



November 2013 Medicaid Bulletin

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Attention: All Providers

Receiving Email Alerts Through NCTracks

Note to Providers: This article was originally published in September 2013.

Providers can subscribe for email alerts through the NCTracks Provider Portal at www.nctracks.nc.gov/. Alerts are sent when there is important information to share between monthly issues of the Medicaid Provider Bulletin. Past email alerts have contained information on these topics:

- Checkwrite Schedule Updates
- Overriding Address Validation Error in Manage Change Request
- How to Update the NCID of an Existing Office Administrator
- Updates to the SkillPort Learning Management System
- Medicare Crossover Update
- Clarification on Roche Rebates for Durable Medical Equipment (DME) Supplies

To receive email alerts and other communications from NCTracks, visit this page <https://www.nctracks.nc.gov/content/public/providers/provider-announcements.html>. Then click on the “Sign up for NCTracks Communications” link under “Quick Links.” Providers who currently receive email alerts will continue to receive them through NCTracks. No other actions are required.

Email addresses will never be shared, sold or used for any purpose other than Medicaid and N.C. Health Choice (NCHC) email alerts and NCTracks communications.

CSC, 1-800-688-6696

Attention: All Providers

Medicare Crossover Update

On October 7, 2013, NCTracks implemented system logic to more precisely pay Medicare crossover claims in accordance with State law and the North Carolina State Plan approved by the Centers for Medicare and Medicaid Services (CMS) on a claim specific basis. The amount of payment is the difference in the amount paid by Medicare and the Medicaid Allowable amount up to the actual amount of the Medicare coinsurance, deductible or both.

This information applies to all secondary claims submitted to NCTracks, not just Medicare crossovers (with the exception of pharmacy). This includes institutional claims. Secondary claims previously paid will be reprocessed by February 15, 2014. No action is required by providers.

The Medicare crossover claim adjudication logic is as follows:

Medicaid Allowable minus Medicare Paid Amount equals the Net Medicaid Allowable. Next, the Net Medicaid Allowable is compared to the Medicare Coinsurance Amount and the lesser of the two is the amount payable by Medicaid.

The following examples illustrate this calculation:

	Example No. 1	Example No. 2
Total Billed Charges	159.00	159.00
Medicare Allowed Amount	100.34	80.26
Medicare Paid Amount	79.95	64.21
Medicare Contractual Adjustment	(58.66)	(78.74)
Medicare Coinsurance Amount	20.39	16.05
Medicaid Allowable	84.29	85.20
Medicare Paid Amount	(79.95)	(64.21)
Net Medicaid Allowable	4.34	20.99
Lesser of Medicare Coinsurance and Net Medicaid Allowable Amount	4.34	16.05

Please also note example 2 in [NCTracks Fact Sheet dated May 30, 2013](#). This bulletin is to further clarify the payment logic.

Although Medicare crossover claims have been processed based on logic that limited the Medicaid reimbursement to the “lesser of” the Medicare cost share amount (coinsurance,

deductible, or both) or the Medicaid allowable, the amounts paid to professional providers (i.e., submitted on claim form CMS 1500 or 837-P) may not be equal to the amount paid for claims processed on the prior Medicaid claims system administered by HP/EDS because it lacked the capability to perform such calculations on a claim specific basis. Instead, the prior Medicaid claims system included a “work around” that estimated the amount payable. In some cases, the “work around” paid more than the amount payable in accordance with State law and the North Carolina State Plan approved by CMS.

In addition, the prior Medicaid claims system made such payment determinations based on “header level” rather than a “detail level.” As a result of NCTracks processing claims based on the “detail level,” specific services that are not covered by Medicaid will be denied and not included in the payment calculation.

Medicare crossover claims previously processed by NCTracks with dates of service on and after July 1st will be reviewed and re-processed, if necessary, by February 15, 2014 to ensure that payment is made in accordance with State law and the North Carolina State Plan approved by CMS. No action is required by providers.

CSC, 1-800-688-6696

Attention: All Providers

NCTracks Tip of the Month: Batch Verify Recipient Eligibility

NCTracks has a helpful feature allowing providers to submit multiple eligibility inquiries in the secure Provider Portal at the same time. The feature is called “Batch Verify” and it is found on the Eligibility tab of the portal. Providers can create a spreadsheet (.csv) or text (.txt) file which list Recipient IDs and dates of service – using applications such as Microsoft Excel or Notepad – then upload the files to the portal. The information is submitted to the system and individual eligibility responses are immediately returned to the Batch Verify Results page. Up to 25 Recipient IDs can be submitted in one batch.

Providers can upload the list of recipients they plan to see on any day and check the eligibility of each one as they come into the office. The eligibility responses remain online until providers upload another batch. If providers see the same recipients regularly, they can keep the template and just update the dates of service.

Samples of the file formats are available on the Batch Verify page. The Help function also provides information to help providers take advantage of this feature of NCTracks.

Note: This functionality should not be confused with the X12 batch eligibility and claims submission, which requires providers or trading partners to test and certify with NCTracks before submitting claims. The Batch Eligibility Inquiry feature is available to all providers who have access to the secure NCTracks Provider Portal.

CSC, 1-800-688-6696

Attention: All Providers

NCTracks Common Questions and Issues

A regularly updated Issues List is available on the NCTracks provider portal at <https://www.nctracks.nc.gov/content/public/providers/nctracks-status-page.html>, reflecting the most common issues affecting providers.

Suspension Due to Reverification on Hold

In August 2013, CSC notified more than 12,000 providers of the requirement to verify their information on file. This is known as the Reverification Process in NCTracks. The letter provided 45 days for providers to submit verification documents through the Provider Portal. For these providers, the deadline was September 30, 2013. The letter stated that failure to respond to the verification requirements will result in the provider's suspension and termination from the program.

Given that providers may still have Manage Change Requests pending in the system, all suspensions and terminations related to Reverification are on hold until further notice.

Submitting Secondary Claims to NCTracks

A new User Guide has been developed to assist with filing secondary claims to NCTracks. No paper submission is required – secondary claims can be billed electronically to NCTracks, either on the portal or as a batch electronic claims transaction. The User Guide “How do I Indicate Other Payer Details or an Override on a Claim in NCTracks and Batch Submissions,” which is posted on the [Provider User Guides and Training page](#) of the Provider Portal, details step-by-step instructions for billing secondary claims to NCTracks.

Prior Approval for Synagis

Providers seeking information about prior approval of Synagis for the 2013-2014 season can go to www.documentforsafety.org. CSC does not process prior approval requests for Synagis and cannot provide information about the procedure or the status of a request. Forms faxed to CSC requesting coverage of Synagis will not be processed.

PA forms for Synagis should be sent to www.documentforsafety.org. Additional information can be found on page 18 of this bulletin.

Attention: Hospice Providers Who File Batch Electronic Claims

Some hospice providers who file batch electronic claims (837I) had previously been reporting Service Facility information in Loop 2310A Attending Provider information. HIPAA version 5010 does not allow for organizations (nursing facilities, hospitals, etc.) to be reported as an Attending Provider. Providers should be using Loop 2310E to report

Service Facility Location information. **As such, effective September 22, 2013, NCTracks no longer allows providers to report Service Facility information in Loop 2310A Attending Provider.**

Hospice providers are encouraged to contact their billing agent or clearinghouse to ensure that claims have Service Facility information in Loop 2310E of the 837I transactions submitted to NCTracks. Failure to do so may result in claim denials.

Providers are encouraged to watch for new announcements posted regularly to the NCTracks Provider Portal at <https://www.nctracks.nc.gov/content/public/providers.html>.

CSC and State Holiday Schedule

CSC and the State of North Carolina will observe the following holidays in November and December 2013:

Holiday	Days Observed
Veteran’s Day	STATE HOLIDAY ONLY: Monday, November 11
Thanksgiving Day	Thursday, November 28
Day after Thanksgiving	Friday, November 29
Christmas Eve	Tuesday, December 24
Christmas Day	Wednesday, December 25
Day after Christmas	STATE HOLIDAY ONLY: Thursday, December 26

Note: For claims received by November 29, there will be a checkwrite on December 3 with an Electronic Fund Transfer (EFT) effective date of December 4.

Checkwrite for the Week of Veteran's Day

Due to the Veteran's Day holiday on Monday, November 11, the checkwrite date that week will be delayed by one day. The posting and availability of funds to provider bank accounts will depend on the provider's financial institution. Wells Fargo customers should see their payments in their accounts on the day that the EFT is processed, which will be Thursday (11/14/2013). Providers who bank at other financial institutions should see payments the business day following the date that the EFT is processed, which will be Friday (11/15/2013) afternoon (some may post sooner.) The change is for this week only, per the published checkwrite schedules.

CSC, 1-800-688-6696

Attention: All Providers**New Medicaid Overview Computer-Based Training (CBT)**

A *Medicaid Overview* Computer-Based Training (CBT) course is now available. The training will give providers a brief overview of N.C. Medicaid, including an explanation of the roles various organizations and individuals play in ensuring the effective delivery of N.C. Medicaid Services.

The training will increase providers' understanding of:

- The N.C. Medicaid program
- The role of the N.C. Department of Health and Human Services (DHHS) in supporting beneficiaries of the N.C. Medicaid program
- The role of Computer Sciences Corporation (CSC) in administering enrollment for N.C. Medicaid program
- The role of Customer Service Representatives (CSR) in responding to provider inquiries/requests

The *Medicaid Overview* CBT is available in SkillPort by clicking on the "Training" button on the NCTracks secure Provider Portal, which is located at <https://www.nctracks.nc.gov/content/public/providers.html>.

Note: Providers must have an NCID to access the secure provider portal.

Updates to Skillport

The file structure of the SkillPort Learning Management System has been updated for ease of use. Separate folders are now available for Reference Documents – including Participant User Guides from the Instructor Led Trainings (ILT), "How to" User Guides, CBT courses and recordings of ILT sessions held prior to go-live. "How to" User Guides are also posted on the provider portal.

The "How to Register for Training in SkillPort" document has also been updated. To access it, visit the NCTracks Provider Training page at <https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training/provider-training.html> and click on "How to Register for Training in Skillport."

CSC, 1-800-688-6696

Attention: All Providers**NC Medicaid EHR Incentive Program – November 2013 Update
Troubleshooting NC-MIPS Log-in and Attestation Issues**

The NC Medicaid Electronic Health Record (EHR) Incentive Program Help Desk has seen a rise in N.C. Medicaid Incentive Payment System (NC-MIPS) log-in and attestation issues as more eligible professionals (EP) and eligible hospitals (EH) attest for EHR incentive payments.

In an effort to assist our providers, the NC Medicaid EHR Incentive Program has created a [Quick Reference Guide for NC Medicaid EHR Incentive Program Attestations](#) to identify solutions to the most common attestation errors. The reference guide also provides initial troubleshooting suggestions for those providers who are experiencing difficulty logging on to NC-MIPS.

Providers are urged to read the quick reference guide and the NC-MIPS Attestation User Guides prior to their attestation to avoid attestation and log-in errors. These documents can be found on the NC Medicaid EHR Incentive Program Website at www.ncdhhs.gov/dma/provider/ehr.htm and on the NC-MIPS attestation portal at <https://ncmips.nctracks.nc.gov/>.

Those having difficulty logging into NC-MIPS should check that they are using the same NCID username and password that they used when completing the NC-MIPS “First Time Account Set-up.” Providers must also check <https://ncid.nc.gov/> to ensure the username and password is valid. **When creating a “First-Time Account SetUp” with NC-MIPS make sure to use the same National Provider Identifier (NPI), social security number and the Centers for Medicare & Medicaid Services (CMS) registration ID used during CMS registration.**

Those experiencing problems logging on to NC-MIPS, or who are unable to create an NC-MIPS account using the ‘First Time Account Set-up,’ should email a screenshot with the error message received to NCMedicaid.HIT@dhhs.nc.gov.

To provide more effective and efficient service when emailing the NC Medicaid EHR Incentive Program Help Desk, provide the providers’ NPI, NCID, CMS Registration Number and a brief description of the situation.

**N.C. Medicaid EHR Incentive Program
DMA, NCMedicaid.HIT@dhhs.nc.gov (preferred), 919-814-0180**

Attention: All Providers**S**terilization Consent Form Requirements

Note to Providers: This article was originally published in July 2013.

The N.C. Division of Medical Assistance (DMA) has revised the requirements of the Sterilization Consent Form guidelines to coincide with the DMA's newly revised Sterilization Policy (1E-3). **As of July 1, 2013, DMA will require the following:**

1. A printed name **is acceptable** as a signature in all areas requiring signatures on the Sterilization Consent form for a sterilization procedure. This includes the areas of the Beneficiary Signature, Interpreter's Signature, Witness Signature, and Physician's Signature.
2. The provider obtaining consent must retain the original completed sterilization consent form in the beneficiary's health records. A copy of this consent form must be provided to the beneficiary. Copies should also be provided to the physician/provider conducting the procedure, the interpreter (if one is being used), and any other state agency or program requiring this documentation in addition to the copy sent to the fiscal agent. A copy should be retained at the service site where the consent is being obtained.
3. Use of a Signature stamp in lieu of signature **is not acceptable** for the **Interpreter's signature, the witness signature, or the physician's signature.**
4. Use of initials and/or abbreviations **is not acceptable** for the **first name** of the recipient, interpreter, witness, **or physician.**
5. Under the *Interpreter's Statement* in the Sterilization Policy, the wording of the attestation **must** be taken directly from the sterilization consent form.
6. If a provider receives a denial of the consent form from DMA's fiscal agent because an error was located in an area that can be changed, providers must **strikethrough the error once on the original consent, make the correction, and send a copy to the fiscal agent. The use of white out or erasures are prohibited.**
7. The Centers for Medicare & Medicaid Services (CMS) has revised the Sterilization Consent Form. Providers must use the consent form document located in the policy. **Consents dated October 1, 2013 and thereafter must be documented using the Sterilization Consent Form located in the policy. Consents signed on or after October 1, 2013 using the old form will be denied with an EOB that states "The consent form submitted is invalid. It is not the federally mandated form. Refer to DMA Clinical Coverage Policy 1E-3. This is not correctable."**

8. The new Sterilization Consent Form has an area documented as “RID” for “Recipient Identification Number.” This is formally known as the “MID” for “Medicaid Identification Number.” Document this area appropriately.
9. National Provider Identifier (NPI) is now required on each Sterilization Consent form. **This area is to be completed by the billing provider (surgeon) of the sterilization procedure.** Other providers can bill using the consent form on file from the billing provider (surgeon). When the NPI on the claim does not match the NPI on the consent, the claim pends in order to determine if ancillary service is appropriate for the consent procedure.
10. The Sterilization Consent form can be partially completed (with the exception of areas needing a signature and date) on the Sterilization Consent Form located at this Web page: www.ncdhhs.gov/dma/provider/forms.htm. The form can also be printed directly from the Website for additional copies of the form. **DMA’s fiscal agent will no longer be responsible for sending providers additional copies of the form.**

DMA’s revisions to The Sterilization Policy are effective immediately. The Sterilization Policy can be found at www.ncdhhs.gov/dma/mp/1E3.pdf.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

Hysterectomy Statement Form Requirements

Note to Providers: This article was originally published in July 2013.

The N.C. Division of Medical Assistance (DMA) revised the Hysterectomy Statement Form guidelines to ease the transition of DMA claims and statement processing from HP to NCTracks.

Effective August 1, 2013, DMA will require the following:

1. **Providers must place the entire Hysterectomy Statement Form on their letterhead so that all three statements are included on the form when submitting a statement for hysterectomies.**
2. Providers must add a title of “Hysterectomy Statement” above the form area before the actual statement information begins.
3. **Providers must add their National Provider Identifier (NPI) across from the RID (Recipient Identification Number - previously known as the MID or Medicaid Identification Number) for proper Hysterectomy Statement Form and claim matching. Hysterectomy Statement Forms filed without an NPI cannot be matched to the correct claim.**
4. Providers must complete only the hysterectomy statement area on the form that is applicable to their situation. The other two form areas can be left blank or can be completed with “N/A” for “Not applicable.”

The revised Hysterectomy Policy will be posted on August 1, 2013. A copy of the revised Hysterectomy Statement Form – which can be copied directly onto provider professional letterhead – will be located at DMA’s Website at www.ncdhhs.gov/dma/provider/forms.htm once the policy is posted.

Providers will begin receiving denials for using the incorrect form on November 1, 2013 for Hysterectomy Statement Forms signed on or after August 1, 2013. The old form will be denied as not correctable after that date. If corrections are needed to the new form, providers should follow the instructions in Section 5.3 of the Hysterectomy Policy, which can be found at www.ncdhhs.gov/dma/mp/1E1.pdf.

Clinical Policy and Programs
DMA, 919-855-4260

To: All Providers

The ‘Be Smart’ Family Planning Waiver Program’s Transition to a State Plan Amendment Has Been Delayed

Originally scheduled for November 1, 2013, the transition of the “Be Smart” Family Planning **Waiver** (FPW) to an amendment to the Medicaid State Plan (to be called the “Be Smart” Family Planning **Program**) has been delayed.

Despite the delay, the Family Planning Waiver will continue to operate with no interruption in service to its beneficiaries.

Providers are advised to continue to check every beneficiary’s Medicaid eligibility category at each visit. Providers and stakeholders will be notified when a new implementation date has been established. Additional information about the Family Planning Waiver can be obtained at:

www.ncdhhs.gov/dma/services/familyplanning.htm.

**Be Smart Family Planning Program
DMA, 919-855-4260**

Attention: Personal Care Services Providers

Personal Care Services (PCS) Program Highlights

Note: This article does not apply to providers billing for Personal Care Services (PCS) under the Community Alternatives Program (CAP) program.

Independent Assessment Entity Transition

N.C. Division of Medical Assistance (DMA) Clinical Coverage Policy 3L for PCS requires the following documentation for prior authorization:

1. An Activities of Daily Living assessment completed by an independent entity for all Medicaid beneficiaries; and
2. A pre-admission screening for serious mental illness completed by an independent entity for Medicaid beneficiaries residing in adult care homes.

Effective October 1, 2013, Liberty Healthcare–NC is the PCS independent assessment agent for DMA, replacing the Carolinas Center for Medical Excellence (CCME). Contact information for Liberty Healthcare–NC:

Address: Liberty Healthcare–NC, PCS Program
5540 Centerview Drive, Suite 114, Raleigh, NC 27606

Call Center Phone: 855-740-1400 or 919-322-5944

Fax: 484-434-1571 or 855-740-1600

**Independent Assessment
Email:** ncfax@libertyhealth.com

Providers with questions regarding the transition of the independent assessment agent can call 919-855-4340 or email PCS_Program_Questions@dhhs.nc.gov.

PCS Request for Services Form

Effective October 1, 2013, current PCS referral/request forms were consolidated into the **DMA 3051 PCS Request for Services Form**. This form replaced the New Referral Request forms, Change of Status forms, and Change of Provider forms. All PCS providers, irrespective of setting, must use the **DMA 3051 PCS Request for Services Form**. To access the form and instructions, visit www.ncdhhs.gov/dma/pcs/pas.html and click “Forms.”

With the implementation of DMA 3051, **the following forms were terminated effective October 31, 2013:**

- DMA 3041 New Referral Request Form – Home Care Agency
- DMA 3068 New Referral Request Form – Licensed Residential Facility

- DMA 3042 Change of Status Request Form – Home Care Agency
- DMA 3069 Change of Status Request Form – Licensed Residential Facility
- DMA 3043 Change of Provider Request Form – Home Care Agency
- DMA 3070 Change of Provider Request Form – Licensed Residential Facility

Providers with additional questions regarding these forms can call the PCS Program at 919-855-4340 or email PCS_Program_Questions@dhhs.nc.gov.

UPDATE: 2013 Session Law: Additional Safeguards for Medicaid PCS

A Medicaid beneficiary who meets the eligibility criteria of [S.L. 2013-306, s. 10.9F.\(c\)](#) is eligible for **up to 50 additional hours** of Medicaid PCS per month for a total of **up to 130 hours** per month in accordance with an assessment and a plan of care. The effective date of the new provision is dependent upon Centers for Medicare & Medicaid Services (CMS) approval of the State Plan Amendment (SPA). To request additional hours, a physician must complete and submit a DMA 3051 Request for Services form on the beneficiary's behalf. For more information, visit www.ncdhhs.gov/dma/pcs/pas.html.

SPA Submission

On September 30, 2013, the N.C. Department of Health and Human Services (DHHS) submitted a Medicaid SPA to CMS in order to implement the additional hours approved by N.C Session Law 2013-306. The SPA will include an effective date determined by CMS. The DHHS-DMA is requesting that CMS approve the effective date of October 1, 2013.

3L, Personal Care Services (PCS) Policy – 30 Day Public Comment

On October 16, 2013, Clinical Policy 3L, PCS, was posted for public comment on the *Proposed Medicaid and N.C. Health Choice Clinical Coverage Policies* Web page, located at www.ncdhhs.gov/dma/mpproposed/. The 30-day Public Comment Period will run through November 15, 2013.

Bridge Funding for .5600A and .5600C Group Homes

In accordance to [Session Law 2013-360](#) Section 12A.2A, the N.C. General Assembly has appropriated \$4.6 million in non-recurring funds to provide supplemental short-term assistance for beneficiaries living in group homes. DHHS will allocate funds through the Local Management Entities/Managed Care Organizations (LME/MCOs), which shall distribute monthly payments as directed in Session Law 2013-360.

For additional information on Bridge Funding for Group Homes, view the press release at www.ncdhhs.gov/mhddsas/updates/.

Upcoming Training

Visit the PCS Web page at www.ncdhhs.gov/dma/pcs/pas.html and click on “Trainings” to view all upcoming trainings. Additional plans for provider training and Webinars will be announced on the PCS Web page. Providers with questions regarding training can call 919-855-4340 or email PCS_Program_Questions@dhhs.nc.gov.

Personal Care Services (PCS) Program Contacts

To contact the PCS program, call 919-855-4340 or email PCS_Program_Questions@dhhs.nc.gov. For PCS updates and to access important links visit the PCS Web page at www.ncdhhs.gov/dma/pcs/pas.html.

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

Attention: Pharmacists, Prescribers and Physicians**P**rior Approval Request for Synagis for Respiratory Syncytial Virus (RSV) Season 2013/2014

Note to Providers: This article was originally published in October 2013

The clinical criteria used by N.C. Medicaid for the 2013/2014 RSV season are consistent with published guidelines in the *Red Book: 2012 Report of the Committee on Infectious Diseases, 29th Edition*. **Prior approval (PA) is required for Medicaid coverage of Synagis during the upcoming RSV season.** The coverage season is November 1, 2013 through March 31, 2014. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) criteria are considered for Synagis requests.

Submit all PA requests for coverage of Synagis for the upcoming season electronically at www.documentforsafety.org. The online Synagis Program will accept requests starting October 15, 2013. This Web-based tool is designed to capture all information for a PA request. When the system offers an opportunity to upload supporting documents, the most recent progress note documenting the patient's pulmonary or cardiac status is required when a specialist is involved in the care. The electronic system can automatically approve a request based on the criteria submitted and it allows a provider to self-monitor the status of a request pending medical review.

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

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

Maximum of Five Doses

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

CLD

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

HSCHD

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

Congenital Abnormalities of the Airway or Neuromuscular Disease

Infants born on or after November 2, 2012 with compromised handling of respiratory secretions secondary to congenital abnormalities of the airway or neuromuscular disease may be eligible for prophylaxis during the first year of life. The diagnosis to justify severe neuromuscular disease or congenital airway abnormalities must be specific.

Prematurity

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

- Born at an Estimated Gestational Age (EGA) of ≤ 28 weeks 6 days and Date of Birth (DOB) is on or after November 2, 2012
- Born at an EGA of 29 weeks 0 days to 31 weeks 6 days and DOB is on or after May 2, 2013

Five-Dose Exceptions

Coverage of Synagis for CLD and HSCHD will terminate when the beneficiary exceeds 24 months of age **and** has received a minimum of three doses during the season.

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

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

Infants meeting clinical criteria as follows may be approved for up to three doses of Synagis during the season:

Born at an *EGA* of 32 weeks 0 days to 34 weeks 6 days and DOB on or after August 2, 2013, with at least one of the two following defined risk factors:

1. Attends child care [defined as a home or facility where care is provided for any number of infants or young toddlers (toddler age is up to the third birthday)]. The name of the day care facility must be submitted with the request.
2. Has a sibling younger than five years of age living permanently in the same household. Multiple births do not qualify as fulfilling this risk factor.

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

- Positive RSV episode during the current season
- Repeated pneumonia
- Sickle cell
- Multiple birth with approved sibling
- Apnea or respiratory failure of newborn

Submitting a Request to Exceed Policy

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

Pharmacy Distributor Information

Synagis claims processing will begin on October 29, 2013, to allow sufficient time for pharmacies to provide Synagis by November 1, 2013. Payment of Synagis claims with date of service prior to October 29, 2013 and after March 31, 2014, will not be allowed. Point of sale claims should not be submitted by the pharmacy distributor prior to the first billable date of service for the season. Pharmacy providers should always indicate an accurate days' supply when submitting claims through NCTracks. Claims for Synagis doses that include multiple vial strengths must be submitted as a single compound-drug claim. Synagis doses that require multiple vial strengths that are submitted as individual claims will be subject to recoupment by DMA Program Integrity. Physicians and pharmacy providers are subject to audits of beneficiary records by DMA Program Integrity.

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

Provider Information

Providers without Internet access should contact the Medicaid Outpatient Pharmacy Program at 919-855-4300 to facilitate submission of a PA request for Synagis. More information about the Synagis program is found at www.documentforsafety.org.

Technical Support

Technical support can assist with provider registration, user name and password issues, beneficiary searches, and other registry functions. Technical support is available Monday to Friday from 8 a.m. to 5 p.m. by calling 1-855-272-6576 (local: 919-657-8843).

**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. If the adoption of a new or amended medical coverage policy is necessitated by an act of the General Assembly or a change in federal law, then the 45 and 15-day time periods shall instead be 30 and 10-day time periods.

2013 Checkwrite Schedule

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
November	11/01/13	11/05/13	11/06/13
	11/08/13	11/13/13	11/14/13*
	11/15/13	11/19/13	11/20/13
	11/22/13	11/26/13	11/27/13
	11/29/13	12/03/13	12/04/13
December	12/06/13	12/10/13	12/11/13
	12/13/13	12/17/13	12/18/13
	12/27/13	12/31/13	01/02/14

** Due to the Veteran's Day holiday on Monday, November 11, posting and availability of funds to provider bank accounts will depend on the provider's financial institution. Wells Fargo customers should see their payments in their accounts on the day that the EFT is processed, which will be Thursday (11/14/2013). Providers who bank at other financial institutions should see payments the business day following the date that the EFT is processed, which will be Friday (11/15/2013) afternoon (some may post sooner.)*

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.

Sandra Terrell, MS, RN
Acting Director
Division of Medical Assistance
Department of Health and Human Services

Paul Guthery
Executive Account Director
Computer Sciences Corp. (CSC)