



November 2011 Medicaid Bulletin

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***Providers are responsible for informing their billing agency of information in this bulletin.
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**Attention: Intermediate Care Facilities – Mental Retardation Centers
(ICF-MR)**

***N*otice of Rate Reductions**

Effective November 1, 2011, there will be a rate reduction of 5.69% for all ICF-MR facilities. This is due to the legislative mandate of a 2% budget cut (2.67% for remaining State Fiscal Year) and a change in Federal Financial Participation from ARRA FMAP to Regular FMAP, causing a 3.02% decrease in rates.

In the future, any SPA related rate changes and corresponding recoups/repays will be posted in bulletin articles and put in the “What’s New” section of the DMA website <http://www.ncdhhs.gov/dma/provider/index.htm>.

**Rate Setting
DMA, 919-647-8112**

Attention: All Providers and NC Health Choice Providers

***N*otice of Rate Reductions**

The Department of Health and Human Services, Division of Medical Assistance (DMA) hereby provides notice of its intent to amend the Reimbursement sections of Medicaid State Plan. To comply with SL 2011 - 145, section 10.37.(a)(6) and N.C. GEN. STAT. Section 108A-70.21(b1), DMA will be submitted State Plan Amendments for the purpose of revising the rate methodology language to reflect rate changes for SFY 2011 – 2012. These changes are effective November 1, 2011 and reflect rates paid to North Carolina Medicaid and Health Choice services providers will be reduced by 2.67%. Nursing Homes will have their rate reductions effective July 1, 2011. Hospital providers will follow their normal rate update schedule of October 1, 2011 with the implementation of the DRG update.

Fee schedules previously posted on the website with the effective date of October 1, 2011 have been removed and revised fee schedules are currently on DMA’s website under the heading of “What’s New” section at <http://www.ncdhhs.gov/dma/provider/index.htm>.

For questions concerning the reductions, please call DMA Finance Management at 919-647-8111.

**Finance Management
DMA, 919-647-8111**

Attention: All Providers and NC Health Choice Providers**Subscribe & Receive Email Alerts on Important North Carolina Medicaid and NC Health Choice Updates**

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

HP Enterprise Services

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

Attention: All Medicaid and NC Health Choice Providers**Medicaid and Health Choice Provider Payment Suspensions**

In accordance with the Federal requirements set forth in 42 C.F.R § 455.23, the Medicaid Agency is required to suspend payments of providers having a credible allegation of fraud. NC Session Law 2011-399 expands DMA's responsibility to include suspending payments to providers who owe a final overpayment, assessment or fine and who have not entered into an approved payment plan the Department of Health and Human Services (DHHS). DHHS may suspend payments to all provider numbers, who share the same IRS Employee Identification Number or corporate parent as the provider who owes the repayment or has a credible allegation of fraud.

Program Integrity

DMA, 919-647-8000

Attention: All Providers and NC Health Choice Providers**H** **Health Choice Outpatient Specialized Therapies**

The Division of Medical Assistance's Outpatient Specialized Therapies contract with The Carolinas Center for Medical Excellence (CCME) has been amended to include Health Choice prior approval reviews (PAs) and post payment validations.

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

PAs for Health Choice will not be required for dates of service prior to 12-05-2011. You may start submitting your PA requests on 11-07-2011 for dates of service on or after 12-5-2011. Please remember your MD order is only good for 6 months and must cover the dates on the PA request. All claims for dates of service on or after 12-5-2011 without PA will deny. No retroactive PA will be required for dates of service prior to 12-4-2011.

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

Pharmacy and Ancillary Services
DMA, 919-855-4310

Attention: NC Health Choice Providers**C**laims Denial and Retro Authorization for Services**Temporary Denial of Select Claims**

Due to a systems start-up issue, the following codes denied for reimbursement as non-covered services for Health Choice recipients. These services **are** covered for Health Choice recipients and the systems problem has now been corrected. Providers may re-submit claims that were previously denied as non-covered services. This notice relates only to claims for Health Choice recipients and only for claims that denied for this reason. This notice does not impact claims denied for Medicaid recipients or claims denied for other reasons. We regret any inconvenience this issue may have caused.

H0032	Targeted Case Management - Mental Health / Substance Abuse
T1017 HE	Targeted Case Management for IDD
S5145	Residential Services Level II, Family and
H2020	Residential Services Level II, Group
H0019	Behavioral Health long term residential
T1023	Diagnostic Assessment
H2011	Mobile Crisis Management
H2012 HA	Child and Adolescent Day Treatment
H2022	Intensive In-Home Services
H2033	Multi-systemic Therapy (MST)

Health Choice Requirements Prohibiting Retro Authorization for Services

Please note: Health Choice is now operating under the same policies as Medicaid: Effective as of the date of publication of this Bulletin, all authorization requests for behavioral health services for children and adolescents covered by Health Choice must be approved PRIOR to the delivery of the service. The ONLY exceptions are for emergency and crisis services, per current Medicaid policy, and for situations in which a recipient receives retro-eligibility for Health Choice and the service has already been delivered. These requirements are the same that apply to Medicaid recipients and include Out Patient Services, Residential Services, Enhanced, Psychiatric Residential Treatment Facilities and In Patient Services.

With only the exceptions noted above, any other claims for behavioral health services submitted without prior authorization approval will be denied and no provision is allowed for retro-authorization after a service has been provided.

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

Attention: All Providers and NC Health Choice Providers***P*rovider Responsibilities in a Program Integrity Review or Audit**

Program Integrity (PI) reviews or audits may be conducted in person or by mail (referred to as a desk review). Onsite visits to providers and their recipients may be unannounced (this is a routine procedure) or unannounced. These reviews may be referred to as post payment reviews, quality assurance reviews or compliance audits.

In order that these reviews run as smoothly as possible, providers should adhere to the following steps when a review has been initiated. PI will request medical and/or financial records either by mail or in person. The records must be provided upon request. The intent of the record request is to substantiate all services and billings to Medicaid or Health Choice adhere to the required medical record documentation standards, substantiate provider qualifications, delivery of service in accordance to policy, requirements and rules, and that business and administrative practices are within acceptable practices. Financial or business record request may include such documents as personnel and timekeeping records, invoices, chart of accounts, general ledger, minutes of committee meetings, audited or internally prepared financial statements, bank loan documents. Failure to submit the requested records will result in recoupment of all payments for the services, suspension of payments and may constitute further actions of investigation resulting in termination from the Medicaid/Health Choice program and referral to the Medicaid Fraud Investigative Unit for review for criminal or civil prosecution.

For the purpose of Medicaid and Health Choice billing, providers must maintain records for six years in accordance with the record keeping provisions of the Medicaid Provider Administrative Participation Agreement. Other record retention schedules may be required by other State or federal oversight agencies, funding streams or accrediting/certification bodies and Medicaid/Health Choice requirements do not override those requirements of other oversight bodies.

If you receive a Tentative Notice of Overpayment letter from PI, review the information in the letter and chart. You have two options:

1. If you agree with the findings of an overpayment, use the form sent with the letter to indicate your preferred method for reimbursing DMA. The options include sending check or having the repayment withheld from future Medicaid payments. It is the preference of the DMA to have the funds withheld in a future checkwrite. If you choose to submit a check, please send your check, along with the form issued to you from DMA Program Integrity which includes your case number, to DMA Accounts Receivable at the address on the letter. **Do not send the check to HP Enterprise Services, as this could result in a duplication of your payment or failure to accurately record the submission of the payment.** Also, do NOT request that HP Enterprise Services adjust for the amount or items identified, as this could result in duplicate recoupment.
2. If you disagree with the overpayment decision by PI and want a reconsideration review, return the enclosed hearing request form enclosed in the letter and return to the DHHS Hearing Unit at the address on the letter. **Please pay close attention to the time frames and procedures for requesting a reconsideration review.**

Appeals:

Informal: Reconsideration Review – A provider who disagrees with the decision may request an informal reconsideration review and submit additional relevant documentation for review. Please read the letter from DMA regarding the time frame for submitting a reconsideration review request. The reconsideration review is an informal procedure. The case will be reviewed by an independent Hearing Officer who will send the provider a written decision.

Formal: Contested Case Hearing – If the provider is not satisfied with the outcome of the informal review, or if the provider chooses not to have an informal review, the provider may file a request for a contested case hearing at the Office of Administrative Hearings (OAH). Pay close attention to the specific time frames and procedures for requesting a contested case hearing at OAH. Once the request is received, OAH will contact the provider regarding scheduling of the case.

Program Integrity
DMA, 919-647-8000

Attention: Local Management Entities, Outpatient Behavioral Health Providers, and Therapeutic Foster Care Providers

***R*esolution for IPRS and Medicaid Claim Denials**

The Division of Assistance (DMA) has determined system modification were required to address the denial of claims billed through the LME for Therapeutic Foster Care and Outpatient Behavioral Health provided by provisionally-licensed individuals. These denials began appearing in April up until the present. The systems issue has been resolved so that claims that were denied during that period may be resubmitted. For denied therapeutic foster care claims for S5145, the LME should resubmit the claim with the correct attending NPI for the service provided. For denied outpatient claims for provisionally licensed professionals, the LME should return the claim to the provider and have them resubmit the claim under the enrolled NPI.

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

Attention: All MH/SA/DD Providers, Psychiatrists, and Hospitals

N.C. Mental Health, Developmental Disabilities, and Substance Abuse Services Health Plan Waiver (Formerly, Piedmont Cardinal Health Plan)

Effective July 2, 2010, all services provided in the ED during an admission with a discharge primary diagnosis of 290 through 319 were added to the N.C. Mental Health, Developmental Disabilities and Substance Abuse Services (MH/DD/SAS) Health Plan 1915 b/c Waiver Capitation rate. The MH/DD/SAS Health Plan currently operates in Alamance, Caswell, Cabarrus, Davidson, Rowan, Stanly, and Union counties and is administered by the area Local Management Entity, Piedmont Behavioral Healthcare (PBH).

Except for the emergency services noted above, MH/DD/SAS providers must continue to obtain prior authorization from PBH as they have been to qualify for reimbursement of services provided to Medicaid recipients who, for Medicaid purposes, are residents of the PBH seven-county catchment area.

All ED fees for services provided in emergency rooms to Medicaid recipients residing in the PBH catchment area with a primary diagnosis in the 290 through 319 range, including professional and facility fees are to be billed to PBH.

If you have been paid by Medicaid for an emergency room service that should have been billed to PBH, you will be subject to a recoup of Medicaid funds. You will then be able to bill PBH and be paid by them for these services. This would only apply to recipients whose Medicaid is active in the PBH catchment area. Please contact DMA Behavioral Health Section if you require further assistance at 919-855-4290.

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

Attention: Local Management Entities (LMEs), Outpatient Behavioral Health Providers, Critical Access Behavioral Health Agencies (CABHAs)**H Code Limits for Provisionally Licensed Professional Billing Through the LME**

As stated in the June 2011 Medicaid Bulletin, the coverage of provisionally licensed providers delivering outpatient behavioral health services as a reimbursable service under Medicaid funds and billed through the Local Management Entity (LME) has been extended to June 30, 2012. There have been concerns voiced that the new changes in Clinical Coverage Policy 8C “Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers” that will be implemented in January 2012, eliminate this option for provisionally licensed professionals. As has already been the case, provisionally licensed professionals can either bill the allowable CPT codes ‘incident to’ a physician, or, they can bill H codes through the LME (if the LME allows for this type of billing). In line with the changes in 8C to be implemented in January 2012, in keeping with generally accepted guidelines for timeframes for outpatient services, and as a part of federal Medicaid fraud initiatives, the following limits will be placed on H codes billed through the LME:

- Individual and family therapy – can bill up to 4 units (60 minutes) per date of service (DOS) of the following codes as clinically appropriate (H0004, H0004HR, H0004HS)
- Group therapy – can bill up to 6 units (90 minutes) per DOS of the following codes as clinically appropriate (H0004HQ, H0005)
- Assessment – can bill up to 8 units (120 minutes) per DOS of the following codes as clinically appropriate (H0001, H0031)

Providers are still responsible for counting unmanaged visits and obtaining prior authorization as needed.

Behavioral Health
DMA, 919-855-4290

Attention: All Providers**NC Medicaid EHR Incentive Program Update**

The NC Medicaid Electronic Health Record (EHR) Incentive Program reached another milestone in September 2011 when the program made its first payment to an Eligible Hospital (EH). Iredell Memorial in Statesville, NC was the first hospital to receive a payment from the program that was created as part of the American Recovery and Reinvestment Act of 2009. Three additional hospitals also received payments in October. Eligible Professionals (EPs) began receiving incentive payments in March 2011 and over 83 payments have been made since then with additional payments going out each week. Payments are distributed after EPs or EHs attest to having adopted, implemented or upgraded to a certified EHR system. In subsequent years, additional payments will be made when a provider achieves meaningful use of the EHR technology. To determine if you are eligible to receive a NC Medicaid EHR Incentive Payment, follow this link http://www.cms.gov/EHRIncentivePrograms/15_Eligibility.asp.

NC Medicaid Health Information Technology (HIT)
DMA, 919-855-4206

Attention: All Providers**EHR Incentive Program Upcoming Deadlines**

NC Medicaid EHR Incentive Program would like to remind Eligible Professionals (EP) and Eligible Hospitals (EH) of key registration deadlines for the EHR Incentive Program.

Important Dates to Remember:

- **November 30, 2011:** Last day for EHs and Critical Access Hospitals to register and attest for an incentive payment for Federal fiscal year 2011.
- **February 29, 2012:** Last day for EPs to register and attest for an incentive payment for calendar year 2011.

Additional information and guides to the attestation process are available at: <https://ncmips.nctracks.nc.gov/>.

NC Medicaid Health Information Technology (HIT)
DMA, 919-855-4206

Attention: Health Departments***E*lectronic Claims Submission**

In accordance with Session Law 2011-90 Senate Bill 245, Local Health Departments, District Health Departments, and Consolidated Human Services Agencies shall have the following four options to bill public health program services to Medicaid:

- 1) Submit claims data to HIS and manage 837/835 billing files within HIS.
- 2) Submit to a clearinghouse/vendor that in turn formats their claims in HIPAA compliant electronic 837 file format and send to HP.
- 3) Purchase software from an approved clearinghouse/vendor and in turn the provider submits their claims directly to HP in the HIPAA compliant electronic 837 format.
- 4) Enter claims into the NCECSWeb Tool portal (free of charge as a way of not contracting with an outside source) and HP processes the claim as an electronic claim.

Please use the following contact information:

- Contact HIS for any necessary steps or processes if wishing to remain with HIS.
- If selecting a Clearing House, contact your Clearing House for any necessary steps or procedures to process HIPAA transactions through them.
- If purchasing vendor software to transmit HIPAA transactions directly to NC Medicaid, please complete and submit a Trading Partner Agreement found on the DMA website; <http://www.ncdhhs.gov/dma/hipaa/index.htm>.
- If entering claims directly on the NCECSWeb Tool portal, contact HPES at 1-800-688-6696 option 1 to set up a log on id and password.

For any further questions, please refer to the Basic Medicaid Billing Guide; Section 8-Electronic Commerce Services. <http://www.ncdhhs.gov/dma/basicmed/index.htm>

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

Attention: Acute Inpatient Hospital Services Providers

Changes to UB-04 Guidelines

In April 25, 2008, the Division of Medical Assistance (DMA) switched from billing UB92 to UB04 claims forms. Due to the incorrect billing and claims processing, effective October 1, 2011, changes were made to the claims processing system and billing guidelines for UB04 Acute Inpatient Hospital claims. The billing includes lower level of care services provided in an acute inpatient hospital that does not have swing beds. A single, all inclusive per diem rate will be paid, when it is determined by the Physician or Utilization Review Committee that a patient no longer requires care provided at the acute hospital services level of care and appropriate placement cannot be located.

The rates for billing lower level of care services, effective for dates of service beginning April 25, 2008, are listed below:

	10/1/2010	10/1/2009	10/1/2008	4/25/2008
Nursing Facility Bed	\$131.79	\$131.79	\$131.83	\$123.00
Vent Bed	\$411.67	\$411.67	\$405.97	\$405.97

Prior Approval for the appropriate level of care must be obtained from HP by submitting a FL-2 or FL-2E form for billing the appropriate lower level of care. Forms may be accessed on line @ <http://www.providerlink.com>.

In order to bill for the lower level of care rate:

- The patient must first be discharged from acute care and then admitted as a lower level of care patient.
- File a Hospital Claim using Bill Type 11X to discharge the patient from the acute hospital inpatient level of care.
- Providers must then file a Hospital Claim for billing the appropriate lower level of care services under the appropriate Bill Type indicated below:
 - Bill Type 66X must be used for billing the Nursing Facility level of care
 - Bill Type 28X must be used for billing the Ventilator level of care

The hospital must continue to actively seek appropriate level of care facility placement for individuals in lower level of care beds. Prepayment and post payment reviews may be performed by DMA or Designated Agents with denial or recoupment of payments when appropriate.

There will be no changes to Swing Bed or Ventilator Care billing or payment methodology for those that already have this level of care within their facilities.

Practitioner and Facility Services
DMA, 919-855-4356

Attention: Pharmacists and Prescribers***New Prior Authorization Requirements for Vusion Ointment***

Effective with date of service of **November 1, 2011**, the N.C. Outpatient Pharmacy Program will begin requiring prior authorization for Vusion ointment. The criteria and PA request forms for this medication are available on the N.C. Medicaid Enhanced Pharmacy Program website at <http://www.ncmedicaidpbm.com>. Prescribers can request prior authorization by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax).

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

Attention: Pharmacists and Prescribers***New Prior Authorization Requirements for Xolair Injection***

Effective with date of service of **November 1, 2011**, the N.C. Outpatient Pharmacy Program will begin requiring prior authorization for Xolair injection. The criteria and PA request forms for this medication are available on the N.C. Medicaid Enhanced Pharmacy Program website at <http://www.ncmedicaidpbm.com>. Prescribers can request prior authorization by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax).

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

Attention: Pharmacists***Vacation Supply Prescriptions Limited to Once a Year***

As previously stated in the September 2011 issue of the N.C. Medicaid Pharmacy Newsletter, effective **October 1, 2011**, the use of the submission clarification code (03) to override a Drug Utilization Review (DUR) alert for a vacation prescription supply will be limited to one fill during a five day span once a year. This will allow the pharmacy provider to call the prescriber when questions arise about the prescription. This will apply to non-controlled medications only. Vacation supply and lost prescriptions are not allowed for controlled substances.

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

Attention: All Providers**N.C. Medicaid Preferred Drug List Changes**

Effective with date of service **November 15, 2011**, the Division of Medical Assistance (DMA) will make changes to the N.C. Medicaid Preferred Drug List. Below are highlights of some of the changes that will occur:

- Addition of N.C. Health Choice
- Addition of the tetracycline derivatives drug class
- Addition of the pancreatic enzymes drug class including grandfathering of current users
- Addition of the topical steroids drug classes
- Addition of a one-time point-of-sale override for Pradaxa and new oral anticoagulants that enter the marketplace as non-preferred to allow transition to a preferred agent
- Removal of coverage from the outpatient pharmacy program of the IV medications Actemra, Orencia, Remicade, Boniva, pamidronate disodium, Reclast, Xgeva, and Zometa. (Coverage will continue under the Physicians Drug Program)
- Updates to the list of preferred brands (please see chart below):

Brand Name	Generic Name
Accolate	Zafirlukast
Alphagan P	Brimonidine
Aricept	Donepezil
Astelin/Astepro	Azelastine Hydrochloride
Benzaclin	Clindamycin/ Benzoyl Peroxide
Differin	Adapalene
Exelon	Rivastigmine
Lovenox	Enoxaparin
Ovide	Malathion

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

Attention: All Providers**Makena No Longer Covered Under the Outpatient Pharmacy Program**

Effective **November 1, 2011**, Makena, the branded version of hydroxyprogesterone caproate (known as 17P), will no longer be covered under the N.C. Medicaid Outpatient Pharmacy Program. Makena will continue to be covered under the Physicians Drug Program. The compounded version of 17P continues to be covered under both programs. Please refer to the July 2011 N.C. Medicaid Bulletin for billing information for compounded 17P and Makena (<http://www.ncdhhs.gov/dma/bulletin/>).

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

Attention: All Providers***Lidoderm and Provigil/Nuvigil Prior Authorization Changes***

Effective with date of service **October 18, 2011**, changes to the prior authorization criteria were implemented for Lidoderm and Provigil/Nuvigil. Lidoderm prior authorization criteria include additional criteria for neuropathic pain and chronic musculo-skeletal pain. In addition to these two changes, new prescriptions are limited to coverage of one box (30 patches) at the time of the first fill. Subsequent refills will be for up to a 34-day supply. Provigil/Nuvigil prior authorization criteria include additional criteria for excessive fatigue associated with multiple sclerosis or myotonic dystrophy.

The criteria and PA request forms for these medications are available on the N.C. Medicaid Enhanced Pharmacy Program website at <http://www.ncmedicaidpbm.com>. Prescribers can request prior authorization by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax).

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

Attention: All Providers***Physician Assistant and Nurse Practitioners Enrollment Update***

The enrollment requirement for Physician Assistants (PAs) and Nurse Practitioners (NPs) is being delayed until further notice from DMA. A State Plan Amendment has been submitted to the Centers for Medicaid and Medicare Services to allow the direct enrollment of PAs. The North Carolina State Plan already has the requirements to allow the direct enrollment of NPs. Providers will receive further guidance in future bulletins.

Clinical Policy**DMA, 919-855-4331**

Attention: Nurse Practitioners and Physicians**Belatacept (Nulojix®), HCPCS code J3590): Billing Guidelines**

Effective with date of service June 23, 2011, the NC Medicaid Program covers belatacept (Nulojix) for use in the Physician's Drug Program when billed with HCPCS code J3590 (unclassified biologicals). Nulojix is available in a 250 mg lyophilized powder single-use vial.

Nulojix is indicated for the prophylaxis of organ rejection in adult patients receiving a kidney transplant. Nulojix should be administered via intravenous infusion over 30 minutes at a dose of 10 mg/kg given on day 1 (day of transplantation, prior to transplant) and day 5. Subsequent doses of 10 mg/kg are given at the end of weeks 2, 4, 8 and 12. A maintenance dose of 5 mg/kg is given after week 16 and every 4 weeks thereafter. Each dose should be rounded to the nearest 12.5 mg increment in order for the dose to be prepared accurately.

For Medicaid Billing

- Providers must bill Nulojix with HCPCS code J3590 (unclassified biologicals). The ICD-9-CM diagnosis codes **V42.0** (kidney replaced by transplant) **AND V58.69** (long-term current use of other (medications)) must be billed with Nulojix.
- Providers must indicate the number of HCPCS units.
- One Medicaid unit of coverage is 12.5 mg. The maximum reimbursement rate per unit is \$48.04.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units for rebatable NDCs. The NDC units for Nulojix should be reported as "UN." To bill for the entire 250 mg vial of Nulojix, report the NDC units as "UN1." If the drug was purchased under the 340-B drug pricing program, place a "UD" modifier in the modifier field for that drug detail.
- Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website (<http://www.ncdhhs.gov/dma/bulletin/>) for additional instructions.
- Providers must bill their usual and customary charge. The new fee schedule for the Physician's Drug Program is available on DMA's website at: <http://www.ncdhhs.gov/dma/fee/>.

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

Attention: HIV Case Management Providers**A**pplication Deadline

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

Training:

The Carolinas Center for Medical Excellence (CCME) and The Division of Medical Assistance are pleased to announce that in November 2011 we are offering HIV Basic Training for case managers and supervisors. This is mandatory training for those individuals who were hired after May 1, 2011 and have not attended Basic Training. It is also mandatory for those individuals who were hired prior to May 1, 2011 and did not attend one of the two day trainings on Clinical Coverage Policy 12B. Registration is now open for the following training: **HIV Case Management Basic Training.** See below for details.

Date	Session Topic	Required Attendees
November 14-17, 2011	HIV Case Management Basic Training	HIV Case Managers and HIV Case Manager Program Supervisors who were hired on or after May 1, 2011. In addition those case managers and supervisors who were hired as of April 1, 2010 and did not attend any of the sessions on Clinical Coverage Policy 12 B offered in 2010 and 2011.

The location of this training is currently scheduled for Comfort Suites Raleigh Durham Airport/RTP Hotel, 5219 Page Road, Durham, NC 27703. Information for the November training including registration is available on [CCME's HIV Case Management web page](http://www.thecarolinascenter.org/HIVCM) at <http://www.thecarolinascenter.org/HIVCM>.

Certification Application Training:

DMA and CCME anticipate offering training on the application process for certification during the month of December 2011. Potential providers are strongly encouraged to read Clinical Coverage policy 12 B to become familiar with the certification requirements for this program. The policy can be accessed at www.ncdhs.gov/dma/mp/12B.pdf. Details regarding potential venue and dates will be available at CCME's site and in the December Medicaid Bulletin. Interested providers should contact Carlton Pulley at CCME (919) 461-5560 and request to have your name placed on the inquiry list.

New:

Effective November 1, 2011 the Division of Medical Assistance and The Carolinas Center for Medical Excellence are requiring HIV Case Management agencies to utilize the following: “Medicaid Verification Form”. This form will provide consistency in how agencies document the criteria in Sub-section 2.1 of Clinical Coverage Policy 12B. This mandated form is available on CCME's web site: <http://www.thecarolinascenter.org/HIVCM>.

HIV Case Management Program
DMA, 919-855-4389

Attention: All Providers**HIPAA ASC X12 5010 Implementation**

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

N.C. Medicaid will implement the HIPAA requirements for the ASC X12 5010 transactions within the current MMIS+ claims processing system. Clearing Houses, Billing Agencies and providers using vendor software to connect to HP Enterprise Services (HPES), will need to update their Trading Partner Agreement – Appendix A in preparation for ASC X12 5010 testing and implementation. Contact the Electronic Commerce (ECS) department at 800-688-6696 or 919-851-8888 option 1 for assistance. HPES will begin dual processing of HIPAA covered ASC X12 4010 and ASC X12 5010 837 transactions on November 4, 2011. In addition, if your Trading Partner Agreement has been updated, you will receive both the ASC X12 version 4010 and ASC X12 versions 5010 of the 835 transaction beginning with the November 8, 2011 checkwrite. HPES will begin processing ASC X12 5010 270/271 eligibility transactions and ASC X12 5010 276/277 claim status transactions in mid November 2011. DMA will continue to notify providers through upcoming Medicaid Bulletins as the HIPAA ASC X12 5010 implementation efforts progress.

Attention: All Providers**HIPAA 5010 Implementation**

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

N.C. Medicaid will be implementing the HIPAA requirements for the 5010 transactions within the MMIS+ claims processing system. DMA will notify providers through upcoming [Medicaid bulletins](#) as the HIPAA 5010 implementation efforts progress.

In order to test and exchange ASC X12 5010 transactions with HP Enterprise Services (HPES), trading partners **MUST** updated their Trading Partner Agreement-Appendix. Follow the attached link to the 5010 version of Appendix A. Complete and mail, with original signature, to HP Enterprise Services. You will be e-mailed a letter with instructions on how to proceed with 5010 transaction testing after your Trading Partner Agreement-Appendix A has been processed. Failure to update could result in interruption of transaction processing, leading to no claim payment.

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

Attention: All Providers**Implementation of Additional Correct Coding Edits: Professional Duplicates**

As announced in previous Medicaid bulletins, the Division of Medical Assistance (DMA) began implementing additional correct coding guidelines. These new correct coding guidelines and edits will be nationally sourced by organizations such as the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA). These edits will identify any duplicate submissions of CPT, HCPCS, AMA, CMS and/or DMA policies and will deny at the claim detail level. Additional correct coding edits for Professional Duplicates will be implemented on January 1, 2012 for dates of service on or after January 1, 2012.

Duplicates – Professional Claims

North Carolina Medicaid and Health Choice will be implementing edits that detect where duplicate submissions of a service were submitted on separate claims. The analytics examine codes that, by definition, cannot be billed more than once on the same date of service, within a defined date range, or over the lifetime of the patient for CPT and HCPCS codes. The following are examples of Professional Duplicate edits:

- Same Day Duplicate edits occur when the same provider submits a procedure on separate claims for the same date of service, and the procedure code description does not support multiple submissions.

Procedure	Claim	Description	Analysis
11200	XX159	Removal of skin tags, up to 15	Allow
11200	XX256	Removal of skin tags, up to 15	Deny

- Date Range Duplicate edits occur when the same provider submits the same procedure more than once on separate claims within a defined time period.

Procedure	Claim	Description	Analysis
94774	XX622	Pediatric home apnea monitoring per 30 days	Allow
94774	XX489	Pediatric home apnea monitoring, performed within 30 days of previous monitoring	Deny

- Lifetime Duplicate edits occur when a procedure is billed more than once in a patient's lifetime on separate claims (e.g. appendectomy, autopsy).

Procedure	Claim	Description	Analysis
58200	XX115	Total abdominal hysterectomy	Allow
58200	XX419	Total abdominal hysterectomy (billed two years later)	Deny

When clinically appropriate, a modifier may be appended to the claim detail to override the edit.

HP Enterprise Services

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

Attention: All Providers**C**hange to CPT Code 17263

Effective with the dates of service January 1, 2010, CPT code 17263 the following can now be billed with modifiers 58 (staged or related procedure or service by the same physician during the postoperative period) and 78 (return to the OR for related procedure during the postoperative period) for the following.

- Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement),
- Trunk,
- Arms, or
- Legs (lesion diameter 2.1 to 3.0 cm)

System changes have been completed and providers may bill using these modifiers. Providers who had claims denied and have kept the claims timely, please resubmit the denied charge as a new claim (not as an adjustment request) for processing.

Practitioner and Clinical Services
DMA, 919-855-4329

Attention: All Providers**O**ffice of Medicaid Management Information System Services (OMMISS)
Provider Relations Management Team Introduction

The North Carolina Office of Medicaid Management Information System Services (OMMISS) is commissioned by the Department of Health and Human Services (DHHS) to provide oversight for the development and installation of the multi-payer system, NCTracks.

Our Provider Relations Management team collaborates with the Division of Medical Assistance (DMA), Division of Mental Health (DMH), Division of Public Health (DPH) and our vendor, Computer Science Corporation (CSC) on the transition to NCTracks.

Our goal is to provide:

- Current NCTracks project news
- Information about NCTracks and the Provider Web Portal
- NCTracks training schedule and locations
- Information on provider participation in NCTracks system testing
- Communications on key subjects related to NCTracks that may impact your business

Please check the OMMISS website at <http://ncmmis.ncdhhs.gov> for information and updates.

Office of MMIS Services
919-647-8446

Attention: All Providers**2012 Checkwrite Schedule**

The following table lists the cut-off dates, checkwrite dates, and the electronic deposit dates for 2012.

2012 Checkwrite Schedule					
Checkwrite Cycle Cutoff	Info to DMA	Checkwrite Date	Date Processed	EFTs Effective	NCAS Post Date
01/05/12	01/09/12	01/10/12	01/10/12	01/11/12	01/09/12
01/12/12	01/17/12	01/18/12	01/18/12	01/19/12	01/17/12
01/19/12	01/25/12	01/26/12	01/26/12	01/27/12	01/25/12
02/02/12	02/06/12	02/07/12	02/07/12	02/08/12	02/06/12
02/09/12	02/13/12	02/14/12	02/14/12	02/15/12	02/13/12
02/16/12	02/21/12	02/22/12	02/22/12	02/23/12	02/21/12
02/23/12	02/28/12	02/29/12	02/29/12	03/01/12	02/28/12
03/01/12	03/05/12	03/06/12	03/06/12	03/07/12	03/05/12
03/08/12	03/12/12	03/13/12	03/13/12	03/14/12	03/12/12
03/15/12	03/19/12	03/20/12	03/20/12	03/21/12	03/19/12
03/22/12	03/28/12	03/29/12	03/29/12	03/30/12	03/28/12
04/05/12	04/09/12	04/10/12	04/10/12	04/11/12	04/09/12
04/12/12	04/16/12	04/17/12	04/17/12	04/18/12	04/16/12
04/19/12	04/25/12	04/26/12	04/26/12	04/27/12	04/25/12
05/03/12	05/07/12	05/08/12	05/08/12	05/09/12	05/07/12
05/10/12	05/14/12	05/15/12	05/15/12	05/16/12	05/14/12
05/17/12	05/21/12	05/22/12	05/22/12	05/23/12	05/21/12
05/24/12	05/30/12	05/31/12	05/31/12	06/01/12	05/30/12
06/07/12	06/11/12	06/12/12	06/12/12	06/13/12	06/11/12
06/14/12	06/18/12	06/19/12	06/19/12	06/20/12	06/18/12
06/21/12	06/27/12	06/28/12	06/28/12	06/29/12	06/27/12
07/05/12	07/09/12	07/10/12	07/10/12	07/11/12	07/09/12
07/12/12	07/16/12	07/17/12	07/17/12	07/18/12	07/16/12
07/19/12	07/25/12	07/26/12	07/26/12	07/27/12	07/25/12
08/02/12	08/06/12	08/07/12	08/07/12	08/08/12	08/06/12
08/09/12	08/13/12	08/14/12	08/14/12	08/15/12	08/13/12
08/16/12	08/20/12	08/21/12	08/21/12	08/22/12	08/20/12
08/23/12	08/29/12	08/30/12	08/30/12	08/31/12	08/29/12

Checkwrite Cycle Cutoff	Info to DMA	Checkwrite Date	Date Processed	EFT's Effective	NCAS Post Date
08/30/12	09/04/12	09/05/12	09/05/12	09/06/12	09/04/12
09/06/12	09/10/12	09/11/12	09/11/12	09/12/12	09/10/12
09/13/12	09/17/12	09/18/12	09/18/12	09/19/12	09/17/12
09/20/12	09/26/12	09/27/12	09/27/12	09/28/12	09/26/12
09/27/12	10/01/12	10/02/12	10/02/12	10/03/12	10/01/12
10/04/12	10/09/12	10/10/12	10/10/12	10/11/12	10/09/12
10/11/12	10/15/12	10/16/12	10/16/12	10/17/12	10/15/12
10/18/12	10/24/12	10/25/12	10/25/12	10/26/12	10/24/12
11/01/12	11/05/12	11/06/12	11/06/12	11/07/12	11/05/12
11/08/12	11/13/12	11/14/12	11/14/12	11/15/12	11/13/12
11/15/12	11/20/12	11/21/12	11/21/12	11/22/12	11/20/12
11/29/12	12/03/12	12/04/12	12/04/12	12/05/12	12/03/12
12/06/12	12/10/12	12/11/12	12/11/12	12/12/12	12/10/12
12/13/12	12/19/12	12/20/12	12/20/12	12/21/12	12/19/12
There are 42 scheduled checkwrite cycles, 21 in the first six months and 21 in the second six months of year.					

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

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

The CABHA temporary rules expired on October 15, 2011. The permanent rules and fiscal note are in the process of going through the Office of State Budget and Management (OSBM) and the Rules Review Commission. They will be posted for public comment and will have a public hearing in line with the permanent rule process. The CABHA infrastructure, core services, and CABHA-only services are delineated in the Medicaid State Plan and were approved by the Centers for Medicare and Medicaid Services (CMS).

The Medicaid State Plan also states “A Critical Access Behavioral Health Agency must meet all statutory, rule and policy requirements for Medicaid mental health and substance abuse service provision and monitoring; be determined to be in good standing with the Department; and have a three year (or longer) accreditation from an accrediting body recognized by the Secretary of the Department of Health and Human Services. State statutory requirements regulating the provision of mental health and substance abuse services are in North Carolina General Statute, Chapter 122C; administrative rules relating to these services are in 10A NCAC 27 and clinical policy requirements are specified in Medicaid Clinical Policy Section 8. Medicaid and enrollment policy require compliance with Federal Medicaid Policy relating to confidentiality, record retention, fraud and abuse reporting and education, documentation, staff qualifications and compliance with clinical standards for each service.”

CABHA's are reminded that they agreed to comply with the CABHA temporary rules when they achieved CABHA status. The expectation is that providers will continue to uphold CABHA standards set forth in those rules and in implementation updates issued by DMA and DMH/DD/SAS. Furthermore, the Medicaid Provider Agreement requires Medicaid providers to comply with the Social Security Act, the North Carolina Medicaid State Plan and any waivers, HIPAA, FERPA, N.C.G.S. 108A-80, and “state laws and regulations, medical coverage policies of the Department, and all guidelines, policies, provider manuals, implementation updates, and bulletins published by CMS, the Department, its divisions and/or its fiscal agent in effect at the time the service is rendered” if the foregoing is “consistent with and expressly or implicitly authorized” by “Title XIX of the Social Security Act and its implementing regulations, the North Carolina State Plan for Medical Assistance, [and] any Title XIX waivers authorized by” CMS. Implementation updates and policy statements regarding CABHA requirements are implicitly authorized by the State Plan and must be adhered to by providers.

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

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.

2011 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
November	11/3/11	11/8/11	11/9/11
	11/10/11	11/15/11	11/16/11
	11/17/11	11/23/11	11/28/11
December	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

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.

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

Melissa Robinson
Executive Director
HP Enterprise Services