November 2012 Medicaid Bulletin

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Note: This article was originally published in October 2012. See highlighted change on page 8.

Attention: All Medicaid and North Carolina Health Choice (NCHC) Providers

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

Each year scientists try to match the viruses in the influenza vaccine to those most likely to cause flu that year. This season's influenza vaccine is comprised of the following three strains:

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

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

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

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

The N.C. Immunization Branch distributes all required childhood vaccines to local health departments, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), hospitals, and private providers under NCIP/VFC guidelines. For the 2012-2013 influenza season, NCIP/VFC influenza vaccine is available at no charge to providers for children 6 months through 18 years of age who are eligible for the Vaccines for Children (VFC) program and other covered groups, according to the N.C. Immunization Program (NCIP) coverage criteria. The current NCIP coverage criteria and definitions of VFC categories may be found on the NCIP website at:
www.immunize.nc.gov/providers/coveragecriteria.htm.

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

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

When NCHC beneficiaries self-declare their status as Alaska Native or American Indian and the provider administers the state-supplied vaccine, the provider must report the CPT vaccine code with $0.00 and may bill for the administration costs. For further details, refer to the June 2012 general Medicaid article, *Billing for Immunizations for American Indian and Alaska Native N.C. Health Choice Recipients* at: www.ncdhhs.gov/dma/bulletin/0612bulletin.htm#AI. All other NCHC beneficiaries are considered ***insured,*** and must be administered privately purchased vaccines.

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

Billing/Reporting Influenza Vaccines for Medicaid Beneficiaries

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

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

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

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

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

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

Note: For the 2012-2013 flu season, the NCIP will not provide LAIV (CPT code 90660, FluMist) for anyone 19 years of age and older.

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

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

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

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

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

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

Billing/Reporting Influenza Vaccines to Medicaid for NCHC Beneficiaries

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

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

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

Notes to remember:

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

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

For beneficiaries 0 through 20 years of age:

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

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

For beneficiaries 21 years of age and older:

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

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

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

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

Attention: All Providers and NC Health Choice Providers

Subscribe & Receive Email Alerts on Important North Carolina Medicaid and NC Health Choice Updates

Note to providers: This article was originally published on November 2011

N.C. Division of Medical Assistance (DMA) allows all providers the opportunity to sign up for N.C. Medicaid/N.C. Health Choice (NCHC) Email Alerts. Providers will receive Email Alerts on behalf of all Medicaid 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.seeuthere.com/hp/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 Providers

Updated EOB Code Crosswalk to HIPAA Standard Codes

Note to providers: This article is published whenever an updated EOB HIPAA Master is placed on the N.C. Division of Medical Assistance (DMA) website.

The list of standard national codes used on the Electronic Remittance Advice (ERA) has been cross-walked to Medicaid EOB codes as an informational aid to research adjudicated claims listed on the Remittance and Status Report (RA). An updated version of the list is available on DMA's website at www.ncdhhs.gov/dma/hipaa/EOBcrosswalk.htm.

Changes to the format of the crosswalk were added in July 2010. The changes allow for codes to be filtered and sorted in a more efficient manner when multiple codes map to the same Medicaid EOB. In addition, the crosswalk has been divided into separate crosswalks based on claims types – Institutional, Professional, Dental, and Pharmacy. This will eliminate some of the one-to-many mappings.

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

Attention: All Providers

Resolving Denied Claims – HPES Call Center

HP Enterprise Services (HPES) is the fiscal agent contracted by the N.C. Division of Medical Assistance (DMA). HPES processes claims for enrolled providers according to DMA's policies and guidelines. The HPES Call Center (1-800-688-6696) is available Monday - Friday 8:00 a.m. - 4:30 p.m. to assist providers with their claim denials. When contacting HPES, providers should have the Explanation of Benefit (EOB) code and/or description provided in the N.C. Medicaid Remittance and Status Report (RA) or the ASC X12 5010 835 transaction.

If the HPES call center determines that the resolution needs further clarification, the HPES phone analyst will escalate the call to the team lead. Providers can also request that the call be referred to the team lead. Should the claim denial need further review, the team lead will forward to the Research Department. If a resolution is not reached, the HPES research team will contact DMA for guidance and will follow-up with the provider on the resolution.

Providers may request an onsite visit with an HPES Travel Representative. To request a visit, call the Provider Services unit and speak with a phone analyst. To locate the name of the Travel Representative assigned to your county please visit: www.ncdhhs.gov/dma/basicmed/AppendixD.pdf

To contact HP Enterprise Services Provider Services unit, call **1-800-688-6696** or **919-851-8888** and select option 3 for the Provider Services Unit and then select the appropriate option from the chart on the following page:

Option Number	Description	Definition
1	NPI Unresolved and Carolina ACCESS denial codes 270, 286, and 2270	All provider types with National Provider Identifier (NPI) or Carolina ACCESS questions
2	Facilities and Hearing Aid	• Children's Developmental Service Agencies (CDSA) • Community Intervention Service (CIS) Agencies • Critical Access Behavioral Health Agencies (CABHA) • dialysis providers • hearing aid services • hospitals • long-term care facilities • mental health services • nursing facilities • psychiatric residential treatment facilities • residential child care facilities (Levels II–IV)

3	Community Services	• dental providers
		• domiciliary care providers
		  • ambulance
		  • Community Alternative Program (CAP)
		  • Department of Social Services (DSS)/Department of Health and Human Services (DHHS)
		  • hospice
		  • home infusion therapy
		  • private duty nursing
		  • rural health centers
		  • federally qualified health clinics
		  • adult care homes
		  • at-risk case management
		• HIV case management
		• durable medical equipment
		• home health care
		• orthotic/prosthetic
		• personal care

4	Outpatient Pharmacy	• pharmacy providers

Option Number	Description	Definition

5	Physician	• ambulatory surgery
		• anesthesiology
		• certified registered nurse anesthetist
		• chiropractor
		• county health department
		• eye care
		• Health Check
		• independent diagnostic testing facility
		• independent mental health providers
		• independent practitioners
		  • audiology
		  • occupational
		  • physical
		  • respiratory therapists
		  • speech/language
		• local education agency
		• nurse midwife
		• nurse practitioner
		• physician's office
		• podiatrist
		• radiologist

6	Health Choice	• all providers

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

Attention: All Providers

N.C. Medicaid EHR Incentive Program's Website – Update

The N.C. Medicaid Electronic Health Record (EHR) Incentive Program has updated its website to make it more user-friendly. It is a **one-stop shop** for all meaningful use and EHR information and news. The information is extensive, but it's easier to find exactly what you are looking for. The website address is: www.ncdhhs.gov/dma/provider/ehr.htm

New Documents on the Website

The Centers for Medicare & Medicaid Services (CMS) recently released the EHR Incentive Program Stage 2 Final Rule. The Rule also included changes to Stage 1, which took effect on October 1, 2012 for **eligible hospitals** or January 1, 2013, for **eligible professionals**.

The N.C. Division of Medical Assistance (DMA) has created several resources to clarify program changes. Other documents have been created to simplify the basic program requirements and assist providers as they attest for incentive payments.

Some of these documents include:

- Stage 1 Changes – This document gives you a snapshot of the changes to Stage 1 as a result of the CMS Stage 2 Final Rule.

- Stage 2 Final Rule Summary – This document highlights the new timeline and Meaningful Use measures required in Stage 2.

- Patient Volume Methodology – Patient Volume (PV) reporting is one of the keys to successfully attesting for an incentive payment. This provides a portrait of group and individual methodology so you can accurately report patient volume. The following methodologies are covered:

    - **Group**

        - At a single practice location
        - Across multiple practice locations within a logical geographical area (i.e., – same city, town, region, etc.)
        - Across practice locations within the state of North Carolina

    - **Individual**

        - At a single practice location
        - At more than one practice location

- Path to Payment – This document gives providers a high-level overview of what they need to do to receive incentive payments.

- Simple Math – If you are new to the program, this document gives you a few reasons why the EHR Incentive Program may be financially beneficial to you and your organization

To access these resources and more, visit our website at www.ncdhhs.gov/dma/provider/ehr.htm

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

Attention: All Providers

EHR Incentive Program Attestation Period Clarification

In the *October 2012 Medicaid Bulletin*, the N.C. Medicaid EHR Incentive Program gave providers guidance regarding the program year 2012 attestation tail period moving from 60 to 120 days.

The EHR program want to reiterate to all providers that while the attestation period extends 120 days, the eligibility requirements for a 2012 Adopt, Implement, Upgrade (AIU) or Meaningful Use (MU) payment must still be met by December 31, 2012 for eligible professionals (EPs) or September 30, 2012 for eligible hospitals (EHs).

Providers planning to attest to a program year 2012 AIU payment must have AIU certified systems in place by December 31, 2012 for EPs or September 30, 2012 for EHs. Those who wait to adopt, implement or upgrade their system until after these dates will not meet AIU requirements for program year 2012.

Similarly, those planning to attest to a program year 2012 MU payment must record their MU measures for the required 90-day or 365-day period by December 31, 2012 for EPs or September 30, 2012 for EHs. Those who do not have 90 or 365 days of MU data by these dates will not have met MU requirements in program year 2012.

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

Attention: All Providers

National Correct Coding Initiative – Billing Guidance

Note to Providers: This article was originally published in October 2012.

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

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

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

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

Attention: All Providers

Decommission of Modem Service

As of Friday, December 14, 2012 at 5 p.m., HP Enterprise Services (HPES) **will no longer** accept claims submitted via the modem electronic transmission method.

Providers that use modem access for claims transmission to HPES are encouraged to reference Section 9, Electronic Commerce Services of the *Basic Medicaid and N.C. Health Choice Billing Guide* for other electronic transmission options. Call the HPES Electronic Commerce Services department at 1-800-688-6696, Option 1, for additional support.

HP Enterprise Services, 1-800-688-6696

Attention: All Providers

CPT Procedure Code 11044 – DMA Global Days Update

The Centers for Medicare & Medicaid Services (CMS) changed the global period on procedure code 11044 [debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed), first 20 sq cm or less] to "0" global days effective with dates of service January 1, 2011. The N.C. Division of Medical Assistance (DMA) had the code set to 10 global days (the global period prior to January 1, 2011), but the global period has been corrected to "0" global days as required by CMS.

Providers with claims for codes that denied due to the post-op days on this code should void the claim that was denied, as well as the claim containing code 11044. A new claim for both should be submitted. If the claim for code 11044 cannot be identified, the provider should submit an adjustment request for the denied claim, noting the denial is related to changes in global days for 11044.

Clinical and Facility Services,
DMA, 919-855-4320

Attention: Behavioral Health Providers, IDD Providers, Local Management Entities

Behavioral Health CPT Code Update 2013

Effective with date of service January 1, 2013, the American Medical Association (AMA) has added new psychiatric CPT codes, deleted others, and changed the descriptions of some existing codes. (For complete information regarding all CPT codes and descriptions, refer to the 2013 edition of *Current Procedural Terminology*, published by the American Medical Association.) DMA will publish information on the new psychiatric CPT codes that are covered by the N.C. Medicaid Program in the near future.

In addition to education provided by national and state professional provider associations, DMA will offer billing training seminars through the LME-Managed Care Organizations and Hewlett-Packard (HP) once the 2013 codes have been fully released in mid-November, 2012.

Behavioral Health Section
DMA, 919-855-4290

Attention: Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), Medicaid and Health Choice Providers

Behavioral Health Services Provided in Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC)

Under current Core Services Policy 1D-4, behavioral health services are considered a part of the core service visit. **Behavioral health services provided should be billed using code T1015-HI only.**

Effective December 1, 2012, the following behavioral health professionals will be allowed to provide behavioral health services in FQHCs and RHCs:

- Licensed Clinical Social Worker (LCSW)
- Licensed Psychologist
- Licensed Psychological Associate (LPA)
- Licensed Professional Counselor (LPC)
- Licensed Marriage and Family Therapist (LMFT)
- Advance Practice Nurse Practitioner Certified in Psychiatric Nursing
- Advance Practice Psychiatric Clinical Nurse Specialist (CNS)
- Licensed Clinical Addiction Specialist (LCAS).

Once again, Behavioral health services are considered a part of the core service visit and should be billed using code T1015-HI only.

The National Provider Identifier (NPI) of the behavioral health provider should not be placed on the claim. FQHCs and RHCs should not change the way they are currently billing for core services.

The behavioral health professionals listed above must be Medicaid-enrolled, FQHC/RHC-affiliated providers for N.C. Medicaid or N.C. Health Choice beneficiaries when completing their individual applications.

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

Attention: Community Care of N.C./Carolina ACCESS (CCNC/CA) Providers

Carolina ACCESS Referral/Authorization Guidelines

Coordination of care for N.C. Medicaid beneficiaries enrolled in the Community Care of N.C./Carolina ACCESS (CCNC/CA) managed care program is a ***contractual requirement*** for all participating CCNC/CA Primary Care Providers (PCP) serving as a medical home. Arranging for beneficiaries to be seen at their assigned PCP offices within the appointment availability standards (refer to the *Basic Medicaid & NC Health Choice Billing Guide - Section 6)* or providing medically necessary Carolina ACCESS (CA) referrals/authorizations to other providers or facilities is adhering to care coordination expectations.

Consideration for a referral/authorization must be given even when a beneficiary has not established a medical record with the assigned PCP. The CA referral is authorization of payment for another provider to treat the beneficiary – and is not the same as Prior Approval.

It is at the discretion of the assigned CCNC/CA provider to issue a CA referral. Appropriate CA referrals/authorizations can be issued by telephone or in writing to the other provider. In determining whether to issue or obtain the Group or Individual NPI, verify if the patient was linked with a practice or individual for the dates in which services were or will be rendered.

Some services do not require a CA referral from the assigned PCP. Refer to the *Basic Medicaid & NC Health Choice Billing Guide - Section 6* for a list of these exemptions.

If beneficiaries elect to change their Medical Homes, providers should encourage them to contact their local social service office. Until the change is made, the assigned PCP remains responsible for care coordination of the beneficiary – by either treating the patient or authorizing services by another provider, as appropriate.

Providers should verify a Medicaid beneficiary's eligibility, coverage, and enrollment (via approved verification methods other than the Medicaid I.D. card) *before* rendering treatment to ensure that CA referral/authorization guidelines are followed. CCNC/CA providers should also document all approved or denied CA referrals in the enrollee's chart. If the enrollee has not established care at the assigned PCP office, DMA encourages documentation on an internal referral log or spreadsheet.

For more information on CCNC/CA guidelines, refer to the CCNC/CA Provider Agreement or to the *Basic Medicaid and NCHC Billing Guide*.

CCNC/CA Managed Care Section
DMA, 919-855-4780

Attention: Dialysis Providers

Clarification about Filing to N.C. Medicaid

Note to Providers: This article was originally published in August 2012

Effective November 1, 2012, claims filed to N.C. Medicaid when Medicare Part B has made a payment must have the sum of both the coinsurance and the deductible on the UB-04 claim form, Form Locator (Estimated Amount Due) alongside the Class and Carrier code of 'MC' in Form UB-04, FL50.

N.C. Medicaid will begin reimbursing providers **the lesser** of the coinsurance and deductible or the difference between the Medicaid allowable and the Medicare payment.

This change only applies to dates of service on and after November 1, 2012.

As an example, under a scenario in which the payment from Medicare Part B was $50.00, and the coinsurance plus deductable was $100, as follows:

- Medicare payment = $50
- Medicare coinsurance = $75
- Medicare deductible = $25
- Contractual adjustment = $10

In such a case, the UB-04 form would read as follows:

50 Payer	51 Provider No.	52 Rel. Info	53 Sag Ben	54 Prior Payments	55 Est. Amount Due	56 NPI
MB	34XXXX			$50.00		
MC	34XXXXX				$100.00	

Note: Providers do not add the contractual adjustment to the payment listed in UB-04, FL54.

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

Attention: Hospice Providers

Hospice Services Policy Prior Approval Requirements

The N.C. Division of Medical Assistance's (DMA) Hospice Services Policy has been amended effective November 1, 2012. Refer to Clinical Coverage Policy 3D, Hospice Services for details about the changes.

Effective with date of service November 1, 2012, prior approval is required:

a. prior to the election of the fifth (5th) benefit period, and after each subsequent benefit period.

b. for beneficiaries with Medicaid for Pregnant Women (MPW) coverage.

Benefit periods on or after December 1, 2012, will need to comply with the new prior approval requirement.

The provider must request prior approval as follows:

1. The provider completes the **NC Medicaid Hospice Prior Approval Authorization Form (NC DMA-3212)** which is located at **www.ncdhhs.gov/dma/provider/forms.htm**.

2. The provider attaches the following required documents to the completed form:

    a. Signed Election Statement
    b. Physician Certification/Recertification
    c. Hospice Plan of Care
    d. Supporting Documentation (e.g., medical history, prognosis)

    The completed hospice prior approval form and required attachments must be received by HP Enterprise Services **NO LATER THAN 10 CALENDAR DAYS** prior to the expiration of the current benefit period in order for services to continue without interruption. The documents should be mailed to:

    HP Enterprise Services
    Attn: Hospice Prior Approval
    P.O. Box 31188
    Raleigh, NC 27626

    Requests for prior approval should NOT be sent to DMA. For complete information about the Division's prior approval policies and procedures, please visit the websites below.

- www.ncdhhs.gov/dma/provider/priorapproval.htm
- www.ncdhhs.gov/dma/mp/index.htm

3. HP Enterprises will notify the provider in writing regarding approval, denial, or termination of the request. If the request is denied or terminated, DMA will also forward the appropriate due process notifications to the beneficiary or legal representative.

4. Medicaid beneficiaries (or their *authorized* personal representatives) have the right to appeal adverse decisions of the State Medicaid agency and receive a fair hearing pursuant to the Social Security Act, 42 C.F.R. 431.200 *et seq.* and N.C.G.S. §108A-70.9. Information regarding due process may be viewed at the websites below.

   - www.ncdhhs.gov/dma/mp/index.htm
   - www.ncoah.com/hearings/medicaid.html

Clinical Policy
DMA, 919-855-4380

Attention: Hospitals

Hospital Cost Report Instructions for Fiscal Year Ending June 30, 2012

Hospital providers have five months to file their cost reports following the end of the state fiscal year.

This information as well as the mailing addresses are located at www.ncdhhs.gov/dma/cost/hospitalreports.htm under Hospitals Cost Reports in the cost reports instructions.

Effective with Cost Reports periods ending **on or after June 30, 2012**, the Provider may file the items listed in the cost report instructions, electronically and/or hard copies. Effective with Cost Reports periods ending **on or after December 31, 2012**, the Provider must submit all items listed in the cost report instructions **electronically**.

Hospital Section
DMA, 919-814-0060

Attention: In-Home Care Providers

Consolidated Personal Care Services Implementation Update

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

Consolidated Personal Care Services Policy

Effective January 1, 2013, Medicaid personal care services for recipients in all settings – including private residences and licensed adult care homes, family care homes, 5600a and 5600c supervised living homes, and combination homes with ACH beds – will be provided under a consolidated Personal Care Services (PCS) benefit. Clinical Coverage Policy 3L, Personal Care Services, has been revised based on comments submitted during the initial public comment period and will be posted for a second, 15-day public comment period in November 2012. The N.C. Division of Medical Assistance (DMA) anticipates that Policy 3L will be posted in final version in November 2012, with a January 1, 2013 effective date. Additional information will be posted on the DMA Consolidated PCS webpage as it becomes available.

Change in Covered Services

Pursuant to N.C. Session Law 2012-142, Sections 10.9F (b) and 10.9F (c), **the new PCS program will not cover errands**. In-Home Care providers should immediately begin to work with beneficiaries currently authorized for errands assistance to identify alternate resources to meet these needs. **Effective on January 1, 2013, beneficiary plans of care should be updated to reflect this service exclusion.** Providers may adjust service hours by the number of hours previously authorized for errands, or may re-assign errand hours to assist with other services covered under the new Clinical Coverage Policy 3L. Continue to request Change of Status reassessments for beneficiaries whose assistance needs have changed as a result of a change in medical condition, informal caregiver status, or environmental conditions.

Beneficiary Transition Notices

All beneficiaries authorized for In-Home Care services on December 31, 2012 will be transitioned **at their current authorized service levels** to the new PCS program, with an effective date of January 1, 2013. DMA's release of beneficiary decision notices is contingent upon approval by the Centers for Medicare & Medicaid Services (CMS) of N.C. Medicaid State Plan Amendment 12-013. DMA anticipates that current authorized IHC beneficiaries will receive decision notices in December 2012 notifying them of their service authorizations under the new PCS program. Service providers will receive copies of beneficiary decision notices.

Upcoming Provider Training

DMA is planning a November 15, 2012 provider webinar training. Webinar topics and registration information will be posted prior to the training on the DMA Consolidated PCS webpage. For additional information about the new PCS program, refer to the DMA Consolidated PCS webpage and to previous and future Medicaid Bulletins for In-Home Care providers.

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

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

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

Transition Planning and Implementation Update, Personal Care Services

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

Consolidated Personal Care Services Policy and State Plan Amendment

Effective January 1, 2013, Medicaid personal care services for recipients in all settings – including private residences and licensed adult care homes, family care homes, 5600a and 5600c supervised living homes, and combination homes with ACH beds – will be provided under a consolidated Personal Care Services (PCS) benefit. Clinical Coverage Policy 3L, Personal Care Services, has been revised based on comments submitted during the initial public comment period and will be posted for a second, 15-day public comment period in November 2012. The N.C. Division of Medical Assistance (DMA) anticipates that Policy 3L will be posted in final version in November 2012, with a January 1, 2013 effective date. Additional information will be posted on the DMA Consolidated PCS webpage as it becomes available.

Timeline of Independent Assessments and Beneficiary Decision Notices

Independent assessments of current Medicaid residents of licensed adult care homes (adult care homes, family care homes, 5600a and 5600c supervised living homes, and combination homes with ACH beds) are ongoing and will continue through November 2012. Please consult the fourth update to the timeline of projected independent assessment dates by facility on the DMA Consolidated PCS webpage.

DMA anticipates that it will begin to issue decision notices to beneficiaries in November 2012, contingent upon approval by Centers for Medicare & Medicaid Services (CMS) of N.C. Medicaid State Plan Amendment (SPA) 12-013. Licensed home providers will receive copies of beneficiary decision notices. Adverse decision notices will include an appeal request form, and instructions and deadlines for filing an appeal. Providers may assist beneficiaries who wish to appeal with completion and submission of the appeal request. In accordance with federal regulation, maintenance of service will be available for beneficiaries whose proper request for continuation of PCS has been denied or reduced, and who have filed a timely appeal.

Reporting New Admissions and Transfers/Provider Changes Through December 31, 2012

Licensed Adult Care Home providers may continue to report any new Medicaid admissions who require independent assessments to determine eligibility for PCS effective January 1, 2013. Report all new admissions who receive PCS in your facility on

or before dates of service through December 31, 2012. Please complete the Independent Assessment Request for New Admissions (Form DMA-3066) and submit by fax to The Carolinas Center for Medical Excellence (CCME) at 877-272-1942. After receipt, CCME will contact your facility to schedule a return visit to assess beneficiaries admitted since the initial assessment visit who have not previously been assessed for PCS eligibility.

Assessments to determine eligibility to transition to PCS effective January 1, 2013 may be requested for new admissions through December 31, 2012. New admission assessments will be scheduled through December 2012 and into January 2013 to determine PCS eligibility with an effective date of January 1, 2013.

To ensure beneficiary prior authorization for PCS is assigned to the correct licensed home provider, please use the Independent Assessment Request for New Admissions (Form DMA-3066) to report all new Medicaid admissions to your facility, including beneficiaries who transfer from other licensed homes and who may have previously received independent assessments. PCS eligibility for beneficiaries previously assessed while residing in a different licensed home will be determined by the previous assessment. **Please note that it is not necessary to report new admissions if CCME has not yet made an initial visit to your facility to complete resident assessments.**

A completed PCS Medical Attestation (Form DMA-3065) is also required to determine PCS eligibility for all ACH residents, including those admitted to provider facilities after an assessor's initial assessment visit. **Failure to complete and submit the medical attestation will result in a denial of services effective January 1, 2013, whether or not a beneficiary has received an independent assessment.** Initiate completion of the PCS Medical Attestation immediately for all Medicaid residents, including new admissions, to ensure that a completed form is available for presentation to the assessor at the time of the resident's scheduled assessment.

PCS New Referrals Beginning January 1, 2013

Beneficiaries who seek admission, are admitted, or first receive services in licensed homes on January 1, 2013 and after, may request new referral assessments through their primary care or attending physicians, nurse practitioners, or physician assistants. A new referral form and additional information about the new referral process will be available on the DMA Consolidated PCS webpage prior to program implementation.

Change of Status Request Process

After DMA receives CMS approval of SPA 12-013 and begins to issue beneficiary decision notices, providers may begin reporting status changes for beneficiaries approved to transition to the new program. A Change of Status reassessment should be requested for a beneficiary who, since the previous assessment, has experienced a change in condition that affects the needs for hands-on assistance with Activities of Daily Living (ADLs). **Please note that Change of Status requests cannot be processed for beneficiaries who have not been approved for PCS.**

The Change of Status request form will be posted on the DMA Consolidated PCS webpage. The form may be completed by the licensed home provider and should be submitted by fax to CCME at 877-272-1942. After receipt, CCME will contact your facility to schedule a return visit to assess beneficiaries whose Change of Status requests support the need for reassessment. The form must be complete and include a description of the status change causing the change in need for PCS assistance.

Upcoming Provider Training

DMA is planning a November 15, 2012 webinar training. Webinar topics and registration information will be posted prior to the training on the DMA Consolidated PCS webpage. For additional information about the new PCS program, refer to the DMA Consolidated PCS webpage and to previous and future Medicaid Bulletins for licensed Adult Care Home providers.

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

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

Attention: N.C. Health Choice (NCHC) Providers

Co-Pay Clarification

The following N.C. Health Choice (NCHC) services are not subject to co-pay:

- injected medications
- laboratory
- pathology
- radiology

The N.C. Division of Medical Assistance (DMA) has found that a $5 co-pay is being deducted from these services as claims are being processed. DMA is working with HPES to make the appropriate system changes. Providers will be notified when the changes are complete.

If a $5 co-pay has been collected from a beneficiary it **MUST** be returned after these changes are complete and claims are reprocessed.

42 C.F.R. 457.540(e) in the federal regulations for State Children's Health Insurance Programs states that the State may only impose one co-payment based on the total cost of services furnished during one office visit.

For detailed information about NCHC beneficiary cost sharing and services exempt from cost sharing, refer to Section 3 of the *Basic Medicaid and Health Choice Billing Guide* at: www.ncdhhs.gov/dma/basicmed/SECTION3_1012.pdf. The entire guide can be accessed at: www.ncdhhs.gov/dma/basicmed/index.htm.

N.C. Health Choice
DMA, 919-855-4100

Attention: Physicians

Affordable Care Act Enhanced Payments to Primary Care Physicians

Note to Providers: This article originally ran in October, 2012

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

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

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

Attention: Nurse Practitioners, Physician Assistants and Physicians

Ranibizumab (Lucentis, HCPCS Code J2778): Update to Billing Guidelines

Effective with date of service August 10, 2012, the N.C. Medicaid and Health Choice programs added the FDA-approved diagnosis of Diabetic Macular Edema (DME) in adult beneficiaries to the already covered diagnoses of macular edema following retinal vein occlusion and wet age-related macular degeneration when billing for Lucentis through the Physician's Drug Program (PDP).

The process of adding new FDA-approved indications for drugs covered under the PDP is delayed due to the need for diagnosis editing. This process is not automated. Therefore, there is always a delay between the date of any new approved indication and date of coverage of the new indication under the PDP.

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

1. For wet age-related macular degeneration

- 362.52 (exudative senile macular degeneration)

2. For macular edema following retinal vein occlusion

- 362.83 (retinal edema)

OR

- 362.53 (cystoid macular degeneration – cystoid macular edema)

PLUS, EITHER

- 362.35 (central retinal vein occlusion)

OR

- 362.36 [venous tributary (branch) occlusion]

3. For DME

- 250.50 (diabetes with ophthalmic manifestations, type 2 or unspecified type, not stated as uncontrolled); or
- 250.51 (diabetes with ophthalmic manifestations, type 1 [juvenile type], not stated as controlled); or
- 250.22 (diabetes with ophthalmic manifestations, type 2 or unspecified type, uncontrolled); or
- 250.53(diabetes with ophthalmic manifestations, type 1 [juvenile type], uncontrolled); or
- 362.01 (background diabetic retinopathy); or

- 362.02 (proliferative diabetic retinopathy); or
- 362.03 (nonproliferative diabetic retinopathy NOS); or
- 362.04 (mild nonproliferative diabetic retinopathy); or
- 362.05 (moderate nonproliferative diabetic retinopathy); or
- 362.06 (severe nonproliferative diabetic retinopathy); or
- 362.07 (diabetic macular edema)

CPT procedure code 67028 (intravitreal injection of a pharmacologic agent [separate procedure]) with the appropriate modifier must be included with the billing of Lucentis.

Refer to Clinical Coverage Policy 1B, *Physician's Drug Program,* on the DMA website at www.ncdhhs.gov/dma/mp/1B.pdf.

Refer to the Physician's Drug Program fee schedule on the DMA website at: www.ncdhhs.gov/dma/fee/fee.htm

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

Attention: Nurse Practitioners, Physician Assistants, and Physicians

Ziv-aflibercept (Zaltrap), HCPCS code J9999): Billing Guidelines

Effective with date of service August 16, 2012, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover ziv-aflibercept injection (Zaltrap) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J9999 (Not otherwise classified, antineoplastic drugs). Zaltrap is currently commercially available in 100 mg/4 mL and 200 mg/8 mL (25mg/mL) lyophilized powder in single use vials.

Zaltrap was added to the MMIS+ system as a rebatable drug on August 16, 2012, and was available at that time through the Outpatient Pharmacy Program by prescription. Regarding coverage of new drugs in the PDP, unlike the Outpatient Pharmacy Program, the coverage process is not automated. Therefore, there is always a delay between the effective date of coverage in the PDP and the posting of the provider bulletin notification.

Ziv–aflibercept is indicated in combination with 5-fluorouracil, leucovorin, irinotecan (FOLFIRI), for the treatment of patients with metastatic colorectal cancer (mCRC) that is resistant to or has progressed following an oxaliplatin-containing regimen.

Ziv–aflibercept acts as a soluble receptor that binds to human VEGF-A, human VEGF-B and human P1GF. This binding can result in decreased neovascularization and decreased vascular permeability, thereby inhibiting the growth of new blood vessels.

Administer ziv–aflibercept injection (Zaltrap) at 4 mg per kg as an intravenous (IV) infusion over one (1) hour every two (2) weeks. Administer ziv-aflibercept injection (Zaltrap) prior to any component of the FOLFIRI regimen on the day of treatment.

For Medicaid and NCHC Billing

- One of the following ICD-9-CM diagnosis codes is required for billing ziv-aflibercept injection (Zaltrap):
    - 153.0 through 153.8 (Malignant neoplasm of colon), or
    - 154.0 (Malignant neoplasm of rectum, rectosigmoid junction and anus; rectosigmoid junction); or
    - 154.1 (Malignant neoplasm of rectum, rectosigmoid junction and anus; rectum); or
    - 154.8 (Malignant neoplasm of rectum, rectosigmoid junction and anus; other).

- Providers must bill ziv-aflibercept injection (Zaltrap) with HCPCS code J9999 (Not otherwise classified, antineoplastic drugs).

- Providers must indicate the number of HCPCS units. An entire single-dose vial of Zaltrap may be billed. **The amount wasted must not be reported to Medicaid**

or NCHC with the "JW" modifier, as this modifier is not recognized by either program and is not used by those programs in claims processing.

- One Medicaid unit of coverage is 25 mg. The maximum reimbursement rate per unit is $416.40.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units.
- The NDC units for Zaltrap should be reported as "ML." To bill for the entire 100 mg vial of Zaltrap, report the NDC units as "ML4." To bill for the entire 200 mg vial of Zaltrap, report the NDC units as "ML8."
- 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 January 2012, Special Bulletin, *National Drug Code Implementation Update,* on DMA's website at www.ncdhhs.gov/dma/bulletin/NDCSpecialBulletin.pdf for additional instructions.
- Providers shall bill their usual and customary charge.
- The fee schedule for the Physician's Drug Program is available on DMA's website at: www.ncdhhs.gov/dma/fee/.

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

Attention: Pharmacists and Prescribers

N.C. Medicaid and N.C. Health Choice Preferred Drug List Changes

Effective with date of service of **November 14, 2012,** the N.C. Division of Medical Assistance (DMA) will make changes to the N.C. Medicaid and N.C. Health Choice Preferred Drug List (PDL). Below are highlights of some of the changes that will occur:

- The prior authorization criteria will be removed from the statin drug class.
- Brand-named Nexium will become a non-preferred drug making the preferred drugs generics and over-the-counters in the proton pump inhibitor drug class.
- Norditropin products will become preferred and Genotropin products will become non-preferred in the growth hormone drug class.
- The use of only one preferred COPD agent will be required before moving to Daliresp.
- The oral beta-adrenergic products will be added as a new drug class.
- Generic budesonide 0.25mg/2ml and 0.5mg/2ml will become non-preferred generics and brand Pulmicort 0.25mg/2ml and 0.5mg/2ml will become preferred brands.

In addition to the changes listed above, effective with date of service **April 1, 2013**, the following change will occur:

- ProAir HFA will become a preferred short-acting beta-adrenergic bronchodilator and Ventolin HFA will become non-preferred.

In addition to the changes above, the preferred brands with non-preferred generic equivalents will be updated and are listed in the chart below:

Brand Name	Generic Name
Accolate	Zafirlukast
Actos	Pioglitazone
Actos Plus Met	Pioglitazone/Metformin
Alphagan P	Brimonidine
Aricept	Donepezil
Arixtra	Fondaparinux
Astelin/Astepro	Azelastine Hydrochloride
Benzaclin	Clindamycin/Benzoyl Peroxide
Derma-Smoothe-FS	Fluocinolone 0.01% Oil
Differin	Adapalene

Brand Name	Generic Name
Diovan HCT	Valsartan Hydrochlorothiazide
Dovonex Cream	Calcipotriene 0.005% Cream
Exelon	Rivastigmine
Felbatol	Felbamate
Kadian ER	Morphine Sulfate ER
Lovenox	Enoxaparin
Opana ER	Oxymorphone ER
Ovide	Malathion
Pulmicort 0.25mg/2ml, 0.5mg/2ml	Budesonide 0.25mg/2ml, 0.5mg/2ml
Uroxatral	Alfuzosin

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Pharmacists and Prescribers

Revised Prior Authorization Requirements for Leukotriene Modifiers

Effective with date of service of **November 14, 2012**, the N.C. Medicaid and N.C. Health Choice (NCHC) pharmacy programs will revise the Singulair prior authorization criteria. According to FDA guidelines, the age criteria for prevention of exercised-induced bronchoconstriction will be changed from 15 years of age and older to 6 years of age and older. Beneficiaries must have a documented failure on a short-acting bronchodilator during the last 12 months.

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

Outpatient Pharmacy
DMA, 919-855-4300

Attention: Pharmacists and Prescribers

New Prior Authorization Requirements for Incivek, Victrelis, Kalydeco, and Cialis

Effective with date of service **November 14, 2012**, the N.C. Medicaid and N.C. Health Choice (NCHC) pharmacy programs will begin requiring prior authorization (PA) for the following medications:

- Incivek and Victrelis: medications used to treat hepatitis C
- Kalydeco: medication used to treat Cystic Fibrosis
- Cialis: medication used to treat benign prostatic hyperplasia

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

Outpatient Pharmacy
DMA, 919-855-4300

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

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

Proposed Clinical Coverage Policies

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

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

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

2012 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
Nov.	11/1/12	11/6/12	11/7/12
	11/8/12	11/14/12	11/15/12
	11/15/12	11/21/12	11/22/12
	11/29/12	12/04/12	12/05/12
Dec.	12/06/12	12/11/12	12/12/12
	12/13/12	12/20/12	12/21/12

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

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

Melissa Robinson
Executive Director
HP Enterprise Services