



October 2010 Medicaid Bulletin

In This Issue . . .

Page

All Providers:

2011 Checkwrite Schedule.....	8
Clinical Coverage Policies.....	7
Copayment Changes.....	14
CPT Procedure Code 29828 and Modifier 51	6
Enrollment Fee Update: Reminders	13
False Claim Act Education Compliance for Federal Fiscal Year 2009	7
Implementation of the National Correct Coding Initiative.....	14
Influenza Vaccine and Reimbursement Guidelines for 2010/2011	15
Medicaid Integrity Contractors Audit	4
Medicare and Medicaid Health Information Technology: Title IV of the American Recovery and Reinvestment Act	2
Optical Character Recognition for Paper Claims.....	6
Payment Error Rate Measurement in North Carolina.....	3
Pregnancy Medical Home Project.....	10
Procedures for Prescribing Synagis for RSV Season 2010/2011.....	11
Provider Enrollment Application Process	9
Reductions to Covered Podiatry Services.....	29
Requirement for Internal Claim Number on Self-Audits.....	3
Unauthorized Use of a Community Care of NC/Carolina ACCESS Provider's NPI Number Is Considered Medicaid Program Abuse.....	6

Critical Access Behavioral Health Agencies:

Enrollment, Authorization, and Billing Frequently Asked Questions.....	23
Prior Authorization and Billing for Mental Health/Substance Abuse Targeted Case Management.....	22
Update on Unmanaged Visits for Children	22

HIV Case Management Providers:

HIV Case Management Provider Training Sessions	26
--	----

Institutional (UB-04/837I) Billers:

Non-Monetary Value Codes.....	20
-------------------------------	----

Local Management Entities:

Injectable Drugs: Update to Billing Guidelines	21
--	----

Nurse Practitioners:

Cabazitaxel Injection (Jevtana, HCPCS Code J9999): Billing Guidelines	18
Injectable Drugs: Update to Billing Guidelines	21
Ranibizumab (Lucentis, HCPCS Code J2778): Update to Billing Guidelines	20
Zoledronic Acid (Reclast, HCPCS Code J3488): Update to Billing Guidelines.....	19

Nursing Facility Providers:

North Carolina Referral Process for MDS 3.0 Section Q.....	27
--	----

Obstetric Providers:

Updates to Prior Authorization for Obstetrical Ultrasounds	23
--	----

Outpatient Behavioral Health Services Providers:

Update on Unmanaged Visits for Children	22
---	----

Personal Care Services Providers:

Independent Assessment Updates and Reminders	25
--	----

Pharmacists:

Recipient Management Lock-in Program Emergency Fill.....	21
--	----

Physicians:

Cabazitaxel Injection (Jevtana, HCPCS Code J9999): Billing Guidelines	18
Ranibizumab (Lucentis, HCPCS Code J2778): Update to Billing Guidelines	20
Zoledronic Acid (Reclast, HCPCS Code J3488): Update to Billing Guidelines.....	19

Radiology Services:

Updates to Prior Authorization for Obstetrical Ultrasounds	23
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**Providers are responsible for informing their billing agency of information in this bulletin.
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All rights reserved. Applicable FARS/DFARS apply.**

Attention: All Providers**Medicare and Medicaid Health Information Technology: Title IV of the American Recovery and Reinvestment Act****Background**

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

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

Funding

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

Criteria for Qualifying for an Incentive

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

Additional Information

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

James Hazelrigs, MITA Manager

DMA, 919-647-8394

NCMedicaid.HIT@dhhs.nc.gov

Attention: All Providers***P*ayment Error Rate Measurement in North Carolina**

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

CMS is using two national contractors to measure improper payments. The statistical contractor, Livanta, will coordinate efforts with the State regarding the eligibility sample, maintaining the PERM eligibility website, and delivering samples and details to the review contractor. The review contractor, A+ Government Solutions, will be communicating directly with providers and requesting medical record documentation associated with the sampled claims. Providers will be required to furnish the records requested by the review contractor within a timeframe specified in the medical record request letter.

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

Providers are reminded of the requirement listed in Section 1902(a)(27) of the Social Security Act and 42 CFR 431.107 to retain any records necessary to disclose the extent of services provided to individuals and, upon request, to furnish information regarding any payments claimed by the provider rendering services.

**Program Integrity
DMA, 919-647-8000**

Attention: All Providers***R*equirement for Internal Claim Number on Self-Audits**

DMA's Program Integrity Section strives to operate the most cost efficient health care system possible while further enhancing the quality and appropriateness of services delivered. DMA Program Integrity supports our health care providers' efforts to identify and resolve issues with overpayments and billing errors themselves.

Providers are encouraged to identify overpayments and correct potential billing errors by performing self-audit reviews. In an effort to properly track refunds of Medicaid monies, internal claim numbers (ICN) are required on all self-audit results submitted to DMA Program Integrity.

Participation in the self-audit program does not alleviate the possibility of further review by Program Integrity in this or future investigations, and does not affect in any manner the government's ability to pursue criminal, civil or administrative remedies or to obtain additional damages, penalties or fines for the matters that are the subject of the self-audit.

Self-audit packets are available by calling DMA Program Integrity at 919-647-8000 or 1-877-362-8471.

**Program Integrity
DMA, 919-647-8000**

Attention: All Providers**Medicaid Integrity Contractors Audit**

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

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

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

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

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

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

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

MIC Audit Process

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

3. **Audit MIC receives audit assignment.** CMS forwards the list of providers to be reviewed to the Audit MIC after the vetting process is completed. The Audit MIC immediately begins the audit process. CMS policy is that the audit period, also known as the “look back” period, should mirror that of the state that paid the provider’s claims.
4. **Audit MIC contacts provider and schedules entrance conference.** The Audit MIC mails a notification letter to the provider. The notification letter
 - identifies a point of contact within the Audit MIC;
 - gives at least two-weeks’ notice before the audit is to begin;
 - includes a records request outlining the specific records that the Audit MIC will be auditing; and
 - asks the provider to send the records to the Audit MIC for a desk audit. For a field audit, the provider must have the records available in time for the Audit MIC’s arrival at the provider’s office.

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

5. **Audit MIC performs audit.** Most of the audits conducted by the Audit MIC are desk audits; however, the Audit MIC also conducts field audits in which the auditors conduct the audit on-site at the provider’s location. Providers are given specific timelines in which to produce records. Because some audits will be larger in scope than others, provider requests for time extensions are seriously considered on a case-by-case basis. The audits are being conducted according to Generally Accepted Government Auditing Standards (<http://www.gao.gov/govaud/ybk01.htm>).
6. **Exit conference held and draft audit report is prepared.** At the conclusion of the audit, the Audit MIC will coordinate with the provider to schedule an exit conference. The preliminary audit findings are reviewed at this meeting. The provider has an opportunity to comment on the preliminary audit findings and to provide additional information if necessary. If the Audit MIC concludes, based on the evidence, that there is a potential overpayment, the Audit MIC prepares a draft report.
7. **Review of draft audit report.** The draft audit report is shared with CMS for approval and is provided to the state for review and comments. The report is then given to the provider for review and comment. The draft report may be subject to revision based on additional information and shared again with the state.
8. **Draft audit report is finalized.** Upon completion of this review process, the findings may be adjusted, either up or down, as appropriate based on the information provided by the provider and the state. The state’s comments and concerns will also be given full consideration. CMS has the final responsibility for determining the final amount of any identified overpayment in any audit. At this point, the audit report is finalized.
9. **CMS issues final audit report to the state, triggering the “1-year” rule.** CMS sends the final audit report to the state. Pursuant to 42 CFR 433.316 (a) and (e), this action serves as CMS’ official notice to the state of the discovery and identification of an overpayment. Under federal law, 42 CFR 433.12 (2), the state must repay the federal share of the overpayment to CMS within one year, regardless of whether the state recovers or seeks to recover the overpayment from the provider.
10. **The state issues final audit report to provider and begins overpayment recovery process.** The state is responsible for issuing the final audit report to the provider. Each state must follow its respective administrative process in this endeavor. At this point, the provider may exercise whatever appeal or adjudication rights are available under state law when the state seeks to collect the overpayment amount identified in the final audit report.

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

Program Integrity
DMA, 919-647-8000

Attention: All Providers**Unauthorized Use of a Community Care of NC/Carolina ACCESS
Provider's NPI Number Is Considered Medicaid Program Abuse**

Community Care of N.C./Carolina ACCESS (CCNC/CA) is a primary care case management program that provides managed care for North Carolina's Medicaid recipients. Coordination of care is a required component of CCNC/CA. All referral authorizations and consultations, including services authorized retroactively, are at the discretion of the CCNC/CA provider.

Unauthorized use of a CCNC/CA provider's NPI number is considered Medicaid program abuse and is prohibited. You are encouraged to report matters involving Medicaid fraud, waste, and program abuse by calling DMA's Program Integrity Section at 1-877-DMA-TIPS (1-877-662-7030).

Managed Care
DMA, 919-855-4780

Attention: All Providers**Optical Character Recognition for Paper Claims**

Paper claims that meet one of the exceptions to the electronic claims submission requirement (see <http://www.ncdhhs.gov/dma/provider/ECSEExceptions.htm>) are submitted to HP Enterprise Services, N.C. Medicaid's fiscal agent for claims processing. Paper claims are now being electronically read using Optical Character Recognition (OCR) equipment. This OCR technology requires that paper claims be submitted on standardized claim forms with the appropriate data fields completed. Examples of non-standard claim forms include forms that have been individually created and printed by a provider, fax copies, carbon copies or photocopies. Non-standard paper claims will be returned to the provider or may be denied in processing.

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

Attention: All Providers**CPT Procedure Code 29828 and Modifier 51**

It has come to the attention of N.C. Medicaid that claims billed for CPT code 29828 [arthroscopy, shoulder, distal claviclectomy (Mumford Procedure) biceps tenodesis] in addition to other surgeries on the same date of service are being denied inappropriately. Effective immediately, claims that were denied with EOB 7996 (Only one surgical code per day is allowed as the primary procedure. Another code has already been billed as primary for this date of service. Correct detail by appending-51 and rebill.) may be resubmitted as a new claim if the claim has been timely filed. Claims should be submitted without Modifier 51. Please do not send as an adjustment.

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

Attention: All Providers**False Claims Act Education Compliance for Federal Fiscal Year 2009**

Effective January 1, 2007, Section 6023 of the Deficit Reduction Act (DRA) of 2005 requires 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.

Each year DMA will notify 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. (A complete list of providers who meet this requirement will be available on DMA's website at <http://www.ncdhhs.gov/dma/fcadata/default.htm>.) 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. A separate notification will be mailed for each Medicaid provider number.

Providers must complete and submit a copy of the Letter of Attestation Form within 30 calendar days of the date of notification. Upon completion, submit the Letter to HP Enterprise Services by fax or by mail.

Mail to

HP Enterprise Services
Attn: PVS-False Claims Act
P.O. Box 30968
Raleigh NC 27622

OR

Fax to

919-851-4014
Attn: PVS-False Claims Act

Compliance with Section 6023 of the DRA is a condition of receiving Medicaid payments. Medicaid payments will be denied for providers who do not submit a signed Letter of Attestation within 30 days of the date of notification. Providers may resubmit claims once the signed Letter is submitted to and received by HP Enterprise Services.

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/>:

- 1K-7, *Prior Approval for Imaging Procedures*

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**2011 Checkwrite Schedule**

The following table lists the cut-off dates, checkwrite dates, and the electronic deposit dates for January through August 2011. The schedule for the remaining months of 2011 will be published at a later date.

Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
01/06/11	01/11/11	01/12/11
01/13/11	01/19/11	01/20/11
01/20/11	01/27/11	01/28/11
01/27/11	02/01/11	02/02/11
02/03/11	02/08/11	02/09/11
02/10/11	02/15/11	02/16/11
02/17/11	02/24/11	02/25/11
02/24/11	03/01/11	03/02/11
03/03/11	03/08/11	03/09/11
03/10/11	03/15/11	03/16/11
03/17/11	03/24/11	03/25/11
03/31/11	04/05/11	04/06/11
04/07/11	04/12/11	04/13/11
04/14/11	04/21/11	04/22/11
04/28/11	05/03/11	05/04/11
05/05/11	05/10/11	05/11/11
05/12/11	05/17/11	05/18/11
05/19/11	05/26/11	05/27/11
06/02/11	06/07/11	06/08/11
06/09/11	06/14/11	06/15/11
06/16/11	06/23/11	06/24/11
06/30/11	07/06/11	07/07/11
07/07/11	07/12/11	07/13/11
07/14/11	07/21/11	07/22/11
07/28/11	08/02/11	08/03/11
08/04/11	08/09/11	08/10/11
08/11/11	08/16/11	08/17/11
08/18/11	08/25/11	08/26/11

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

Attention: All Providers**P**rovider Enrollment Application Process

Recent reports indicate improvements in CSC's processing times for provider enrollment. DMA will continue to monitor the process and to work with CSC to identify areas for improvement.

To ensure that provider enrollment applications continue to be processed in a timely manner, applicants are reminded to complete all required fields and to fully answer all of the required disclosure questions. Please refer to the online help text when completing the application.

Complete information is critical to ensuring an accurate background check [as required by PL 111-148 Subtitle E, Section 6401(b)]. Applicants are reminded that

- Individual information requested on the application must match the applicant's federal tax form.
- If applicable, the full middle name should be indicated.
- Social Security Numbers are required.

Information about **Managing Relationships** between the applicant and any employee who exercises operational or managerial control of the provider agency or who directly or indirectly conducts the day-to-day operations of the provider agency must be disclosed (see 42 CFR 1002.3). Company officers, directors, general managers, business managers, and office administrators, as well as any personnel authorized for electronic funds transfers, are considered to be a managing relationship.

- Please enter the individual's full middle name, if applicable.
- The individual's Social Security Number and date of birth are required.
- The business relationship to the provider must be indicated.

Ownership information for any applicant that is a corporation, partnership or non-profit organization must be disclosed (see 42 CFR 1002.3). Applicants must report all **Ownership Information** for each owner/shareholder with 5% or more direct or indirect controlling interest in the applicant's organization.

- For individual owners, enter the full name (including full middle name, if applicable), Social Security Number, and date of birth.
- For corporate owners, enter the complete legal name of the business and the Employer Identification Number.

All applicants must answer each question in the **Exclusion Sanction Information** section of the application.

- For each question that is answered with a "yes," applicants must attach or submit a complete copy of the applicable criminal complaint or disciplinary action, Consent Order, documentation regarding recoupment/repayment/settlement actions, and/or final disposition clearly indicating the final resolution as applicable. A written explanation in lieu of supporting documentation is not acceptable.
- Disclosure is not time-limited; all adverse legal actions must be reported regardless of whether any records were expunged or any appeals are pending.

Disclosure of adverse legal actions may not preclude participation with the N.C. Medicaid Program; however, full and accurate disclosure is critical to determining an applicant's eligibility for participation with the N.C. Medicaid Program and is required by federal law (see 42 CFR Chapter IV, part 455, Subpart B).

Provider Services
DMA, 919-855-4050

Attention: All Providers**Pregnancy Medical Home Project**

DMA is working in partnership with Community Care of North Carolina (CCNC) and other community stakeholders including providers, local health departments, and the Division of Public Health, to create a program that provides pregnant Medicaid recipients with a pregnancy medical home (PMH). The goal is to improve the quality of perinatal care given to Medicaid recipients thereby improving birth outcomes and reducing Medicaid spending. This will be done by modeling the PMH after the enhanced primary care case management (PCCM) program developed by CCNC.

If a pregnant Medicaid recipient's aid program category covers pregnancy services, they are eligible to participate in this program. This program is **NOT** just for recipients of Medicaid for Pregnant Women (MPW). Pregnant Medicaid patients will receive care management (population management). High-risk pregnant women in a PMH will receive case management services. The level of service provided will be in proportion to the individual's identified needs. Case managers are expected to closely monitor the pregnancy through regular contact with the physician and patient to promote a healthy birth outcome.

To qualify for participation as a PMH, the provider must agree to the following:

- Ensuring that no elective deliveries are performed before 39 weeks of gestation by agreement with all professional providers
- Engaging fully in the 17P project in each pregnancy medical home
- Decreasing the cesarean section rate among nulliparous women
- Completing a high-risk screening on each pregnant Medicaid recipient in the program and integrating the plan of care with local care/case management
- Open chart audits

In exchange for meeting the program expectations described above, the PMH will receive the following incentives:

- Exemption from prior approval on ultrasounds
- \$50 for completing a high risk screening tool at initial visit
- \$150 incentive for the postpartum visit per Medicaid recipient
- Increased rate for a vaginal delivery

Any provider who bills global, package or individual pregnancy procedures is eligible to participate in this program as long as he/she agrees to the program requirements. It is **NOT** just for obstetric providers.

Please watch for additional information in future Medicaid bulletins.

Managed Care Section**DMA, 919-855-4780**

Attention: All Providers**Procedures for Prescribing Synagis for RSV Season 2010/2011**

Effective with date of service, November 1, 2010, through March 31, 2011, the N.C. Medicaid Program reimburses for respiratory syncytial virus (RSV) immune globulin (Synagis) **ONLY** through the Outpatient Pharmacy Program. Synagis is not covered when billed through the Physician Drug Program or when billed on institutional claims by outpatient hospitals. This does not include outpatient hospital pharmacy billing through point of sale (POS).

The clinical criteria utilized by N.C. Medicaid for the 2010/2011 RSV season are consistent with published guidelines in the *Red Book: 2009 Report of the Committee on Infectious Diseases, 28th Edition*. **Prior authorization is required** for Medicaid coverage of Synagis during the upcoming RSV season. The coverage season is November 1, 2010, through March 31, 2011.

The **Prior Authorization Synagis Drug Request Form** is required for all Synagis requests. This includes requests for children meeting the explicit clinical criteria such as date of birth (DOB) and estimated gestational age (EGA). The Prior Authorization Synagis Drug Request Form should also be used when requesting Synagis for a child not meeting the clinical criteria. Complete the justification of medical need section of the form for those requests. Please ensure the person completing the Prior Authorization Synagis Drug Request Form has verified that the conditions exist and are accurately reported.

Submit requests for coverage of Synagis doses exceeding policy or for coverage outside of the defined coverage period on the **Non-Covered State Medicaid Plan Services Request Form for Recipients Under 21 Years of Age**. The form is available on DMA's website at <http://www.ncdhhs.gov/dma/epsdt/>.

N.C. Medicaid will begin coverage of Synagis on November 1, 2010. During the season, Medicaid will cover up to five monthly doses of Synagis. The number of doses billed to Medicaid should be in accordance with policy and adjusted if an infant received the first dose prior to a hospital discharge. Delays in request processing can occur if a Medicaid identification number is not provided or the form is not complete.

The Prior Authorization Synagis Drug Request Form

The **Prior Authorization Synagis Drug Request Form** must be signed by the prescriber and submitted to ACS, DMA's pharmacy prior authorization vendor. Fax the completed Prior Authorization Synagis Drug Request Form to ACS at 1-866-246-8507. The Prior Authorization Synagis Drug Request Form is available on DMA's Synagis web page at <http://www.ncdhhs.gov/dma/pharmacy/synagis.htm>.

N.C. Medicaid does not participate in RSV Connection. **The Prior Authorization Synagis Drug Request Form** should not be submitted to RSV Connection. It is important for a pharmacy to ensure that Synagis is approved prior to billing Medicaid. A claim transmitted at POS will be denied if a prior authorization request was not submitted by the provider or if the request was not approved. Limited claims for Synagis may be approved through Smart PA when submitted electronically. Please refer to the guidance below when submitting a request for Synagis.

The Prior Authorization Synagis Drug Request Form includes a prescription section at the bottom. Use of the prescription section is optional. It is the responsibility of the provider to ensure that the pharmacy has a prescription for Synagis. It is the responsibility of the pharmacy to ensure that all prescription requirements are met.

Maximum of Five Doses

An EPDST medical necessity review will be performed for all Synagis requests. Please describe the severity of diagnoses to help justify the medical need for Synagis. The clinical information section of the Prior Authorization

Synagis Drug Request Form can be used to provide supplemental information for all requests. Up to five doses during the season will be approved for chronic lung disease (CLD) and hemodynamically significant congenital heart disease (HSCHD) for infants and children less than two years of age. Use of an ICD-9-CM code is encouraged to help ensure that accurate information is processed from the form.

For **CLD**, please specify the diagnosis causing the long-term respiratory problems to help to establish the severity of the condition. Please indicate treatments received in the six months before the start of the season such as supplemental oxygen, bronchodilator, diuretic or chronic corticosteroid therapy.

For **HSCHD**, please specify the diagnosis causing the condition and identify medications prescribed for the condition. 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, 2009;
- Born at an EGA of 29 weeks 0 days to 31 weeks 6 days and DOB is on or after May 2, 2010; or
- Born at an EGA of ≤ 34 weeks 6 days and DOB is after March 31, 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.

Please specify the specific diagnosis to justify severe neuromuscular disease or congenital airway abnormalities.

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 and 0 day to 34 weeks 6 days, and DOB is on or after August 2, 2010, 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)].
 - ◆ Has a sibling younger than five years of age in the home.

Requesting Synagis for RSV Prophylaxis when Clinical Criteria Are Not Met

Use the **Prior Authorization Synagis Drug Request Form** for these requests. Clinical information must be provided to justify the medical need for Synagis for infants or children not meeting any of the above the criteria. A medical necessity review will determine if medical need is justified based on the information provided. Provide the information in the section of the form for clinical information. Use ICD-9-CM codes to ensure that accurate information is processed from the form.

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 Prior Approval Requests

All prior approval requests should be submitted on the **Prior Authorization Synagis Drug Request Form**. Fax the form to ACS at 1-866-246-8507. The Prior Authorization Synagis Drug Request Form is for all requests for Synagis during the season. ACS will fax approval notifications to the provider and pharmacy.

Use the **Non-Covered State Medicaid Plan Services Request Form for Recipients Under 21 Years of Age** to request Synagis doses exceeding policy or for Synagis administration outside the defined coverage period. A medical necessity review will be done under EPSDT (see <http://www.ncdhhs.gov/dma/epsdt/>); if the information provided justifies medical need, the request will be approved and an approval notification will be faxed to the provider and pharmacy.

Medicaid will allow Synagis claims processing to begin on October 26, 2010, to allow sufficient time for pharmacies to provide Synagis by November 1, 2010. Payment of Synagis claims prior to October 26, 2010, and after March 31, 2011, will not be allowed. 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.

Pharmacy Distributor Information

ACS will fax the approval notification to the pharmacy identified on the Prior Authorization Synagis Drug Request Form. Please ensure that approval notification is received before billing Synagis claims to Medicaid. The prior approval notification should be maintained according to required record keeping time frames.

HP Enterprise Services**1-800-688-6696 or 919-851-8888****Attention: All Providers****Enrollment Fee Update: Reminders**

As mandated by Session Law 2009-451, beginning September 1, 2009, the N.C. Medicaid Program implemented a \$100 enrollment fee for all new enrollments and at 3-year intervals when providers are re-credentialed.

APPLICANTS SHOULD NOT SUBMIT PAYMENT WITH THEIR APPLICATION. Upon receipt of your enrollment application, an invoice will be mailed to you if the fee is owed. An invoice will only be issued if the tax identification number in the enrollment application does not identify the applicant as a currently enrolled Medicaid provider.

Providers are reminded that payment

- is due immediately upon receipt of an invoice for the enrollment fee;
- should be remitted to the address on the invoice and not directly to CSC; and
- is accepted by check or money order made payable to DMA.

Please make every effort to remit payment promptly. Applications will not be processed if payment is not received. If payment is not received after 30 business days, your application will be voided.

CSC, 1-866-844-1113

Attention: All Providers**Copayment Changes**

On November 1, 2010, DMA will implement two new copayment requirements. A copayment of \$3.00 will be charged for clinic and outpatient services including local health department visits and outpatient behavioral health services. A \$6.00 copayment will be charged for non-emergency visits to a hospital emergency room.

Providers are reminded that they may not charge copayments for

- Dental services provided in a health department
- Family planning services
- Federally Qualified Health Center (FQHC) core services
- Health Check (EPSDT)-related services
- Emergency visits to a hospital emergency department services, including physician services delivered in the emergency department
- Rural Health Clinic (RHC) core services
- Services covered by both Medicare and Medicaid
- Services provided to Community Alternatives Program participants
- Services related to pregnancy
- Services to individuals under the age of 21

Refer to Section 2 of the Basic Medicaid Billing Guide (<http://www.ncdhhs.gov/dma/basicmed/>) for a complete list of copayments and copayment exemptions.

HP Enterprise Services**1-800-688-6696 or 919-851-8888****Attention: All Providers****Implementation of the National Correct Coding Initiative**

This bulletin article provides initial guidance regarding DMA's implementation of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), as amended by the Health Care and Education Recovery Act of 2010 (P.L. 111-152), together referred to as the Affordable Care Act (ACA). Specifically, this article is regarding Title VI – Transparency and Program Integrity, Subtitle F – Additional Medicaid Program Integrity Provisions, Section 6507 – Mandatory State Use of National Correct Coding Initiative (NCCI).

Implementation of the NCCI according to the ACA by the N.C. Medicaid Program will be retroactive to date of processing October 1, 2010. The NCCI edits supersede the Medicaid State Plan, all N.C. Medicaid policies, bulletin articles, and other previous guidance provided on procedure-to-procedure and units-of-service edits.

DMA will notify providers through the Medicaid Bulletin when NCCI system changes are complete. At that time, DMA may recoup claims for dates of processing on or after October 1, 2010, when they are adjudicated through the NCCI edits.

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

Attention: All Providers**Influenza Vaccine and Reimbursement Guidelines for 2010/2011**

The N.C. Medicaid Program reimburses for vaccines in accordance with guidelines from the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP). Each year, scientists try to match the viruses in the influenza vaccine to those most likely to cause flu that year. This season's vaccine is comprised of the following three strains: an A/California/7/2009 (H1N1)-like virus; an A/Perth/16/2009 (H3N2)-like virus; and a B/Brisbane/60/2008-like virus. There will be **NO** single-antigen H1N1 vaccine manufactured this season because it is one of the three antigens included in the seasonal formulation for all seasonal vaccine products, as stated above. ACIP recommendations on 2010/2011 influenza can be found on the CDC website at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5808a1.htm?s_cid=rr5808a1_e. Note that there is an update and an erratum to the recommendations.

North Carolina Immunization Program/Vaccines for Children

The N.C. Immunization Branch distributes all required childhood vaccines to local health departments, hospitals, and private providers under North Carolina Immunization Program/Vaccines for Children (NCIP/VFC) guidelines. For the 2010/2011 influenza season, NCIP/VFC influenza vaccine is available at no charge to providers for children aged 6 months through 18 years who are eligible for the VFC program. **Providers wishing to immunize children who are not VFC-eligible and adult patients must purchase vaccine for those groups.** The current NCIP coverage criteria and definitions of VFC categories may be found on the NCIP website at <http://www.immunizenc.com/coveragecriteria.htm>. Refer also to the new influenza page on the NCIP website at <http://www.immunizenc.com/flu vaccineproviders.htm> for helpful information regarding this season's influenza vaccine.

Billing/Reporting Influenza Vaccines

The following tables indicate the vaccine codes that can be either reported or billed for influenza vaccine, depending on the age of the recipient and the formulation of the vaccine. The tables also indicate the administration codes that can be billed, depending on the age of the recipient.

Note: The information in the following tables is **not** detailed billing guidance. Specific information on billing all immunization administration codes for the Health Check recipients can be found in the April 2010 Special Bulletin, *Health Check Billing Guide 2010* (<http://www.ncdhhs.gov/dma/bulletin/>).

Table 1: Influenza Billing Codes for Recipients Less Than 19 Years of Age

Note: In the tables below, the + sign indicates an add-on code.

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
90465 EP	Immunization administration under 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); when the physician counsels patient/family; first injection (single or combination vaccine/toxoid), per day
+90466 EP	Each additional injection (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure). Note: Providers may bill more than one unit of 90466EP as appropriate.
90467 EP	Immunization administration under age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; first administration (single or combination vaccine/toxoid), per day. Note: Billing CPT code 90468 for a second administration of an intranasal/oral vaccine when physician counseling was performed is not applicable at this time.
+90468 EP	Each additional administration (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure). Note: Billing CPT code 90468 for a second administration of an intranasal/oral vaccine is not applicable at this time.
90471 EP	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
+90472 EP	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.
90473 EP	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	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 Recipients 19 and 20 Years of Age

Use the following codes to **bill** Medicaid for an influenza vaccine **purchased** and administered to recipients **19 through 20 years of age**.

Vaccine CPT Code to Report	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 EP	Immunization administration; (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
90472 EP	Each additional vaccine (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure)
90473 EP	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)
90474 EP	Each additional vaccine (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure).

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

Use the following codes to **bill** Medicaid for an influenza vaccine **purchased** and administered to recipients **21 years of age and older**.

Note: In the tables below, the + sign indicates an add-on code.

Vaccine CPT Code to Report	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	Each additional vaccine (single and combination vaccine/toxoid) (List separately in addition to primary procedure)

For a recipient 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 (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:

For federally qualified health centers (FQHCs) and rural health clinics (RHCs), for recipients 0 through 20 years of age, if the vaccine was obtained at no cost to the clinic, the clinic may bill only for the administration costs under the C suffix provider number. For recipients 21 years of age and older, the costs of the vaccine and its administration may be included on the cost report and not billed to Medicaid.

Private providers, FQHCs, and RHCs may bill Medicaid for the vaccine and administration fees for the influenza vaccine administered to Medicaid Pregnant Women (MPW) recipients. Refer to the above guidelines.

HP Enterprise Services

1-800-688-6696 or 919-688-6696

Attention: Nurse Practitioners and Physicians**Cabazitaxel Injection (Jevtana, HCPCS Code J9999): Billing Guidelines**

Effective with date of service July 15, 2010, the N.C. Medicaid Program covers cabazitaxel (Jevtana) for use in the Physician's Drug Program when billed with HCPCS code J9999 (not otherwise classified, antineoplastic drugs). Jevtana is available in a 60-mg/1.5-ml single-dose vial kit. Jevtana is a microtubule inhibitor indicated in combination with prednisone for the treatment of patients with hormone-refractory metastatic prostate cancer previously treated with a docetaxel-containing treatment regimen. Jevtana should not be used in patients with a neutrophil counts of $\leq 1,500/\text{mm}^3$. Jevtana is contraindicated in patients who have a history of severe hypersensitivity reactions to Jevtana or to other drugs formulated with polysorbate 80.

The individual dosage of Jevtana is based on the calculation of the Body Surface Area (BSA) and is 25 mg/m² administered as a 1-hour intravenous infusion every three weeks in combination with oral prednisone (10 mg) administered daily throughout Jevtana treatment. Jevtana should be administered under the supervision of a qualified physician experienced in the use of antineoplastic medicinal products. Appropriate management of complications is possible only when the adequate diagnostic and treatment facilities are readily available. The Jevtana dose should be reduced to 20 mg/m² if patients experience certain adverse reactions. Refer to the full prescribing information at http://www.accessdata.fda.gov/drugsatfda_docs/label/2010/2010231bl.pdf.

Jevtana injection single-use vial requires **two** dilutions prior to administration. Jevtana should not be mixed with any other drugs.

Premedication is suggested at least 30 minutes prior to each dose of Jevtana with the following intravenous medications to reduce the risk and/or severity of hypersensitivity:

- antihistamine (dexchlorpheniramine 5 mg or diphenhydramine 25 mg or equivalent antihistamine)
- corticosteroid (dexamethasone 8 mg or equivalent steroid)
- H2 antagonist (ranitidine 50 mg or equivalent H2 antagonist)

Antiemetic prophylaxis is recommended and can be given orally or intravenously as needed. Refer to the full prescribing information at the web address listed above.

For Medicaid Billing

- The ICD-9-CM diagnosis code required for billing Jevtana is 185 (malignant neoplasm of prostate).
- Providers must bill Jevtana with HCPCS code J9999 (not otherwise classified, antineoplastic drugs).
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage is one 60-mg/1.5-ml single-dose vial kit. The maximum reimbursement rate per 60-mg single-dose vial kit is \$5,760.00.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for Jevtana should be reported in "MLs." To bill for the entire 60-mg/1.5-ml injection of Jevtana, report the NDC units as "ML1.5." If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website (<http://www.ncdhhs.gov/dma/bulletin/>) for additional instructions.
- Providers must bill their usual and customary charge.

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

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

Attention: Nurse Practitioners and Physicians**Zoledronic Acid (Reclast, HCPCS Code J3488): Update to Billing Guidelines**

The N.C. Medicaid Program covers the FDA-approved indications for Reclast. These include

1. treatment of Paget's disease;
2. treatment of osteoporosis in postmenopausal women (PMO) (to reduce the incidence of fractures or to reduce the incidence of new clinical fractures in patients with low-trauma hip fracture);
3. treatment of osteoporosis in men (to increase bone mass);
4. treatment and prevention of glucocorticoid-induced osteoporosis [in patients initiating or continuing prednisone ≥ 7.5 mg/day (or equivalent) and expected to remain on glucocorticoids for at least 12 months]; and
5. prevention of osteoporosis in postmenopausal women.

Effective with date of service June 1, 2009, the N.C. Medicaid Program added the FDA-approved diagnosis of prevention of osteoporosis in post-menopausal women to the list of covered ICD-9-CM diagnosis codes when billed through the Physician's Drug Program. Effective with date of service March 16, 2009, the indication for treatment and prevention of glucocorticoid-induced osteoporosis was added to the list of covered diagnoses.

One of the following ICD-9-CM diagnosis codes must be billed with Reclast, HCPCS code J3488:

1. For Paget's disease
 - 731.0 (osteitis deformans without mention of bone tumor)
2. For the treatment of postmenopausal women with osteoporosis and men with osteoporosis
 - 733.01 (senile osteoporosis)
3. For glucocorticoid-induced osteoporosis treatment
 - 733.09 (osteoporosis, other)
 - The following secondary code should also be used:
 - ◆ E932.0 (drugs, medicinal and biological substances causing adverse effects in therapeutic use, adrenal cortical steroids)
4. For the prevention of PMO
 - 733.90 (disorder of bone and cartilage, unspecified)
5. For the prevention of glucocorticoid-induced osteoporosis due to long-term steroid
 - 733.90 (disorder of bone and cartilage, unspecified)
 - The following secondary code should also be used:
 - ◆ V58.65 [long-term (current) use of steroids]

HP Enterprise Services

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

Attention: Nurse Practitioners and Physicians**Ranibizumab (Lucentis, HCPCS Code J2778): Update to Billing Guidelines**

Effective with date of service June 22, 2010, the N.C. Medicaid Program added the FDA-approved diagnosis of macular edema following retinal vein occlusion to the already covered diagnosis of wet age-related macular degeneration for Lucentis when billed through the Physician's Drug Program.

One of the following ICD-9-CM diagnosis codes must be billed with Lucentis, HCPCS code J2778:

1. For wet age-related macular degeneration
 - 362.52 (exudative senile macular degeneration)

OR

2. For macular edema following retinal vein occlusion
 - 362.83 (retinal edema)

PLUS, EITHER

 - ◆ 362.35 (central retinal vein occlusion)

OR

 - ◆ 362.36 [venous tributary (branch) occlusion]

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

Attention: Institutional (UB-04/837I) Billers**Non-Monetary Value Codes**

Paper claims received by HP Enterprise Services are now processed using Optical Character Recognition (OCR) technology. To maximize the functionality of this technology, data elements must be aligned properly on the paper claims as they are processed. Providers should refer to the National Uniform Billing Committee (NUBC) UB manual for claim form instructions.

Value Codes 80 through 83 represent days and are non-monetary value codes. When billing N.C. Medicaid, the value for these codes should be entered as the number of units (1 unit = 1 day). The proper placement of these non-monetary value codes are to the left of the dollars/cents delimiter. The number of units should be right-justified; zeros should not be entered to the right of the delimiter.

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

Attention: Local Management Entities and Nurse Practitioners**Injectable Drugs: Update to Billing Guidelines**

The N.C. Medicaid Program covers the following psychotropic injectable drugs for use by nurse practitioners and LMEs.

1. J1630 [haloperidol, up to 5 mg (Haldol)]
2. J1631 [haloperidol decanoate, per 50 mg (Haldol Decanoate-50)]
3. J2680 [fluphenazine decanoate, up to 25 mg (Prolixin)]
4. J2794 [risperidone, long acting, 0.5 mg (Risperdal Consta)]
Refer to the April 2010 Medicaid Bulletin for additional information.

5. J3230 [chlorpromazine HCl, up to 50 mg (Thorazine)]

6. J3490 (unclassified drugs)

Note: Olanzapine extended release formulation (Zyprexa Relprevv) is billed under J3490. Refer to the May 2010 Medicaid Bulletin for additional information.

7. S0166 [olanzapine, 2.5 mg (Zyprexa)]

Refer to the May 2010 Medicaid Bulletin for additional information.

For Medicaid Billing

- Providers must bill with 11-digit National Drug Codes (NDCs) and appropriate NDC units.
- Only rebatable NDCs will be reimbursed.
- 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.

HP Enterprise Services

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

Attention: Pharmacists**Recipient Management Lock-in Program Emergency Fill**

The N.C. Medicaid Program will reimburse an enrolled Medicaid pharmacy for a 4-day supply of a prescription dispensed to a recipient locked into a different pharmacy and prescriber in response to an emergent situation. The emergency supply is limited to a 4-day supply. The provider will be paid for the drug cost only, and the recipient will be responsible for the appropriate copayment. A “3” in the Level of Service field (418-DI) should be used to indicate that the transaction is an emergency fill.

Only one emergency occurrence will be reimbursed per lock-in period. Records of the dispensing of emergency supply medications are subject to review by DMA Program Integrity. Paid quantities for more than a 4-day supply are subject to recoupment.

HP Enterprise Services

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

Attention: Critical Access Behavioral Health Agencies and Direct-Enrolled Outpatient Behavioral Health Services Providers**Update on Unmanaged Visits for Children**

As a result of action by the General Assembly, the 26 unmanaged outpatient behavioral health therapy visits limit for children will decrease to 16 unmanaged visits. Prior authorization will be required for all outpatient services for children after the 16th visit. As a reminder, prior authorization will continue to be required for adults after the 8th visit. To ease the transition for providers and recipients, this change will now be effective January 1, 2011, to correspond with the new benefit year.

**Behavioral Health Unit
DMA, 919-855-4290**

Attention: Critical Access Behavioral Health Agencies**Prior Authorization and Billing for Mental Health/Substance Abuse Targeted Case Management**

In order for Mental Health/Substance Abuse Targeted Case Management (MH/SA TCM) claims to adjudicate appropriately, when submitting claims for MH/SA TCM, please ensure that prior authorization has been received from the appropriate utilization management vendor (ValueOptions, The Durham Center or Eastpointe LME). If the authorization request has not been approved, when a claim is submitted, it will be denied.

To request prior authorization for recipients who are being transitioned from the case management component of Community Support Services (CS) to MH/SA TCM, providers must submit a Letter of Attestation to ValueOptions for each recipient who will be transitioned. Eastpointe and The Durham Center **WILL NOT** be able to process these attestation requests. Detailed information on submitting Letters of Attestation can be found in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services' Implementation Update # 77 (<http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/>).

Critical Access Behavioral Health Agencies (CABHAs) may also submit prior authorization requests for recipients new to case management services. These would be recipients who are not currently receiving the case management portion of CS. As a reminder, all initial requests for MH/SA TCM for recipients in The Durham Center's and Eastpointe's catchment areas should be sent to The Durham Center and Eastpointe, respectively **IF** the provider will not be using the attestation. To request initial prior authorization for these recipients, providers must submit the inpatient treatment request (ITR), person centered plan (PCP), and a signed service order to the appropriate utilization management vendor for the recipient's catchment area (ValueOptions, The Durham Center, or Eastpointe LME).

**Behavioral Health Unit
DMA, 919-855-4290**

Attention: Critical Access Behavioral Health Agencies***E*rollment, Authorization, and Billing Frequently Asked Questions**

Based on feedback from participants in the Critical Access Behavioral Health Agency (CABHA) enrollment/authorization/billing seminars that took place in August, DMA, in conjunction with their vendors (CSC, ValueOptions, and HP Enterprise Services), has developed a list of frequently asked questions (FAQs) related to the key areas of enrollment, authorization, and billing. These FAQs can be found on DMA's CABHA web page at <http://www.ncdhhs.gov/dma/services/cabha.htm>.

Behavioral Health Unit
DMA, 919-855-4290

Attention: Obstetric Providers and Radiology Services***U*dates to Prior Authorization for Obstetrical Ultrasounds**

The following prior approval requirements are effective with date of service October 1, 2010. All obstetrical (OB) ultrasounds must be registered with or authorized by MedSolutions in order for claims to be processed.

- A. CPT procedure code 76813 (ultrasound pregnant uterus first trimester fetal nuchal translucency measurement single or first gestation) and 76814 (for each additional gestation):
 1. Allow one fetal nuchal translucency scan per pregnancy without requiring medical necessity indication if performed between 11 through 13 weeks gestation.
 2. This first trimester scan includes an assessment of fetal viability, crown rump measurement for dating, and measurement of nuchal fold thickness.
 3. Register the procedure with MedSolutions.
- B. CPT procedure code 76805 (ultrasound pregnant uterus fetal and maternal evaluation after first trimester single or first gestation) and 76810 (for each additional gestation):
 1. Allow one complete ultrasound per pregnancy without requiring medical necessity indication if performed after 16 weeks gestation.
 2. Register the procedure with MedSolutions.
- C. CPT procedure code 76811 (ultrasound pregnant uterus fetal and maternal evaluation plus detailed fetal anatomic examination single or first gestation) and 76812 (for each additional gestation):
 1. These procedure codes require medical necessity indication, such as a known or suspected fetal anatomic or genetic abnormality, and can only be performed by:
 - a. Providers with sub-specialty in Maternal Fetal Medicine (Perinatology) or Radiology; or
 - b. OB ultrasound providers who are in an American Institute of Ultrasound in Medicine (AIUM) accredited practice or an American College of Radiology (ACR) accredited practice.

2. Allow one of these detailed anatomic scans per practice (same group practice, same tax identification number, etc.), per pregnancy for appropriate medical necessity indications.
 3. These examinations will be audited for report content and practice referral patterns.
 4. 76805 and 76811 should not be requested nor billed for the same date of service and should not be requested on the same authorization request.
- D. All other OB ultrasound studies are subject to medical necessity review. If there is an urgent medical need for an OB ultrasound in addition to or at dates/codes not identified above, the ultrasound can be obtained and the request for authorization can be made to MedSolutions within two business days after the date of service. These requests will be reviewed for both urgent and medical necessity indications.

Example: A recipient presents early in pregnancy with bleeding or no fetal heart tones with Doppler at 12 weeks gestation. The provider can perform the ultrasound and bill for CPT procedure code 76801 (ultrasound pregnant uterus fetal and maternal evaluation first trimester single or first gestation) and 76802 (each additional gestation) and request prior authorization for medical necessity within two business days of the date of service. The provider can still provide complete ultrasound and bill for CPT procedure code 76805 after 16 weeks gestation without requiring medical necessity.

- E. Obstetrical ultrasound indications for sequential imaging:
OB ultrasound indications for sequential imaging are based upon the MedSolutions Obstetrical Ultrasound Imaging Guidelines. Refer to Attachment C, Obstetrical Ultrasound Indications for Sequential Imaging, in Clinical Coverage Policy 1K-7, *Prior Approval for Imaging Procedures*, which will be used for evaluating requests for OB ultrasounds in certain patients with known or suspected high risk diagnoses with references to the appropriate guidelines. Some of these patients may require sequential imaging (batching).
1. Verbal approval for these batched authorizations cannot be requested online. Requests must be submitted by fax (1-888-693-3210) or by phone (1-888-693-3211) to the MedSolutions nurse. Batched authorizations will be approved at the suggested frequency for a 30-day period.
 2. If ultrasounds or other OB studies that require preauthorization are requested over and above those approved in the batched authorization for the 30-day period, another authorization will need to be started and audits will be conducted to ensure proper coding, billing, and medical appropriateness of these additional studies.
 3. The traditional, single use obstetrical ultrasound CPT codes (76801, 76802, 76805, 76810, 76811, 76812, 76813, and 76814) will not be included in the batching process.

Clinical Coverage Policy 1K-7, *Prior Approval for Imaging Procedures*, can be accessed from DMA's Clinical Coverage Policy web page at <http://www.ncdhhs.gov/dma/mp/>, from the Radiology Services web page at <http://www.ncdhhs.gov/dma/services/radiology.htm> or from the OB/GYN Services web page at <http://www.ncdhhs.gov/dma/services/obgyn.htm>.

Diane Holder, Clinical Policy and Programs
DMA, 910-355-1883

Attention: Personal Care Services Providers

Independent Assessment Updates and Reminders

Registration forms for the new web-based Provider Interface were due by October 1, 2010. All registered providers will receive their user name and password by e-mail between October 1 and October 4, 2010. If you have not submitted Provider Interface registration forms, please do so immediately. Refer to the **Independent Assessment website** (<http://www.qireport.net>) for forms and instructions.

Beginning Monday, October 4, 2010, all Personal Care Services (PCS) providers must use the Provider Interface to receive and respond to recipient referrals and to view copies of recipient independent assessments and notices. Also, beginning October 4, 2010, please discontinue the use of the weekly discharge update form and report recipient discharges using the Provider Interface.

CCME will offer additional provider regional trainings in October 2010. The trainings will cover the following topics:

- Using the web-based Provider Interface to receive and respond to recipient referrals, to view recipient assessments and authorization and denial notices, to request change of status reassessments, and to report recipient discharges.
- The recipient appeal process and maintenance of service

Training dates and locations for October 2010 are as follows:

Date	Location
October 19, 2010	Chapel Hill, NC
October 20, 2010	Fayetteville, NC
October 21, 2010	New Bern, NC
October 26, 2010	Greensboro, NC
October 28, 2010	Hickory, NC

Refer to the **Independent Assessment website** (<http://www.qireport.net>) for additional information and to register for an upcoming training in your region.

Continue to visit the **Independent Assessment website** (<http://www.qireport.net>) regularly for PCS forms, reference documents, educational content, announcements, and updates to frequently asked questions. New educational information on recipient appeals and Maintenance of Service (MOS) will be posted this month.

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

CCME, 1-800-228-3365

Attention: HIV Case Management Providers**HIV Case Management Provider Training Sessions**

The Carolinas Center for Medical Excellence (CCME) is pleased to announce that comprehensive Provider Certification and HIV Case Management Trainings are scheduled for November and December 2010 (see schedule below). At this time, **training is limited to those providers who are currently enrolled with Medicaid to provide HIV Case Management.**

Date	Session Topic	Required Attendees
November 15, 2010	New Certification/Application Process	The official agency/program administrator (i.e., the agency owner or director)
November 16, 2010	New Certification/Application Process	The official agency/program administrator (i.e., the agency owner or director)
November 17 and 18, 2010	New Policy Requirements	HIV CM Program supervisors
December 14 and 15, 2010	New Policy Requirements	HIV CM Program supervisors

All participating providers will be required to certify/recertify their agencies as a result of the significant changes in Clinical Coverage Policy 12B, which went into effect on October 1, 2010. The certification/recertification process will begin in January 2011. The official agency/program administrator is required to attend either the November 15 or the November 16 training session. These sessions will be dedicated to the new certification process, including the application. Applications will be distributed to providers who attend the November 15 and November 16 training sessions.

The 2-day training sessions scheduled for November 17 and 18 and for December 14 and 15 will be dedicated to training the program supervisors and will focus on the new policy. **These training sessions are restricted to HIV CM program supervisors from those agencies that registered and attended one of the training sessions on the certification/application process.**

All of the trainings will be located at the McKimmon Center in Raleigh, North Carolina. Registration information for the November 2010 and December 2010 training is available on CCME's website (<http://www.thecarolinascenter.org/events> or <http://www.thecarolinascenter.org/HIVCM>).

It is anticipated that training on the new policy for case managers will begin in January 2011. Training on the certification and application process for those agencies currently not enrolled to provide HIV Case Management will begin once CCME and DMA complete the training schedule for those agencies currently enrolled to provide this service.

Information on trainings to be conducted in the future will be published in upcoming Medicaid Bulletins and on CCME's website (<http://www.thecarolinascenter.org/events> or <http://www.thecarolinascenter.org/HIVCM>).

CCME, 1-800-682-2650

Attention: Nursing Facility Providers**North Carolina's Referral Process for MDS 3.0 Section Q****MDS 3.0 Section Q**

On October 1, 2010, nursing facilities across the country will begin using a new iteration of the Minimum Data Set, called MDS 3.0. The new version includes a revised Section Q designed to identify people residing in nursing facilities who may be interested in talking to someone about moving back into the community.*

With guidance from the N.C. Health Care Facilities Association, DMA, DHHS Office of Long-Term Services and Supports, Division of Health Service Regulation, and other entities are finalizing the referral process required as part of this MDS 3.0 Section Q implementation.

Referral Process in North Carolina

As is required under MDS 3.0, facilities will make a referral when a person residing in a nursing facility indicates under Section Q an interest in speaking with someone about the possibility of returning to the community.

Effective October 1, 2010, nursing facilities can call **1-866-271-4894** (9:00 a.m. through 5:00 p.m., Monday through Friday) to submit Section Q referrals to trained call-center staff.

When submitting the referral, facilities will need to provide the following information:

- Resident's name and phone contact information
- Name of referring facility's contact, including:
 - ◆ Name of staff contact
 - ◆ Phone
 - ◆ Email
 - ◆ Name of facility
 - ◆ Facility address
 - ◆ County
- Following the logic in Section Q, information about who (if anyone) assisted the resident in completing Section Q:
 - ◆ Family
 - ◆ Significant other
 - ◆ Guardian
 - ◆ Legally Authorized representative
 - ◆ Other
- Pay source/number
- Date of admission
- Date of birth

A facility will receive written confirmation that the referral was made and forwarded to the appropriate entities.

The Local Contact Agency

Call center staff will forward the facility's referral to the appropriate local agency for a face-to-face follow-up meeting with the interested person.

The Local Contact Agency (LCA) is a local community organization that has been designated by the Office of Long-Term Services and Supports as an LCA. LCAs are responsible for contacting referred residents and providing information about community support options.* The LCA will coordinate these face-to-face conversations with the person residing in the facility, the facility point of contact, and, as appropriate, family members or other supports.

Importantly, the MDS 3.0, Section Q referral process does not otherwise change a facility's discharge planning responsibilities.

Additional Information Available

For more information about MDS 3.0, Section Q, please visit the CMS website at https://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp.

In addition to the MDS training that has already been provided, DHHS will be developing additional training and feedback opportunities about the MDS 3.0 Section Q implementation effort.

Margaret Comin, Facility Services Manager
DMA, 919-855-4260

* Excerpts from "Local Contact Agencies," developed by the Aging and Disability Resource Center: Technical Assistance Exchange.

Attention: All Providers

Reductions to Covered Podiatry Services

This bulletin article serves as a correction to the August 2010 Medicaid Bulletin article titled *Reduction to Covered Podiatry Services*. Due to legislated budget reductions, the N.C. Medicaid Program will implement reductions and limitations for podiatry services with an effective date of December 1, 2010. Clinical Coverage Policy 1C-1, *Podiatry Services*, and Clinical Coverage Policy 1C-2, *Medically Necessary Routine Foot Care*, will be revised to list the covered diagnosis codes that will be required on claims from podiatrists and podiatry practices.

Margaret White, Clinical Policy and Programs
DMA, 919-855-4320

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Proposed Clinical Coverage Policies

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

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

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

2010 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
October	9/30/10	10/5/10
	10/7/10	10/13/10
	10/14/10	10/19/10
	10/21/10	10/28/10
November	10/28/10	11/2/10
	11/4/10	11/9/10
	11/10/10	11/18/10

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

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

Melissa Robinson
Executive Director
HP Enterprise Services