September 2012 Medicaid Bulletin

IMPORTANT NOTICE

Attention: All Providers

Recredentialing is Required for All N.C. Medicaid and N.C. Health Choice Providers a Minimum of Every Three Years

The N.C. Division of Medical Assistance (DMA) is federally mandated to ensure that all provider information is accurate and current in the Enrollment, Verification and Credentialing (EVC) System. To that end, it is the State's policy to recredential providers and provider groups a minimum of every three years.

The EVC Operations Center electronically generates and distributes enrollment renewals for all enrolled providers 75 days prior to their three-year anniversary date or the date of their last renewal contract. Within 30 days of receiving the invitation letter, providers must verify their provider information and submit any additional information requested via the online recredentialing application.

Providers that do not take action within the specified time frame risk being terminated from the N.C. Medicaid and N.C. Health Choice programs. As a reminder, termination from the programs requires providers to re-enroll and pay any applicable fees. **Additionally, no claims will be paid during the time that providers are not enrolled in the programs.**

The explanation of benefits for **claims denial** will state:

- "1815-Payments denied for failure to re-credential billing provider enrollment. Please direct inquiries to CSC at 866-844-1113 for assistance in addressing this denial" or,
- "1813-Payments denied for failure to re-credential individual attending provider enrollment. Please direct inquiries to CSC at 866-844-1113 for assistance in addressing this denial."

The explanation of benefits for **provider termination** will state:

- "1814-Payments denied-Billing Provider eligibility terminated for failure to re-credential provider enrollment. Please direct inquiries to CSC at 866-844-1113 for assistance in addressing this denial" or,
- "1812-Payments denied-Attending Provider eligibility terminated for failure to re-credential provider enrollment. Please direct inquiries to CSC at 866-844-1113 for assistance in addressing this denial."

Providers are encouraged to be on the lookout for recredentialing invitations. The State will be targeting between 5,000 and 9,000 providers for recredentialing each month between now and the end of 2012.Additional information regarding the recredentialing process can be found at:

https://www.nctracks.nc.gov/provider/providerEnrollment/assets/onlineHelp/recredentialing_101_help.pdf

Questions should be directed to the EVC Operations Center at 866.844.1113 or by e-mail at NCMedicaid@csc.com.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Clinical Coverage Policies

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

- *1A-16, Surgery of the Lingual Frenulum (8/15/12)*
- *1E-6, Pregnancy Medical Home (8/15/12)*
- *1K-2, Bone Mass Measurement (8/1/12)*
- *3H-1, Home Infusion Therapy (8/15/12)*
- *8D-1, Psychiatric Residential Treatment Facilities for Children under the Age of 21 (8/1/12)*
- *8D-2, Residential Treatment Services (8/1/12)*
- *8E, Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (8/1/12)*
- *8J, Children's Developmental Service Agencies (CDSAs) (8/1/12)*
- *9, Outpatient Pharmacy Program (8/16/12)*
- *11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells (3/12/12)*
- *11B-1, Lung Transplantation (8/1/12)*
- *11B-2, Heart Transplantation (8/1/12)*
- *11B-3, Islet Cell Transplantation (8/1/12)*
- *11B-5, Liver Transplantation (8/1/12)*
- *11B-6, Heart/Lung Transplantation (8/1/12)*
- *11B-7, Pancreas Transplant (8/1/12)*
- *11B-8, Small Bowel and Small Bowel/Liver and Multivisceral Transplants (8/1/12)*

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

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

CPT Procedure Code 93278

On March 20, 2012, the North Carolina Physician Advisory Group approved the N.C. Medicaid and N.C. Health Choice (NCHC) clinical coverage policy "Electrocardiography, Echocardiography and Intravascular Ultrasound". As noted in the policy when it was posted for public comment, CPT code 93278 (Signal-Averaged electrocardiography with or without ECG) was removed from Medicaid coverage. It had been in section 3.2.6. N.C. Health Choice never covered this service. This policy was posted as a final policy effective July 1, 2012.

CPT procedure code 93278 is considered investigational and experimental. N.C. Medicaid and NCHC do not cover procedures that are investigational and experimental.

System changes to enforce the policy are now complete. Providers billing for this procedure for dates of service on or after July 1, 2012 will receive a denial.

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

Attention: All Providers

CPT Procedure Code 97598 – Unit Limitations

Included in the new CPT codes effective January 1, 2011 was a procedure code description change. The new description of CPT procedure code 97598 is "debridement, open wound, including topical application(s), wound assessment, use of a whirlpool, when performed, and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 sq cm or part thereof (list separately in addition to code for primary procedure.)" This code became an add on code to primary code 97597 "first 20 sq cm or less".

Prior to this change, the description read "total wound(s) surface area greater than 20 square centimeters" and had a unit limitation of 1.

The N.C. Division of Medical Assistance (DMA) was notified that providers were receiving denials for multiple units instead of receiving reimbursement for "each addition 20 sq cm". System changes needed after the description change have been completed and CPT 97598 now has a unit limitation of 14 per day and must be billed with 97597. These changes have been made effective with the date of the description changes, January 1, 2011.

Providers who received a denial when billing CPT 97598 for unit limitations after January 1, 2011 may resubmit the denied charges as a new claim (not as an adjustment request) for processing.

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

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Attention: All Providers

System Changes From the Annual CPT Update 2012

The following changes were noted from the 2012 Resource-based Relative Value Scale (RBRVS) file and the *2012 CPT Professional Edition Manual*.

CPT procedure code 29826
Description: Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament release, when performed (List separately in addition to code for primary procedure).

- Effective with date of service January 1, 2012, CPT procedure code 29826 was changed from a procedure with 90 global days to an add-on procedure.
- Pre-care day is changed from 1 to 0 and post-op days are changed from 90 to 0.
- CPT 29826 with a 54 modifier (surgical care only) and with a 55 modified (postoperative management only) are end-dated.
- CPT 29826 must be billed with CPT procedure codes 29806-29825, 29827 or 29828.

CPT procedure code 38230
Description: Bone marrow harvesting for transplantation; allogeneic.

- Effective with date of service January 1, 2012, CPT procedure code 38230 was changed from a procedure with 10 global days to 0 global days.
- Post-op days are changed from 10 to 0.
- CPT 38230 with a 54 modifier (surgical care only) and with a 55 modifier (postoperative management only) are end-dated.

CPT procedure codes 99354, 99356, and 99357
Description: Prolonged service codes with direct patient contact.

- Effective with date of service January 1, 2012, the description was changed from "physician" to "physician or other qualified health care professional."
- Nurse practitioners and physician assistants are added to the allowed providers to provide these services.

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

Attention: All Providers

Update for Prior Approval of Imaging Procedures and MedSolutions

The Prior Approval for Imaging Policy – www.ncdhhs.gov/dma/mp/1K-7.pdf – was updated March 12, 2012. Note the following reminders and updates for this program.

- MedSolutions only does prior approval for the procedure codes listed in Attachment B. Do not contact MedSolutions for authorization on any other procedures. For questions about prior approval of any other procedure codes, contact HP Enterprises at (800) 688-6696 or (919) 851-8888.

- This is a **PRIOR** approval program. The request for authorization must be done **before** the test is done.

  The only exceptions are:

    o **Retrospective Requests** – Requests made after service performance (retrospective requests) will be permitted only in cases where imaging is clinically urgent. Retrospective requests for cases that are clinically urgent can be submitted up to and including two business days after the service was performed. The ordering physician must call MedSolutions (888-693-3211) with the required medical information. Authorizations on retrospective requests are valid for the date of service only. Requests will be denied if they are submitted beyond the established time limit, or if medical necessity and clinical urgency requirements are not met. (See Section 5.5)

    o **Retroactive Beneficiary Eligibility** –MedSolutions will accept retroactive requests for beneficiaries who obtained Medicaid retroactively. MedSolutions will accept these requests up to 12 months from date of service. Providers must fill out the N.C. Division of Medical Assistance (DMA) Retro Request Fax Form (located at www.medsolutionsonline.com) – including evidence of retroactive eligibility and clinical information to support medical appropriateness. The form should be faxed to MedSolutions at (888) 693-3210. This process will also include beneficiaries with presumptive eligibility. Once the beneficiary is issued a Medicaid number, the provider must follow the same procedure as described above. (See Section 5.3.1)

    o **Misrepresentation of Medicaid** – MedSolutions will accept retroactive requests for beneficiaries who misrepresented their Medicaid coverage on the date of service. This would include beneficiaries who failed to tell the provider of Medicaid coverage and beneficiaries who did not have their Medicaid information. Providers must fill out the N.C. DMA Retro

Request Fax Form (located at www.medsolutionsonline.com) – including evidence of registration error and clinical information to support medical appropriateness. The form should be faxed to MedSolutions at (888) 693-3210. (See Section 5.3.2)

- o **Pregnancy Medical Home Providers** – Providers enrolled in the Pregnancy Medical Home must register the obstetrical ultrasounds with MedSolutions within five business days from the date when procedure was performed. (See Section 3.2.1)

- **Claims Submission --** The following items will be used to identify situations where prior approval is not required (this applies to for both the technical and professional components). (See Section K)

Type of Stay/Visit	Billing Instruction	
	Institutional Format	Professional Format
Inpatient stay	Enter bill type 11x in form locator 4	Enter modifier U2 in field 24D
Emergency department visit	Enter revenue code 450 in form locator 42	Enter modifier U2 in field 24D
Observation stay	Enter revenue code 762 in form locator 42	Enter modifier U2 in field 24D
Observation stay in labor & delivery	Enter modifier U2 in form locator 44	Enter modifier U2 in field 24D
Hospital emergency department or urgent care facility referral	Enter modifier U2 in form locator 44	Enter modifier U2 in field 24D

- **Adverse Decisions** – MedSolutions must notify the ordering physician and requesting facility in writing of any denial, and provide a rationale for the determination within five business days of the request. The provider may do a peer-to-peer and reconsideration request on the same denial – but both must be requested within five business days of the date of the denial. (See Section 5.6)

- **Provider Claims Denial Appeal** – If a provider files a claim on a procedure without prior approval and receives a denial, the provider can file a provider claims denial appeal. The provider would send a letter explaining the circumstances of the claim denial and any medical information that is pertinent to the DMA Claims Unit, 2501 Mail Service Center, Raleigh, N.C. 27699-2501.

- **Physician Assistants** – Physician Assistants currently enrolled in N.C. Medicaid can now be the ordering provider to have a procedure authorized with MedSolutions.

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

Attention: All Providers

Basic N.C. Medicaid and N.C. Health Choice Seminars

Basic Medicaid and N.C. Health Choice (NCHC) seminars are scheduled for the months of October and November 2012. Seminars are intended to educate providers on the basics of Medicaid and NCHC billing, as well as to provide an overview of policy updates, contact information, and fraud, waste and abuse.

The focus of the morning session will be the first eight sections of the revised October 2012 *Basic Medicaid and N.C. Health Choice 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 2012 Billing Guide will be reviewed during these breakout sessions focusing 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 October 2012 Billing Guide, which will be posted on the DMA seminar web page 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. Alternatively, 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 these documents 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. Bring your seminar confirmation with you to the morning and afternoon sessions of 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. Please include a fax number or a valid e-mail address for your return confirmation.

The morning session will begin at 9 a.m. and end at 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 run from 1 p.m. to 4 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 9, 2012	**Greensboro** Clarion Hotel Airport 415 Swing Road Greensboro, NC 27409 get directions
October 11, 2012	**Charlotte** Crowne Plaza 201 South McDowell Street Charlotte, NC 28204 **Note: Parking fee of $5.00 per vehicle for parking at this location.** get directions
October 17, 2012	**Greenville** Hilton 207 SW Greenville Blvd Greenville, NC 27834 get directions
October 23, 2012	**Asheville** Crowne Plaza Tennis & Golf Resort One Resort Drive Asheville, NC 28806 get directions
October 30, 2012	**Fayetteville** Cumberland County DSS 1225 Ramsey Street Fayetteville, NC 28301 get directions
November 1, 2012	**Raleigh** Wake Tech Community College Student Service Building Conference Center Second Floor, Rooms 213 & 214 9191 Fayetteville Road Raleigh NC 27603 get directions

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

Attention: All Providers

N.C. Health Check Seminars

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

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

Providers may register for the seminars by completing and submitting the online registration form. Include a valid e-mail address. Providers may also register by fax to the number listed on the form. Include a fax number or a valid e-mail address.

Providers will receive a registration confirmation by fax or e-mail. Indicate the session you plan to attend on the registration form. Bring a copy of the latest version of the Health Check Billing Guide with you to the seminar. Copies will not be provided.

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

Seminar Dates and Locations:

Date	Location
September 12, 2012	**Charlotte** Crowne Plaza 201 South McDowell Street Charlotte, NC 28204 **Note: Parking fee of $5.00 per vehicle for parking at this location.** get directions
September 18, 2012	**Winston-Salem** Marriott Winston-Salem 425 N. Cherry Street Winston-Salem, NC 27101 get directions
September 25, 2012	**Raleigh** Wake Tech Community College Student Service Building Conference Center 9191 Fayetteville Road, Rooms 213 & 214 Raleigh NC 27603 get directions

Date	Location
September 27, 2012	**Fayetteville** Cumberland County DSS 1225 Ramsey Street Fayetteville, NC 28301 get directions

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

Attention: All Providers

At-Risk Case Management Services (ARCM) for Eligible N.C. Health Choice (NCHC) Beneficiaries

Effective September 1, 2012, the At-Risk Case Management (ARCM) program provides coverage to children eligible under the N.C. Health Choice (NCHC) program. NCHC beneficiaries – ages 6 through 18 years of age – must be enrolled on the date of service to be eligible and must meet policy coverage criteria unless otherwise specified. All NCHC clinical coverage policies are posted electronically with the N.C. Medicaid Program clinical coverage policies and provider manuals. For more information, visit www.ncdhhs.gov/dma/mp/.

When billing for ARCM for NCHC, providers should use procedure code T1017. The NCHC reimbursable rate is the same as the N.C. Medicaid reimbursable rate. Providers should bill their usual and customary charges. More information is located at: www.ncdhhs.gov/dma/fee/tcm/TCM_ARCM_fee111101.pdf.

Effective with the June 1, 2012 service month, a new SIS Code and a new Program Code was implemented to distinguish between N.C. Medicaid and NCHC services for day sheet coding purposes.

The new codes are:

- SIS Code 392 (At Risk Case Management Services – Child Welfare)
- Program Code HC2 (Health Choice CM)

The following chart gives examples of how the code would be used.

Code	Example
SIS Code 392 and Program Code HC2	Use when coding the day sheet for an ARCM-NCHC beneficiary
SIS Code 392 and Program Code 2	Use when coding the day sheet for an ARCM-Medicaid beneficiary.

ARCM adults would continue to be coded using SIS Code 395 and Program Code 2.

Rate Setting
DMA, 919-814-0062

Attention: All Providers and N.C. Health Choice Providers

Influenza Vaccine and Reimbursement Guidelines for 2012-2013 for Medicaid and N.C. Health Choice (NCHC)

Each year scientists try to match the viruses in the influenza vaccine to those most likely to cause flu that year. This season's influenza vaccine is comprised of the following three strains:

- A/California/7/2009 (H1N1)pdm09-like virus
- A/Victoria/361/2011 (H3N2)-like virus
- B/Wisconsin/1/2010-like virus (from the B/Yamagata lineage of viruses)

For further details on the 2012-2013 influenza vaccine, see the Advisory Committee on Immunization Practices (ACIP) recommendations found on the CDC website at: www.cdc.gov/mmwr/preview/mmwrhtml/mm60e0818a1.htm?s_cid=mm60e0818a1_w

N.C. Medicaid does not expect that providers will be vaccinating beneficiaries with the 2012-2013 influenza season's vaccine after date of service June 30, 2013.

N.C. Immunization Program/Vaccines for Children (NCIP/VFC)

The N.C. Immunization Branch distributes all required childhood vaccines to local health departments, hospitals, and private providers under NCIP/VFC guidelines. For the 2012-2013 influenza season, NCIP/VFC influenza vaccine is available at no charge to healthcare providers serving children 6 months through 18 years of age who are eligible for the VFC program and other covered groups, according to the NCIP coverage criteria. The current NCIP coverage criteria, and definitions of VFC categories, may be found on the NCIP website at: www.immunize.nc.gov/providers/coveragecriteria.htm.

Eligible children include American Indian and Alaska Native (AI/AN) N.C. Health Choice (NCHC) beneficiaries. These beneficiaries are identified as MIC-A and MIC-S on their NCHC Identification Cards. All other NCHC beneficiaries are considered *insured,* and must be administered privately purchased vaccines. However, the NCIP/VFC program allows beneficiaries/parents to declare their VFC eligibility status. When an NCHC beneficiary self-declares their status as Alaska Native or American Indian and the provider administers the state-supplied vaccine, the provider must report the CPT vaccine code with $0.00 and may bill for the administration costs. Refer to the June 2012 general Medicaid article, *Billing for Immunizations for American Indian and Alaska Native N.C. Health Choice Recipients* at: www.ncdhhs.gov/dma/bulletin/pdfbulletin/0612bulletin.pdf for further details.

For VFC or NCIP vaccines, providers will only report the vaccine code but may bill for the administration fee for Medicaid and eligible AI/AN NCHC beneficiaries. Providers wishing to immunize children who are *not* VFC-eligible – including all NCHC children who are not AI/AN – and adult patients who do not meet the eligibility criteria for NCIP influenza vaccine must purchase vaccine for those groups. If Medicaid-eligible

beneficiaries over 18 years of age do not qualify for the NCIP vaccine, vaccine purchase and administration costs may be billed to Medicaid.

Billing/Reporting Influenza Vaccines for Medicaid Beneficiaries

The following tables indicate the vaccine codes that can be either reported (with $0.00 billed) or billed (with the usual and customary charge) for influenza vaccine, depending on the age of the beneficiaries and the formulation of the vaccine. The tables also indicate the administration codes that can be billed, depending on the age of the beneficiaries.

Note: The information in the following tables is **not** detailed billing guidance. Specific information on billing all immunization administration codes for NCHC beneficiaries can be found in the July 2012 Special Bulletin, *Health Check Billing Guide 2012,* at: www.ncdhhs.gov/dma/healthcheck/BillingGuide2012.pdf.

Table 1: Influenza Billing Codes for Medicaid Beneficiaries Less Than 19 Years of Age Who Receive VFC Vaccine

Vaccine CPT Code to Report	CPT Code Description
90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90660	Influenza virus vaccine, live, for intranasal use (FluMist)
Administration CPT Code(s) to Bill	**CPT Code Description**
90471EP	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **1 vaccine** (single or combination vaccine/toxoid)
+90472EP (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **each additional vaccine** (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note**: Providers *may* bill more than one unit of 90472EP as appropriate.
90473EP	Immunization administration by intranasal or oral route; **1 vaccine** (single or combination vaccine/toxoid). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.

[Table 1 is continued on the next page]

(Table 1 – Continued)

Administration CPT Code(s) to Bill	CPT Code Description
+90474EP (add-on code)	Immunization administration by intranasal or oral route; **each additional vaccine** (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.

Table 2: Influenza Billing Codes for Medicaid Beneficiaries 19 and 20 Years of Age

Use the following codes to report influenza vaccine provided through NCIP or to **bill** Medicaid for an influenza vaccine **purchased** and administered to beneficiaries **19 through 20 years of age.**

Note: For the 2012-2013 flu season, the NCIP will not provide LAIV (CPT code 90660, FluMist) for adults.

Vaccine CPT Code to Report or Bill	CPT Code Description
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90660 (purchased vaccine only)	Influenza virus vaccine, live, for intranasal use (FluMist)
Administration CPT Code(s) to Bill	**CPT Code Description**
90471EP	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **1 vaccine** (single or combination vaccine/toxoid)
+90472EP (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **each additional vaccine** (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure
90473EP	Immunization administration by intranasal or oral route; **1 vaccine** (single or combination vaccine/toxoid). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.
+90474EP (add-on code)	Immunization administration by intranasal or oral route; **each additional vaccine** (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.

Table 3: Influenza Billing Codes for Medicaid Beneficiaries 21 Years of Age and Older

Use the following codes to report the *injectable* influenza vaccine provided by NCIP or to **bill** Medicaid for an *injectable* influenza vaccine **purchased** and administered to beneficiaries **21 years of age and older.**

Note: For the 2012-2013 flu season, the NCIP will not provide LAIV (CPT code 90660, FluMist) for adults. Medicaid does NOT reimburse for purchased LAIV for those beneficiaries 21 years of age and older.

Vaccine CPT Code to Report or Bill	CPT Code Description
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
Administration CPT Code(s) to Bill	**CPT Code Description**
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **1 vaccine** (single or combination vaccine/toxoid)
+90472 (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **each additional vaccine** (single and combination vaccine/toxoid) (List separately in addition to primary procedure)

For beneficiaries 21 years of age or older receiving an influenza vaccine, an evaluation and management (E/M) code *cannot* be reimbursed to any provider on the same day that injection administration fee codes (e.g., 90471 or 90471 and +90472) are reimbursed, unless the provider bills an E/M code for a separately identifiable service by appending modifier 25 to the E/M code.

Note: The influenza vaccine is one of four vaccines for which Medicaid will reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). These providers may bill the appropriate CPT code for the vaccine used (90656, 90658 or 90660) along with the appropriate administration code (90471 through 90474). For beneficiaries 0-20 years of age, if the vaccine was provided through the NCIP, the center/clinic may bill only for the administration costs under the C suffix provider number.

Billing/Reporting Influenza Vaccines to Medicaid for NCHC Beneficiaries

The following table indicates the vaccine codes that can be either reported (with $0.00) or billed (with the usual and customary charge) for influenza vaccine, depending on an NCHC beneficiary's VFC eligibility and the formulation of the vaccine. The table also indicates the administration codes that may be billed.

Table 4: Influenza Billing Codes for NCHC Beneficiaries 6 through 18 Years of Age Who Receive VFC Vaccine (MIC-A and MIC-S Eligibility Categories or Beneficiaries in Other Categories who Self Declare AI/AN Status) or Purchased Vaccine (All Other NCHC Eligibility Categories)

Vaccine CPT Code to Report/Bill	CPT Code Description
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90660	Influenza virus vaccine, live, for intranasal use (FluMist)
Administration CPT Code(s) to Bill	**CPT Code Description**
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **1 vaccine** (single or combination vaccine/toxoid)
+90472 (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **each additional vaccine** (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note**: Providers *may* bill more than one unit of 90472 as appropriate.
90473	Immunization administration by intranasal or oral route; **1 vaccine** (single or combination vaccine/toxoid). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.
+90474 (add-on code)	Immunization administration by intranasal or oral route; **each additional vaccine** (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.

Note: The EP modifier should NOT be billed on NCHC claims.

For FQHCs and RHCs, for NCHC beneficiaries 6 through 18 years of age, if the vaccine was obtained through the NCIP, the clinic may bill only for the administration costs under the C suffix provider number. The vaccine CPT code must be reported and $0.00 should be billed.

Refer to the Physician's Drug Program fee schedule on the N.C. DMA website at: www.ncdhhs.gov/dma/fee/fee.htm.

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

Attention: All Providers

Changes in the Medicaid Beneficiary Fair Hearing Process (Appeal Process)

Medicaid is an entitlement program. As a result, the beneficiary has a constitutional right to appeal a Medicaid decision that denies, reduces, terminates, or suspends a request for Medicaid services (medical, dental, behavioral health) and to a fair hearing pursuant to the Social Security Act, 42 C.F.R. 431.200 *et seq.*, and N.C.G.S. §108A-70.9. Under these regulations, a hearing is held before the Office of Administrative Hearings (OAH) by an administrative law judge who issues a decision in the case. Currently, that decision is sent to the State agency – the N.C. Division of Medical Assistance (DMA) – for a final agency decision which is the decision healthcare providers implement.

Effective no later than February 1, 2013, the N.C. General Assembly enacted Session Laws 2011-398 and 2012-187, which grants final decision authority to the Office of Administrative Hearings. As this action is different from the federal requirements found at 42 C.F.R. 431.200 *et seq.*, the State of North Carolina must obtain permission from the Centers for Medicare and Medicaid (CMS) for the final decision to be made by OAH rather than DMA.

This request has been sent to CMS but has not yet been approved.

If approval is granted, providers will be notified via the Medicaid Bulletin and will then be able to implement the OAH decision as the final decision.

This information will be communicated to beneficiaries. Questions about the Medicaid beneficiary appeal process may be addressed to OAH at 919-431-3000 or the Appeals Section, Clinical Policy and Programs, Division of Medical Assistance (Medicaid) at 919-855-4350.

Appeals Section, Clinical Policy and Programs
DMA, 919-855-4350

Attention: All Providers

N.C. Health Choice (NCHC) Medical Transportation

Session Law 2011-145 was passed in the last legislative session. It mandated that "Except as otherwise provided for eligibility, fees, deductibles, co-payments, and other cost sharing charges, health benefits coverage provided to children eligible under the NC Health Choice Program must be equivalent to coverage provided for dependents under the North Carolina Medicaid Program."

G.S. 108A-70.21(b) (2) requires that *non-emergency* medical transportation <u>not</u> be a covered service for NC Health Choice (NCHC) beneficiaries.

There are differences between emergency and non-emergency transportation. Transportation is only covered for NCHC recipients as outlined below. This article will provide clarification for providers regarding the billing processes for emergency transportation services for NCHC beneficiaries.

Emergency Ground Transportation

NCHC covers ground transportation for emergency medical conditions that meet the criteria outlined in 42 C.F.R. 489.24:

> A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in:
> > (a) Serious impairment to bodily functions; or
> > (b) Serious dysfunction of any body organ or part.

Emergency Air Transportation

NCHC covers licensed air ambulance transportation when it is medically necessary for the health and safety of the beneficiary when the following criteria are met:

1. A beneficiary confined in a hospital has a condition which requires immediate treatment to maintain life, limb, or function and this treatment cannot be performed at the institution where the beneficiary is presently confined, and the beneficiary must be transferred to a facility that can accept him and provide the appropriate treatment; **or**

2. A beneficiary is not confined to a hospital but has a condition which requires immediate treatment to maintain life, limb, or function, **and** the beneficiary must be transported to the nearest or most medically appropriate facility that can accept him and provide the appropriate treatment.

Prior Approval for Emergency Transportation

Prior approval is never required for emergency ground or air transportation.

Billing for Emergency Transportation Services

NCHC reimburses claims with the following CPT codes for emergency transportation services:

HCPCS Procedure Code	Description
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALSI-emergency)
A0429	Ambulance service, basic life support, emergency transport (BLS, emergency)
A0425	Ground mileage, per statute mile
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0435	Fixed wing air mileage, per statute mile
A0436	Rotary wing air mileage, per statute mile

Other

NCHC reimburses the following:
1. **Loaded mileage**
   For ground ambulance, loaded mileage is from the point of origin to the nearest appropriate facility. Mileage to a facility that does not meet this criterion is not covered.

   For air medical ambulance (fixed wing and rotary wing), the point of origin includes the recipient loading point and runway taxiing until the recipient is offloaded from the air medical ambulance. Air mileage is based on loaded miles flown, as expressed in statute miles, and is reimbursable.

2. **Out-of-county ground mileage**
   Ground ambulance loaded mileage is reimbursable **only** for out-of-county transport. In-county loaded ground mileage is not reimbursable

N.C. Health Choice
DMA, 1-800-688-6696

Attention: All Providers

Communicating Effectively with Deaf, Hard of Hearing and Deaf-Blind Patients and Family Members in Healthcare Settings

Effective communication between healthcare providers and their patients is essential. For communication with patients or family members who are Deaf, Hard of Hearing and Deaf-Blind to be effective, healthcare providers may need sign language interpreting services.

The Americans with Disabilities Act requires the provision of auxiliary aids and services (i.e., sign language interpreters) to ensure equal access to services. For individuals who are Deaf, Deaf-Blind or Hard of Hearing, equal access may be achieved through effective communication with their service provider. Ultimately, "effective communication" is information that is equally clear and understandable to all parties, just as it would be if the individual was not Deaf, Deaf-Blind or Hard of Hearing. In the healthcare setting, effective communication is paramount to preventing misdiagnosis or improper medical treatment and to fully informing patients of their medical needs.

It is important to recognize that for most individuals who use American Sign Language (ASL), English is a second language. ASL, as a recognized foreign language, differs greatly from English. Therefore, communicating in written English may not meet the standard for effective communication, especially in healthcare settings where emotions may be involved and the healthcare provider may be using specialized vocabulary unfamiliar to the patient. Lip-reading is another method of communication that is often ineffective in healthcare settings – approximately only 30% of English is visible on the lips and, therefore, the potential for miscommunication is extremely high.

Although there are various communication methods utilized by Deaf, Hard of Hearing and Deaf-Blind individuals, often the best way to ensure effective communication for both the patient and the healthcare provider is through the use of a qualified sign language interpreter. Using a qualified interpreter allows both parties to communicate in their preferred and natural language and supports the goal of equal access to services as outlined in the ADA.

Qualified sign language interpreters may hold national certifications and interpreting degrees. In North Carolina, however, they must be licensed in order to provide services (per N.C.G.S 90D). Interpreters must adhere to a professional code of conduct and should be considered a part of the healthcare team. Family members and/or friends of the Deaf, Deaf-Blind or Hard of Hearing individual should never be used as interpreters.

Another method of communication that is gaining in popularity is Video Remote Interpreting (VRI). This is a service that allows the healthcare provider to use a laptop computer, webcam and high-speed Internet connection to communicate with the Deaf patient through a sign language interpreter on video. In certain situations, this service can cut down on the waiting time for an interpreter to become available – or provide a

solution to the difficulty of obtaining a qualified interpreter in locations where such interpreters are scarce. However, it is vital to understand that there are a number of situations in the healthcare setting where it is very difficult and even impossible to achieve effective communication through VRI.

In addition, not all videoconferencing software programs are HIPAA-compliant.

The cost of providing accommodations to an individual with disability cannot be passed onto that individual. However, the Internal Revenue Code does provide tax credits for businesses that incur expenses in assuring accessibility for people with disabilities.

Given the potential complexity of trying to assure effective communication, Interpreting Services Specialists at the N.C. Division of Services for the Deaf and the Hard of Hearing (DSDHH) regional centers are available to provide consultation, guidance and training to healthcare providers on assuring effective communication with their Deaf, Hard of Hearing and Deaf-Blind patients and family members. **There is no charge for these services.** Contact information can be found at www.ncdhhs.gov/dsdhh/where.htm.

The Division of Services for the Deaf and the Hard of Hearing (DSDHH), of the N.C. Department of Health and Human Services (DHHS), is required by General Statue 8B to "prepare and maintain an up-to-date list of qualified and available interpreters." Below are links to DSDHH's directories listing sign language interpreters (by region) who are licensed in North Carolina.

DSDHH Statewide Licensed Interpreter Directories:

- www.ncdhhs.gov/dsdhh/services/pdf/directory_asheville.pdf
- www.ncdhhs.gov/dsdhh/services/pdf/directory_charlotte.pdf
- www.ncdhhs.gov/dsdhh/services/pdf/directory_greensboro.pdf
- www.ncdhhs.gov/dsdhh/services/pdf/directory_morganton.pdf
- www.ncdhhs.gov/dsdhh/services/pdf/directory_raleigh.pdf
- www.ncdhhs.gov/dsdhh/services/pdf/directory_wilmington.pdf
- www.ncdhhs.gov/dsdhh/services/pdf/directory_wilson.pdf
- www.ncdhhs.gov/dsdhh/services/pdf/directory_CLT.pdf
- www.ncdhhs.gov/dsdhh/services/pdf/directory_ISA.pdf

Guidelines for procuring interpreting/transliterating services are available to assist healthcare providers in selecting an interpreter who is qualified to interpret in healthcare settings: www.ncdhhs.gov/dsdhh/services/hiring_SLI.htm

Additional Resources:

- ADA: www.ada.gov
- ADA Business Brief: www.ada.gov/hospcombr.htm

- RID Standard Practice Paper, Interpreting in Healthcare Settings:
  http://rid.org/UserFiles/File/pdfs/Standard_Practice_Papers/Drafts_June_2006/Health_Care_Settings_SPP.pdf
- NC Interpreter/Transliterator Law:
  www.ncga.state.nc.us/enactedlegislation/statutes/pdf/bychapter/chapter_90d.pdf

Division of Services for the Deaf and the Hard of Hearing
(919) 874-2212 or (800) 851-6099

Attention: All Providers

EHR Incentive Program Updates

Meaningful Use Attestation Portal is Open!

As of Monday, August 20, 2012, eligible professionals (EP) are able to attest for
Meaningful Use (MU) via the NC-MIPS Portal.

If you have received a 2011 Adopt, Implement or Upgrade (AIU) incentive payment, the
earliest opportunity to attest for a Year 2 MU incentive payment was August 20, 2012.
The reporting period for a 2012 MU payment is any continuous 90 days between January
1, 2012 and December 31, 2012.

If you attest to and receive a payment for AIU in 2012, the earliest you will be able to
attest to MU will be April 1, 2013 (for the continuous 90-day period, January 1, 2013 –
March 31, 2013).

If you have not yet attested for the N.C. Medicaid Electronic Health Record (EHR)
Incentive Program, you must register for the EHR Incentive Programs with CMS before
attesting with North Carolina for a payment.

Please watch for announcements posted on the DMA EHR Incentive Program website
(www.ncdhhs.gov/dma/provider/ehr.htm) or the NC-MIPS Portal
(https://ncmips.nctracks.nc.gov/) regarding system availability and updates.

DMS is committed to providing continued enhancements and system upgrades to the
provider community. We appreciate your support.

Definition of a Group for Patient Volume Reporting

The N.C. Medicaid EHR Incentive Program has defined a "group" for the purposes of
using group methodology when determining N.C. Medicaid patient volume, as follows:

A **group** is one or more eligible professionals practicing together at one practice location or at multiple practice locations within a logical geographical region under the same healthcare organization.

This definition was written to be as flexible as possible within the federal regulation, while still lending enough definition for auditing and program integrity purposes.

Oct. 3 is the Last Day for EPs to Begin their 90-Day MU Reporting Period with Medicaid for 2012

The last day to begin the 90-day reporting period is Wednesday, Oct. 3 for those EPs who plan on attesting with Medicaid for an MU payment for calendar year 2012.

This means that EPs who have **not** already recorded 90 days of MU data in their electronic health record system **must** begin their consecutive 90-day MU reporting period by Oct. 3 in order to attest and receive a Medicaid incentive payment for MU for calendar year 2012.

N.C. Medical Society Holds Meaningful Use for Specialists Webinar

Did you know that Specialists can claim exclusions to MU criteria that do not apply to their specialty, as well as enjoy great flexibility in the reporting requirements for Quality Measures?

The N.C. Medical Society invites you to an overview of the MU requirements as they pertain to specialists on **Sept. 12 at noon** for a one-hour webinar.

More information can be found on the N.C. Medicaid EHR Incentive Program website at www.ncdhhs.gov/dma/provider/ehr.htm.

Additional Program Resources

As MU requirements ramp up, providers may be feeling overwhelmed. In addition to our website, here are a few other online resources that provide additional guidance.

- The Health Resources and Services Administration (HRSA) has created a website dedicated to Health IT Adoption & Quality Improvement. Its Health Information Technology (Health IT) Toolkit is a compilation of planning, implementation, and evaluation resources to help community health centers, other safety net providers, and ambulatory care providers implement health IT applications in their facilities. This is a good resource to better understand what questions to ask vendors and what technology system is best for your specific practice and specialty type.

- The N.C. Area Health Education Center (AHEC) has created the AHEC Digital Library, which houses full-text journals and textbooks, and serves as a reference for all North Carolina healthcare professionals to support their clinical and

educational needs. The Library contains OVID databases – such as MEDLINE and CINAHL – comprehensive health information sites – such as MDConsult – links to drug information and health news, patient education materials, and continuing education opportunities.

NC Medicaid EHR Incentive Program Special Bulletin Updated

The *June 2012 Special Bulletin – Electronic Health Records (EHR) Program Updates* will be revised and reposted in September 2012. Section 6 *Path to Payment* has been updated to include the possibility of EH attestation to MU in the first year of program participation. Attachment E has been updated with the definition of a group for purposes of calculating Patient Volume with Group Methodology.

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

Attention: All Hospitals

Clarification on CMS Guidance around Medicaid Attestations for Eligible Hospitals

The N.C. Medicaid Electronic Health Record (EHR) Incentive Program is providing all eligible hospitals (EH) with additional guidance about attesting for its program.

In short, once an EH attests to Medicare, it will follow the Medicare reporting schedule for Medicaid attestation.

As the charts below indicate, EHs that attest with Medicaid before Medicare may receive an incentive payment for adopting, implementing or upgrading (AIU), while EHs that attest with Medicare first must report on Meaningful Use (MU) in order to receive Medicaid payments.

Even if you've already attested to MU for Medicare, it is a simple process to submit your MU attestation for Medicaid:

1. Ensure dual eligibility applies for both the Medicare and Medicaid programs
2. Sign into the NC-MIPS Portal with your NCID
3. Confirm demographic information and enter cost report, patient volume, and contact information
4. Select MU on the attestation page, and key in the same reporting period used for the current year's Medicare attestation
5. Print, sign and send your attestation

Those are the only steps. There is no need to re-report the MU data you submitted to Medicare.

The tables below describe examples of scenarios in which hospitals may find themselves. The tables are based on the assumption that after the EH attests once, it will be attesting to both programs each year.

> ***NOTE:*** *The scenarios below are based on the assumption that an EH is dually-eligible for both Medicare and Medicaid. After attesting to 90 days of MU with Medicare, EHs will always attest to 365 days of MU for each of their payment years thereafter. Even if the EH skips a year with Medicaid, it will still be required to attest to 365 days of MU.*

Scenario 1: **EH attests to Medicare first and then attests with Medicaid in 2012**

	Payment Schedule (Based on FFY)	**Earliest Date to Attest with Medicaid in the NC-MIPS MU Portal**
Attests with Medicare before Medicaid in same year	In 2012: First payment year for **Medicare & Medicaid** – attest to 90 days of MU In 2013 & beyond: For **Medicare & Medicaid** – attest to 365 days of MU	Aug. 20, 2012 (after attestation with Medicare) - opening of NC-MIPS MU Portal

For Medicaid Participation: Attest to 90 days of MU for the first payment year and then attest to 365 days of MU for each of the following payment years (payment years 1, 2, and 3).

If the EH first attested with Medicare, and would like to attest with Medicaid in the same year, the EH will follow the Medicare reporting requirements when attesting with Medicaid.

This means, if the EH reported 90 days of MU with Medicare in 2012, it will report 90 days of MU in 2012 with Medicaid as well. This is true even if 2012 is its first payment year with the Medicaid EHR Incentive Program. Furthermore, after its first year of participation, the EH will attest to 365 days of MU for every additional year it participates (payment years 2 and 3).

In other words, if the EH attests with Medicare first, the EH will NOT attest to AIU for the Medicaid program.

Scenario 2: **EH attests with Medicaid first and then attests with Medicare in 2012**

	Payment Schedule (Based of FFY)	**Earliest Date to Attest with Medicaid in the NC-MIPS MU Portal (for year 2 MU payment)**
Attested to Medicaid before Medicare in same year	In 2012: For **Medicaid** – attest to AIU For **Medicare** – attest to 90 days of MU In 2013 & beyond: For **Medicaid & Medicare** – attest to 365 days of MU	Oct. 1, 2013 (after attestation with Medicare) - need a full fiscal year to report on 365 days of MU

For Medicaid Participation: Attest to AIU the first payment year and then attest to 365 days of MU for each of the following payment years (payment years 2 and 3).

If the EH reports with Medicaid first in 2012 and would like to attest with Medicare in the same year, the EH will attest to AIU during its first payment year in the N.C. Medicaid EHR Incentive Program. It will attest to 90 days of MU with Medicare.

Because Medicare requires an EH to attest to 90 days of MU during its first payment year, when the EH comes back to attest with Medicaid (in payment years 2 and 3), it will be attesting to 365 days of MU for both Medicaid & Medicare. The EH will **not** attest to 90 days of MU with Medicaid.

Scenario 3: **EH attested with Medicare in 2011 and attests with Medicaid for the first time in 2012.**

	Payment Schedule (Based on FFY)	**Earliest Date to Attest with Medicaid in the NC-MIPS MU Portal**
Attested with Medicare in 2011, and then attested to Medicaid in 2012	In 2011: First payment year for **Medicare** – attest to 90 days of MU In 2012 & beyond: For **Medicare & Medicaid** – attest to 365 days of MU	Oct. 1, 2012 (after attestation with Medicare) - need a full fiscal year to report on 365 days of MU

For Medicaid Participation: Attest to 365 days of MU for the first payment year and beyond (payment years 1, 2, and 3).

If the EH successfully attested with Medicare in 2011 and waits until 2012 to attest with Medicaid for the first time, it will be required to attest to 365 days of MU with Medicaid.

In other words, if the EH attests with Medicaid a year after attesting with Medicare, it will NOT attest to AIU or 90 days of MU with Medicaid. Instead, it will attest to 365 days of MU for every year of its participation in the Medicaid Incentive Program (payment years 1, 2, and 3).

Scenario 4: **EH attested with Medicaid in 2011, and then attests with Medicare for the first time in 2012**

	Payment Schedule (Based on FFY)	**Earliest Date to Attest with Medicaid in the NC-MIPS MU Portal**
Attested with Medicaid in 2011, and then attests with Medicare in 2012	In 2011: 1st payment year For **Medicaid** – attest to AIU In 2012: For **Medicare & Medicaid** - attest to 90 days of MU In 2013: For **Medicare & Medicaid** – attest to 365 days of MU	Aug. 20, 2012 (after attestation with Medicare) - opening of NC-MIPS MU Portal

For Medicaid Participation: Attest to AIU in the first payment year, attest to 90 days of MU in the second payment year, and attest to 365 days of MU in the third payment year.

If the EH attested with Medicaid in 2011 and waits until 2012 to attest with Medicare, it attested to AIU for its first payment year with the NC Medicaid EHR Incentive Program. When the EH comes back to attest for its second payment year with Medicaid in 2012, it will attest to 90 days of MU. When the EH comes back to attest with Medicaid, it will attest to 365 days of MU.

Those with questions should contact the NC Medicaid Health Information Technology (HIT) program at 919-855-4200.

N.C. Medicaid Health Information Technology (HIT)
DMA, 919-855-4200

Attention: Adult Care Home Providers, Family Care Home Providers and Supervised Living Homes Billing PCS services

Update on Independent Eligibility Assessments for Consolidated Personal Care Services

Independent assessments of residents of licensed adult care home – Adult Care Homes (ACH), Family Care Homes, 5600a and 5600c Supervised Living Homes, and combination facilities with ACH beds – are ongoing and expected to continue through November 2012. Please consult the updated timeline of estimated independent assessment dates by facility on the DMA Consolidated PCS webpage (www.ncdhhs.gov/DMA/pcs/pas.html).

This article does not apply to providers billing for Personal Care Services under the CAP program.

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

As a reminder, the N.C. Medicaid Provider Agreement requires updating any change in site location or business address within 30 days (Paragraph 6.a.vi.). Failure to keep your contact information current with DMA may result in sanctions, up to and including suspension or termination of participation in the program. To verify and update facility contact information, contact the Medicaid Provider Enrollment, Verification, and Credentialing (EVC) Call Center at 866-844-1113. Select the menu option to speak to a representative about "all other questions."

In order to ensure that PCS services continue on January 1, 2013, residents of licensed adult homes must have completed independent assessments that demonstrate PCS qualifications are met and that completed attestation forms have been submitted to CCME by the close of the transition assessment period. The attestation form and instructions for completion are available on the DMA Consolidated PCS webpage. Providers are encouraged to initiate completion of Medical Attestation forms for all Medicaid residents **immediately** to ensure a completed form is available at the time of each resident's scheduled assessment.

Completed attestation forms should be presented to the CCME assessor at the time of each resident's scheduled assessment. If a completed attestation form is not available at the time of a resident's assessment, please mail the completed form as soon as it is available to:

CCME
ATTN: PCS Independent Assessment
100 Regency Forest Drive, Suite 200
Cary NC 27518-8598.

Forms for more than one resident may be bundled and sent together. Certified mail with delivery confirmation is recommended. Forms may also be faxed to CCME at 877-272-1942, and receipt may be confirmed by calling 800-228-3356.

Please refer to the July Medicaid Special Bulletin, the August Medicaid Bulletin, and the DMA Consolidated PCS webpage for additional background information, provider training materials, and planning resources for the January 1, 2013 implementation of the consolidated PCS program.

Provider trainings on the consolidated PCS benefit are ongoing. Updates and materials from completed provider trainings are available and will continue to be added to the DMA Consolidated PCS webpage. CCME and DMA are planning a second regional provider training for licensed adult care home and home care agency providers between October 22 and November 2, 2012. Dates, times, locations and registration information will be announced in October 2012 on the Consolidated PCS webpage.

The following table provides an overview and timeline of completed and planned provider trainings for the consolidated PCS program.

Date	Description	Topic
June 21, 2012 10 a.m. – 11:30 a.m.	Webinar Training: Transition Planning for Licensed Adult Care Home Providers	Eligibility, Independent Assessments (Completed)
July 11, 2012 10 a.m. – 11:30 a.m.	Institutions for Mental Disease (IMD) Training for Licensed Adult Care Home, Family Care Home, & Supervised Living Home (5600a and 5600c) Providers	IMD characteristics and reviews (Completed)
July 26, 2012 10 a.m. – 11:30 a.m.	Webinar Training: Eligibility, Independent Assessments, and Recipient Notification	(Completed)
August 6 – August 17, 2012	Regional Trainings for Licensed Adult Care Home Providers	Proposed Policy, Eligibility Assessments, Recipient Decision Notices (Completed)
September 20, 2012 10 a.m. – 11:30 a.m.	Webinar Training	Recipient Appeals Registration information will be posted on the Consolidated PCS webpage.

Date	Description	Topic
October 11, 2012 10 a.m. – 11:30 a.m.	Webinar Training	To be determined
October 22 – November 2, 2012	Regional Trainings for Licensed Home and Home Care Agency Providers	PCS Policy, Billing and Aide Documentation
November 15, 2012 10a.m. – 11:30 a.m.	Webinar Training	To be determined

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

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

Attention: In-Home Care Providers

Transition Planning for Consolidated Personal Care Services Program

Effective January 1, 2013, N.C. Medicaid personal care services for recipients in all settings –including private residences and licensed adult care homes – will be provided under a consolidated Personal Care Services (PCS) benefit. Beneficiary (recipient) eligibility criteria for the new PCS benefit will be the same as the current In-Home Care (IHC) beneficiary eligibility criteria. All beneficiaries authorized for IHC services on December 31, 2012 will be transitioned to the new consolidated PCS program with no interruption of services.

In accordance with North Carolina General Assembly Session 2011 House Bill 950, errands will no longer be covered in the consolidated PCS program.

Regional trainings for home care agency and licensed adult care home providers are being planned from October 22 through November 2, 2012. The following table provides a timeline of upcoming trainings for home care agencies and licensed adult care home providers.

Date	Description	Topic
October 11, 2012 10:00 – 11:30 a.m.	Webinar Training	To be determined
October 22 through November 2, 2012	Regional Trainings for Licensed Home and Home Care Agency Providers	PCS Policy, Billing and Aide Documentation
November 15, 2012 10:00 – 11:30 a.m.	Webinar Training	To be determined

Registration information will be posted prior to each training on the DMA Consolidated PCS webpage at www.ncdhhs.gov/DMA/pcs/pas.html. Please refer to future Medicaid Bulletins for additional information about the new PCS program.

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

Attention: Case Management Agencies, CAP Providers, Hospitals, ICF-MR Providers, LME-MCO, Nursing Facility Providers

Money Follows the Person: An Introduction

When Christina moved home with her family after years of residing in an institution, her mother noted, "She's so much happier now." When Ronald transitioned back into his community after years in a state hospital, he soon became a regular at his local Starbuck's. After Jabreel moved out of an institution and into an apartment with his support companion, his mother observed, "My son now has a warm, broad network of people in his life."

These life-changing experiences were facilitated by the state, regional and local partners of North Carolina's *Money Follows the Person Demonstration Project* ("MFP" or "the Project").

Often regarded as "the best kept secret" in long-term care, the MFP staff and stakeholder network is pleased to introduce this effort to the larger Medicaid provider community. We will be providing regular updates on the Project's progress and activity through the NC Medicaid Bulletin. MFP's success relies on the interests and efforts of local community members and provider networks.

WHAT IS MFP?

MFP is a federal/state Medicaid demonstration project housed within the N.C. Division of Medical Assistance (DMA). It is designed to support interested, eligible individuals living in nursing facilities and other qualified long-term care facilities to transition into community housing with support.

Since its inception in 2005 under the federal *Deficit Reduction Act*, MFP has become an increasingly robust vehicle for North Carolina and other states to strengthen and expand their home and community-based service structure. Under the 2010 *Affordable Care Act,* Congress increased and extended MFP funding to be available through 2020.

MFP supports North Carolina in meeting its transition and community-capacity building objectives under the Americans with Disabilities Act and the US Supreme Court's *Olmstead* decision.

QUALIFICATIONS FOR MFP:

To be approved for MFP participant, a person must:
- Be a **current** resident of a skilled nursing facility, Intermediate Care Facility for People with Intellectual/Developmental Disabilities (ICF-I/DDs) or acute care facility

- Have been receiving continuous care in one or more of these qualified facilities for **at least three months**, without using Medicare Rehab funding
- Be Medicaid eligible prior to discharge from the facility

WHAT AN MFP PARTICIPANT IS ELIGIBLE TO RECEIVE:
- Priority access to Community Alternatives Program (CAP) services and PACE services, if they otherwise qualify for those programs. MFP participants will also have targeted waiver slots under the N.C. Innovations waiver.
- Up to $3,000.00 to cover transition-specific expenses, such as pre-transition staff training, rent and utility deposits, and other transition needs not covered under the applicable waiver.
- Access to MFP staff and contracted transition coordinators to assist the participant in planning the transition and accessing the supports and services necessary to successfully transition back into his/her home and community.

HOW TO SUBMIT AN APPLICATION

Anyone may assist a potential MFP participant in submitting an application/informed consent. However, we strongly encourage the following groups to explore the viability of MFP participation for individuals they know who may be interested in transitioning back into their homes and communities:

- Residents and their families
- Nursing facility discharge planners
- CAP Lead Agencies and Lead Management Agencies-Managed Care Organizations (LMEs-MCOs)

MFP recently updated its application. Visit our website at <u>www.mfp.ncdhhs.gov</u> to access the most current version.

For more information about MFP, the application process, or to join the stakeholder Listserv, either:
- Send an e-mail to Diane Upshaw at <u>diane.upshaw@dhhs.nc.gov</u>
- Visit the website at www.mfp.ncdhhs.gov
- Call our toll free number: 1-855-761-9030

Money Follows the Person
DMA, 1-855-761-9030

Attention: CAP/Choice and CAP/DA Providers

Implementation of Updated Rates

Claims for CAP/Choice (CAPCO) and CAP/DA (CAPDA) providers with dates of service from July 1, 2012 to July 19, 2012 were paid at the rates in effect prior to July 1, 2012. The updated rates shown on the fee schedule effective July 1, 2012 have been implemented.

In order to obtain the additional payment, providers can submit electronic replacement claims using their vendor software or using the NCECSWeb Tool, which is free of charge. Please refer to *Appendix A* of the *December Special Bulletin: NCECS Web Tool Instruction Guide* (www.ncdhhs.gov/dma/bulletin/NCECSWebGuide.pdf) for assistance with filing replacement claims via the NCECSWeb Tool.

Providers who wish to file paper adjustments should first request a full recoupment of each of the paid claims, and then file new day claims electronically after the recoupments have processed.

Provider Services
DMA, 919-855-4050

Attention: Laboratories

Clinical Laboratory Improvement Amendments of 1988 (CLIA) Recertification Procedures

Some Clinical Laboratory Improvement Amendment (CLIA) certified providers have experienced claims issues when submitting claims after merging or being acquired by another lab.

CLIA recertification in the N.C. Medicaid and N.C. Health Choice (NCHC) programs requires providers to submit the Medicaid provider change form with a copy of the CLIA certificate attached to the form. If a lab is acquired by or merges with another lab, CLIA numbers must be updated so that they match the provider name listed on the provider's N.C. Medicaid and NCHC files. If the name does not match the CLIA number, the provider's claim will deny with an Explanation of Benefit (EOB).

To access provider enrollment applications, download forms, or to report a change to provider information, visit www.nctracks.nc.gov. Providers with questions should contact CSC at 866-844-1113.

Provider Services
DMA, 919-855-4050

Attention: Nurse Practitioners, Physician Assistants and Physicians

Taliglucerase alfa (Elelyso, HCPCS code J3590): Billing Guidelines

Effective with date of service May 8, 2012, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover taliglucerase alfa (Elelyso) through the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biological). Taliglucerase alfa is available in 200 unit single-use vials.

Elelyso was added to the MMIS+ system as a rebatable drug on May 8, 2012, and was available at that time through the Outpatient Pharmacy Program by prescription. Regarding coverage of new drugs in the Physician's Drug Program, unlike the Outpatient Pharmacy Program, the coverage process is not automated. Therefore, there is always a delay between the effective date of coverage and the posting of the provider bulletin notification.

Taliglucerase alfa is indicated for long-term Enzyme Replacement Therapy (ERT) for **adults 18 years and older** with a confirmed diagnosis of Type 1 Gaucher disease.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis code required for billing taliglucerase alfa is:
    - 272.7 Lipidoses
- Providers must bill taliglucerase alfa with HCPCS code J3590 (unclassified biologicals).
- Providers must indicate the number of HCPCS units. An entire single-dose vial of Elelyso may be billed. **The amount wasted must not be reported to Medicaid or NCHC with the "JW" modifier, as this modifier is not recognized by either program and is not used by those programs in claims processing.**
- One Medicaid or NCHC unit of coverage is one single-use vial containing 200 units of taliglucerase alfa. The maximum reimbursement rate per unit (single use vial) is $619.40.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for taliglucerase alfa should be reported as "UN". To bill for the entire 200-unit vial of taliglucerase alfa, report the NDC units as "UN1".
- If the drug was purchased under the 340B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the January 2012 NDC Special Bulletin, *National Drug Code Implementation Update,* on DMA's website at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf, for additional instructions.
- Providers must bill their usual and customary charges.

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

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

Attention: Nurse Practitioners, Physician Assistants and Physicians

Pertuzumab (Perjeta, HCPCS Code J3590): Billing Guidelines

Effective with date of service June 11, 2012, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover pertuzumab (Perjeta) through the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologicals). Pertuzumab is available in 420mg/14 ml single-use vials.

Perjeta was added to the MMIS+ system as a rebatable drug on June 11, 2012, and was available at that time through the Outpatient Pharmacy Program by prescription. Regarding coverage of new drugs in the Physician's Drug Program, unlike the Outpatient Pharmacy Program, the coverage process is not automated. Therefore, there is always a delay between the effective date of coverage and the posting of the provider bulletin notification.

Pertuzumab is a HER2/neu receptor antagonist indicated in combination with trastuzumab and docetaxel for the treatment of patients with HER2-positive metastatic breast cancer who have not received prior anti-HER2 therapy or chemotherapy for metastatic disease.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis codes required for billing pertuzumab include:
    - o 174.0 through 174.9: Malignant neoplasm of female breast
    - o 175.0 through 175.9: Malignant neoplasm of male breast
- Providers must bill pertuzumab with HCPCS code J3590 (unclassified biologicals).
- Providers must indicate the number of HCPCS units. The entire single-use vial of pertuzumab may be billed. **Any amount wasted must not be reported to Medicaid or NCHC with the "JW" modifier as this modifier is not recognized by either program and is not used by those programs in claims processing.**
- One Medicaid or NCHC unit of coverage is one single-use vial containing 420 mg/14 ml of pertuzumab. The maximum reimbursement rate per unit is $4,242.99.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for pertuzumab should be reported as "ML." To bill for the entire 420 mg/14 ml vial of pertuzumab, report the NDC units as "ML14."
- If the drug was purchased under the 340B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the January 2012 Special Bulletin, *National Drug Code Implementation Update*, on DMA's website at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf for additional instructions.
- Providers must bill their usual and customary charges.
- The fee schedule for the Physician's Drug Program is available on DMA's website at: www.ncdhhs.gov/dma/fee/.

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

Attention: Physicians

Sipuleucel-T (PROVENGE, HCPCS Code Q2043): Billing Guidelines

Effective with date of service September 1, 2012, **PROVENGE,** billed with HCPCS code Q2043, is covered by the N.C. Medicaid and N.C. Health Choice (NCHC) programs.

PROVENGE is an autologous cellular immunotherapy indicated for the treatment of asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer.

Treatment with PROVENGE for other uses (e.g., prevention of prostate cancer and treatment of localized prostate cancer) is considered off-label or experimental, is NOT covered, and is subject to recoupment.

Evidence that the beneficiary has asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer must be in the patient chart and available on request.

PROVENGE is expected to be administered by oncologists or urologists, and is considered medically necessary for those beneficiaries with the diagnosis described above who have a life expectancy of greater than 6 months and are at least 18 years of age.

Treatment with PROVENGE consists of cell collection and leukapheresis, sending the immune cells to the facility that prepares the immunotherapy product, and then transporting the immune cells back to the site of service to be administered to the patient.

Q2043 represents all routine costs associated with PROVENGE with the exception of its administration. The administration of PROVENGE may be billed separately.

Coverage of PROVENGE includes one treatment regimen in a beneficiary's lifetime, consisting of three doses with each dose administered approximately two weeks apart, for a total treatment period not to exceed 30 weeks from the first administration.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis code required for billing PROVENGE is:
  o 185 – Malignant neoplasm of prostate;

AND

- An additional diagnosis code from the list below must be billed:
  o 196.1 – secondary and unspecified malignant neoplasm of intrathoracic lymph node;
  o 196.2 - secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes;
  o 196.5 - secondary and unspecified malignant neoplasm of lymph nodes of inguinal region and lower limb;
  o 196.6 - secondary and unspecified malignant neoplasm of intrapelvic lymph nodes;
  o 196.8 - secondary and unspecified malignant neoplasm of lymph nodes of multiple sites;
  o 196.9 - secondary and unspecified malignant neoplasm of lymph node, site unspecified;
  o 197.0 - secondary malignant neoplasm of lung;
  o 197.7 – malignant neoplasm of liver specified as secondary;
  o 198.0 – secondary malignant neoplasm of kidney;
  o 198.1 – secondary malignant neoplasm of other urinary organs;
  o 198.5 – secondary malignant neoplasm of bone and bone marrow;
  o 198.7 – secondary malignant neoplasm of adrenal gland; or
  o 198.82 – secondary malignant neoplasm of genital organs.

- Beneficiaries must be at least 18 years of age.
- One Medicaid and NCHC unit of PROVENGE equals 50 million units/250 ml infusion bag (for one infusion).
- Providers must bill PROVENGE with HCPCS code Q2043 and indicate the number of HCPCS units as one (1). This code is all inclusive and represents all routine costs associated with PROVENGE with the exception of administration costs. **Any amount wasted should not be reported to Medicaid or NCHC with the "JW" modifier as this modifier is not recognized by Medicaid or NCHC and is not used by those programs in claims processing.**
- The cost of the actual administration of PROVENGE may be billed separately with CPT procedure code 96365.
- The maximum reimbursement rate for Q2043 is $31,627.34.

- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for PROVENGE should be reported as "ML." To bill for the entire 250 ml PROVENGE infusion bag, report the NDC units as "ML250".
- If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Providers must bill their usual and customary charges.

Refer to the revised *January 2012 Special Bulletin, National Drug Code Implementation Update*, on DMA's website at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf for additional information.

Refer to the fee schedule for the Physician's Drug Program on DMA's website at www.ncdhhs.gov/dma/fee/fee.htm for the latest available fees.

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

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

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

Proposed Clinical Coverage Policies

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

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

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

2012 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
Sept.	9/6/12	9/11/12	9/12/12
	9/13/12	9/18/12	9/19/12
	9/20/12	9/27/12	9/28/12
	9/27/12	10/2/12	10/3/12
Oct.	10/4/12	10/10/12	10/11/12
	10/11/12	10/16/12	10/17/12
	10/18/12	10/25/12	10/26/12

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

Michael Watson   **Melissa Robinson**
Director   **Executive Director**
Division of Medical Assistance   **HP Enterprise Services**
Department of Health and Human Services