



November 2010 Medicaid Bulletin

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**Providers are responsible for informing their billing agency of information in this bulletin.
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All rights reserved. Applicable FARS/DFARS apply.**

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

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

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

Funding

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

Criteria for Qualifying for an Incentive

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

Additional Information

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

CSC, 1-866-844-1113NCMedicaid.HIT@dhhs.nc.gov

Attention: All Providers**Medicaid Integrity Contractors Audit: Updated Information Effective October 1, 2010****Implementation of Revised Policies Related to Audit Look-Back Period and Provider Response Time for Documentation Requests**

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

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

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

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

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

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

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

MIC Audit Process

1. **Identification of potential audits through data analysis.** The MIG and the Review MICs examine all paid Medicaid claims using the Medicaid Statistical Information System. Using advanced data mining techniques, MIG identifies potential areas that are at risk for overpayments that require additional review by the Review MICs. The Review MICs, in turn, identify specific potential provider audits for the Audit MICs on which to focus their efforts. This data-driven approach to identifying potential overpayments helps ensure that efforts are focused on providers with truly aberrant billing practices.

2. **Vetting potential audits with the state and law enforcement.** Prior to providing an Audit MIC with an audit assignment, CMS vets the providers identified for audit with state Medicaid agencies, state and federal law enforcement agencies, and Medicare contractors. Vetting is the process whereby CMS provides a list of potential audits generated by the data analysis mentioned above. If any of these agencies are conducting audits or investigations of the same provider for similar billing issues, CMS may elect to cancel or postpone the MIC audit to avoid duplicating efforts.
3. **Audit MIC receives audit assignment.** CMS forwards the list of providers to be reviewed to the Audit MIC after the vetting process is completed. The Audit MIC immediately begins the audit process. CMS believes that having a consistent national policy on look back and record production will allow States and providers to know exactly what to expect from our contractors. There are no federal statutory limitations on the time period that an Audit MIC may look back. Originally CMS directed the Audit MICs to follow the States' established look back policies when conducting audits, while reserving the right to exceed a State's look back period when facts warranted. The evolution of the MIC audit process, and lessons learned from collaborating with States, has influenced CMS' determination that establishing a consistent national audit look back period is necessary.

Therefore, effective October 1, 2010, the general policy of the Audit MICs will be to follow a five (5) year audit look-back period. The five-year period begins on the date of issuance of the Notification Letter to the provider. For example, if an audit begins in October 2010, the look-back period for reviewing claims and request for records would go back to October 2005. CMS retains the right to adjust the five-year look-back period if the facts warrant such action.

4. **Audit MIC contacts provider and schedules entrance conference.** The Audit MIC mails a notification letter to the provider. The notification letter
 - identifies a point of contact within the Audit MIC;
 - gives at least two-weeks' notice before the audit is to begin;
 - includes a records request outlining the specific records that the Audit MIC will be auditing; and
 - asks the provider to send the records to the Audit MIC for a desk audit. For a field audit, the provider must have the records available in time for the Audit MIC's arrival at the provider's office.

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

5. **Audit MIC performs audit.** Most of the audits conducted by the Audit MIC are desk audits; however, the Audit MIC also conducts field audits in which the auditors conduct the audit on-site at the provider's location.

An Audit MIC initiates an audit through an engagement letter to the provider, at which time the MIC requests records to support the claims audit. Current policy requires the provider to submit the required documentation within ten (10) business days from the date the provider would reasonably be expected to have received the engagement letter, plus an allowance of five (5) business days for delivery.

CMS has approved a revised policy which will allow the provider thirty (30) calendar days to produce the records. The Audit MIC can authorize a fifteen (15) business day extension if requested, and appropriately justified, by the provider. If the provider needs more than forty-five (45) business days to produce the documents, CMS approval is required. In the latter case, the Audit MIC will send the written request to CMS.

CMS Medicaid Integrity Group is working to develop an internet-based Medicaid Integrity Manual (MIM) that will include additional granularity on these topics, as well as other topics regarding the Medicaid Integrity Program (MIP) activities. The purpose of the Manual is to promote continuity and consistency in the MIP by providing a comprehensive guide to its overall operations. The MIM will primarily serve as a reference tool to assist State Medicaid officials, providers, health care organizations, CMS components, and other Federal agencies in: (1) understanding the goals and objectives of the MIP; (2) improving the communication and transparency of the MIP; and (3) educating outside entities of the evolving functions of the MIP.

The audits are being conducted according to Generally Accepted Government Auditing Standards (<http://www.gao.gov/govaud/ybk01.htm>).

6. **Exit conference held and draft audit report is prepared.** At the conclusion of the audit, the Audit MIC will coordinate with the provider to schedule an exit conference. The preliminary audit findings are reviewed at this meeting. The provider has an opportunity to comment on the preliminary audit findings and to provide additional information if necessary. If the Audit MIC concludes, based on the evidence, that there is a potential overpayment, the Audit MIC prepares a draft report.
7. **Review of draft audit report.** The draft audit report is shared with CMS for approval and is provided to the state for review and comments. The report is then given to the provider for review and comment. The draft report may be subject to revision based on additional information and shared again with the state.
8. **Draft audit report is finalized.** Upon completion of this review process, the findings may be adjusted, either up or down, as appropriate based on the information provided by the provider and the state. The state's comments and concerns will also be given full consideration. CMS has the final responsibility for determining the final amount of any identified overpayment in any audit. At this point, the audit report is finalized.
9. **CMS issues final audit report to the state, triggering the "1-year" rule.** CMS sends the final audit report to the state. Pursuant to 42 CFR 433.316 (a) and (e), this action serves as CMS' official notice to the state of the discovery and identification of an overpayment. Under federal law, 42 CFR 433.12 (2), the state must repay the federal share of the overpayment to CMS within one year, regardless of whether the state recovers or seeks to recover the overpayment from the provider.
10. **The state issues final audit report to provider and begins overpayment recovery process.** The state is responsible for issuing the final audit report to the provider. Each state must follow its respective administrative process in this endeavor. At this point, the provider may exercise whatever appeal or adjudication rights are available under state law when the state seeks to collect the overpayment amount identified in the final audit report.

Program Integrity
DMA, 919-647-8000

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

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

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

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

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

Program Integrity
DMA, 919-647-8000

Attention: All Providers***C*hange in Implementation Date for Revised Coverage Criteria for Breast Surgeries**

The implementation of revised coverage criteria for breast surgeries has been changed from October 1, 2010, to December 1, 2010. Effective with date of service December 1, 2010, Medicaid will no longer cover reduction mammoplasty except when performed on a contralateral breast as part of a reconstruction surgery as described in Section 3.6 of Clinical Coverage Policy 1A-12. **Prior approval will be required for this procedure.**

Providers may continue to request prior approval for breast reduction surgery that is not related to reconstructive surgery as long as the procedure can be completed prior to December 1, 2010.

Effective December 1, 2010, Medicaid will no longer cover CPT procedure code 19316 (mastopexy) except during reconstruction of the affected or contralateral breast after mastectomy as outlined in the policy.

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

Attention: All Providers**Incomplete Application Final Notice**

As the provider enrollment, verification, and credentialing (EVC) vendor for the N.C. Medicaid Program, CSC processes enrollment applications, enrollment additions, and Medicaid Provider Change Forms. When an EVC credentialing coordinator determines that an application is missing information, the coordinator suspends the application as “Incomplete” and sends a letter to the applicant indicating the information that must be provided in order to complete the application. If the missing information is not provided within 30 days from the date of the letter, CSC sends a system-generated e-mail to the applicant (see below) stating that the application will be voided. Any applicant who feels that he/she has received this notice in error should immediately contact the CSC EVC Call Center at 1-866-844-1113. CSC will promptly investigate and address your concerns.

The following paragraph is excerpted from the e-mail message that CSC sends to an applicant when an application is voided because CSC has not received all of the required information within 30 days.

After reviewing your application, an EVC Credentialing Coordinator determined that the information provided was incomplete. CSC sent notification to your office via mail and/or e-mail of the necessary corrections to complete your request for enrollment. As of the date of this letter, the records indicate that it has been more than thirty (30) days since CSC notified you of the necessary correction(s), and we have not received a response from you. Therefore, your application will be voided as an inactive, incomplete application for enrollment. There will be instances where the application is completed in processing but the follow-up status of Incomplete was not removed. Please contact CSC for verification and investigation.

If you have questions regarding the notice, please contact the CSC EVC Call Center (1-866-844-1113) and reference the Enrollment Tracking Number (ETN) indicated in the final notice. Customer service agents are available Monday through Friday, 8:00 a.m. through 5:00 p.m. Eastern Time, at 1-866-844-1113.

CSC, 1-866-844-1113

Attention: All Providers**Diagnosis Codes V18.11 and V18.19**

ICD-9-CM diagnosis code V18.1 (other endocrine and metabolic diseases) has been further subdivided into V18.11 [multiple endocrine neoplasia (MEN) syndrome] and V18.19 (other endocrine and metabolic diseases). However, some claims have been denied because these diagnosis codes were not identified. Providers receiving a denial when billing with V18.11 or V18.19 for dates of service on or after January 1, 2009, may resubmit the denied charges as a new claim (not as an adjustment request) for processing as long as the claims have been filed timely.

HP Enterprise Services

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

Attention: All Providers***The N.C. Health Insurance Premium Payment Program***

Effective November 1, 2010, the N.C. Health Insurance Premium Payment (HIPP) Program will no longer be administered by DMA's Third Party Recovery Unit. In our efforts to expand the HIPP Program, DMA has partnered with HMS to assume all responsibilities of administering the Program on behalf of the Division.

As you may know, pursuant to the Omnibus Budget Reconciliation Act of 1990, the HIPP Program is a premium payment program. It is designed for Medicaid recipients

1. with high cost medical conditions; **and**
2. who have **access** to private health insurance through an employer.

If cost effective, Medicaid will also consider the benefit of paying for a family plan premium to include those not eligible for Medicaid.

The patient must be Medicaid eligible at all times for DMA to pay the health insurance premium. DMA does not cover the cost of Medicare supplements that have prescription coverage due to Part D. Therefore, if you have a patient who is on the transplant list, has had a transplant or is currently undergoing cancer treatment, please inform them of the Program. To be considered they must complete and submit a Health Insurance Premium Payment Application (DMA-2069).

For further information:

- HIPP website: <http://www.MyNCHIPP.com>
- Phone: 1-855-MyNCHIPP (1-855-696-2447)
- E-mail: customerservice@MyNCHIPP.com
- Fax: 1-855-888-3333

Please be aware that the Health Insurance Premium Payment Application (DMA-2069) has been revised for use beginning November 1, 2010. It can be accessed from the DMA Third Party Recovery web page at <http://www.ncdhhs.gov/dma/provider/tpr.htm>.

**Deborah Wilkins, Third Party Recovery
DMA, 919-647-8100**

Attention: All Providers**Prior Approval for Imaging Procedure Policy and Update for Lesser Intensity Procedures****Policy**

Clinical Coverage Policy 1K-7, *Prior Approval for Imaging Services*, is now available on the DMA website at <http://www.ncdhhs.gov/dma/mp/>. Please read this policy as it contains all of the information about the process for obtaining authorization for imaging procedures. A complete list of the CPT codes of all the diagnostic imaging procedures that require prior approval is included in Attachment B. These are the only diagnostic imaging procedures that require prior approval through MedSolutions. Prior approval must be obtained before the test is provided. The only exceptions to this rule are:

1. A recipient receives retro-eligibility or misrepresents his/her Medicaid status on the date of service (refer to Section 5.3.1 and 5.3.2).
2. The procedure is urgent or emergent – approval requests for these tests can be submitted up to two business days after the service was performed (refer to Section 5.5).

For retroactive requests, providers must submit the request on the N.C. DMA Retro Request Fax Form (refer to Section 5.1). This form is located on the MedSolutions website at <https://www.medsolutionsonline.com>. If you do not have access to the web, please call MedSolutions at 1-888-693-3211 and request a faxed version. The completed N.C. DMA Retro Request Fax Form plus supporting medical documentation must be submitted by fax. A retroactive request will not be accepted via the web or by phone. A retroactive request for other reasons (e.g., failed to obtain prior approval) will not be accepted.

Lesser Intensity Update for CT, MRI and MRA Scans

Effective December 1, 2010, system changes will be in place that will allow a provider to bill a “lesser intensity” procedure code from the same contrast family of the code that had been approved by MedSolutions. The system will match the claim detail to an approved authorization that contains a procedure code within the same contrast family of the procedure code billed. Claim details where the billed procedure code is the same or of lesser intensity than the authorized procedure will be reimbursed as billed. Claim details where the billed procedure code is of greater intensity than the authorized procedure code will be denied. This applies to CT, MRI, and MRA scans only.

Scenario 1

Approved procedure – CPT procedure code 70460 (CT of the head with contrast)
Test performed and billed – CPT procedure code 70450 (CT of the head without contrast)
Test paid – claim will pay 70450 based on the lesser intensity procedure than the authorized procedure

Scenario 2

Approved procedure – CPT procedure code 70460 (CT of the head with contrast)
Test performed and billed – CPT procedure code 70470 (CT of the head without contrast followed by with contrast)
Test paid – claim will be denied because the test billed is of greater intensity than the authorized procedure

Scenario 3

Approved procedure – CPT procedure code 70470 (CT of the head without contrast followed by with contrast)
Test performed and billed – CPT procedure code 70460 (CT of the head with contrast)
Test paid – claim will pay 70460 based on the lesser intensity procedure than the authorized procedure

The following table lists the procedure reduction criteria:

CONTRAST FAMILY	AUTHORIZED CPT CODES (CONTRAST STATUS)	LESSER INTENSITY PROCEDURE ALLOWED
CT HEAD	70450 (without)	70450 – must be exact match
	70460 (with)	70450 or 70460
	70470 (without followed by with)	70450 or 70460 or 70470
CT ORBIT	70480 (without)	70480 – must be exact match
	70481 (with)	70480 or 70481
	70482 (without followed by with)	70480 or 70481 or 70482
CT MAXILLO-FACIAL	70486 (without)	70486 – must be exact match
	70487 (with)	70486 or 70487
	70488 (without followed by with)	70486 or 70487 or 70488
CT SOFT TISSUE NECK	70490 (without)	70490 – must be exact match
	70491 (with)	70490 or 70491
	70492 (without followed by with)	70490 or 70491 or 70492
CT CHEST	71250 (without)	71250 – must be exact match
	71260 (with)	71250 or 71260
	71270 (without followed by with)	71250 or 71260 or 71270
CT CERVICAL SPINE	72125 (without)	72125 – must be exact match
	72126 (with)	72125 or 72126
	72127 (without followed by with)	72125 or 72126 or 72127
CT THORACIC SPINE	72128 (without)	72128 – must be exact match
	72129 (with)	72128 or 72129
	72130 (without followed by with)	72128 or 72129 or 72130
CT LUMBAR SPINE	72131 (without)	72131 – must be exact match
	72132 (with)	72131 or 72132
	72133 (without followed by with)	72131 or 72132 or 72133
CT ABDOMEN	72150 (without)	72150 – must be exact match
	72160 (with)	72150 or 72160
	72170 (without followed by with)	72150 or 72160 or 72170
CT PELVIS	72192 (without)	72192 – must be exact match
	72193 (with)	72192 or 72193
	72194 (without followed by with)	72192 or 72193 or 72194
CT UPPER EXTREMITY	73200 (without)	73200 – must be exact match
	73201 (with)	73200 or 73201
	73202 (without followed by with)	73200 or 73201 or 73202
CT LOWER EXTREMITY	73700 (without)	73700 – must be exact match
	73701 (with)	73700 or 73701
	73702 (without followed by with)	73700 or 73701 or 73702
MRI BRAIN (HEAD)	70551 (without)	70551 – must be exact match
	70552 (with)	70551 or 70552
	70553 (without followed by with)	70551 or 70552 or 70553

CONTRAST FAMILY	AUTHORIZED CPT CODES (CONTRAST STATUS)	LESSER INTENSITY PROCEDURE ALLOWED
MRI CHEST	71550 (without)	71550 – must be exact match
	71551 (with)	71550 or 71551
	71552 (without followed by with)	71550 or 71551 or 71552
MRI CERVICAL SPINE	72141 (without)	72141– must be exact match
	72142 (with)	72141 or 72142
	72158 (without followed by with)	72141 or 72142 or 72158
MRI THORACIC SPINE	72146 (without)	72146-must be exact match
	72147 (with)	72146 or 72147
	72157 (without followed by with)	72146 or 72147 or 72157
MRI LUMBAR SPINE	72148 (without)	72148 – must be exact match
	72149 (with)	72148 or 72149
	72158 (without followed by with)	72148 or 72149 or 72158
MRI PELVIS	72195 (without)	72195 – must be exact match
	72196 (with)	72195 or 72196
	72197 (without followed by with)	72195or 72196 or 72197
MRI UPPER EXTREMITY	73218 (without)	73218 – must be exact match
	73219 (with)	73218 or 73219
	73220 (without followed by with)	73218 or 73219 or 73220
MRI UPPER EXTREMITY ANY JOINT	73221 (without)	73221 – must be exact match
	73222 (with)	73221 or 73222
	73223 (without followed by with)	73221 or 73222 or 73223
MRI LOWER EXTREMITY	73718 (without)	73718 – must be exact match
	73719 (with)	73718 or 73719
	73720 (without followed by with)	73718 or 73719 or 73720
MRI LOWER EXTREMITY ANY JOINT	73721 (without)	73721 – must be exact match
	73722 (with)	73721 or 73722
	73723 (without followed by with)	73721 or 73722 or 73723
MRI ABDOMEN	74181 (without)	74181 – must be exact match
	74182 (with)	74181 or 74182
	74183 (without followed by with)	74181 or 74182 or 74183
MRA HEAD	70544 (without)	70544 – must be exact match
	70545 (with)	70544 or 70545
	70546 (without followed by with)	70544 or 70545 or 70546
MRA NECK	70547 (without)	70547 – must be exact match
	70548 (with)	70547 or 70548
	70549 (without followed by with)	70547 or 70548 or 70549

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

Attention: All Providers**2011 Checkwrite Schedule**

The following table lists the cut-off dates, checkwrite dates, and the electronic deposit dates for 2011.

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

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

Attention: All Providers**Contact E-Mail Addresses**

All applicants are asked at the time of enrollment to provide a valid e-mail address for the individual or authorized agent who is authorized to receive information or make business decisions on behalf of the applying provider. This e-mail address is used by CSC—the provider enrollment, verification, and credentialing contractor—to communicate important information to an applicant once the application has been submitted. The e-mail address is entered into a provider’s record and may also be used by DMA to communicate important information in a timely manner to providers related to participation with the N.C. Medicaid Program. All communication from the N.C. Medicaid Program is important and should be handled promptly.

Providers are reminded that it is important to maintain accurate contact information and to notify CSC when there is a change to the e-mail address on file with Medicaid. Changes should be reported using the Medicaid Provider Change Form. The form can be accessed from the NC Tracks website at <http://www.nctracks.nc.gov/provider/cis.html>.

Questions about your contact e-mail address information may be directed to CSC at the number listed below.

CSC, 1-866-844-1113

Attention: Critical Access Behavioral Health Agencies, Enhanced Behavioral Health (Community Intervention) Services Providers, and Local Management Entities**Critical Access Behavioral Health Agency Benchmarks and Transition Planning**

CMS approved a State Plan Amendment that allows only certified Critical Access Behavioral Health Agencies (CABHAs) to deliver Community Support Team (CST), Intensive In-home Services (IIH), and Day Treatment Services (DT) effective with date of service January 1, 2011. On and after that date, only CABHAs are authorized to be reimbursed for the provision of CST, IIH and DT. Additionally, Community Support (CS) will no longer be a covered service, effective with date of service January 1, 2011. Recipients in need of continued case management who meet the eligibility requirements for Mental Health/Substance Abuse Targeted Case Management (MH/SA TCM) may need to be transitioned to MH/SA TCM if clinically appropriate. Only CABHAs are authorized to be reimbursed for the provision of MH/SA TCM.

While most providers currently providing services may continue service delivery until December 31, 2010, it is critically important that all providers understand the benchmarks established so that consumers receiving CS, CST, DT, and IIH services from non-CABHA-certified agencies experience a timely and seamless transition to CABHA-certified agencies or other basic outpatient services.

To facilitate a smooth transition for recipients from providers who will not meet CABHA certification by January 1, 2011, benchmarks for transition planning and authorizations have been established in consultation with CMS. Benchmarks will apply to Medicaid, State-funded, and Health Choice recipients.

Benchmarks and Transition Plan information can be found in DHHS Implementation Update #79 at <http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/>.

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

Attention: Orthotics and Prosthetics Providers**Coverage of Prosthetic Components**

Effective with date of service December 1, 2010, the following HCPCS code will be end-dated and removed from the Orthotics and Prosthetics (O&P) fee schedule.

Code	Description
L5990	Addition to lower extremity prosthesis, user adjustable heel height

Refer to Clinical Coverage Policy 5B, *Orthotics and Prosthetics*, on DMA's website for detailed coverage information of orthotics and prosthetics. Please refer to the O&P Fee Schedule on DMA's website for the maximum allowable rates for all of the orthotics and prosthetics codes covered by N.C. Medicaid.

HP Enterprise Services

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

Attention: Critical Access Behavioral Health Agencies**Service Orders for Mental Health/Substance Abuse Targeted Case Management**

As detailed in DHHS Implementation Update #77, there are currently two ways to request prior authorization for Mental Health/Substance Abuse Targeted Case Management (MH/SA TCM) services depending on the status of the authorization. Existing authorizations for recipients currently receiving the case management component of Community Support (CS) services may be transferred from a CS authorization to a MH/SA TCM authorization when a valid Critical Access Behavioral Health Agency (CABHA) submits a Letter of Attestation to ValueOptions stating that MH/SA TCM is clinically appropriate and that the person meets eligibility for the service. As a reminder, all MH/SA Attestation requests must be submitted to ValueOptions regardless of the recipient's catchment area.

CABHA providers do not need to submit a person centered plan (PCP) or inpatient treatment report (ITR) when submitting a Letter of Attestation for the transfer of an existing authorization. In these instances, the current service order for the case management component of CS will be honored as the service order for MH/SA TCM. This service order will remain valid until the next concurrent request for MH/SA TCM. A new service order, updated PCP, and ITR, specific to TCM, is required when the provider submits the next concurrent request. The updated PCP must include goals related to MH/SA TCM.

For those recipients who have completed the full authorization period of the case management component of CS and have not used the MH/SA TCM attestation process, or for those recipients new to case management (who have never had case management via CS), any request for MH/SA TCM will be considered an initial authorization request for a new service. In these instances, an updated PCP with goals related to MH/SA TCM including a new signed service order for MH/SA TCM and an ITR must be submitted to the appropriate utilization review (UR) vendor (ValueOptions, The Durham Center or Eastpointe) for this initial authorization request. As a reminder, these requests should be submitted to the appropriate UR vendors based upon the recipient's catchment area.

Behavioral Health Unit

DMA, 919-855-4290

Attention: All Behavioral Health Providers and Local Management Entities

Next Medicaid Managed Care Vendor Selected

DHHS is pleased to announce that Western Highlands Network has been selected as the next Local Management Entity (LME) to operate a managed care plan under the State's 1915 (b)/(c) Medicaid Waiver for mental health, developmental disabilities, and substance abuse services. Western Highlands Network (WHN) was selected through a formal procurement process. DHHS appointed a ten-person review team comprised of staff from DMA, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and consumers and family members. The review team, with assistance from Mercer Government Human Services Consulting, performed a thorough desk review of WHN's application and conducted an onsite review. It was through this process that DHHS selected WHN as an LME that demonstrates the skills, ability, and infrastructure necessary to successfully operate under a 1915 b/c waiver.

DHHS will now work with WHN and all stakeholders in the counties served by WHN (Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, and Yancey) to plan a successful implementation. We will be assisted in this effort by PBH, the LME serving Cabarrus, Davidson, Rowan, Stanly and Union counties, which has been operating a managed care plan under the 1915 b/c waiver successfully for five years, as well as Mecklenburg LME, which will begin operating a managed care plan under the 1915 b/c waiver in July 2011.

Updates regarding this effort will be posted on DMA's websites at <http://www.ncdhhs.gov/dma/lme/MHwaiver.htm>.

Behavioral Health Unit
DMA, 919-855-4290

Attention: Personal Care Services Providers

Independent Assessment Updates and Reminders

Effective October 4, 2010, registered agencies began using the Provider Interface to view and respond to recipient referrals, to view copies of independent assessments and authorizations and denial notices, to request change of status reassessments, and to report recipient discharges. The Provider Interface allows personal care services (PCS) agencies to perform all of these actions using a secure internet-based system instead of by fax and reduces the time required to process and exchange documents with the Carolina Center for Medical Excellence (CCME).

Provider Interface registration forms are still being accepted. If you would like to register to use the Provider Interface, please complete and submit the QiReport Provider Registration Form available on the Independent Assessment website (<http://www.qireport.net>).

Provider service area information also may be reported using the Provider Interface. Beginning November 22, 2010, provider choice lists presented to recipients at the time of independent assessment will be updated to include your reported service area information. If you wish to appear on the provider choice lists for all of the counties that you serve, please register to use the Provider Interface and report your service area information by November 15, 2010. Providers who do not report additional counties in their service area will continue to be listed on the provider choice list for the county in which their agency office is located.

Continue to visit the **Independent Assessment website** (<http://www.qireport.net>) regularly for PCS forms, reference documents, educational content, announcements, and frequently asked questions.

Questions may be directed to the CCME Independent Assessment Help Line at 1-800-228-3365 and by e-mail to PCSAssessment@thecarolinascener.org. Please direct questions regarding recipient status or referrals to the Help Line for faster response and to avoid the transmission of protected health information over e-mail.

CCME, 1-800-228-3365

Attention: Critical Access Behavioral Health Agencies and Enhanced Behavioral Health (Community Intervention) Services Providers**Reminder about Authorizations for Community Support Team, Intensive In-Home, Day Treatment, and Community Support Services for Providers Who Have Not Achieved CABHA Status**

As a reminder, per the Critical Access Behavioral Health Agency (CABHA) Transition Benchmarks outlined in DHHS Implementation Update # 79, Intensive In-Home, Day Treatment, and Community Support Service providers who did not successfully pass the Desk Review by September 30, 2010, will no longer receive initial or concurrent authorizations for these services after November 1, 2010. Remaining units on current authorizations will be allowed to be utilized so that discharge or transition can occur, but no new authorizations will be approved by ValueOptions, The Durham Center or Eastpointe LME. Requests for these services, received on or after November 1, 2010 by providers who have not passed the Desk Review, will be returned as “Unable to Process.”

Community Support Team, Intensive In-Home, Day Treatment, and Community Support Service providers who do not successfully pass the Interview and Verification process by October 31, 2010, will no longer receive initial or concurrent authorizations for these services after December 1, 2010. Remaining units on current authorizations will be allowed to be utilized so that discharge or transition can occur, but no new authorizations will be approved by ValueOptions, The Durham Center or Eastpointe LME. Requests for these services received on or after December 1, 2010, by providers who have not passed the Interview and Verification process, will be returned as “Unable to Process.”

Non-CABHA providers who have failed to meet the stipulated CABHA benchmarks are strongly encouraged to submit a discharge ITR for recipients who are transitioning to a CABHA. When submitting a discharge ITR, it must be submitted to the utilization review vendor that initially authorized the service. **ValueOptions, The Durham Center, and Eastpointe LME will end-date existing authorizations for non-CABHA providers for individual recipients when they receive an authorization request for the same services for that recipient from a CABHA, regardless of whether or not a discharge ITR has been received.**

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

Attention: N.C. Health Choice Providers**N.C. Health Choice Review Process**

Session Law 2010-70 modified the appeals process for North Carolina Health Choice (NCHC) recipients. Beginning October 15, 2010, NCHC recipients will have a new two-level process for appealing denials for services or for claim denials. The process is now called a **review process** rather than an appeals process. There are now two levels of review. The first level of review is as an internal review by DMA. The second level of review is an external review completed by the DHHS Hearing Office.

NCHC recipients will receive instructions on the new review process with any denial of services issued on or after October 15, 2010, and with Explanation of Benefits received for claim denials.

**Margaret Watts, N.C. Health Choice
DMA, 919-855-4104**

Attention: Critical Access Behavioral Health Agencies, Enhanced Behavioral Health (Community Intervention) Services Providers, Outpatient Behavioral Health Services Providers, and Targeted Case Management Providers for Individuals with Intellectual and Developmental Disabilities

ValueOptions ProviderConnect Reminders

As a reminder, providers must register their Medicaid Provider Number (MPN) on ProviderConnect in order to submit authorization requests electronically, view authorizations, and retrieve authorization letters online. Providers interested in submitting enhanced, residential, Mental Health /Substance Abuse Targeted Case Management (MH/SA TCM), Intellectual/Developmental Disabilities (I/DD) Targeted Case Management (I/DD TCM), or outpatient behavioral health services requests via ProviderConnect are encouraged to participate in regularly scheduled webinar training. To register for an upcoming session, go to http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm and scroll to the section titled *Provider Training Opportunities*. Click on the date you wish to attend and complete the registration form. The website is routinely updated with additional webinar dates.

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

Attention: Dental Providers and Health Department Dental Centers

Dental Program Changes Included in the 2010 Budget Bill

Effective with date of service December 1, 2010, the following changes will be implemented for the N.C. Medicaid Dental Program. These changes are a result of the DMA section of the Conference Committee Money Report attached to the Budget Bill (SB 897/SL 2010-31), which refers to dental policy adjustments resulting in program cost savings of approximately \$16,982 in State appropriations. Acting upon the direction of DHHS/DMA leadership, the Dental Program staff consulted with the Dental Committee of the Physician Advisory Group to ensure that the recommended policy changes would not only save money, but that the changes would also make sense from a clinical perspective.

Clinical Coverage Policy 4A, *Dental Services*, has been updated to reflect the changes listed below and will be available on the DMA website beginning December 1, 2010.

- Limit intraoral – complete series (including bitewings) (D0210) to recipients ages 6 and older unless the service is rendered in the inpatient hospital, outpatient hospital, or ambulatory surgical center (Place of Service 1, 2, or F)
- Limit bitewings – three films (D0273) to recipients age 13 and older
- Limit any combination of resin-based posterior composites (D2391, D2392, and D2393) rendered on a single **posterior primary tooth** on the same date of service to the maximum reimbursement of D2393 (same total fee as D2393)

For coverage criteria and additional billing guidelines, please refer to Clinical Coverage Policy 4A, *Dental Services*, on DMA's website at <http://www.ncdhhs.gov/dma/mp/>.

**Dental Program
DMA, 919-855-4280**

Attention: Enhanced Behavioral Health (Community Intervention) Services Providers and Local Management Entities**Community Support Authorizations**

Community Support authorizations will be end-dated no later than December 31, 2010, regardless of the start date of an authorization. Recipients currently receiving Community Support Services should be transitioned by January 1, 2011, to the appropriate rehabilitative or case management service.

Community Support will no longer be a covered service under Medicaid as of January 1, 2011. Therefore, all new requests for this service for recipients under 21 years of age are considered **non covered services** requests and should be requested on the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years Old following EPSDT guidelines. The guidelines and the form are available on DMA's website at <http://www.ncdhhs.gov/dma/epsdt/>. Providers should not submit ITRs or PCPs with the request. This form should be sent to:

Director
c/o Assistant Director for Clinical Policy and Programs
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
Fax: 919-715-7659

Note: A recipient under the age of 21 may receive a medically necessary service not included in the N.C. Medicaid State Plan **only** when the service may be covered under federal Medicaid law and when it will **correct or ameliorate** a diagnosed condition in accordance with Federal Medicaid law at 42 U.S.C. § 1396d(a) and (r) of the Social Security Act.

Behavioral Health Unit
DMA, 919-855-4290

Attention: Adult Care Home Providers**N.C. Medicaid Applies to CMS for Services Authorized Under 1915(I) Adult Care Home Residents**

A 1915(I) application was submitted to CMS, which will enable DMA and its partners [the Division of Health Service Regulation (DHSR), the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), and the Division of Aging and Adult Services (DAAS), as well as the county departments of social services] to provide N.C. Home and Community Based Residential Services within the State to qualified persons living in licensed adult care homes, family care homes, and supervised living A and C homes.

A task force is meeting and beginning in December, information will be posted on the DMA website. The website will include links to both the DHSR website and the DAAS website. Providers with resident stakeholders, whom they would like to nominate for participation on the task force should notify their Provider Association, Executive Director for more information.

Julie Budzinski, MA
DMA, 919-855-4368

Attention: HIV Case Management Providers**Reminders and Updates for HIV Case Management Services**

As of October 1, 2010, Medicaid's new HIV Case Management policy (Clinical Coverage Policy 12B) went into effect. The policy can be accessed on DMA's website at <http://www.ncdhhs.gov/dma/mp/>.

As a reminder, the **Carolinas Center for Medical Excellence (CCME)** is now responsible for management of the day-to-day operations of the Medicaid HIV Case Management Program. The official website for CCME is <http://www.thecarolinascenter.org> and their contact number is 919-380-9860 and 1-800-682-2650.

Information regarding training for **current providers** was published in the October 2010 Medicaid Bulletin. Training on the certification and application process for those agencies currently not certified and enrolled to provide HIV Case Management will begin once CCME and DMA complete the training schedule for existing agencies. It is anticipated that training for those providers **not currently certified** will begin in the spring of 2011.

To meet the requirement in **Section 6.1.a.** of the policy stating , that all providers must have a successful record documenting three years of providing or managing HIV case management programs, initial applicants will be allowed to provide documentation showing previous experience in HIV Case Management in arenas other than Medicaid, such as Ryan White. Exceptions to the requirements documented in this section will be reviewed for approval by DMA and CCME as part of the certification process.

The Performance Bond requirement documented in the policy (**Section 6.1.I**), is under review by the Attorney General's office. Consequently, providers will not be required to obtain a Performance Bond at this time. Updates regarding this requirement will be provided as they are received.

It is recognized that provider agencies will not be able to fulfill the requirement to have newly hired staff trained within 90 days of hire. Therefore, DMA and CCME are extending the training period requirement to May 1, 2011. Beginning **May 1, 2011**, all HIV Case Management staff must receive North Carolina state-sponsored basic policy training within 90 days of their employment.

The requirement documented in **Section 5.2** to obtain a physician's written order to initiate services only applies to recipients who are evaluated for services beginning October 1, 2010.

Victoria Landes, HIV Case Management Program
DMA, 919-855-4389

Attention: Radiology Services**CPT Procedure Code 77470**

According to Clinical Cover Policy 1K-6, *Radiation Oncology*, radiation management procedures billed with CPT procedure code 77470 [special treatment procedure (e.g., total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation)] can be performed once during the course of therapy in addition to daily or weekly patient management. However, some claims have denied with EOB 54 (radiation management limited to one per day) when billing 77470 with 77427, 77431, 77432, and 77435.

Providers receiving a denial for dates of service on or after October 1, 2009, with EOB 54 when billing 77470 with 77427, 77431, 77432 or 77435 may resubmit the denied charges as a new claim (not as an adjustment request) for processing.

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

Attention: Nursing Facilities**MDS Validation and Case Mix Documentation Review Policies for Onsite Reviews**

Effective January 1, 2011, two policies affecting case mix reimbursement will be implemented. These policies will address nursing facility requests for cancellation of a review and excessive wait time for medical records. The policies will be available on the Myers and Stauffer's website at <http://nc.mslc.com/Resources.aspx>.

Facility Request for Cancellation of Review**Policy:**

After the notification of a Case Mix Documentation Review, under certain circumstances a facility may request a cancellation of the review. Following is the facility procedure.

Procedure:

1. The facility administrator or designee must submit the request for cancellation in writing to the Myers and Stauffer MDS supervisor.
 - Request may be either e-mailed or faxed on the same day as the request
 - Request must be signed by either the facility administrator or designee
 - Request must include the reason for cancellation
2. After receipt of the request, the Myers and Stauffer MDS supervisor will make a final decision as to granting or denying the request for cancellation of the review and will notify the facility. The reasons that a facility request for cancellation may be approved include, but are not limited to:
 - State surveyors are in the facility on the day of the scheduled review
 - Inclement weather/weather emergency

Note: This list is not all inclusive; there may be additional circumstances that will be evaluated on a case-by-case basis
3. In the event of a second consecutive request for cancellation during the same review year, DMA will be notified. DMA will render a final decision and the facility will be notified.

Excessive Wait Time for Medical Records**Policy:**

During a Case Mix Documentation Review, the facility must provide medical records as requested within established time limits. There are procedures that the RN reviewer will follow if excess wait time occurs. Following is the facility procedure.

Procedure:

1. During the entrance conference be sure to read the statement on the Entrance Conference Information Form: *"The availability of supporting original legal medical documentation will determine length of review. Excessive delay(s) in providing documentation to the RN Reviewer may result in a possible additional review as directed by DMA."* The facility designee must initial that the statement was read.
2. The facility must provide a minimum of two requested records within 15 minutes of the completion of the entrance conference.
3. If at least two medical records from the list are not provided within 15 minutes of the request, the RN reviewer will request the facility liaison to obtain the records to facilitate the review.
4. If the remainder of the medical records from the list is not provided within 30 minutes of the entrance conference, the RN reviewer will notify the Director of Nursing or the facility administrator.

5. If all of the records from the list are not provided within 60 minutes of the entrance conference, the RN reviewer will notify his/her supervisor.
6. The supervisor will then notify DMA that it has been 60 minutes since the records have been requested and DMA will provide further instructions on the next step.
7. When nearing the completion of the review, the RN reviewer will notify the facility of the approximate time of exit.
8. During the exit conference, be sure to read the statement on the Exit Conference Preliminary Findings Information form: *"I have received a copy of the preliminary review findings and agree that the RN Reviewer has been provided all the necessary original documentation requested and/or other applicable records requested in order to fully disclose the extent of documentation necessary to verify the RUG classification for the assessments. I further understand that the facility could not submit additional supporting documentation after each exit conference."* The facility administrator or designee is required to sign and date the receipt of the preliminary findings to indicate understanding of the above statement.
9. Once the exit conference is complete, no additional documentation will be accepted for the review.
10. This procedure applies to all resident lists for medical record requests.

Deana Dolan, RN RAC-CT, Nursing Facility Consultant
DMA, 919-855-4340

Attention: Psychiatric Residential Treatment Facilities, and Free-Standing Psychiatric Inpatient Hospitals

Updated Authorization Request Forms

Please note that changes that have been made to the following forms:

- The Certificate of Need (CON) for Psychiatric Residential Treatment Facilities
- The Certificate of Need (CON) for Inpatient Psychiatric Hospitalization
- The Criterion V Request Form and Instructions

These revised forms can be accessed from DMA's website at <http://www.ncdhhs.gov/dma/services/inpatientbh.htm>.

The updated forms can also be accessed from the utilization review (UR) vendors' websites as follows:

- ValueOptions: http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm
- The Durham Center: http://www.durhamcenter.org/index.php/provider/ur_resources/mhsa
- Eastpointe LME: http://www.eastpointe.net/providers/providerforms/providerforms_main.aspx

These revised forms must be used for requests to UR vendors for dates of service January 1, 2011, and forward. Requests for Criterion V services submitted with the incorrect forms after January 1, 2011, will be returned as "Unable to Process."

Behavioral Health Unit
DMA, 919-855-4290

Attention: CAP/C Case Managers, CAP/C Service Providers, and Private Duty Nursing Providers

New Rate for Split of Services for Private Duty Nursing and CAP/C Nursing Services and Congregate Nursing Code

Effective with date of service, November 1, 2010, a modifier is required when billing HCPCS codes T1000 [Private duty/independent nursing service(s)] and T1005 (Respite care services). Modifiers TD [Registered Nurse (RN)] and TE [Licensed Practical Nurse (LPN)] are used to indicate the respective level of care provided to the recipient.

- This addition of the modifier does not affect the Maximum Reimbursement Rate for the service as announced in the September 2010 Medicaid Bulletin article.
- Claims submitted for HCPCS codes T1000 or T1005 will be denied if the TD or TE modifier is not appended to the code.
- Congregate Nursing G1054 TD and G1054 TE will not be implemented on November 1, 2010, as indicated in the September 2010 Medicaid Bulletin article.

The codes and maximum reimbursement rates are indicated below.

HCPCS Code	Code Description	Maximum Reimbursement Rate
T1000 TD CAP/C Nursing – RN PDN – RN	Private duty/independent nursing service(s), licensed, up to 15 minutes	\$ 9.18
T1000 TE CAP/C Nursing – LPN PDN – LPN	Private duty/independent nursing service(s), licensed, up to 15 minutes	\$ 9.18
T1005 TD Respite Care, In-Home RN	Respite care services, up to 15 minutes	\$ 9.18
T1005 TE Respite Care, In-Home LPN	Respite care services, up to 15 minutes	\$ 9.18

**Teresa Piezzo, Home and Community Care
DMA, 919-855-4380**

Attention: All Providers

Urine Drug Screens

This bulletin articles serves as a correction to the September 2010 Medicaid Bulletin article titled *Urine Drug Screening*. Effective with date of service March 31, 2010, DMA end-dated CPT code 80101 and replaced it with HCPCS code G0431 [Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class] for initial drug screenings. HCPCS code G0430 (Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure) has also been added. Please note that HCPCS codes G0430 and G4031 and CPT code 80100 can be used for urine or blood specimens. System changes have now been entered for drug screen codes G0430 and G0431 with an effective date of April 1, 2010. Providers who received claim denials may resubmit as new claims for processing.

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

Attention: All Behavioral Health Providers**A**dverse Determination Notification Changes

Adverse determination letters from ValueOptions, The Durham Center, and Eastpointe will no longer include alternate recommendations. Letters will advise that recipients may also be eligible for other Medicaid services and recipients may check with their physician, other licensed clinician or provider to determine if other Medicaid services are appropriate. Outgoing calls by customer service representatives may notify the provider of the decision, but will not include alternate recommendations. Again, such calls are a professional courtesy and are clinical and educational in nature.

If the provider believes that medical necessity exists for the alternate service and the recipient wishes the request submitted, the provider may submit the request at any time. **The adverse action outstanding remains in effect** and, if the recipient and/or legal representative disagree with that decision, they may appeal the decision to the Office of Administrative Hearings as described in the adverse notice.

If a provider calls customer service at a later time to request the alternate recommendations, they should be transferred to a clinical care manager, who may provide the requested information and may discuss appropriate clinical and educational issues relevant to the recommendations.

Behavioral Health Unit
DMA, 919-855-4290

Attention: CAP/MR-DD Service Providers and Local Management Entities**C**hanges in Utilization Review Vendor for CAP/MR-DD Utilization

The contract with the statewide utilization review vendor expires on January 19, 2010. Utilization review for CAP/MR-DD services will not be included in the new contract for whomever is chosen at the end of the bid process for a statewide vendor. These services will be returned to the local level. To this end, DMA, in collaboration with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), recently sent out a request for response from qualified local management entities (LMEs) who are interested in providing utilization review functions for CAP/MR-DD services for recipients who reside in the LME's catchment area. The deadline for submission of these requests was October 18, 2010. Several LMEs expressed an interest in providing these services as evidenced by submission of proposal packets. Notifications of the decision will be sent to the LMEs on November 1, 2010. As selections are made, further information will be provided.

Behavioral Health Unit
DMA, 919-855-4290

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Proposed Clinical Coverage Policies

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

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

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

2010 Checkwrite Schedule

Month	Electronic Cut-Off Date	Checkwrite Date
November	10/28/10	11/2/10
	11/4/10	11/9/10
	11/10/10	11/18/10
December	11/24/10	12/1/10
	12/2/10	12/7/10
	12/9/10	12/14/10
	12/16/10	12/22/10

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

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

Melissa Robinson
Executive Director
HP Enterprise Services