October 2011 Medicaid Bulletin

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Attention: All Providers

Letter of Attestation Revision

As previously announced in the September 2011 Medicaid bulletin, the Division of Medical Assistance (DMA) will no longer notify providers who received a minimum of $5 million in Medicaid payments during the federal fiscal year (October 1, 2009 through September 30, 2010). Upon enrollment and re-enrollment in the N.C Medicaid program, providers are required to complete and sign the Letter of Attestation on the NCTracks website at http://www.nctracks.nc.gov/provider/forms/ as a condition of participation in the Medicaid and N.C. Health Choice programs.

In accordance with Session Law 2011-399, § 108C-9 requires the revised provider attestation to contain a statement that the provider:

- "has met the minimum business requirements necessary to comply with all federal and State requirements governing the Medicaid and Children's Health Insurance programs,
- does not owe any outstanding taxes or fines to the U.S. or North Carolina Departments of Revenue or Labor or the Employment Security Commission,
- does not owe any final overpayment, assessment, or fine to the North Carolina Medicaid or North Carolina Health Choice programs or any other State Medicaid or Children's Health Insurance program, and
- has implemented a corporate compliance program as required under federal law."

DMA is currently modifying the Letter of Attestation to include statements regarding educating employees, contractors, and agents about federal and state fraud and false claims laws and the whistleblower protections available under those laws, and to include additional statements as required in the Affordable Care Act and Session Law 2011-399. To avoid any delay in reimbursement, providers should review their corporate compliance programs and be prepared to submit the signed revised Medicaid Letter of Attestation. All providers will receive further guidance on completing and submitting attestations for Medicaid. Information will be available in upcoming Medicaid bulletins and on the "What's New" page of the DMA's website at http://www.ncdhhs.gov/dma/provider/index.htm.

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

Attention: All Providers

Medicaid Fraud: Protect Your Tax Dollars

WHY IT IS IMPORTANT?

The Medicaid program is funded with state and federal tax dollars. It is designed to pay for health care and certain support services for low-income and vulnerable North Carolinians (children, pregnant women, disabled adults and seniors). Tax dollars are wasted and services are taken away from people who need them when people obtain benefits they are not entitled to or when services are delivered that don't meet the policy and requirements.

WHAT IS MEDICAID FRAUD, WASTE AND ABUSE?

- **Fraud:** Deception or misrepresentation made by a health care provider with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under Federal requirements set forth in 42 C.F.R § 455 which relates to Medicaid.
- **Waste:** The overutilization of services, or other practices that result in unnecessary costs generally not considered caused by criminal negligent actions but rather the misuse of resources.
- **Abuse:** Provider practices that are inconsistent with sound fiscal, business or clinical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet recognized standards for health care or clinical policy.

WHAT MEDICAID FRAUD LOOKS LIKE?

Most types of Medicaid fraud, waste or abuse fall into one or more of these categories:

- Billing for "phantom patients" who did not really receive services
- Billing for medical services or goods that were not provided
- Billing for old items as if they were new
- Billing for more services that could be provided in 24 hours a day
- Billing for unnecessary tests
- Paying a "kickback" in exchange for a referral for medical services or goods
- Charging Medicaid for expenses that have nothing to do with caring for a Medicaid client
- Overcharging for health care services or goods that were provided
- Concealing ownership in a related company
- Using false credentials for staff
- Double-billing for health care services or goods that were provided
- Providing services by untrained staff

To report suspected Medicaid Fraud, Waste or Abuse, please call the North Carolina DHHS Customer Service Center toll-free number at 1-800-662-7030 or the North Carolina Medicaid Program Integrity Tip-Line at 1-877-DMA-TIP1 (1-877-362-8471).

You may submit an Online Medicaid Fraud and Abuse Confidential Complaint Form using the website http://www.ncdhhs.gov/dma/fraud/reportfraudform.htm. Callers may request to remain anonymous.

Before making a report, try to get as much information as possible, including:

- The name of the provider/recipient you suspected of committing fraud. This might be a person receiving medical benefits or a health care professional, hospital, nursing home, or other facility that provides Medicaid services
- The Recipient Medicaid ID number
- The Provider ID number
- The date of services
- The amount of money involved, and/or
- A description of the acts that you suspect involve fraud

Program Integrity
DMA, 919-647-8000

Attention: All Medicaid and North Carolina Health Choice Providers

Audits and Post Payment Reviews

In accordance with Session Law 2011-399, Program Integrity authorized audits and post payment reviews conducted during the state fiscal year 2011-2012 will utilize extrapolation of findings to determine recoupment amounts. Providers who have been designated as high or moderate risk are subject to review during this fiscal year. In addition to moderate or high risk providers, other providers may be identified for review through the use of the analytical data mining software by identifying outlier billing patterns, irregular service or referral trends. Additional methods of identification for provider review include the receipt of complaints of credible allegation fraud or abuse and tips received through the Fraud/Abuse Tip Line.

Providers who receive post payment review will be subject to review for all services and codes authorized by their participation agreement with the Division of Medical Assistance (DMA). The review or audit may take the form of a desk review of medical records or an onsite review or a combination of both. The onsite review may be announced or unannounced.

If the audit is a desk review, providers will receive a request for medical records as part of the post payment review process. The letter will outline the exact dates of medical records or claims to be reviewed, documentation being requested and the consequences for failure to comply with the request by the date identified in the letter. Based upon DMA or contractor post payment review of the submitted documentation, the desk review may lead to an onsite review or an expanded period of review.

The results of the audits will be extrapolated to determine the final overpayment amount. The time period of extrapolation may go back for 36 months from date of payment of a provider's claim or longer as allowed by federal law or regulation or in instances of credible allegations of fraud.

Program Integrity
DMA, 919-647-8000

Attention: All Medicaid Providers

Update to Provider Self Audit Process

In 1999, the Division of Medical Assistance (DMA) Program Integrity started a Provider Self-Audit process, which offered Medicaid providers an opportunity to conduct internal compliance audits and have a mechanism for reporting their outcomes directly to Medicaid. This process still exists, and parts of it are being expanded and incorporated into new activities introduced through NC Session law 2011-399.

In the current process, a provider may request a Self-Audit packet from Program Integrity, which contains instructions and forms to be returned to DMA. Providers will be able to access the packet on our web site in the near future. The provider will submit a Notice of Intent to Conduct Self Audit form to Program Integrity, which includes a description of the intended type of audit and anticipated date of completion. This information is assigned to a Program Integrity analyst, who works with you through the process.

NC Session Law 2011-399 offers providers the opportunity to conduct a self audit as a method for contesting the outcome of certain Program Integrity audits. As part of a provider investigation Program Integrity and its vendors review a random sample of claims from the "universe" of claims submitted by a provider over a period of time. Errors identified in the sample may be extrapolated across the full universe of claims. In cases where a "low risk" or "moderate risk" provider is notified of tentative findings of errors that could result in extrapolation, they may contest the extrapolation by conducting a self-audit. Providers should carefully review NC Session Law 2011-399, N.C.G.S. § 108C-5(n) "Payment suspension and audits utilizing extrapolation" for further details.

Program Integrity
DMA, 919-647-8000

Attention: All Providers

Submitting Claims for Reimbursement

Program Integrity has identified some trends in outpatient mental health non-physician practices, independent and group. Some providers are operating after-school programs, summer programs, or non-licensed day treatment programs and submitting claims for reimbursement from the North Carolina Medicaid Program. Medicaid only reimburse for services that are medically necessary, meets the criteria established through clinical policy and when the provider is qualified to provide the services.

A recent example included, a provider who was a county school counselor and licensed as a Professional Counselor who operated an afterschool tutorial program as an outpatient mental health practice. The provider rendered free teacher-supervised tutoring services, snacks and transportation to children of lower-income families and also had his employees obtain copies of each recipient's Medicaid card. He is suspected of submitting false claims for therapy sessions to his billing agent in Florida for reimbursement from the North Carolina Medicaid program. The night before the Provider was scheduled to meet with investigators his business burned down.

Defrauding the NC Medicaid program is a serious offense and will be dealt with accordingly. Sometimes the penalty includes civil and/or criminal remedies. Medicaid providers may receive a federal indictment involving wire fraud, identity theft, and arson by the U.S. Attorney's Office.

Behavioral Health Review Section
DMA, 919-647-8000

Attention: All Providers

Subscribe and Receive Email Alerts for Medicaid Updates

NC Medicaid allows all providers the ability to sign up for NC Medicaid email alerts. Email alerts send notices to providers on behalf of the NC Division of Medical Assistance (DMA) and NC Health Choice (NCHC) programs. Email alerts are sent to providers when there is important information to share outside of the general Medicaid Provider Bulletins. To receive email alerts, subscribe to the Email alerts at www.hp.com/go/medicaidalert. Providers and their staff members may subscribe to the email alerts. Contact information including an email address and provider type of specialty is essential for the subscription process. You may unsubscribe at any time. **Email addresses are never shared, sold or used for any purpose other than Medicaid email alerts.**

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

Attention: All Providers

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

The Medicaid **Recipient** Prior Approval and Appeal Processes and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) seminar is scheduled for October 18, 2011. Seminars are intended to address Medicaid **recipient** prior approval and appeal processes when a Medicaid service is denied, reduced or terminated. The seminar will also focus on an overview of EPSDT-Medicaid for Children. Billing will not be addressed during the presentation.

The seminar is scheduled at the location listed below. This session will begin at 9:00 a.m. and will end at 4:00 p.m. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided at the seminar. **Because meeting room temperatures vary, dressing in layers is strongly advised.** Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

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

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

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

Attention: All Providers

Filing a Medicaid Recipient Appeal Request

It is important to maintain documentation that the appeal was filed with the Office of Administrative Hearings (OAH). For example, if the form is faxed to OAH, maintain a copy of the fax confirmation sheet. If you have questions about the Medicaid recipient appeal process, please contact OAH at 919-431-3000 or the Medicaid Appeals/EPSDT Section at 919-855-4350.

Medicaid Appeals/EPSDT
DMA, 919-855-4350

Attention: All Providers

HIPAA ASC X12 5010 Implementation

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

N.C. Medicaid will implement the HIPAA requirements for the ASC X12 5010 transactions within the legacy MMIS+ claims processing system. HPES will begin Vendor/or Trading Partner testing of the 837 transactions for compliance in October, 2011. Clearing Houses, Billing Agencies and providers using vendor software to connect to HPES, will need to update their Trading Partner Agreement – Appendix A in preparation for ASC X12 5010 testing and implementation. HPES will begin dual processing of transactions on November 4, 2011. In addition, if your Trading Partner Agreement has been updated, you will receive both the ASC X12 versions 4010 and ASC X12 versions 5010 of the 835 transaction beginning with the November 8, 2011 checkwrite. The Division of Medical Assistance will continue to notify providers through upcoming Medicaid Bulletins as the HIPAA ASC X12 5010 implementation efforts progress.

Attention: All Providers

HIPAA 5010 Implementation

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

N.C. Medicaid will be implementing the HIPAA requirements for the 5010 transactions within the MMIS+ claims processing system. The Division of Medical Assistance (DMA) will notify providers through upcoming Medicaid bulletins as the HIPAA 5010 implementation efforts progress.

In preparation for 5010 testing and implementation, HP Enterprise Services began receiving updated Trading Partner Agreement-Appendix A effective July 1, 2011 which was published in the July 2011 Medicaid Bulletin. Follow the attached link to the 5010 version of Appendix A. Complete and mail, with original signature, to HP Enterprise Services. You will be e-mailed a letter with instructions on how to proceed with 5010 transaction testing after your Trading Partner Agreement-Appendix A has been processed. Trading Partners/Vendors will be notified about testing timelines through upcoming Medicaid bulletins as HIPAA 5010 efforts progress.

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

Attention: All Providers

Enrollment of Nurse Practitioners

In response to provider requests, the Division of Medical Assistance (DMA) has removed the November 30, 2011 deadline for Nurse Practitioner (NP) enrollment. NPs should continue their current billing method. NPs not enrolled with NC Medicaid should begin the enrollment process and may continue billing "incident to" until further notice. DMA will monitor the enrollment of NPs and will notify providers when they should begin using the NP National Provider Identifier (NPI) as the rendering/attending provider number. The effective date of any change to the current "incident to" policy will be communicated to providers via bulletin articles, website updates, and provider email blasts.

Clinical Policy
DMA, 919-855-4320

Attention: All Providers

Enrollment of Physician Assistants

In response to provider requests, the Division of Medical Assistance (DMA) has removed the December 31, 2011 deadline for Physician Assistant (PA) enrollment. PA's should begin the enrollment process and continue billing "incident to" until further notice. DMA will monitor the enrollment of PA's and will notify providers when they should begin using the PA National Provider Identifier (NPI) numbers as the rendering/attending provider number. The effective date of any change to the current "incident to" policy will be communicated to providers via bulletin articles, website updates, and provider email blasts.

Clinical Policy
DMA, 919-855-4320

Attention: All Providers

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

Provider Registration begins September 27, 2011

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

Requesting PA for Synagis for the upcoming season will be an electronic process. Prompts, alerts, dropdown choices, attachment capability as well as free text opportunities will allow the provider to submit a request with all information essential to justify medical necessity. When available, a note documenting the patient's pulmonary or cardiac status should always be submitted as an attachment. The electronic system can automatically approve requests and allows the provider to monitor the status of a pending request.

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

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

Provider Registration

Providers must register for access to the web-based system prior to submitting PA requests for Synagis. The registration process is completed online using the website www.smartDUR.com. Providers receive a user ID and temporary password within several days of submitting a complete registration request. Providers who are already registered users of www.documentforsafety.com may use the same user ID and password to access www.smartDUR.com. Please call technical support at (855) 272-6576 for assistance with registration. System access will be restricted to registration for a limited period.

Registered providers can begin submitting prior approval requests for Synagis using the website www.smartDUR.com in early October. An email alert with the start date will be sent to providers who have completed registration.

Maximum of Five Doses

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

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

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

In addition to the two conditions listed above, a premature infant (prematurity must be counted to the exact day) may qualify for five doses as follows:
- Born at an EGA of ≤28 weeks 6 days and DOB is on or after November 2, 2010;
- Born at an EGA of 29 weeks 0 days to 31 weeks 6 days and DOB is on or after May 2, 2011; or
- Born at an EGA of ≤34 weeks 6 days and DOB is on or after November 2, 2010, and also has severe neuromuscular disease that compromises handling of respiratory secretions; **or** congenital abnormalities of the airways that compromises handling of respiratory secretions.

The conditions of severe neuromuscular disease and congenital airway abnormalities should have an applicable ICD9-CM.

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

Maximum of Three Doses; Last Dose Administered at Three Months of Age (90 Days of Life)
Infants meeting clinical criteria as follows may be approved for up to three doses of Synagis during the season:
- Born at an EGA of 32 weeks 0 days to 34 weeks 6 days, and DOB is on or after August 2, 2011, and has at least one of the two following defined risk factors:
  - ♦ Attends child care [defined as a home or facility where care is provided for any number of infants or young toddlers (toddler age is up to the third birthday)]. The child care facility must be identified.
  - ♦ Has a sibling younger than five years of age in the home. A multiple birth sibling does not meet this requirement.

Generally, the following diagnoses do not singularly justify medical necessity for Synagis prophylaxis:
- a positive RSV episode during the current season
- repeated pneumonia
- sickle cell
- multiple birth with approved sibling
- apnea or respiratory failure of newborn

Submitting a Request to Exceed Policy

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

Pharmacy Distributor Information

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

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

Provider Information

- Provider should call (855)272-6576 for assistance with registration or technical issues. Contact DMA at (919)855-4300 for other concerns including policy questions.
- Providers without internet access should contact Charlene Sampson at (919)855-4300 to facilitate submission of a PA request for Synagis.
- Providers are responsible for the accuracy of information inputted for a Synagis request. Physicians and pharmacy providers are subject to audits of patient records by DMA Program Integrity.

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

Attention: All Providers

Influenza Vaccine and Reimbursement Guidelines for 2011-2012 for Medicaid and North Carolina Heath 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, the same strains as the 2010-2011 seasonal vaccine: an A/California/7/2009 (H1N1)-like virus; an A/Perth/16/2009 (H3N2)-like virus; and a B/Brisbane/60/2008-like virus. A dose of 2011-2012 vaccine is recommended regardless of whether the person received 2010-2011 vaccine. For further details on the 2011-2012 influenza vaccine, see the ACIP recommendations found on the CDC web site at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm60e0818a1.htm?s_cid=mm60e0818a1_w
Medicaid does not expect that providers will be vaccinating recipients with the 2011-2012 influenza season's vaccine after date of service June 30, 2012.

North Carolina 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 2011-2012 influenza season, NCIP/VFC influenza vaccine is available at no charge to providers for 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: *http://www.immunize.nc.gov/providers/coveragecriteria.htm*. Eligible children include American Indian and Alaska Native (AI/AN) NC Health Choice recipients. These recipients are identified as MIC-A and MIC-S on their Health Choice Identification Cards. All other NC Health Choice (NCHC) recipients are considered ***insured,*** and must be administered privately purchased vaccines.

For VFC or NCIP state-supplied vaccines, providers will only report the vaccine code but may bill for the administration fee for Medicaid and eligible AI/AN Health Choice recipients. Providers wishing to immunize children who are *not* VFC-eligible (including all Health Choice 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 recipients over 18 years of age do not qualify for the NCIP vaccine, purchased vaccine and administration costs may be billed to Medicaid.

Billing/Reporting Influenza Vaccines for Medicaid Recipients
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 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 Health Check recipients can be found in the July 2011 Special Bulletin, *Health Check Billing Guide 2011,* at *http://www.ncdhhs.gov/dma/healthcheck/guide2011.pdf*.

Table 1: Influenza Billing Codes for Medicaid Recipients Less Than 19 Years of Age Who Receive VFC State-supplied 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.
+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 Recipients 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 recipients **19 through 20 years of age.**

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	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)
+90474EP (add-on code)	Immunization administration by intranasal or oral route; **each additional vaccine** (single and 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 Recipients 21 Years of Age and Older

Use the following codes to report the *injectable or intranasal* influenza vaccine provided by NCIP or to **bill** Medicaid for an *injectable* influenza vaccine **purchased** and administered to recipients **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
90660 (**report only**)	Influenza virus vaccine, live, for intranasal use (FluMist) **Note: Medicaid does not reimburse for purchased intranasal (FluMist) for those recipients 21 years of age and older.**
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)
90473EP	Immunization administration by intranasal or oral route; **1 vaccine** (single or combination vaccine/toxoid)
+90474EP (add-on code)	Immunization administration by intranasal or oral route; **each additional vaccine** (single and 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.

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:
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 or 90473). For recipients 0-20 years of age, if the vaccine was obtained 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 Recipients
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 a NCHC recipient'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 Recipients 6 through 18 Years of Age Who Receive VFC State-supplied Vaccine (MIC-A and MIC-S Eligibility Categories) 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, ubcutaneous, 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 90472EP 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.

For FQHCs and RHCs, for NCHC recipients 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 Division of Medical Assistances website at: *http://www.ncdhhs.gov/dma/fee/index.htm*.

Note: N.C. Health Choice and N.C. Medicaid use codes other than 90460 and 90461 for reimbursement of vaccine administration.

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

Attention: All Providers

Change in Cardiac Imaging Prior Approval Program Implementation Date

Pending approval from the Centers for Medicare and Medicaid Services (CMS), the effective date of the cardiac imaging prior approval program has been delayed. Updates will be posted in future Medicaid Bulletins and on the Medicaid website at http://www.ncdhhs.gov/dma/services/radiology.htm.

Practitioner and Clinic Services
DMA, 919-855-4320

Attention: All Providers

Implementation of Additional Correct Coding Edits: New Visit and Obstetric Care

As previously announced in the May 2011 Bulletin, the Division of Medical Assistance (DMA) began implementing additional correct coding guidelines. These new correct coding guidelines and edits are nationally sourced by organizations such as the Centers for Medicare and Medicaid Services (CMS) and The American Medical Association (AMA). These edits identify any inconsistencies with CPT, HCPCS, AMA, CMS and/or DMA policies and will deny the claim line. As previously announced in the August and September 2011 Bulletins, additional correct coding edits for New Visit and Obstetric Care codes will be implemented on October 1, 2011 for dates of service on or after October 1, 2011.

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

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

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

44950	Appendectomy	04/12/2011	Allow
99205	Office or other outpatient visit for the evaluation and management of a new patient	01/05/2012	Deny

Obstetric Care
Obstetric Care edits are based on guidance per the AMA. Per AMA, the total obstetric package includes the provision of antepartum care, delivery, and postpartum care. The Obstetric Care edits apply acceptable methods of billing obstetric services, and identify duplicate or conflicting methods of billing obstetric services and/or their components, as well as appropriate and/or inappropriate use of modifiers.

The following are examples of Obstetric Care Edits:

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

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

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

Attention: All Providers

Family Planning Waiver Procedure Code 55250 Change

Ambulatory surgical Centers have received denials for CPT code 55250 "Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)" under the Family Planning Waiver (FPW) program. Effectively immediately, Ambulatory Surgical Centers may bill CPT code 55250 with the FP modifier for reimbursement of this procedure. Claims that were denied since May 25, 2011 can be resubmitted to HP for reimbursement.

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

Attention: All Providers

Family Planning Waiver Procedure Code 86781 Change

The Division of Assistance (DMA) has become aware of the need to replace procedure code 86781 (Treponema pallidum, confirmatory test) with procedure code 86780 (Treponema pallidum) for the Family Planning Waiver (FPW) program. The change reflects the deletion of old code 86781 in the CPT code book for 2010. Effective immediately, providers may bill code 86780 with the FP modifier for reimbursement for this procedure. Claims that were denied since January 1, 2010 can be resubmitted to HP for reimbursement if kept filed timely.

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

Attention: All Providers

Amendment Approval to the Family Planning Waiver

On February 1, 2011, Centers for Medicare and Medicaid Services (CMS) approved the coverage of additional procedures/devices under the Medicaid Family Planning Waiver (MAFD). The procedures/devices listed in the following table are now included.

Procedure Code	Devices
87621	Papillomavirus human amplified probe technique
Q0111	Wet mounts, including preparations of vaginal, cervical or skin specimens
11983	Removal, with reinsertion, non-biodegradable drug delivery implant

Claims for dates of service on or after February 1, 2011, may now be submitted for processing. Please be reminded that an annual exam date is required on all claims submitted for laboratory services. The annual exam date is not required on claims for approved contraceptive supplies and devices. For additional information regarding Family Planning Waiver claims, please refer to the Revised Family Planning Waiver "Be Smart" Bulletin on our website http://www.ncdhhs.gov/dma/bulletin/FPW.pdf.

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

Attention: All Providers

Scheduling Hysterosalpingogram (HSG) After the Essure Procedure

The Division of Medical Assistant (DMA) has become aware that some providers are receiving claim denials because the Hysterosalpingogram (HSG) test (CPT code 58340) "Catherization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography") is being performed prior to three full months (90 days) after the placement of Essure (CPT code 58565 "Hysteroscopy with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants") micro inserts. The HSG test must occur on or after (but no later than six months after) the 91st day after the Essure procedure is performed. If a second (2nd) HSG test is needed to confirm occlusion of the fallopian tubes because the first test was not conclusive, it must also be performed within six months after the date of service for the Essure procedure. Please refer to the clinical coverage policy at http://www.ncdhhs.gov/dma/mp/1E3.pdf.

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

Attention: All Dental Providers and Health Department Dental Centers

Dental Program Changes

In accordance with Senate Law 2011-145 the following changes will be implemented for the Division of Medical Assistance (DMA) Dental Program which refers to the dental policy adjustments resulting in program cost savings. The Dental Program recommended policy changes result in cost savings which are clinically sound.

The following changes are effective October 1, 2011:

- Limit periodontal scaling and root planning—four or more teeth per quadrant (D4341) and periodontal scaling and root planning—one to three teeth per quadrant (D4342) to one time per 24 month interval
  - Approvals granted for the recipient prior to October 1, 2011 and rendered within the effective dates of the approval will still be honored
- Eliminate coverage of cast partial dentures (D5213 and D5214)
  - Approvals granted for the recipient prior to October 1, 2011 and rendered within the effective dates of the approval will still be honored
- Change the frequency of replacement of covered acrylic partial dentures (D5211 and D5212) from every 10 years to every 8 years
  - If there is a cast partial denture in history, the recipient will be required to wait the full ten years before approval can be granted for an acrylic partial denture
  - If there is an acrylic partial denture in history, the recipient can receive approval for an acrylic partial denture at the end of eight years

The following changes are effective November 1, 2011:

- Limit the total reimbursement paid for two or more separate fillings (D2391, D2392, D2393, and D2394) on a single **posterior permanent tooth** to the rate paid for a single four or more surface resin-based composite restoration (D2394)
- Limit the total reimbursement paid for two or more separate fillings (D2140, D2150, D2160, and D2161) on a single **posterior primary or permanent tooth** to the rate paid for a single four or more surface amalgam restoration (D2161)
- Protective restoration (D2940) will deny if billed on the same date of service as any restorative procedure code (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2930, D2931, D2932, D2933, D2934, D2950, and D2970) for the same tooth number

Clinical Coverage Policy 4A, Dental Services is currently posted as a proposed policy for 45 day comment on the DMA website. The policy will be finalized to reflect these changes and should be available on November 1, 2011 on the DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

Dental Program
DMA, 919-855-4280

Attention: All Providers

Dental Services and Presumptive Eligibility for Pregnancy

The Obstetrics policy 1E-5 located on Division of Medical Assistant (DMA) website http://www.ncdhhs.gov/dma/mp/1E5.pdf states the following: "Section 1920 (b) of the Social Security Act allows for a pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid to receive ambulatory antepartum care, including pharmacy, laboratory, and diagnostic tests, while her eligibility is being determined." Dental services are not covered during the Presumptive Eligibility period. Please see Section 2.1.4 of the Obstetrics policy about services covered under presumptive eligibility.

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

Attention: All Dental Providers and Health Department Dental Centers

North Carolina Health Choice (NCHC) Dental Policy

Effective with dates of service on or after October 1, 2011, NC Health Choice (NCHC) prior approvals and claims will be processed by HP Enterprise Services (HP). For dates of service prior to October 1, 2011, providers must continue to submit claims to by Blue Cross Blue Shield (BCBS). All claims that need to be processed BCBS must be received by February 29, 2012.

Effective October 1, 2011, NCHC policy will mirror NC Medicaid dental policy with a few exceptions. The exceptions are listed below:

- Prior approval will be required for procedure codes D7220, D7230, D7240, D7241 for the extraction of all impacted teeth including the extraction of **symptomatic** third molars (wisdom teeth)
- Providers must document why approval is needed for the extraction of the impacted teeth including the third molars (pain, swelling, infection, previous antibiotic therapy, etc)
- Orthodontic coverage (procedure codes D8070, D8080, D8670, and D8680) will only be allowed for severe malocclusions caused by craniofacial anomalies like cleft lip and palate and other conditions caused by a syndrome
- No coverage for pre-prosthetic surgeries (alveoloplasty, tori removal, exostoses removal, and vestibuloplasty)
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) does not apply to NCHC recipients

Note: As a result of this change, effective October 1, 2011 premolar sealants will no longer be covered for NCHC recipients.

Dental Program
DMA, 919-855-4280

Attention: North Carolina Health Choice and Behavioral Health Providers

North Carolina Health Choice (NCHC) Transition

As previously announced in the September 2011 Medicaid Bulletin, for North Carolina Health Choice (NCHC) recipients, the count of 16 unmanaged outpatient treatment service visits will begin anew on October 1, 2011. For NCHC recipients who have been enrolled exclusively in NCHC over the course of the calendar year, all 16 unmanaged visits will be available. However, for children who have been enrolled in NCHC **and** Medicaid at various times over the course of the calendar year, the already paid Medicaid claims for these services will be deducted from the 16 visit count.

For NCHC recipients who have been enrolled exclusively in NCHC over the course of the calendar year, those enhanced services that allow a "pass-through" or maximum units for the calendar year or another specified timeframe (e.g. SAIOP) will also begin anew on October 1, 2011. For children who have been enrolled in NCHC **and** Medicaid, as with the outpatient count, the already paid Medicaid claims for those services will be deducted from the "pass-through" count.

Behavioral Health Section
DMA, 919-855-4294

Attention: North Carolina Health Choice Providers

North Carolina Health Choice (NCHC) Claims Processing Transition

As previously announced in the Medicaid bulletins, claims for NC Health Choice (NCHC) will be processed by the Division of Medical Assistance (DMA) fiscal agent, HP Enterprise Services (HPES). For dates of service prior to the transition date of October 1, 2011 providers will continue to submit claims to BCBSNC. The run-out period with Blue Cross Blue Shield of North Carolina (BCBSNC) begins on October 1, 2011 and will end on February 29, 2012. **You must file all claims for dates of service through September 30, 2011 with BCBSNC by February 29, 2012.**

As of the transition date of October 1, 2011, active NC Medicaid providers who want to render service to NCHC recipients may do so without taking any action for NCHC enrollment. Providers who are not NC Medicaid-enrolled providers but who want to begin or continue serving NCHC recipients must complete the Medicaid provider enrollment application on www.nctracks.nc.gov. Computer Sciences Corporation, Inc. (CSC), DMA's agent for enrollment, verification, and credentialing (EVC), will process the applications. Any questions regarding provider enrollment for NCHC should be directed to the CSC EVC Center at 866-844-1113.

NC Health Choice
DMA, 919-855-4100

Attention: North Carolina Health Choice Providers

Forms Required for Processing and Payment of North Carolina Health Choice (NCHC) Claims

As previously announced in the Medicaid bulletins, claims for NC Health Choice (NCHC) will be processed by Division of Medical Assistance (DMA) fiscal agent, HP Enterprise Services (HPES). DMA's current fiscal agent, HPES will begin processing claims for NCHC. NCHC providers who are newly enrolled with Medicaid must complete and submit additional forms to HPES after they receive their NC Medicaid provider number. Please be advised that these forms are essential for proper and timely claim processing. After completing the Medicaid provider enrollment process and receiving an NC Medicaid provider number from CSC, NCHC providers should submit the Electronic Claims Submission Agreement and the Electronic Funds Transfer (EFT) Authorization Agreement to HPES. More information about the requirements for electronic claims submission can be found at http://ncdhhs.gov/dma/provider/billing.htm#ec.

In accordance to Session Law SL2011-145 § 10.31(b)(6) Medicaid-enrolled providers must submit claims electronically. However, certain exceptions require claims to be filed on paper. The exceptions are listed on DMA's website at http://ncdhhs.gov/dma/provider/ECSExceptions.htm. Only those claims which comply with the exceptions will be accepted on paper. NCHC providers should mail paper claims and any NCHC claims-related written correspondence to:

HP Enterprise Services
P.O. Box 300001
Raleigh, NC 27622-0001

The HPES mailing address for NCHC Prior Approval is:
HP Enterprise Services
Prior Approval
P.O. Box 322490
Raleigh, NC 27622

If providers want to be able to submit their paper claims without a signature, they must complete the Provider Certification for Signature on File form and submit that to HPES.

Legislation also requires HPES to issue Remittance and Status Reports to providers electronically. The Remittance and Status Report (RA) is a computer-generated document showing the status of all claims submitted, along with a detailed breakdown of payment. RA's are posted in PDF format on the NC Electronic Claims Submission/Recipient Eligibility Verification Web Tool. All providers who want to download a PDF version of their RA must register for the NCECS Web Tool and submit the Remittance and Status Reports in PDF Format and National Correct Coding Initiative Information Request Form. Refer to the *Basic Medicaid Billing Guide* for more information about NCECS Web Tool and Electronic Commerce Services (ECS).

All of the aforementioned forms and their respective instructions are located on the DMA website at: http://ncdhhs.gov/dma/provider/forms.htm. Questions regarding the forms or NCHC claims submission for dates of service 10/1/2011 and after should be directed to the HPES Provider Services Department at 1-800-688-6696, menu option 3.

NC Health Choice
DMA, 919-855-4100

Attention: North Carolina Health Choice Providers

New ID Cards and Referral Requirements for North Carolina Health Choice (NCHC) Recipients

In accordance with Session Law 2011-145 it requires the provision of services for children to enroll in the NC Health Choice Program through Community Care of North Carolina (CCNC) which will help ensure that each Health Choice Program recipient has a medical home. Effective October 1, 2011, NC Health Choice (NCHC) enrollees will be required to select a CCNC primary care provider (PCP) practice to serve as their medical home for sick and well-child visits. CCNC PCP practices are required to provide direct care and care coordination including authorizing and documenting medically necessary referrals to specialty care for its NCHC panel members. In addition to fee-for-service reimbursement, CCNC PCP practices will be paid per member, per month fee for coordinating the care of their NCHC panel members. For primary care providers who are interested in enrolling in CCNC, please visit the following web address: http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm.

Effective October 1, 2011, there will be a new annual NCHC Identification card. The card will be gray in color and will bear the NCHC logo, but it will resemble the Medicaid ID card. The card will list the NCHC recipient and his or her identification number, and the CCNC PCP practice's name, address, and telephone number. As a function of CCNC/CA, all NCHC recipients **must** be referred by their PCP for all services not performed at their medical home. Contact the PCP located on the card if there is any question about the referral. The Division of Medical Assistance will mail the new ID card to all current NCHC recipients during the month of September for use with services from October 1, 2011, and after. NCHC recipients approved after October 1, 2011 will also receive the new card. If someone is approved after October 1 for a time period prior to October 1, he or she will receive the old Blue Cross/Blue Shield NCHC card which should be used for billing for all services received prior to October 1, 2011.

The NCHC card is not proof of eligibility. The provider must verify eligibility by using one of the following:

- Recipient Eligibility Verification Web Tool
- Real Time Eligibility Verification (270/271 Transaction)
- Batch Eligibility Verification (270/271 Transaction)
- Automated Voice Response (AVR) System – 1-800-723-4337, Option 6

Additional information about the verification process can be found in Appendix F of the *Basic Medicaid Billing Guide*.

NC Health Choice
DMA, 919-855-4100

Attention: North Carolina Health Choice Providers

Recipient ID Cards

Effective October 1, 2011, NC Health Choice (NCHC) recipients will be linked to a Primary Care Provider (PCP) in the Community Care of North Carolina / Carolina Access (CCNC) Managed Care Provider network. NCHC recipients will select or be assigned to a CCNC Medical Home PCP. Provider contact information will be printed on recipient health insurance ID cards. Recipients will be instructed to establish a medical history with their PCP; recipients must see the PCP for most health care services and obtain referrals to see other providers.

There may be instances in which you do not see PCP information on an NCHC recipient's ID card. **Pursuant to federal law [42 U.S.C. 1397cc(f)(3), and 42 U.S.C. 1396u-2(1)(c)], enrollment in CCNC is *optional* for federally recognized American Indian Medicaid and NC Health Choice recipients whether or not they receive services through tribal facilities.** The Eastern Band of Cherokee Indians is the only federally recognized American Indian tribe in North Carolina.

NC Health Choice
DMA, 919-855-4100

Attention: North Carolina Health Choice Providers

North Carolina Health Choice (NCHC) Prior Authorization Processing Transition

Effective for dates of service on and after October 1, 2011, prior authorizations for NC Health Choice (NCHC) will be processed by the Division of Medical Assistance (DMA) fiscal agent, HP Enterprise Services (HPES) and other Medicaid vendors. Providers must submit recipient Medicaid numbers and the legacy Medicaid provider number on prior authorization forms. Incomplete or incorrect data will increase the processing time, as HP will have to return forms to providers for additional information.

NC Health Choice
DMA, 919-855-4100

Attention: North Carolina Health Choice Providers

North Carolina Health Choice (NCHC) Proposed Clinical Coverage Policies

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

Proposed Policy	Date Posted	Comment Period End Date
NCHC Surgery for Clinically Severe or Morbid Obesity	September 12, 2011	October 27, 2011
NCHC Kidney (Renal) Transplantation	August 31, 2011	October 15, 2011
NCHC Heart (Cardiac) Transplantation	August 29, 2011	October 13, 2011
NCHC Liver Transplantation	August 29, 2011	October 13, 2011
NCHC Heart/Lung Transplantation	August 29, 2011	October 13, 2011
NCHC Islet Cell Transplantation	August 29, 2011	October 13, 2011
NCHC Pancreas Transplantation	August 29, 2011	October 13, 2011
NCHC Lung/Lobar Lung Transplantation	August 29, 2011	October 13, 2011
NCHC Small Bowel, Small Bowel/Liver and Multivisceral Transplantation	August 29, 2011	October 13, 2011
NCHC Ventricular Assist Devices	August 29, 2011	October 13, 2011
NCHC Home Health Services	August 26, 2011	October 10, 2011
NCHC Off Label Antipsychotic Monitoring in Health Choice Recipients	August 26, 2011	October 10, 2011
NCHC Wireless Capsule Endoscopy	August 23, 2011	October 7, 2011
NCHC Anticonvulsants PA Criteria	August 23, 2011	October 7, 2011
NCHC Vusion PA Criteria	August 23, 2011	October 7, 2011
NCHC Xolair PA Criteria	August 23, 2011	October 7, 2011
NCHC Botox PA Criteria	August 23, 2011	October 7, 2011
NCHC Celebrex PA Criteria	August 23, 2011	October 7, 2011
NCHC CII Narcotics PA Criteria	August 23, 2011	October 7, 2011
NCHC Suboxone PA Criteria	August 23, 2011	October 7, 2011
NCHC Topic Anti-Inflammatories PA Criteria	August 23, 2011	October 7, 2011
NCHC Qualaquin PA Criteria	August 23, 2011	October 7, 2011
NCHC Sedative Hypnotics PA Criteria	August 23, 2011	October 7, 2011

Proposed Policy	Date Posted	Comment Period End Date
NCHC Triptans PA Criteria	August 23, 2011	October 7, 2011
NCHC Emend PA Criteria	August 23, 2011	October 7, 2011
NCHC Growth Hormones PA Criteria	August 23, 2011	October 7, 2011
NCHC Hematinics PA Criteria	August 23, 2011	October 7, 2011
NCHC Leukotrienes PA Criteria	August 23, 2011	October 7, 2011
NCHC Lidoderm PA Criteria	August 23, 2011	October 7, 2011
NCHC Oral Inhaled Steroids PA Criteria	August 23, 2011	October 7, 2011
NCHC Provigil/Nuvigil PA Criteria	August 23, 2011	October 7, 2011
NCHC Statins and Zetia PA Criteria	August 23, 2011	October 7, 2011
NCHC Bone Mass Measurement	August 15, 2011	September 29, 2011

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

Proposed Policy	Date Posted	Comment Period End Date
NCHC Carotid Artery Angioplasty/Stinting	August 15, 2011	September 29, 2011

NC Health Choice
DMA, 919-855-4100

Attention: North Carolina Health Choice Providers

North Carolina Health Choice (NCHC) Non-Covered Policies

The following NCHC polices have been recommended as non-covered by the Physician Advisory Group (PAG):

1.	Automated Nerve Conduction Tests
2.	Cerebellar Stimulator-Pacemaker
3.	Complementary and Alternative Medicine
4.	Screening for Vertebral Fracture with Dual X-Ray Absorptiometry (DEXA)
5.	Dynamic Posturography
6.	Magnetic Resonance Spectroscopy
7.	Sensory Integration Therapy
8.	Signal Averaged ECG
9.	Suprachoroidal Delivery

NC Health Choice
DMA, 919-855-4100

Attention: All Providers

North Carolina Health Choice (NCHC) Outpatient Specialized Therapies

The Division of Medical Assistance's Outpatient Specialized Therapies contract with The Carolinas Center for Medical Excellence (CCME) will be amended on or after October 1, 2011 to include North Carolina Health Choice (NCHC) prior approval reviews and post payment validations.

If you are currently registered with CCME, you will not need to re-register. If you are not currently registered with CCME, detailed information and instructions for registering and submitting requests is available on the Carolinas Center of Medical Excellence (CCME) website http://www.medicaidprograms.org/nc/therapyservices CCME will post a notice on its website http://www.medicaidprograms.org/nc/therapyservices when it begins accepting prior approval requests.

Please refer to *Section 12* of the *October 2011 Basic Medicaid Billing Guide* for NCHC Program policies and procedures related to prior authorizations.

Pharmacy and Ancillary Services
DMA, 919-855-4310

Attention: All Providers

Outpatient Specialized Therapies

In accordance with Senate Law 2011-145 there will be changes to the N.C. Medicaid Outpatient Specialized Therapies program. The Outpatient Specialized Therapies policy 10A is currently under public comment. The changes and effective dates are under review.

Further information will be posted in a Special Bulletin on DMA's website at http://www.ncdhhs.gov/dma/provider/library.htm.

Pharmacy and Ancillary Services
DMA, 919-855-4310

Attention: North Carolina Health Choice Providers

New Vaccine Billing Procedure

The Vaccines for Children (VFC) program is federally funded through the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC). For the VFC program, the CDC purchases vaccines at a discount and distributes them to state, local, and territorial public health agencies. The agencies then distribute the vaccines at no charge to private physicians' offices and public health clinics registered as VFC providers. In North Carolina, the agency responsible for administering the VFC program is the NC Division of Public Health's Immunization Branch.

Children who are eligible for VFC vaccines are entitled to receive pediatric vaccines that are recommended by the CDC's Advisory Committee on Immunization Practices. (*Source: Centers for Disease Control and Prevention, http://www.cdc.gov/vaccines/programs/vfc/).* In general, children enrolled in a separate State Children's Health Insurance Program (SCHIP), known as NC Health Choice (NCHC) are not eligible for the VFC program because they are considered "insured" by VFC program eligibility standards. (*Please see VFC Program eligibility policies at http://www.cdc.gov/vaccines/programs/vfc/provders/elig0scrn-rec-doc-req.htm*). However:

- American Indian and Alaska Native children are VFC-eligible, including those enrolled in a separate SCHIP Program (such as NCHC)
- All NCHC recipients who are American Indian or Alaska Native qualify for the VFC vaccines.

In the September 2011 *Medicaid Bulletin*, the Division of Medical Assistance (DMA) published a table with all NCHC eligibility categories and their respective copayments. Native American and Alaska Native recipients fall within MIC-A and MIC-S eligibility categories. Effective for dates of service on and after October 1, 2011, if the NC Health Choice recipient is in eligibility group MIC-A or MIC-S, providers must access the state-supplied vaccines available through the VFC program and report the corresponding CPT vaccine codes on claims with a $0.00 amount. Providers will not be reimbursed for purchased vaccines administered to VFC-eligible Health Choice recipients with ID cards MIC-A and MIC-S. However, providers may continue to bill and be reimbursed for the administration costs of vaccines for these recipients. Refer to the following table for detailed immunization administration billing guidance. Billing Codes below are for NCHC Recipients 6 through 18 Years of Age who receive VFC state-supplied vaccine**. Note: N.C. Health Choice and N.C. Medicaid use codes other than 90460 and 90461 for reimbursement of vaccine administration.**

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 90472EP 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.

NC Health Choice
DMA, 919-855-4100

Attention: Community Alternatives Program (CAP/DA) and CAP/Choice Lead Agencies

Case Management Hours Procedural Change

Effective November 1, 2011, the monthly case management limit will change to an annual limit. The current three hours per month and six hour annual limit will changed to a 42 hour annual limit under a 365 calendar day authorization period. Any claims using T1016 (CAP/DA) or T2041 (CAP/CO) will be deducted from the 42 hour (168 units) annual limit. The 365 calendar day authorization period begins with the first date of service billed after November 1, 2011. For instance, if the first claim for case management services (T1016 or T2041) is for a date of service of December 6, 2011, the 365 day annual limit will be December 6, 2011 through December 5, 2012.

While this change does not increase the case management units per year, it provides the case manager or the Lead Agency more flexibility in administering case management based on the CAP participants needs. This eliminates the restrictiveness of complying with a three hour (12 units) monthly and six hour (24 units) yearly allotment to assess, plan, monitor, refer and link our CAP/DA and CAP/Choice participants. This procedure change allows the case manger to use any number of case management or advisement units/hours in a month to meet the demands of the participant as long as these hours or units do not exceed the 42 hour (168 units) limit within 365 calendar days.

Each time the Lead Agency files a claim for case management or case advisement services using service codes T1016 (CAP/DA) and T2041 (CAP/CO), case management units will be deducted from the 42 hour (168 units) balance until the balance becomes zero. When the balance becomes zero, all future claims against service codes T1016 and T2041 will deny. Any units/hours not used within the 365th day will be forfeited. On the 366th day, the 42 hour limit (168 units) starts over.

It is imperative for Lead Agencies to keep up with their 365 calendar day annual authorization period. Providers must track the number of units used and remaining in order to ensure you do not run out of case management hours before the end of the 365 day period. Additional hours will not be granted unless approved under EPSDT (ages 0 to 21). The current EPSDT policies remain in effect.

After October 30, 2011, service codes T1016SC (CAP/DA) and T2041SC (CAP/CO) will be end-dated and unavailable for future use.

For questions or guidance about this procedure change, contact your assigned consultant.

Clinical Policy
DMA, 919-855-4371

Attention: Community Alternatives Program for Children (CAP/C) Service Providers

Case Managers Claim Approvals for CAP Services

As previously announced to the Case Managers and Home Care Association, effective September 6, 2011 there was a change in the process for approval of claims for CAP/C Nursing, CAP/C Pediatric Nurse Aide Services, CAP/C Personal Care Services, and all CAP/C In-Home Respite Services. Instead of sending claims to the CAP/C Case Manager for approval prior to submitting them to HP, providers now submit claims to The Carolinas Center for Medical Excellence (CCME).

The CAP/C Case Manager continues to issue providers a Service Authorization based upon the approved plan of care, and this authorization is copied to CCME. Providers continue to contact the CAP/C Case Manager regarding deviations or any changes needed to the Service Authorization.

Providers submit new claims to CCME. Claims for any date of service may be submitted to CCME as long as that claim was not previously submitted to the Case Manager. Any claims that were submitted to the Case Manager between September 6, 2011 and October 1, 2011 were forwarded to CCME by the Case Manager.

There is a standardized Deviation Notice available at http://www.thecarolinascenter.org in "Quick Links", CAP/C Forms. Providers may use this form or continue to use their agency specific form. A deviation notice is provided for any claim (or lack of claim) that differs from what is indicated on the Service Authorization.

A sample of service notes (3 days) is also included. Service notes are forwarded to the Case Manager upon completion of the claims review so that the Case Manager can fulfill their requirement for quarterly review of service notes. Providers do not need to submit service notes to both CCME and the Case Manager. The claim, deviation notice(s) and service notes are sent via mail to:

The Carolinas Center for Medical Excellence
100 Regency Forest Drive, Suite 200
Cary, NC 27518-8598
Attention: CAP/C Claims Review.
CCME is not able to accept fax submissions at this time.

The information submitted is compared to the Service Authorization. Claims that can not be substantiated by the Service Authorization are sent back to the provider and must be reviewed and resolved with the CAP/C Case Manager prior to billing.

At the completion of the claims review, providers receive a Claims Review Summary via fax with the results of the review and instructions for claims corrections and revisions if necessary. The claim is not returned. Therefore, please maintain an original and send CCME a copy.

Case Managers receive monthly reports for each of their recipients containing a summary of the results of claims reviews (including deviations and revisions) and the service notes.

Clinical Policy
DMA, 919-855-4380

Attention: HIV Case Management Providers

Application Deadline

The Division of Medical Assistance (DMA) announced in the September 10, 2010 Medicaid Bulletin that there would be a restructuring of the certification process. The article went on to state that "All providers who are currently certified to provide HIV Case Management and enrolled with DMA will be required to complete a new application and undergo the certification process." **The deadline for submission of the application to The Carolinas Center for Medical Excellence (CCME) is December 31, 2011.** Any agency that has not submitted an application by cob on December 31, 2011 will have their certification terminated and Provider Enrollment will be notified to terminate their provider number.

Training:
(CCME) and DMA are pleased to announce that in October 2011 we are offering Resource Day Training on the following topics: **Integrated Case Management Document on** October 19th and **Advanced HIV Case Management Care Planning** on October 20th. While attendance for both days is recommended, these trainings are designed to allow participants to attend either one or both. The target audience is HIV Case Managers and Supervisors. See below for details.

Integrated Case Management Documentation – Oct 19th
This training is intended to build upon knowledge and skills acquired in HIV Case Management Basic Training and will provide HIV case managers with the skills to accurately and comprehensively document information in a timely manner while maintaining high quality service delivery. This participatory training will focus on the purpose and best practices of documentation of information pertaining to client care, especially in regard to assessment and progress notes. It will also provide case managers with an in-depth understanding of the documentation requirements of Medicaid Clinical coverage Policy 12B.

As a result of this training, participants will be able to:
• Understand the skills, knowledge and resources needed for quality documentation;
• Develop skills in writing client information in clear, concise and objective ways; and
• Understand timeframes and requirements of CCP12B as they apply to documentation and billing.
• Understand components

Advanced HIV Case Management Care Planning – Oct 20th
This training is intended to build upon knowledge and skills acquired in HIV Case Management Basic Training and will provide HIV case managers with advanced care plan development training. Participants will increase their knowledge in developing successful goals with clients through instruction, skills practice and group exercises.

As a result of this training participants will be able to:
• Understand the relationship between the steps of the case management process and clearly connect identified needs with care plan goals;
• Develop appropriate goals and tasks for clients based on needs and client readiness; and
• Understand the importance of care plan outcomes and documentation of clear outcomes.

Registration is now open for training listed below.

Date	Session Topic	Required Attendees
October 19-20 , 2011	**Integrated Case Management Documentation and Advanced HIV Case Management Care Planning**	This is recommended for HIV Case Managers and HIV Case Manager Program Supervisors who are currently employed with agencies that are certified providers of HIV Case Management.

The location of this training is currently scheduled for: Comfort Suites Raleigh Durham Airport/RTP Hotel, 5219 Page Road, Durham, NC 27703. It is recommended that attendees verify the location with CCME closer to the actual day of the training. Information for the October 2011 training including registration and up to date location information is available on CCMEs' HIV Case Management web page.

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

HIV Case Management Program
DMA, 919-855-4389

Attention: Critical Access Behavioral Health Agencies (CABHA's)

Payment on Professional Crossover Claims

The Division of Medical Assistance (DMA) has made provisions to allow Medicaid crossover claims processing for Critical Access Behavioral Health Agencies (CABHA's) who bill Medicare for outpatient behavioral health services. CABHA providers will receive a percentage of the Medicare coinsurance/deductible for the claim. The percentages can be found on the DMA website at http://www.ncdhhs.gov/dma/fee/.

This provision will be retro-active to July 1, 2010. CABHA Crossover claims for dates of service July 1, 2010 and after, that were paid at $0.00, may be resubmitted electronically to Medicaid as an 837 void transaction and a new day claim, or resubmitted as a manual adjustment using the Medicaid Claim Adjustment form. In order for previously denied claims to process, they must be resubmitted on or before December 31, 2011.

Finance Management
DMA, 919-647-8178

Attention: All Providers

Intrauterine Copper Contraceptive (Paragard) and Diagnosis V25.1

The Division of Medical Assistance (DMA) has become aware that for date of service prior to October 1, 2010 claims for J7300 "Intrauterine copper contraceptive" (Paragard) have inappropriately denied when billed with diagnosis V25.1 "Insertion of intrauterine contraceptive device". Systems updates have been completed to correct this issue. Claims that were denied can be resubmitted to HP for reimbursement.

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

Attention: Outpatient Behavioral Health Services Providers and Critical Access Behavioral Health Agencies (CABHA's) Providers

Outpatient Behavioral Health Services Seminars

Outpatient Behavioral Health Services Provider seminars are scheduled for November 2011. Information presented will include:

- A review of Clinical Coverage Policy 8C – Outpatient Behavioral Health services provided by Direct-Enrolled Providers and policy updates
- Billing procedures including billing "incident to" a physician
- Prior approval
- National Correct Coding Initiative,
- Carolina Access for recipients under age 21
- Health Choice
- Fraud 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 Outpatient Behavioral Health Services seminars by completing and submitting the online registration form www.hp.com/go/medicaid_seminar_Nov. Sessions will begin at 9:00 a.m. and end at 12:00 p.m. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided at the seminars. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Date	Location
November 2, 2011	**Asheville** Crowne Plaza Asheville One Resort Drive Asheville, NC 28806
November 3, 2011	**Charlotte** Crowne Plaza Charlotte 201 S. McDowell Street Charlotte, NC 28204 **Note: Parking fee of $6.00 per vehicle for parking at this location.**
November 9, 2011	**Raleigh** Royal Banquet and Convention Center 3801 Hillsborough Street Suite 109 Raleigh, NC 27607
November 17, 2011	**Wilmington** Hilton Wilmington Riverside 301 North Water Street Wilmington, NC 28401 **Note: Parking fee of $5.00 per vehicle for parking at this location.**

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

Attention: Inpatient Hospital Services Providers

Hospital Rates

Effective October 1, 2011, existing hospital rates are adjusted by a negative 9.80%, and non-state-owned freestanding psychiatric and rehabilitation hospitals existing rates are adjusted by a negative 2.67%.

Finance Management
DMA, 919-647-8111

Attention: Inpatient Hospital Services Providers

Cost Report

North Carolina Hospital Facilities complete their Medicaid cost report based on the hospital's completed 2552 cost report. Centers for Medicare and Medicaid Services (CMS) issued a Memorandum dated September 02, 2011 with the subject of "Cost Report Filing Extensions" reflecting revised due dates for cost reports using the newly issued 2552-10 software. CMS requires the use of the 2552-10 software for all hospital providers with full 12 months or greater cost reporting periods, which begin on or after May 1, 2010 (and end on or after April 30, 2011). **North Carolina Medicaid cost reports for Hospital Facility Providers will follow the same schedule for due dates as outlined below.**

Cost Report FYE	Current Due Date	Revised Due Date	Extension Granted
04/30/2011	09/30/2011	11/30/2011	60 Days
05/31/2011	10/31/2011	11/30/2011	30 Days
06/30/2011	11/30/2011	01/31/2012	60 Days
07/31/2011	12/31/2011	01/31/2012	30 Days
08/31/2011	01/31/2012	02/29/2012	30 Days
09/30/2011	02/29/2012	03/31/2012	30 Days
10/31/2011	03/31/2012	03/31/2012	None
11/30/2011	04/30/2012	04/30/2012	None

Finance Management
DMA, 919-647-8111

Attention: All Providers

Notice of Rate Reductions

The Division of Medical Assistance (DMA) published the following notice in the August 2011 Medicaid Bulletin notifying providers of the rate reductions effective October 1, 2011. The Department of Health and Human Services/DMA hereby provides notice of its intent to amend the "Reimbursement Sections" of the Medicaid State Plan. To comply with Session Law 2011-145, section 10.37.(a) (6), DMA will submit State Plan Amendments for the purpose of revising rate methodology language to reflect for SFY 2011 – 2012 effective October 1, 2011 rates paid to North Carolina Medicaid services providers will be reduced by 2.67%.

Nursing Homes will have their rate reductions effective July 1, 2011. The public notice announcing the submission of the reduction State Plan Amendments with more detailed information is posted on DMA's website at http://www.ncdhhs.gov/dma/plan/SPANotices/PublicNotice_102011_Reductions.pdf

To assist providers to better understand the impact on the rates for their programs, DMA has published on our website the October 1, 2011, fee schedules with the note that the State Plan Amendments are pending the Centers for Medicare and Medicaid Services (CMS) approval. As each program reduction receives CMS approval, DMA will update the fee schedules by removing the note of pending CMS approval. For questions concerning the reductions please call DMA Finance Management at 919-647-8111.

Finance Management
DMA, 919-647-8111

Attention: Durable Medical Equipment, Home Health, Private Duty Nursing and Community Alternatives Program Providers

Rate Revisions for Select Incontinence Products

Effective November 1, 2011, rates for select incontinence supplies will be revised. Additional codes* will be implemented for bariatric diapers and protective underwear/pull-on products. Rates for the affected codes are listed in the table below.

HCPCS Code	Code Description	NC Medicaid Reimbursement Rate effective November 1, 2011
A4554	Disposable under pads, all sizes	0.43
T4521	Adult size disposable incontinence product, brief/diaper, small, each	0.74
T4522	Adult sized disposable incontinence product, brief/diaper, medium, each	0.78
T4523	Adult sized disposable incontinence product, brief/diaper, large, each	0.86
T4524	Adult sized disposable incontinence product, brief /diaper, extra large, each	0.86
T4525*	Adult sized disposable incontinence product, protective underwear/pull on, small size, each	0.76
T4526*	Adult sized disposable incontinence product, protective underwear/pull on, medium size, each	0.78
T4527*	Adult sized disposable incontinence product, protective underwear/pull on, large size, each	0.86
T4528*	Adult sized disposable incontinence product, protective underwear/pull on, extra large size, each	0.86
T4529	Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each	0.49
T4530	Pediatric sized disposable incontinence product, brief/diaper, large size, each	0.55
T4531*	Pediatric sized disposable incontinence product, protective underwear/pull on, small/medium size, each	0.70
T4532*	Pediatric sized disposable incontinence product, protective underwear/pull on, large size, each	0.85
T4533	Youth-sized disposable incontinence product, brief/ diaper, each	0.67

HCPCS Code	Code Description	NC Medicaid Reimbursement Rate effective November 1, 2011
T4534*	Youth-sized disposable incontinence product, protective underwear/pull on, each	0.84
T4535	Disposable liner/shield/guard/pad/undergarment, for incontinence, each	0.34
T4543*	Disposable incontinence product, brief/diaper, bariatric, XXL, each	1.29

Please refer to individual NC Medicaid clinical policies for details on product coverage and limitations on the Division of Medical Assistance website at http://www.ncdhhs.gov/dma/mp/.

Finance Management
DMA, 919-647-8111

Attention: Carolina ACCESS Providers

Per Member/Per Month (PM/PM) Rates for Care Management

The Per Member/Per Month (PM/PM) rates paid to Carolina Access primary care providers (PCPs), Community Care of North Carolina (CCNC) PCPs and the CCNC Networks are now published on the following DMA website at http://www.ncdhhs.gov/dma/provider/financial.htm.

Managed Care
DMA, 919-855-4790

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

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

Proposed Clinical Coverage Policies

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

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

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

2011 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
October	10/6/11	10/12/11	10/1311
	10/13/11	10/18/11	10/19/11
	10/20/11	10/27/11	10/28/11
	10/27/11	11/1/11	11/2/11
November	11/3/11	11/8/11	11/9/11
	11/10/11	11/15/11	11/16/11
	11/17/11	11/23/11	11/28/11

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

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

Melissa Robinson
Executive Director
HP Enterprise Services