October 2012 Medicaid Bulletin

In This Issue ……Page

All Providers:

Recredentialing is Required for All N.C. Medicaid and N.C. Health Choice Providers a Minimum of Every Three Years……2
Processing Changes for Duplicate Remittance and Status Reports (RAs) ……3
2013 Checkwrite Schedule……...4
Basic Medicaid and N.C. Health Choice (NCHC) Seminars……...5
Payment Error Rate Measurement (PERM) in North Carolina……7
Billing Reminder for CPT Code 36415……8
New ICD-10 Deadline Set for October 1, 2014……9
National Correct Coding Initiative – Billing Guidance……9
Clinical Coverage Policies……..10
Termination of Inactive N.C. Medicaid and N.C. Health Choice Provider Numbers……...11
Influenza Vaccine and Reimbursement Guidelines for 2012-2013 for Medicaid and NCHC – REVISED……12
Procedures for PA Request for Synagis for RSV Season 2012/2013…….....19
NC Medicaid Recovery Audit Contractors (RAC)……23
EHR Incentive Program Updates……24

Adult Care Home and Family Care Home Providers

Consolidated PCS Policy Update, Independent Assessments and New Admission Reporting for Consolidated PCS Submission of 1915(i) Alzheimer's Services, Benefit Application Provider Training Schedule…….....27
Review for Institute for Mental Disease (IMD) Determination Update ……...32

CAP-DA Providers

Quality Improvement Strategies for CAP/DA 1915(c) HCBS Waiver……..34

In This Issue……Page

Dental Providers

Dental Services and Medicaid for Pregnant Women (MPW) Eligibility……35

Health Department Dental Centers

Dental Services and Medicaid for Pregnant Women (MPW) Eligibility……35

Hospitals

EHR Eligible Hospital (EH) Payment Calculation Information and Required Documentation……26

In-Home Care Providers

Consolidated Personal Care Services Policy Update, Submission of 1915(i) Alzheimer's Services Benefit Application, Upcoming Provider Trainings……30

N.C. Health Choice

Influenza Vaccine and Reimbursement Guidelines for 2012-2013 for Medicaid and NCHC – Revised.....12

Nurse Practitioners and Physicians Assistants

Carfilzomib (Kyprolis, HCPCS Code J9999): Billing Guidelines……34

Physicians

Carfilzomib (Kyprolis, HCPCS Code J9999): Billing Guidelines……36
Affordable Care Act Enhanced Payments to Primary Care Physicians……37

Supervised Living Homes Billing PCS

Consolidated PCS Policy Update, Independent Assessments and New Admission Reporting for Consolidated PCS Submission of 1915(i) Alzheimer's Services, Benefit Application Provider Training Schedule……27
Review for Institute for Mental Disease (IMD) Determination Update ……32

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

Attention: All Providers

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

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

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

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

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

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

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

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

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

Providers are encouraged to be on the lookout for recredentialing invitations. The State will be targeting between 5,000 and 9,000 providers for recredentialing each month

between now and the end of 2012. Additional information regarding the recredentialing process can be found at:
https://www.nctracks.nc.gov/provider/providerEnrollment/assets/onlineHelp/recredentialing_101_help.pdf

Questions should be directed to the EVC Operations Center at 866-844-1113 or by e-mail at NCMedicaid@csc.com.

Provider Services
DMA, 919-855-4050

Attention: All Providers

Processing Changes for Duplicate Remittance and Status Reports (RAs)

The Remittance and Status Report (RA) is a computer-generated document showing the status of all claims submitted to HP Enterprise Services (HPES), along with a detailed breakdown of payment.

The RA is available through the North Carolina Claims Submission/Recipient Eligibility Verification Web (NCECSWeb) Tool All providers who want to download their RA in PDF format from the NCECSWeb Tool are required to register for that service using this form: www.ncdhhs.gov/dma/forms/RARequest.pdf. Providers are encouraged to print the RAs or save an electronic copy to assist in keeping all claims and payment records current. Printed RAs should be kept in a notebook or filed in chronological order for easy reference.

RAs generated in the most recent 10 checkwrites are available free of charge via the NCECSWeb Tool. Duplicate copies of RAs older than 10 checkwrites are available for 35 cents per page.

Effective September 1, 2012, HP will no longer mail duplicate RAs to providers. Duplicate RAs requested by providers will be posted on the NCECSWeb Tool. Providers may request duplicate RAs by contacting the HPES Provider Services Unit at 1-800-688-6696, menu option 3. Since the duplicate RAs will be posted electronically on the NCECSWeb Tool, you must be registered to receive PDF RAs in order to access the RAs you request. HP charges and collects a fee of 35 cents per page. After payment is received, your request should appear on the next checkwrite after it is processed and will remain posted for at least 9 checkwrites.

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

Attention: All Providers

2013 Checkwrite Schedule

The following table lists the cut-off dates, checkwrite dates, and the electronic deposit dates for January 2013 through June 2013. The schedule for the remaining months of 2013 will be published at a later date.

Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
01/03/13	01/08/13	01/09/13
01/10/13	01/15/13	01/16/13
01/17/13	01/23/13	01/24/13
01/24/13	01/31/13	02/01/13
02/07/13	02/12/13	02/13/13
02/14/13	02/20/13	02/21/13
02/21/13	02/28/13	03/01/13
02/28/13	03/05/13	03/06/13
03/07/13	03/12/13	03/13/13
03/14/13	03/19/13	03/20/13
03/21/13	03/28/13	03/29/13
04/04/13	04/09/13	04/10/13
04/11/13	04/16/13	04/17/13
04/18/13	04/25/13	04/26/13
05/02/13	05/07/13	05/08/13
05/09/13	05/14/13	05/15/13
05/16/13	05/21/13	05/22/13
05/23/13	05/30/13	05/31/13
06/06/13	06/11/13	06/12/13
06/13/13	06/18/13	06/19/13
06/20/13	06/27/13	06/28/13

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

Attention: All Providers

Basic Medicaid and N.C. Health Choice (NCHC) Seminars

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

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

The focus of the morning session will be the first eight sections of the revised October 2012 *Basic Medicaid and N.C. Health Choice Billing Guide*, which is the primary document that will be referenced during the seminar.

The afternoon sessions will be broken out by claim type: Professional, Institutional, and Dental /Pharmacy. The remaining sections of the October 2012 Billing Guide will be reviewed during these breakout sessions focusing on claims submission, resolving denied claims, and the uses of N.C. Electronic Claims Submission/Recipient Eligibility Verification Web Tool.

Providers are encouraged to print the October 2012 Billing Guide, which will be posted on the DMA seminar webpage prior to the first scheduled session. This material will assist providers in following along with the presenters. If preferred, you may download the Billing Guide to a laptop and bring the laptop to the seminar. Alternatively, you may access the Billing Guide online using your laptop during the seminar. **However, HP Enterprise Services cannot guarantee a power source or Internet access for your laptop.** Copies of these documents will not be provided.

Pre-registration is required for both the morning session and the afternoon session of your choice. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend, if space is available. Please bring your seminar confirmation with you to the morning and afternoon sessions of the seminar.

Providers may register for the seminars by completing and submitting the online registration form. Please include a valid e-mail address for your return confirmation. Providers may also register by fax. Please include a fax number or a valid e-mail address for your return confirmation.

Providers may attend the morning session only, the afternoon session only, or both morning and afternoon sessions.

The morning session will begin at 9 a.m. and end at noon. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided; however, there will be a lunch break. The afternoon sessions will begin at 1 p.m. and end at

4 p.m. Providers are encouraged to arrive at 12:45 p.m. to complete registration. **Because meeting room temperatures vary, dressing in layers is advised.**

Seminar Dates and Locations

Date	Location
October 9, 2012	**Greensboro** Clarion Hotel Airport 415 Swing Road Greensboro, NC 27409 get directions
October 11, 2012	**Charlotte** Crowne Plaza 201 South McDowell Street Charlotte, NC 28204 **Note: Parking fee of $5.00 per vehicle at this location.** get directions
October 17, 2012	**Greenville** Hilton 207 SW Greenville Blvd Greenville, NC 27834 get directions
October 23, 2012	**Asheville** Crowne Plaza Tennis & Golf Resort One Resort Drive Asheville, NC 28806 get directions
October 30, 2012	**Fayetteville** Cumberland County DSS 1225 Ramsey Street Fayetteville, NC 28301 get directions
November 1, 2012	**Raleigh** Wake Technical Community College 9101 Fayetteville Road Raleigh, NC 27603 get directions

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

Attention: All Providers

Payment Error Rate Measurement (PERM) in North Carolina

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

In compliance with the Improper Payments Information Act of 2002, the federal Centers for Medicare & Medicaid Services (CMS) has implemented a national Payment Error Rate Measurement (PERM) program to determine the extent of improper Medicaid and State Children's Health Insurance Program (SCHIP) payments.

North Carolina was selected as 1 of 17 states required to participate in PERM reviews of Medicaid fee-for-service and managed care claims paid in federal fiscal year 2010 (October 1, 2009, through September 30, 2010).

The SCHIP program did not participate in the 2010 PERM measurement.

CMS used two national contractors to measure improper payments. The statistical contractor – Livanta – coordinated 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 – communicated directly with providers and requested medical record documentation associated with the sampled claims. Providers were required to furnish the records requested by A+ Government Solutions within a timeframe specified in the medical record request letter.

The following are North Carolina PERM medical record documentation errors identified during federal fiscal year 2010:

1. No medical record documentation provided for the review
2. Diagnosis Related Group (DRG) code errors
3. Incorrect number of units of service billed
4. Medicaid policy violations errors (Policy violations included undated prescription and billing for services without a physician order)
5. Administrative/other medical review errors (This included billing for dates of service when services were not provided, and billing for dentures prior to the date of delivery to the recipient.)

The N.C. Division of Medical Assistance (DMA), Program Integrity Section, recouped the overpayments identified by CMS. In addition, provider noncompliance led to a recommendation of Prepayment Review and possible exclusion of providers from the Medicaid program.

Providers are reminded of Social Security Act (SSA) requirements – listed in SSA Section 1902(27)(a) 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 for medical services rendered.

North Carolina will be required to participate in federal fiscal year 2013 PERM reviews of Medicaid fee-for-service, Medicaid Managed Care and SCHIP program claims starting in a few months**. CMS is in the process of selecting the review contractor that will request and review medical records and documentation.** This is a good time to review medical record documentation to ensure it meets program requirements.

Program Integrity
DMA, 919-814-0000

Attention All Providers

Billing Reminder for CPT Code 36415

Collection of Specimens

CPT procedure code 36415 (collection of venous blood by venipuncture) was added as a covered service during the 2005 CPT code update. CPT code 36415 replaced G0001 as of January 1, 2005. Providers must use 36415 when billing this service to N.C. Medicaid. N.C. Medicaid will not reimburse for the collection of venous blood when providers performs testing in their facilities. Medicaid will only reimburse for the collection of venous blood when a provider draws the blood and sends it to a non-related outside facility without performing any testing. One collection fee is covered per beneficiary regardless of the number of specimens drawn.

Hospital Inpatient Services

When the recipient is an inpatient in the hospital, venipuncture and specimen collections are included in the Diagnostic Related Group (DRG) payments and are not reimbursed separately.

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

Attention: All Providers

New ICD-10 Deadline Extended to October 1, 2014

On August 24, 2012, the U.S. Department of Health and Human Services announced the final rule that extends the *International Classification of Diseases, 10th Edition* (ICD-10), compliance date from Oct. 1, 2013, to Oct. 1, 2014. In addition to codes that allow for greater specificity when classifying diseases and health problems, ICD-10 includes codes for new procedures and diagnoses aimed at improving the amount of detailed information available to healthcare providers for quality improvement and payment purposes.

To view the complete release, visit ncmmis.ncdhhs.gov/files/icd10/HHS_Release_CMS_HPID_Admin_Simp_20120824.pdf.

For more information regarding NCTracks and the ICD-10 implementation, visit the Office of Medicaid Management System Services **(**OMMISS) website at http:/ncmmis.ncdhhs.gov. From the top navigation you can access more detailed information regarding both NCTracks and ICD-10 activities by clicking on the appropriate link.

Office of Medicaid Management System Services (OMMISS)
N.C. DHHS, 919-647-8300

Attention: All Providers

National Correct Coding Initiative – Billing Guidance

The federal Centers for Medicare and Medicaid Services (CMS) has decided that the edits that deny **Alcohol and/or substance (other than tobacco) abuse structured screening, and brief intervention (SBIRT) services (99408 and 99409) on the same day as the Smoking and tobacco use cessation counseling codes (99406 and 99407) are <u>not</u> appropriate for the Medicaid program.**

They will be deleted in the Medicaid National Correct Coding Initiative (NCCI) fourth-quarter edits retroactive to April 1, 2011. Any claims denied for dates of service on or after April 1, 2011 that were filed in a timely manner can be re-filed as a new claim beginning October 1, 2012.

For more information, providers can contact the Provider Services unit of HP Enterprise Services (HPES), at 1-800-688-6696 or 919-851-8888 and press option 3 for assistance.

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

Attention: All Providers

Clinical Coverage Policies

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

- *1A-12, Breast Surgeries (9/12/12)*
- *1B-1, Botulinum Toxin Treatment: Type A (Botox) and Type B (Myobloc) (posted 9/1/12)*
- *1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments (9/15/12)*
- *1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics (9/15/12)*
- *8L, Mental Health/Substance Abuse Targeted Case Management (9/1/12)*
- *11B-4, Kidney Transplantation (3/12/12)*

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

Termination of Inactive N.C. Medicaid and N.C. Health Choice Provider Numbers

Note to Providers: This article originally ran in September 2011.

The N.C. Division of Medical Assistance (DMA) wants to remind all providers of its policy for terminating inactive providers to reduce the risk of fraudulent and unscrupulous claims billing practices. DMA's updated policy was announced in the *July 2011 Medicaid Bulletin*.

N.C. Medicaid and N.C. Health Choice (NCHC) provider numbers that do not reflect any billing activity within the previous 12 months will be terminated.

If providers **cannot** attest that they have provided services to N.C. Medicaid or NCHC recipients in the previous 12-month period, their provider numbers will be terminated. A new enrollment application and agreement to re-enroll must be submitted to CSC for any provider who was terminated. **As a result, a lapse in the provider's eligibility may occur.**

Terminated providers who wish to re-enroll can reach CSC by phone at 1-866-844-1113 or by e-mail at NCMedicaid@csc.com.

Termination activity occurs on a quarterly basis with provider notices being mailed out on April 1, July 1, October 1, and January 1 of each year with termination dates of May 1, August 1, November 1, and February 1, respectively. These notices are sent to the current mailing address listed in the provider's file. **Providers are reminded to update their contact and ownership information in a timely manner.**

Provider Services
DMA, 919-855-4050

Attention: All Providers and North Carolina Health Choice Providers

Influenza Vaccine and Reimbursement Guidelines for 2012-2013 for Medicaid and NCHC - REVISED

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:

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

For further details on the 2012-2013 influenza vaccine, see the ACIP recommendations found on the CDC web site at:
www.cdc.gov/mmwr/preview/mmwrhtml/mm6132a3.htm?s_cid=mm6132a3_e.

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

North Carolina Immunization Program/Vaccines for Children (NCIP/VFC)

The N.C. Immunization Branch distributes all required childhood vaccines to local health departments, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), hospitals, and private providers under NCIP/VFC guidelines. For the 2012-2013 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 Vaccines for Children (VFC) program and other covered groups, according to the N.C. Immunization Program (NCIP) coverage criteria. The current NCIP coverage criteria and definitions of VFC categories may be found on the NCIP website at:
www.immunize.nc.gov/providers/coveragecriteria.htm.

Eligible VFC children include American Indian and Alaska Native (AI/AN) N.C. Health Choice (NCHC) beneficiaries. These beneficiaries are identified as AI/AN in one of two ways:

1) They are either identified as MIC-A and MIC-S on their NCHC Identification Cards or,
2) Beneficiaries/parents may self declare their VFC eligibility status in accordance with NCIP/VFC program policy.

When NCHC beneficiaries self-declares their status as Alaska Native or American Indian and the provider administers the state-supplied vaccine, the provider must report the CPT vaccine code with $0.00 and may bill for the administration costs. For further details,

refer to the June 2012 general Medicaid article, *Billing for Immunizations for American Indian and Alaska Native N.C. Health Choice Recipients* at: www.ncdhhs.gov/dma/bulletin/0612bulletin.htm#AI. All other NCHC beneficiaries are considered ***insured,*** and must be administered privately purchased vaccines.

For VFC or NCIP vaccines, providers shall only report the vaccine code but may bill for the administration fee for Medicaid and eligible AI/AN Health Choice beneficiaries. Providers must purchase vaccine for children who are *not* VFC-eligible (including all NCHC children who are not AI/AN) and adult patients who do not meet the eligibility criteria for NCIP influenza vaccine. For those Medicaid-eligible beneficiaries 19 years of age and older who do not qualify for the NCIP vaccine, purchased vaccine and administration costs may be billed to Medicaid. In order to determine who is eligible for NCIP influenza and other vaccines, go to: www.immunize.nc.gov/providers/coveragecriteria.htm.

Billing/Reporting Influenza Vaccines for Medicaid Beneficiaries

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

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

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

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

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

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

Note: For the 2012-2013 flu season, the NCIP will not provide LAIV (CPT code 90660, FluMist) for anyone 19 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 (purchased vaccine only)	Influenza virus vaccine, live, for intranasal use (FluMist)
Administration CPT Code(s) to Bill	**CPT Code Description**
90471EP	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **1 vaccine** (single or combination vaccine/toxoid)
+90472EP (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **each additional vaccine** (single and combination vaccine/toxoid) (List separately in addition to code for primary procedure
90473EP	Immunization administration by intranasal or oral route; **1 vaccine** (single or combination vaccine/toxoid). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.
+90474EP (add-on code)	Immunization administration by intranasal or oral route; **each additional vaccine** (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure). **Note:** Billing CPT code 90474 for a second administration of an intranasal/oral vaccine is *not* applicable at this time.

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

Use the following codes to report the *injectable* influenza vaccine provided by NCIP or to **bill** Medicaid for an *injectable* influenza vaccine **purchased** and administered to beneficiaries **21 years of age and older.** In order to determine who is eligible for NCIP influenza and other vaccines, go to: www.immunize.nc.gov/providers/coveragecriteria.htm.

Note: For the 2012-2013 flu season, the NCIP will not provide LAIV (CPT code 90660, FluMist) for anyone 19 years of age and older. Medicaid does NOT reimburse for purchased LAIV for those beneficiaries 21 years of age and older.

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

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

Billing/Reporting Influenza Vaccines to Medicaid for NCHC Beneficiaries

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

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

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

Notes to remember:

- The EP modifier should NOT be billed on NCHC claims.
- There is no co-pay for office visits and wellness checks.

Note Regarding Billing for Medicaid and NCHC for FQHCs and RHCs:

***For beneficiaries 0 through 20 years of age*:**

If vaccines were provided through the NCIP/VFC, the center/clinic shall report the CPT vaccine codes (with $0.00 billed) under the C suffix provider number and may bill for the administration codes (CPT procedure codes 90471EP through 90474EP). This billing is appropriate if only vaccines were provided at the visit or if vaccines were provided in conjunction with a wellness check. If a core visit was billed, CPT vaccine codes shall be reported (with $0.00 billed) under the C suffix provider number and an administration code shall not be billed.

If purchased vaccines were administered, the center/clinic may bill the CPT vaccine codes (with their usual and customary charge) under the C suffix provider number for the vaccines administered and may bill for the administration codes (with the usual and customary charge). This billing is appropriate if only vaccines were given at the visit or if vaccines were given in conjunction with a wellness check. If a core visit was billed, CPT vaccine codes shall be reported (with $0.00 billed) under the C suffix provider number and the administration codes shall not be billed. For detailed billing guidance, refer to the July 2012 Special Bulletin, *Health Check Billing Guide 2012,* at: http://www.ncdhhs.gov/dma/healthcheck/BillingGuide2012.pdf.

***For beneficiaries 21 years of age and older*:**

When purchased vaccines were administered, the CPT vaccine codes shall be reported (with $0.00 billed) and administration codes may be billed (with the usual and customary charge) under the C suffix provider number when vaccine administration was the only service provided that visit. When a core visit was billed, the CPT vaccine code shall be reported (with $0.00 billed) under the C suffix provider number and an immunization administration code may not be billed.

When billing for NCHC beneficiaries, also refer to the detailed billing guidance above including Table 4. Refer to the Core Visit policy at www.ncdhhs.gov/dma/provider/library.htm.

All providers should refer to the provider-specific fee schedules on the DMA website at: www.ncdhhs.gov/dma/fee/index.htm.

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

Attention: All Providers

Procedures for PA Request for Synagis for RSV Season 2012/2013

Note to Providers: This medication is indicated for children up to 2 years of age. It does not apply to the N.C. Health Choice (NCHC) program, which does not cover children under the age of 6.

The clinical criteria used by N.C. Medicaid for the 2012/2013 RSV season are consistent with published guidelines in the *Red Book: 2012 Report of the Committee on Infectious Diseases, 29th Edition*. **Prior approval (PA) is required** for Medicaid coverage of Synagis during the upcoming RSV season. The coverage season is November 1, 2012 through March 31, 2013. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) criteria are considered for Synagis requests.

Submit all PA requests for coverage of Synagis for the upcoming season electronically online at www.documentforsafety.org. The Synagis Program will accept online requests starting early October 9, 2012. Dropdown lists, free text sections, and the attachment option incorporated into the system's design will capture all necessary information for a PA request. When the system offers an opportunity to upload supporting documents, the most recent progress note documenting the patient's pulmonary or cardiac status is required when a specialist is involved in the care. The electronic system can automatically approve a request based on the criteria submitted and allows a provider to self-monitor the status of a pending request.

For approved requests, each Synagis dose will be individually authorized to promote appropriate product distribution. After the initial approval, providers must submit a "next dose request" to obtain an authorization for each subsequent dose up to the approved number of doses. If an infant received one or more Synagis doses prior to hospital discharge, the provider should indicate as part of the request the most recent date a dose was administered. The number of doses administered by the provider should be adjusted accordingly. Providers should ensure the previously obtained supply of Synagis is administered before submitting a next dose request.

It is important for a Synagis distributor to have the appropriate single-dose authorization on hand prior to shipping Synagis for a beneficiary. An individual dose authorization is required for each paid Synagis claim. The claim should not exceed the quantity indicated on the document. A Synagis claim will deny if a dose request was not done by the provider.

Maximum of Five Doses

During the season, up to five doses 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. Information about treatment in the six months before the start of the season is required – such as supplemental oxygen, bronchodilator, diuretic or chronic corticosteroid therapy.

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.

Congenital Abnormalities of the Airway or Neuromuscular Disease

Infants born on or after November 2, 2011 with compromised handling of respiratory secretions secondary to congenital abnormalities of the airway or neuromuscular disease may be eligible for prophylaxis during the first year of life. The diagnosis to justify severe neuromuscular disease or congenital airway abnormalities must be specific.

Prematurity

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

- Born at an Estimated Gestational Age (EGA) of ≤ 28 weeks 6 days and DOB is on or after November 2, 2011
- Born at an EGA of 29 weeks 0 days to 31 weeks 6 days and DOB is on or after May 2, 2012

Five Dose Exceptions

Coverage of Synagis for CLD and HSCHD will terminate when the beneficiary exceeds 24 months of age **AND** has received a minimum of three doses during the season. Coverage of Synagis for congenital abnormalities of the airways and severe neuromuscular disease that compromises handling of respiratory secretions will terminate when the beneficiary exceeds 12 months of age **AND** has received a minimum of three doses during the season.

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

Infants meeting the following clinical criteria 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, 2012, and has at least one of the two following defined risk factors:
  - Attends child care [defined as a home or facility where care is provided for any number of infants or young toddlers (toddler age is up to the third birthday)]. The name of the day care facility must be submitted with the request.
  - Has a sibling younger than five years of age living permanently in the same household. Multiple births do not qualify as fulfilling this risk factor.

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

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

Submitting a Request to Exceed Policy

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

Pharmacy Distributor Information

Synagis claims processing will begin on October 29, 2012, to allow sufficient time for pharmacies to provide Synagis by November 1, 2012**. Payment of Synagis claims prior to October 29, 2012, and after March 31, 2013, will not be allowed.** Point of sale claims should not be submitted by the pharmacy distributor prior to the first billable date of service for the season. Pharmacy providers should always indicate an accurate days' supply when submitting claims to N.C. Medicaid. **Claims for Synagis doses that include multiple vial strengths must be submitted as a single-compound drug claim. Synagis doses that require multiple vial strengths that are submitted as individual claims will be subject to recoupment by DMA Program Integrity.** Physicians and pharmacy providers are subject to audits of beneficiary records by DMA Program Integrity.

Providers will fax each single-dose authorization to the pharmacy distributor of choice. Single-dose vial specific authorizations – up to the maximum number of doses approved for the beneficiary – will be issued by Medicaid. Ensure that appropriate authorization is received before submitting a claim to Medicaid. The authorizations should be maintained in accordance with required record keeping time frames.

Provider Information

Providers without internet access should contact the Medicaid Outpatient Pharmacy Program at 919-855-4300 to facilitate submission of a PA request for Synagis. The Synagis program is found at www.documentforsafety.org. Providers should note the new website location for Synagis PA requests.

Technical Support

Technical support is available from 8 a.m. to 5 p.m. by calling 855-272-6576 (local: 919-657-8843). Technical support can assist with provider registration, user name and password issues, beneficiary searches, and other registry functions.

Outpatient Pharmacy Program
DMA, 919-855-4300

Attention: All Providers

N.C. Medicaid Recovery Audit Contractors (RAC)

On September 16, 2011, the federal Centers for Medicare & Medicaid Services (CMS) published the *Final Rule for Medicaid Recovery Audit Contractors (RAC).* Under the Medicaid RAC program, states must enter into contracts consistent with State law and in accordance with 42 CFR subpart F with one or more eligible Medicaid RACs to perform post-payment audits in order to identify Medicaid payments that may have been underpaid or overpaid. RACs must follow federal and state guidelines to recover overpayments or inform the N.C. Division of Medical Assistance (DMA) of underpayments.

As described in the *February 2012 Medicaid Bulletin*, DMA partnered with its current post-payment review vendor, Public Consulting Group (PCG), to be one of North Carolina's Medicaid RAC vendors. PCG will perform audits on select Medicaid fee-for-service claims. Initial audits for claims showing an overlap of services for Medicaid beneficiaries receiving hospice care will begin in October 2012.

Effective October 1, 2012, DMA has contracted with HMS to become the second RAC vendor. HMS will perform post-pay audits on inpatient and outpatient hospital, long-term care, laboratory, x-ray and specialized outpatient therapy claims. DMA will be working with HMS to establish a schedule for RAC audits and will publish notice in the Medicaid Bulletin regarding the service types selected for audit prior to the audit implementation period.

Providers are reminded that DMA is authorized by Section 1902 (a) (27) of the Social Security Act and 42 CFR Section 431.107 to access patient records for purposes directly related to the administration of the Medicaid Program. Federal regulations and provider agreements with DMA require the provider to keep any records necessary to disclose the extent of services furnished – including but not limited to all information contained in beneficiary financial and medical records and agency personnel records.

For additional questions please contact:
Linda Marsh linda.marsh@dhhs.nc.gov or Jeff Horton jeff.horton@dhhs.nc.gov

Program Integrity
DMA, 919-814-0000

Attention: All Providers

EHR Incentive Program Updates

Meaningful Use Reporting Period extends to 120-Day Attestation Tail Period for 2012

The attestation tail period is defined as a period of time beyond the end of the Fiscal Year – for eligible hospitals (EHs) – or Calendar Year – for Eligible Professionals (EPs) during which providers may attest for an incentive payment for the prior payment year.

For payment year 2012, North Carolina has extended the attestation tail period to 120 days to allow for attestation beyond the end of the payment year. This means:

- for EHs the last day to attest for payment year 2012 is January 28, 2013
- for EPs the last day to attest for payment year 2012 is April 30, 2013

Providers wishing to attest to Meaningful Use must select a continuous 90-day reporting period **within** the Fiscal Year (for EHs) or Calendar Year (for EPs) of the attested payment year – even if they plan to attest during the attestation tail period.

CMS Releases the Final Rule for Stage 2

On August 23, 2012, the federal Centers for Medicare & Medicaid Services (CMS) published the final rule for Stage 2 of the Medicare and Medicaid EHR Incentive Programs. The rule provides new criteria that EPs and EHs must meet in order to successfully participate in the EHR Incentive Program.

CMS has delayed the onset of Stage 2 criteria so that any provider attesting to Stage 1 of Meaningful Use in 2011 or 2012 will attest to Stage 2 in 2014 instead of 2013. Providers first attesting in 2013 will not be required to demonstrate Stage 2 until 2015. For more information about the final rule see the CMS Stage 2 Final Rule Fact Sheet.

CMS has provided a few "Tipsheets" to help providers navigate through the intricacies of Stage 2. Some these resources are:

- Stage 2 Overview Tipsheet – Provides an overview of the rule, including important dates, basic requirements, new audiences, and additional Stage 2 resources
- Stage 1 vs. Stage 2 Comparison Tables – Compares basic requirements of Stage 1 versus Stage 2 for both EPs and EHs
- Stage 1 Changes Tipsheet – Outlines major changes to Stage 1 included in the rule
- 2014 Clinical Quality Measures Tipsheet – An overview of the 2014 CQM requirements that will apply to all providers, regardless of their stage of meaningful use.

To view the Stage 2 Final Rule in its entirety, please click here.

Patient Volume Methodology Guidance

In the *September 2012 Medicaid Bulletin*, the N.C. Medicaid EHR Incentive Program published a new definition of the word "group" to be used when determining Medicaid patient volume using group methodology. That definition is as follows:

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

The N.C. Medicaid EHR Incentive Program has developed visual guidance to further demonstrate how to calculate patient volume using group or individual methodology. To see these visual aids and to obtain additional information about the N.C. Medicaid EHR Incentive Program, visit www.ncdhhs.gov/dma/provider/ehr.htm.

EHR Incentive Program Audits

In accordance with 42 CFR § 495.368, States must comply with Federal requirements to ensure the qualifications of the providers who request Medicaid EHR incentive payments, to detect improper payments and to take corrective action in the case of improper payments. All providers who receive EHR incentive payments will be subject to post-payment review when they attest to AIU, as well as MU of electronic health records. EPs and EHs selected for audit will be determined based on risk categories designated as high, medium or low risk. DMA Program Integrity, or its authorized agents, will conduct the audits. The audits may be conducted onsite at a provider location or by desk review. The onsite visits may be announced or unannounced.

If an audit is conducted as a desk review, providers will receive a request for records that will outline the type of documentation needed. Failure to submit the requested records or failure to meet the criteria for payment will result in recoupment of EHR incentive payments. A desk review may lead to an onsite review when a reviewer needs additional information after review of the documentation provided. In accordance with 42 CFR §455.15 and §455.21, suspected cases of fraud and abuse must be referred to the N.C. Medicaid Fraud Control Unit.

Post-payment audits of providers who attested for AIU and MU are expected to be conducted during the first quarter of 2013.

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

Attention: Hospitals

EHR Eligible Hospital (EH) Payment Calculation Information and Required Documentation

The attestation and EHR payment calculation for EHs contains a data field for *Medicaid* (Title XIX) *HMO Inpatient Days* from Worksheet S-3, Part I of the hospital's N.C. Medicaid cost report (2552-96/2552-10). This cost report field is used to calculate the Medicaid share of the EHR payment.

As permitted by Medicare cost reporting regulations, some hospitals have counted in the cost report field both inpatient days paid by a North Carolina Local Management Entity/Prepaid Inpatient Health Plan (LME/PIHP) and Medicaid eligible days. **Hospitals are reminded that 42 CFR Section 495.310 permits only paid inpatient bed days in the calculation of the Medicaid share of the EHR payment.**

EHs that submit attestations for EHR payments should identify **only** those inpatient days from their Medicaid cost report that were paid by a North Carolina LME/PIHP in the *Medicaid HMO Inpatient Days* data field.

The patient days identified by the provider in the EHR attestation are subject to review and/or audit for supporting documentation.

Along with their signed attestation, EHs will be required to submit patient-level detailed documentation that substantiates the number of Medicaid HMO inpatient days listed on the provider's Medicaid EHR attestation that were paid by a Medicaid LME/PIHP. Documentation in support of Medicaid HMO inpatient days should be sent via an encrypted CD or via encrypted e-mail file to the NC-MIPS Help Desk using one of these methods:

E-mail a scanned copy to: ncmips@csc.com
Fax a copy to: 866-844-1382
Mail a copy to:
NC-MIPS CSC EVC Center
PO Box 300020
Raleigh, NC 27622-8020

NC Medicaid Health Information Technology (HIT)
DMA, 919-814-0030

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

Consolidated PCS Policy Update, Independent Assessments and New Admission Reporting for Consolidated PCS, Submission of 1915(i) Alzheimer's Services Benefit Application, Provider Training Schedule

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

Consolidated Personal Care Services Policy

Effective January 1, 2013, N.C. Medicaid personal care services for recipients in all settings – including private residences and licensed adult care homes, family care homes, and 5600a and 5600c supervised living homes – will be provided under a consolidated Personal Care Services (PCS) benefit.

Clinical Coverage Policy 3L, Personal Care Services, was posted for public comment from July 18, 2012 to September 1, 2012. The N.C. Division of Medical Assistance (DMA) is reviewing comments submitted during the public comment period and anticipates that Policy 3L will be finalized and posted in final version in October 2012 – **with a January 1, 2013 effective date**. Additional information will be posted on the DMA Consolidated PCS web page as it becomes available.

Independent Assessments and New Admission Reporting of Licensed Adult Care Home Residents

Independent assessments of N.C. Medicaid residents living in licensed adult care homes – (Adult Care Homes, Family Care Homes, 5600a and 5600c Supervised Living Homes, and combination facilities with ACH beds) – are ongoing and expected to continue through November 2012. Please consult the third update to the timeline of projected independent assessment dates by facility on the DMA Consolidated PCS web page.

Beginning October 15, 2012, licensed Adult Care Home providers may report any new Medicaid admissions that require independent assessments to determine eligibility for Personal Care Services (PCS) effective January 1, 2013. Complete the Independent Assessment Request for New Admissions (Form DMA-3066) and submit it by fax to The Carolinas Center for Medical Excellence (CCME) at 877-272-1942. After receipt, CCME will contact your facility to schedule a return visit to assess beneficiaries admitted since the initial assessment visit. **Please note that it is not necessary to report new admissions if CCME has not yet made an initial visit to your facility to complete resident assessments.**

A completed PCS Medical Attestation (Form DMA-3065) is required to determine PCS eligibility for all ACH residents, including those admitted to provider facilities after an assessor's initial assessment visit. **Please initiate completion of the PCS Medical Attestation immediately for all Medicaid residents – including new admissions – to ensure that a completed form is available for presentation to the assessor at the time of the resident's scheduled assessment.**

Application for 1915(i) Alzheimer's Services Benefit

As required by the North Carolina General Assembly, Session Law 2012-142, House Bill 950, the N.C. Department of Health and Human Services (DHHS) and the N.C. Division of Medical Assistance (DMA) have submitted to the federal Centers for Medicare & Medicaid Services (CMS) an application to provide services to individuals with Alzheimer's and related dementias under the authority of a separate 1915(i) State Plan benefit. Qualified professionals may include some providers of State Plan PCS – including licensed Home Care Agencies; residential facilities licensed as Adult Care Homes; and residential facilities licensed as Supervised Living Facilities (5600a and 5600c) for two or more adults whose primary diagnosis is mental illness, developmental disability, or substance abuse dependency. The 1915(i) State Plan Home and Community Based Services application is available on the DMA Consolidated PCS web page. DMA is planning an October 11, 2012 webinar to review the application submitted to CMS.

Provider Training Schedule

Regional trainings for home care agency and licensed adult care home providers will be held October 22, 2012 through November 2, 2012. The following table provides a timeline of completed and planned provider trainings for the consolidated PCS program. Registration information for upcoming trainings will be posted prior to each training on the DMA Consolidated PCS web page.

Date	Description	Topic
June 21, 2012 10:00 – 11:30 a.m.	Webinar Training: Transition Planning for Licensed Adult Care Home Providers	Eligibility, Independent Assessments (Completed)
July 11, 2012 10:00 – 11:30 a.m.	Institutions for Mental Disease (IMD) Training for Licensed Adult Care Home, Family Care Home, & Supervised Living Home (5600a and 5600c) Providers	IMD characteristics and reviews (Completed)
July 26, 2012 10:00 – 11:30 a.m.	Webinar Training: Eligibility, Independent Assessments, and Recipient Notification	(Completed)

Date	Description	Topic
Aug. 6 – Aug.17, 2012	Regional Trainings for Licensed Adult Care Home Providers	Proposed Policy, Eligibility Assessments, Recipient Decision Notices (completed)
Sept. 20, 2012 10:00 – 11:30 a.m.	Webinar Training	Recipient Appeals (Completed)
Oct. 11, 2012 10:00 – 11:30 a.m.	Webinar Training	1915(i) Home and Community Based Services Benefit: Alzheimer's and Dementia Services
Oct. 22 – Nov. 2, 2012	Regional Trainings for Licensed Home and Home Care Agency Providers	PCS Policy, Billing and Aide Documentation
Nov. 15, 2012 10:00 – 11:30 a.m.	Webinar Training	To be determined

Refer to the *July 2012 Special Medicaid Bulletin*, and articles in the August 2012 and September 2012 Medicaid Bulletins addressing Licensed Adult Care Home providers, and to the DMA Consolidated PCS web page, for additional background information, provider training materials, and planning resources for the January 1, 2013 implementation of the consolidated PCS program.

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

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

Attention: In-Home Care Providers

Consolidated Personal Care Services Policy Update, Submission of 1915(i) Alzheimer's Services Benefit Application, Upcoming Provider Trainings

Consolidated Personal Care Services Policy

Effective January 1, 2013, N.C. Medicaid personal care services for recipients in all settings – including private residences and licensed adult care homes, family care homes, and 5600a and 5600c supervised living homes – will be provided under a consolidated Personal Care Services (PCS) benefit. Clinical Coverage Policy 3L, Personal Care Services, was posted for public comment from July 18, 2012 to September 1, 2012. The N.C. Division of Medical Assistance (DMA) is reviewing comments submitted during the public comment period and anticipates that Policy 3L will be finalized and posted in final version in October 2012 – **with a January 1, 2013 effective date**. Additional information will be posted on the DMA Consolidated PCS web page as it becomes available.

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Upcoming Provider Trainings

Regional trainings for home care agency and licensed adult care home providers will be held October 22 through November 2, 2012. The following table provides a timeline of upcoming trainings of relevance for home care agencies, as well as licensed adult care home providers. Registration information will be posted prior to each training on the DMA Consolidated PCS web page.

Date	Description	Topic
October 11, 2012 10:00 – 11:30 a.m.	Webinar Training	1915(i) Home and Community Based Services Benefit: Alzheimer's and Dementia Services
October 22 – November 2, 2012	Regional Trainings for Licensed Home and Home Care Agency Providers	PCS Policy, Billing and Aide Documentation
November 15, 2012 10:00 – 11:30 a.m.	Webinar Training	To be determined

Refer to the *September 2012 Medicaid Bulletin* for In-Home Care providers and to future Medicaid Bulletins for additional information about the new PCS program.

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

Attention: Adult Care Homes, Family Care Homes and Supervised Living Facilities

Review for Institute for Mental Disease (IMD) Determination Update

In the Institute for Mental Disease (IMD), determination trainings previously conducted for Adult Care Homes, Family Care Homes and Supervised Living facilities (5600 A and C group homes), the methodology used to determine whether more than 50% of the patients in the facility reside there primarily because of the individual's mental health or substance abuse diagnosis used licensed beds as the denominator in the calculation.

As of September 5, 2012, the federal Centers for Medicare & Medicaid Services (CMS) clarified the criteria to be used in determining IMD methodology as it relates to the numerator and denominator for analyzing data. **CMS has instructed the N.C. Division of Medical Assistance (DMA) that the denominator must be occupied beds instead of licensed beds.**

DMA has had several discussions and presentations to the public, providers, legislative committees, consumers, associations, advocacy groups and other state entities regarding this change by CMS.

DMA is required to use CMS methodology in determining IMDs. The IMD methodology is as follows:

Screening of Facilities for Phase II

1. Identify all Residential Settings licensed under Chapter 131D or 122C with more than 16 beds (individual license and federal tax ID) and which are billing for state plan personal care services (PCS)
2. Run claims data to identify all recipients in the above facilities with at least one claim by any provider in the previous 6 month period listed as a Mental Health/Substance Abuse (MH/SA) diagnosis on the claim
3. Identify one month within date range of unduplicated recipient count
4. Calculate if the amount is more than 50% by:

    - Numerator: Primary MH/SA diagnosis
    - Denominator: One month of unduplicated claims (*) which will serve as the occupied bed
    - Licensed beds per N.C. Division of Health Service Regulation is used to determine >16 beds as single or a shared ownership

5. Conduct phone interviews to verify scope of shared ownership

6. **Conduct facility onsite review** of those providers that were "screened in" for more than 16 beds and 50% MH/SA occupancy

7. **Conduct final IMD At-Risk Determinations to determine if the overall character of the facility is that of an IMD, including whether more than 50% of the patients in the facility reside there because of the individual's mental health or substance abuse diagnosis. The calculation of the 50% is based on:**

    - Numerator: No. of primary reason (medical or MH/SA) for living in residential setting
    - Denominator: Occupied beds (headcount on date of visit)

No other changes have been made in the IMD determination process. The training slides have been revised to reflect this change and will be reposted on the DMA website at http://www.ncdhhs.gov/dma.

Director's Office
DMA, 919-855-4317

Attention: Community Alternative Program for Disabled Adults (CAP/DA-Choice) Lead Agencies

Quality Improvement Strategies for CAP/DA 1915(c) HCBS Waiver

Effective October 1, 2012, The Carolina Centers for Medical Excellence (CCME), approved through an RFP, began performing two Quality Improvement Strategy functions on the behalf of the N.C. Division of Medical Assistance (DMA) for the CAP/DA 1915(c) Home and Community-Based Services (HCBS) waiver.

These two Quality Improvement Strategies will include:

1. conducting a compliance review to each designated lead agency and,
2. sending a welcome letter to newly approved CAP/DA-Choice beneficiaries.

Function 1: In November 2012, the CCME will begin conducting site visits to each of the 97 CAP/DA appointed entities to randomly review selected case files and compare them against the federal waiver assurances and CAP/DA-Choice Clinical Coverage Policy (3K-2). Each randomly selected beneficiary will also receive a satisfaction survey to rate the approval of services rendered and the performance of the case management entity. The CCME will notify the identified lead agency one month in advance of the scheduled compliance review.

Each Lead Agency is required to cooperate with the compliance review by providing any necessary information or documentation. CCME will use a comprehensive program review tool to conduct the compliance review. CCME is responsible for reviewing supporting documentation and evaluating compliance based on the indicators listed on the comprehensive program review tool. Upon completion of the audit, CCME will compile the report findings; CAP/DA DMA staff will determine the need for ongoing technical guidance, training or oversight for a corrective action.

Function 2: On October 1, 2012, CCME began mailing welcome letters to each initial new CAP/DA beneficiary via data uploaded into the Automated Quality and Utilization Improvement Program (AQUIP©). The welcome letter will be mailed directly to the newly approved beneficiary within seven days of their AQUIP approval. This mailing will welcome the beneficiary into the federal waiver program, identify the waiver services to which he/she may be entitled, inform recipients of provider choice and waiver options – participation in the waiver and the option to select the traditional CAP/DA program or consumer-direction program –
and provide information on how to report concerns of abuse, neglect or exploitation.

Clinical Coverage Policy
DMA, 919-855-4371

Attention: Dental Providers and Health Department Dental Centers

Dental Services and Medicaid for Pregnant Women (MPW) Eligibility

The N.C. Division of Medical Assistance (DMA), Program Integrity Section has identified provider noncompliance when billing for dental services rendered while the recipient is covered under the Medicaid for Pregnant Women (MPW) program class.

According to *Clinical Coverage Policy 4A, Dental Services*:

> "For pregnant Medicaid-eligible recipients covered under the Medicaid for Pregnant Women program class 'MPW,' dental services as described in this policy are covered through the day of delivery."

Therefore, claims for dental services rendered for recipients under "MPW" eligibility after delivery are outside the policy limitation and are subject to recoupment.

Medicaid providers are required to verify each Medicaid recipient's eligibility each time a service is rendered. Please refer to the *Basic Medicaid and NC Health Choice Billing Guide* for verification methods.

Program Integrity
DMA, 919-814-0000

Attention: Nurse Practitioners, Physician Assistants and Physicians

Carfilzomib (Kyprolis, HCPCS Code J9999): Billing Guidelines

Effective with date of service July 31, 2012, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover carfilzomib injection (Kyprolis) for use in the Physician's Drug Program when billed with HCPCS code J9999 (Not otherwise classified, antineoplastic drugs). Carfilzomib is currently commercially available in a single-use vial containing 60 mg sterile lyophilized powder.

Kyprolis was added to the MMIS+ system as a rebatable drug on July 31, 2012 and was available at that time through the Outpatient Pharmacy Program by prescription. Regarding coverage of drugs in the Physician's Drug Program, unlike the Outpatient Pharmacy Program, the coverage process is not automated. Therefore, there is always a delay between the effective date of coverage and the posting of the provider bulletin notification.

Carfilzomib is a proteasome inhibitor indicated for the treatment of patients with multiple myeloma who have received at least two prior therapies including bortezomib and an immunomodulatory agent and have demonstrated disease progression on or within 60 days of completion of the last therapy.

Carfilzomib is administered intravenously over 2 to 10 minutes, on two consecutive days each week for three weeks (Days 1, 2, 8, 9, 15 and 16), followed by a 12-day rest period (Days 17 to 28). Each 28-day period is considered one treatment cycle. Recommended Cycle 1 dose is 20 mg/m2/day and, if tolerated, increase Cycle 2 dose and subsequent cycles' doses to 27 mg/m2/day. Treatment may be continued until disease progression or until unacceptable toxicity occurs.

For Medicaid and NCHC Billing

- The ICD-9-CM diagnosis code required for billing carfilzomib is:
  - 203.00 Multiple myeloma, without mention of having achieved remission
  OR
  - 203.02 Multiple myeloma, in relapse
- Providers shall bill carfilzomib with HCPCS code J9999 (Not otherwise classified, antineoplastic drugs).
- Providers shall indicate the number of HCPCS units. An entire single-dose vial of carfilzomib may be billed. The amount wasted shall not be reported to Medicaid or NCHC with the JW modifier as this modifier is not recognized by either program.
- One unit of coverage is 60 mg. The maximum reimbursement rate per unit is $1,726.00.

- Providers shall bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC units for carfilzomib should be reported as "UN." To bill for the entire 60 mg vial of carfilzomib, report the NDC units as "UN1."
- If the drug was purchased under the 340-B drug pricing program, providers shall place a "UD" modifier in the modifier field for that drug detail.
- Refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update,* on DMA's website at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf, for additional instructions.
- Providers shall bill their usual and customary charge.
- The fee schedule for the Physician's Drug Program is available on DMA's website at: www.ncdhhs.gov/dma/fee/

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

Attention: Physicians

Affordable Care Act Enhanced Payments to Primary Care Physicians

According to Section 1202 of the Affordable Care Act (ACA) – which amends section 1902(a)(13) of the Social Security Act – Medicaid is federally required to pay at the Medicare rate for certain primary care services and to reimburse 100% Medicare Cost Share for services paid in calendar years 2013 and 2014. The codes included in this provision include evaluation and management (E&M) services and immunization administration for vaccines and toxoids.

The N.C. Division of Medical Assistance (DMA) has reviewed the Proposed Rule published by the Centers for Medicare & Medicaid Services in the Federal Register. Enhanced payments to eligible providers begin January 1, 2013 and expire December 31, 2014. N.C. Medicaid will be implementing the ACA Enhanced Payments to Primary Care Physicians within the MMIS+ claims processing system. Some of the provisions in the Proposed Rule may change when the federal government publishes the Final Rule which is expected in November 2012. DMA will notify providers through upcoming Medicaid bulletins as the ACA Enhanced Payments to Primary Care Physicians implementation efforts progress.

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

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

Employment opportunities with DMA are advertised on the Office of State Personnel's Website at 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." If you identify a position for which you are both interested and qualified, complete a state application form online and submit it. 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. To submit a comment related to a policy, refer to the instructions on the Proposed Clinical Coverage Policies Web page at http://www.ncdhhs.gov/dma/mpproposed/. Providers without Internet access can submit written comments to the address listed below.

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

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

2012 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
October	9/27/12	10/2/12	10/3/12
	10/4/12	10/10/12	10/11/12
	10/11/12	10/16/12	10/17/12
	10/18/12	10/25/12	10/26/12
November	11/1/12	11/6/12	11/7/12
	11/8/12	11/14/12	11/15/12
	11/15/12	11/21/12	11/22/12
	11/29/12	12/04/12	12/05/12

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

Michael Watson
Director
Division of Medical Assistance
Department of Health and Human Services

Melissa Robinson
Executive Director
HP Enterprise Services