
78469	Myocardial imaging, infarct avid, planar; tomographic SPECT with or without quantification
78472	Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress, (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing
78473	Cardiac blood pool imaging, gated equilibrium; multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or pharmacologic), with or without additional quantitative processing
78481	Cardiac blood pool imaging (planar), first pass technique; single study, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification
78483	Cardiac blood pool imaging (planar), first pass technique; multiple studies at rest and with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification
78494	Cardiac blood pool imaging (planar), gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing
78496	Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique (List separately in addition to code for primary procedure)
78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine

E. Transthoracic echocardiography (TTE)

CPT CODE	DESCRIPTION
93303	Transthoracic echocardiography for congenital cardiac anomalies; complete
93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study
93306	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography

93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study

F. Transesophageal echocardiography (TEE)

CPT CODE	DESCRIPTION
93312	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
93318	Echocardiography, transesophageal, (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis

The following transesophageal echocardiography (TEE) codes do not require prior approval. However they are reimbursable only when billed with an authorized code.

CPT CODE	DESCRIPTION
93313	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only
93314	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only
93316	Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only
93317	Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only

G. Stress and Doppler Echocardiography

CPT CODE	DESCRIPTION
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; (List separately in addition to codes for echocardiographic imaging); complete
93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study (List separately in addition to codes for echocardiographic imaging)
93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)
93350	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically includes stress, with interpretation and report

93351	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically includes stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision

The following procedure code (93352) does not require prior approval. However it is reimbursable only when billed with an authorized code.

CPT CODE	DESCRIPTION
93352	Use of echocardiographic contrast agent during stress echocardiography (List separately in addition to code for primary procedure)

H. Injection Procedures

The following radiopharmaceutical procedure codes do not require prior approval. However they are reimbursable only when billed with an authorized code.

HCPCS CODE	DESCRIPTION
A9500	Technetium Tc-99m sestamibi, diagnostic, per study dose
A9501	Technetium Tc-99m teboroxime, diagnostic, per study dose
A9502	Technetium Tc-99m tetrofosmin, diagnostic, per study dose
A9504	Technetium TC-99m apcitide, diagnostic, per study dose, up to 20 millicuries
A9505	Thallium T1-201 thallous chloride, diagnostic, per millicurie
A9512	Technetium Tc-99m pertechnatate, diagnostic, per millicurie
A9524	Iodine I-131 iodinated serum albumin, diagnostic, per 5 microcuries
A9526	Nitrogen N-13 ammonia, diagnostic, per study dose, up to 40 millicuries
A9538	Technetium Tc-99m pyrophosphate, diagnostic, per study dose, up to 25 millicuries
A9552	Fluordeoxyglucose F-18 FDG, diagnostic, per study dose, up to 45 millicuries
A9555	Rubidium Rb-82, diagnostic, per study dose, up to 60 millicuries
A9560	Technetium Tc-99m labeled red blood cells, diagnostic, per study dose, up to 30 millicuries
A9576	Injection, gadoteridol, (ProHance Multipack), per ml
A9577	Injection, gadobenate dimeglumine (MultiHance), per ml
A9578	Injection, gadobenate dimeglumine (MultiHance Multipack), per ml
A9579	Injection, gadolinium-based magnetic resonance contrast agent, not otherwise specified, per ml
A9700	Supply of injectable contrast material for use in echocardiography, per study
J0152	Injection, adenosine, for diagnostic use, 30 mg
J1245	Injection, dipyridamose, per 10 mg (Persantin®)
J1250	Injection, dobutamine HCL, per 250 mg (Dobutamine®)
J2785	Injection, regadenoson, 0.1 mg
Q9951	Low osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml
Q9957	Injection, perflutren lipid microspheres, per ml (Definity®)
Q9965	Low osmolar contrast material, 100-199 mg/ml iodine concentration, per ml (Omnipaque®, Optiray®, Ultravist®)
Q9966	Low osmolar contrast material, 200-299 mg/ml iodine concentration, per ml (Isovue®, Omnipaque®, Optiray®, Ultravist®, Visipaque®)
Q9967	Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml (Hexabrix®, Isovue®, Omnipaque®, Optiray®, Oxilan®, Ultravist®, Visipaque®)

I. Revenue Codes

Institutional providers billing on a UB claim, shall bill the revenue code (RC) with the exact CPT code.

REVENUE CODE	DESCRIPTION
254	Drugs; Incident to Other Diagnostic Services
255	Drugs: Incident to Radiology
341	Nuclear Medicine; Diagnostic
343	Nuclear Medicine; Diagnostic Radiopharmaceuticals
359	Ct Scan; Other
404	PET Scan
480	Cardiology; General Classification
481	Cardiology; Cardiac Cath Lab
482	Cardiology; Stress Test
483	Cardiology; Echocardiology
489	Cardiology; Other Cardiology
614	MRI; Other

Practitioner and Clinic Services
DMA, 919-855-4320

Attention: Acute Inpatient Hospital Services Providers

Changes to UB-04 Guidelines

Effective October 1, 2011, changes will be made to the UB-04 guidelines for billing lower level of care services provided in an acute inpatient hospital that does not have swing beds. A single all inclusive per diem rate will be paid, when it is determined by the Physician or UR Committee that a patient no longer requires care provided at the acute hospital services level of care and appropriate placement can not be located.

Prior Approval for the appropriate level of care must be obtained from HP by submitting a FL-2 or FL-2E form for billing the appropriate lower level of care. Forms may be accessed on line @ http://www.providerlink.com.

In order to bill for the lower level of care rate, the patient must first be discharged from acute care and then admitted as a lower level of care patient.

- File an S Claim using Bill Type 11X to discharge the patient from the acute hospital inpatient level of care.
- You must file a T Claim for billing the lower level of care services
- Bill Type 66X must be used for billing the Nursing Facility level of care
- Bill Type 28X must be used for billing the Ventilator level of care
- The hospital must continue to actively seek appropriate level of care facility placement for individuals in lower level of care beds. Prepayment and post payment reviews may be performed by DMA or Designated Agents with denial or recoupment of payments when appropriate.

There will be no changes to Swing Bed or Ventilator Care billing or payment methodology for those that already have this level of care within their facilities.

Practitioner and Facility Services
DMA, 919-855-4356

Attention: Behavioral Health Providers

Electronic Prior Approval Requests

Mandatory electronic submission of authorization requests
Effective October 1, 2011, the Appropriations Act of 2011 (House Bill 200) mandates that providers submit authorization requests electronically via the vendor's website. For purposes of submitting mental health, substance abuse, and developmental disability requests to the appropriate Utilization Review vendors, please note the following information for submission:

ValueOptions
ValueOptions continues to offer live webinar training on ProviderConnect submission. Providers unable to participate in live webinar training can access pre-recorded webinars for self-paced training. Navigate to the link below and scroll to the *Provider Training Opportunities* section to view webinar details and access additional ProviderConnect resource documents such as the ProviderConnect User Guide, Quick Reference Guide, and Frequently Asked Questions (FAQ) document:
http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm

Eastpointe Human Services Providers
For purposes of submitting mental health, substance abuse, intellectual and other developmental disability requests to Eastpointe Human Services, providers should utilize the LME ProviderConnect web portal at https://carelink.carenetasp.com/EastpointePC/.

Eastpointe providers can access pre-recorded webinars for self-paced training. Navigate to the link below and scroll to the bottom of the page and see the section labeled *Webinars*. Providers can also view additional Medicaid utilization review materials from this page.
http://www.eastpointe.net/providers/MedicaidUR/mur.aspx

The Durham Center Providers
For purposes of submitting mental health, substance abuse, IDD and CAP I/DD requests to The Durham Center, providers should utilize the ProviderConnect web portal:
https://carelink.carenetasp.com/DurhamPC/

The Durham Center will be providing several live webinars in the coming months. Please visit the Durham Center's training/events calendar located on their website or use the following link to get directly to the calendar: http://www.durhamcenter.org/index.php/provider/calendar. Providers unable to participate in live webinar training can access pre-recorded webinars for self-paced training. Navigate to the link below and scroll to the *ProviderConnect* section to access a recorded webinar and to access the Durham Center ProviderConnect User Manual. The webinar and user manual will provide information regarding obtaining a ProviderConnect user name and password.
http://www.durhamcenter.org/index.php/provider/docs/service

Pathways LME Providers
For the Purpose of submitting CAP I/DD requests to Pathways LME, providers should utilize the following link and select "CAP MR/DD Authorization Request":
http://www.pathwayslme.org/capur/

The "CAP MR/DD Authorization Request" link is under construction at this time. Please visit Pathways LME website for updates on electronic submissions and trainings they will be providing.

Crossroads Behavioral Healthcare Providers
For the Purpose of submitting CAP I/DD requests to Crossroads Behavioral Healthcare, providers should utilize the following ProviderConnect web portal:
https://carelink.carenetasp.com/crossroadspc/login.asp

Crossroads providers can access a ProviderConnect presentation at the link below and select "CAP MR/DD UR" and scroll down to Provider Training Presentations:
http://crossroadsbhc.org/. To obtain a login and/or individualized training on Provider Connect, you can contact Pat Draughn at pdraughn@crossroadsbhc.org

TFC Requests Submitted Online via ValueOptions ProviderConnect
Therapeutic Foster Care requests can be submitted on ValueOptions ProviderConnect using any Medicaid Provider Number available to the submitting provider. The Medicaid Provider Number included on the submission will be replaced by ValueOptions staff with the appropriate LME Medicaid Provider Number corresponding to the recipient's county of eligibility at the time of review.

Therapeutic Foster Care providers that do not have any Medicaid Provider Number should visit the website below to learn how to obtain a "ValueOptions provider number" which will allow for online submission of TFC requests via the ValueOptions ProviderConnect online provider portal.
http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm

Behavioral Health Section
DMA, 919-855-4290

Attention: CAP Providers

CAP I/DD Policy Requirements Extension and Exception Process

THIS IS A REMINDER OF THE EXTENSION/EXCEPTION PROCESS FOR CAP-MR/DD WAIVER RECIPIENTS POSTED IN IMPLEMENTATION UPDATE # 80.

Implementation Updates # 76 and 80, and Form and Instructions posted on the DMH/DD/SAS website on 10/1/10 and revised 11/1/10 set forth an erroneous Extension/ Exception Request Process for the limit of 129 hours per month of habilitation services for adults. DMA is RESCINDING the requirement to request an exception because the 129 hour limit does not go into effect until November 1, 2011. For the remainder of this waiver, which is ending October 31, 2011, it is not necessary to submit a request to exceed the 129 hours per month of habilitation. All Continued Need Reviews that exceed 129 hours a month of habilitation services that meet Medical Necessity will be approved through October 31, 2011, and the new limit for adults will go into effect November 1, 2011. CNRs which include more than 129 hours will need to be revised effective November 1, 2011 or a request to exceed the limit for children under age 21 must be submitted. Requests to exceed 129 hours per month for children under 21 years of age after November 1, 2011 will be reviewed under EPSDT and if denied, the recipient will be provided with appeal rights.

Effective November 1, 2011, No More Than 129 hours of Habilitation per Month:

- **Effective November 1, 2011, the total habilitation hours received by a participant must not exceed 129 hours of habilitation per month**. Please review the CAP MR/DD services that are available. The 129 hours per month limit is inclusive of the habilitation the participant may receive through engagement in Day Supports, Supported Employment, Long Term Vocational Supports and Home and Community Supports.

NOTE: *The combination or distinct utilization of these services is not to exceed 129 hours a month.*

- The 129 hours a month is not viewed as an average yearly amount. **The 129 hour per month limitation does NOT include habilitation hours provided in Residential Supports and/or Home Supports**. (Please see next section for more detail)

Residential Supports and Home Support services (direct contact hour requirements):

- Due to the number of individuals who will be affected by the implementation of the Utilization Review Criteria posted in Implementation Update #76 on July 7, 2010, a decision has been made to extend the transition period specific to Residential Supports and Home Support services (direct contact hour requirements) to October 31, 2011. This extension serves to ensure there is no interruption in services.

Utilization Review:

- All CAP MR/DD service requests as of May 30, 2011 will be reviewed according to the Utilization Review Criteria set forth in Clinical Coverage Policy No. 8M.

New Waiver effective November 1, 2011

- The new waiver, effective November 1, 2011, allows for a **maximum total of** 129 hours of habilitation per month. This includes Days Supports, Support Employment, Long Term Vocational Support and Home and Community Supports. **This is a firm limit FOR ADULTS**

over age 21. Requests to exceed the limit for children under age 21 will be reviewed under EPSDT.

- All requests authorized prior to October 31, 2011 that exceed the Utilization Criteria for habilitation will need to be in compliance by November 1, 2011. Because of the quantity of Revisions that will be submitted, it is strongly recommended that services are transitioned prior to October, 31 2011or at least 15 business days prior to the effective date of the request to allow the UR Vendors ample time to complete the authorizations.
- Billing of more than 129 hours a month of habilitation will result in denial of units above the maximum allowable regardless of prior approval, unless more units have been approved for a child under EPSDT.

Due Process

- As of November 1, 2011the 129 hours a month of habilitation will be a limitation for adults and therefore it cannot be appealed for recipients 21 and over. Requests submitted for recipients under the age of 21 will be reviewed under EPSDT and if denied, the recipient will be provided with an adverse decision notice that includes an appeal form and a description of how to appeal to the Office of Administrative Hearings.

Reminder:

- As stated in Implementation Update # 78, when submitting CAP MR/DD revision 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 MR2.
3. Copies of any revisions that were approved by VO after the last CNR and prior to the revision being requested.

If the Targeted Case Manager has not needed to submit a revision or provider change to the new UR Vendor, please include the last approved CNR packet and copies of any revisions that were approved by VO when the annual CNR is submitted to the appropriate UR Vendor.

Clinical Policy
DMA, 919-855-4372

Attention: Critical Access Behavioral Health Agencies and Utilization Review Vendors

Implementation of Independent Assessments for Community Support Team (CST)

The final revised policy for Community Support Team (CST) was posted in early August 2011. Although the policy stated that there was a 6-month per year hard limit for CST, the policy revision allows for exceptions to this limit when medical necessity is shown. The revision states:

Any request for an exception to this six month limit must be accompanied by a comprehensive clinical assessment completed by an independent licensed professional and an updated PCP with new service order signed by an MD, Licensed Psychologist, NP or PA. The Clinical Assessment must meet the requirements as specified in IU #36 and clearly document medical necessity as defined in the continued stay criteria in this policy. The independent licensed mental health professional must meet the criteria included in 10A NCAC 27G .0104 and must not be employed by the agency providing the Community Support Team service or have any financial or other interest in the agency providing the Community Support Team service.

Beginning on and after October 1, 2011, all requests for concurrent authorizations that extend the authorization beyond a 6 month period for that consumer per that year, must be accompanied by an independent assessment indicating that CST continues to be medically necessary as well as an updated PCP as noted above and in the policy. The independent assessment must have been completed within 60 days of the new authorization request. The 6 months per calendar year are cumulative and include any time over that calendar year when the consumer received CST services. If there has been a gap in services, and an initial authorization is requested that would lead to an individual receiving 6 or more months of CST that year, those initial requests must be accompanied by an independent assessment and PCP as noted above. Requests that do not include this documentation will be sent back as incomplete.

Behavioral Health Section
DMA, 919-855-4294

Attention: Dental Providers

Dental Seminars

Dental seminars are scheduled for the month of September, 2011. Information presented at these seminars will include a review of clinical coverage guidelines including prior approval and billing procedures, uses of the N.C. Electronic Claims Submission/Recipient Eligibility Verification Tool, and a review of common problems from provider enrollment to unintended billing errors to fraud, waste, and abuse. The seminars are scheduled at the locations listed below. Clinical Coverage Policy 4A, *Dental Services*, (January 1, 2011 revision) will be used as the primary training document for the seminar. Please review and print the Policy (on DMA's Clinical Coverage Policy and Provider Manuals web page) and bring it to the seminar. If preferred, you may download the Clinical Coverage Policy to a laptop and bring the laptop to the seminar or you may access the Clinical Coverage Policy 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.

Providers may register for the dental seminars by completing and submitting the online registration form. Or, providers may register by fax using the Dental Services Seminar Registration Form (fax it to the number listed on the form). Sessions will begin at 10:00 a.m. and end at 1:00 p.m. Providers are encouraged to arrive by 9:45 a.m. to complete registration. Lunch will not be provided at the seminars. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Date	Location
September 8, 2011	**New Bern** New Bern Convention Center Ballroom C 203 South Front Street New Bern NC 28563 get directions
September 13, 2011	**Asheville** Crowne Plaza Tennis & Gold Resort One Resort Drive Asheville NC 28806 get directions
September 14, 2011	**Charlotte** Crowne Plaza 201 South McDowell Street Charlotte, NC 28204 **Note: Parking fee of $6.00 per vehicle for parking at this location.** get directions

Date	Location
September 21, 2011	**Raleigh** Wake Tech Community College Student Service Building Conference Center Second Floor, Rooms 212-215 9191 Fayetteville Road Raleigh NC 27603 get directions
September 27, 2011	**Greensboro** Clarion Hotel Airport 415 Swing Road Greensboro NC 27409 get directions

Dental Seminars
September 2011 Seminar Registration Form
(No Fee)

Provider Name and Discipline ______________________________

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

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

Attention: HIV Case Management Providers

Application Deadline

The Division of Medical Assistance announced in the September 10, 2010 Medicaid Bulletin that there would be a restructuring of the certification process. The article went on to state that "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." **The deadline for submission of the application to The Carolinas Center for Medical Excellence is December 31, 2011.** Any agency that has not submitted an application by cob on December 31, 2011 will have their certification terminated and Provider Enrollment will be notified to terminate their provider number.

Training:
The Carolinas Center for Medical Excellence (CCME) and The Division of Medical Assistance are pleased to announce that in September 2011 we are offering HIV Basic Training for case managers and supervisors. This is mandatory training for those individuals who were hired after May 1, 2011 and have not attended Basic Training. It is also mandatory for those individuals who were hired prior to May 1, 2011 and did not attend one of the two day trainings on Clinical Coverage Policy 12B. See below for details.

Registration is now open for the following training: **HIV Case Management Basic Training.**
The location of this training is to be announced. Information for the September 2011 training including location is available on CCMEs' HIV Case Management web page.

Date	Session Topic	Required Attendees
September 12-15, 2011	**HIV Case Management Basic Training**	HIV Case Managers and HIV Case Manager Program Supervisors who were hired on or after May 1, 2011. In addition those case managers and supervisors who were hired as of April 1, 2010 and did not attend any of the sessions on Clinical Coverage Policy 12 B offered in 2010 and 2011.

The Carolinas Center for Medical Excellence in collaboration with the Division of Medical Assistance began in August 2011 the first round of site visits to certify agencies under Clinical Coverage Policy12 B. As part of this endeavor portions of new audit tool used for measuring compliance with Quality Assurance requirements were posted on CCME's web site. Those providers who are registered with CCME can access this tool by going to their web site (http://www.thecarolinascenter.org/HIVCM).

HIV Case Management Program
DMA, 919-855-4389

Attention: Nurse Practitioners and Physicians

Injection, Factor XIII Concentrate, 1 IU (Corifact®, HCPCS code J7199): billing Guidelines

Effective with date of service April 4, 2011, the NC Medicaid Program covers factor XIII concentrate (human) (Corifact) for use in the Physician's Drug Program when billed with HCPCS code J7199 (hemophilia clotting factor, not otherwise classified). Corifact is available in single-unit kit of 1000-1600 units of Factor XIII (FXIII).

Corifact is indicated for routine prophylactic treatment of congenital Factor XIII (FXIII) deficiency.

Corifact should be administered as 40 units/kg infused intravenously at a rate not exceeding 4 ml/minute, as an initial dose. A dose should be administered every 28 days and be adjusted +/- 5 units/kg based on trough levels from the Berichrom Activity Assay.

For Medicaid Billing

- Providers must bill Corifact with HCPCS code J7199 (hemophilia clotting factor, not otherwise classified).
- Providers must indicate the number of HCPCS units. Providers may bill for a whole single-dose kit.
- ICD-9-CM diagnosis code 286.3 (congenital deficiency of other clotting factors) must be billed with Corifact.
- One Medicaid unit of coverage is 1 IU. The maximum reimbursement rate per unit is $8.12.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units on rebatable NDCs. The NDC units for Corifact should be reported in international units as "F2." To bill for the whole single-dose kit of Corifact, report the NDC units as the total number of IUs in the kit. For example, if the kit contains 1000 IUs, report the NDC units as "F21000."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 new fee schedule for the Physician's Drug Program is available on DMA's website at: http://www.ncdhhs.gov/dma/fee/.

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

Attention: Nurse Practitioners

Nurse Practitioner Enrollment and Billing Instruction

All Nurse Practitioners must be enrolled with North Carolina Medicaid and all services provided by Nurse Practitioners must be filed to Medicaid with their NPI as the rendering (or attending) provider by October 1, 2011. Nurse Practitioners will not be allowed to bill "incident to" the physician after November 30, 2011.

Applicants must meet all program requirements and qualifications for enrollment before they can be enrolled as a Medicaid provider. Nurse Practitioners may enroll by completing the Medicaid provider enrollment application on www.nctracks.nc.gov. CSC, DMA's Enrollment, Verification and Credentialing vendor, is available to assist providers who want to enroll in NC Medicaid at 866-844-1113 or NCMedicaid@csc.com.

Clinical Policy
DMA, 919-855-4331

Attention: Optical Providers

Elimination of Adult Routine Eye Exams, Refractions, and Visual Aids Services and Related Prior Approval and Billing Issues

In accordance with House Bill 200, Section 10.37.(a), effective with date of service October 1, 2011, all routine eye exams, refractions, and visual aids for adult Medicaid recipients 21 years of age and older will no longer be covered.

In preparation for this policy revision, providers may view the proposed Routine Eye Exam and Visual Aids for Recipients under Age 21 Policy at http://www.ncdhhs.gov/dma/mpproposed/index.htm.

Regarding prior approval for visual aids:

- Visual aids may be approved for adult Medicaid recipients when the initial fitting date (date prior approval request is completed by the provider) is on or before September 30, 2011.

Regarding billing for visual aids:

- For prior approved visual aids with an initial fitting date on or before September 30, 2011 and a dispensing date on or after October 1, 2011, the provider must bill the refraction date. Otherwise, the claim will deny.
- Effective October 1, 2011, providers must bill S0620 (routine ophthalmological examination including refraction, new patient) or S0621 (routine ophthalmological examination including refraction, established patient) for routine eye exams.

Optical Program
DMA, 919-855-4310

Attention: Outpatient Behavioral Health Services Providers

Outpatient Behavioral Health Services Seminars

Outpatient Behavioral Health Services Provider seminars have been scheduled for November 2011. Information presented will include a review of Clinical Coverage Policy 8C -- Outpatient Behavioral Health services provided by Direct-Enrolled Providers and policy updates, billing procedures including billing "incident to" a physician, prior approval, National Correct Coding Initiative, Carolina Access for recipients under age 21, and Health Choice.

The seminar sites and dates will be announced in the October 2011 Medicaid Bulletin, which will be posted to http://www.ncdhhs.gov/dma/bulletin/index.htm. Pre-registration will be required. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Behavioral Health Section
DMA, 919-855-4290

Attention: PASRR Screeners for Instate and Out of State

N.C. Preadmission Screening and Resident Review

North Carolina and Out of State PASRR Screeners are required to accurately complete and attest to the accuracy of the screening information prior to admission to a NC Nursing Facility. The screen information must be accurate in order to comply with Subpart C CFR 483.100 and 483.126. Placement of an individual with mental illness (MI) or mental retardation (MR) in a nursing facility (NF) may be considered appropriate only when the individual's needs are such that he or she meets the minimum standards for admission and the individual's needs for treatment do not exceed the level of services which can be delivered in the NF to which the individual is admitted either through NF services alone or, where necessary, through NF services supplemented by specialized services arranged for by the State Mental Health Authority. The accuracy of the PASRR information is required for appropriate NF placement for individuals with MI or MR.

Note: The NC PASRR contractor (HP Enterprise Services) will review all PASRR documentation PRIOR TO ADMISSION to ensure nursing facility placement is appropriate.

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

Attention: Physicians and Physician Assistants

Physician Assistant Enrollment

Physician Assistants will be required to enroll with North Carolina Medicaid effective November 1, 2011. All services rendered by Physician Assistants must be filed to Medicaid with their NPI as the rendering (or attending) provider. Physician Assistants will not be allowed to bill "incident to" the physician after December 31**, 2011**.

Applicants must meet all program requirements and qualifications for enrollment before they can be enrolled as a Medicaid provider. Physician Assistants may enroll by completing the Medicaid provider enrollment application on www.nctracks.nc.gov. CSC, DMA's Enrollment, Verification and Credentialing vendor, is available to assist providers who want to enroll in NC Medicaid at 866-844-1113 or NCMedicaid@csc.com.

Clinical Policy
DMA, 919-855-4331

Attention: Residential Behavioral Health Providers

New Utilization Review Guidelines for Residential Behavioral Health Providers

As per legislation, Session Law, House Bill 200 on page 126 –127,

- Effective November 1, 2011, a comprehensive clinical assessment (CCA) completed and signed by a licensed mental health professional within 30 days of the requested admission date must be submitted with the ITR for initial reviews to assure the appropriateness of placement. Requests for transfer from one Level III or Level IV facility to another do not require a new CCA completed if the transfer is for the same level of care. Please see Implementation Update #36 for more information regarding comprehensive clinical assessments.
- Effective November 1, 2011, a psychiatric or psychological assessment is required for authorization requests past the 180 day mark, to be completed by a psychiatrist (MD/DO) or psychologist (PhD) within 60 days of the requested start date of the requested re-authorization period. This psychiatric or psychological assessment must be completed by an independent practitioner who is not associated with the residential services provider if the provider is not a Critical Access Behavioral Health Agency (CABHA).. If the residential services provider is a certified CABHA the assessment may be completed by a professional associated with the CABHA.. The UR vendor will require a statement from the independent evaluator who completes the CCA for the non-CABHA attesting that he or she is independent from, and not employed by or under contract with, the residential provider seeking prior authorization for services. When prior authorization is being requested by a CABHA, the UR Vendor will require a statement signed by the CABHA Clinical Director that the person completing the assessment is employed by or under contract with the CABHA.
- Documentation in the request for an extension past the 180 day mark must support that a Child and Family Team has reviewed goals and treatment progress and that the child or adolescent's

family or discharge setting is involvement in treatment planning and engaged in the treatment interventions.

- Independent assessments for extensions on Level III and Level IV past the 120 day mark are no longer required for requests for prior authorization.
- Providers will continue to submit an updated discharge summary but it will no longer need to be signed by the System of Care coordinator at the time of submission.

Clinical Policy
DMA, 919-855-4289

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

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

Proposed Clinical Coverage Policies

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

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

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

2011 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
September	9/1/11	9/7/11	9/8/11
	9/8/11	9/13/11	9/14/11
	9/15/11	9/22/11	9/23/11
	9/29/11	10/4/11	10/5/11
October	10/6/11	10/12/11	10/1311
	10/13/11	10/18/11	10/19/11
	10/20/11	10/27/11	10/28/11
	10/27/11	11/1/11	11/2/11

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

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

Melissa Robinson
Executive Director
HP Enterprise Services